CENTERS FOR MEDICARE & MEDICAID SERVICES AMENDED WAIVER LIST AND EXPENDITURE AUTHORITY

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

All requirements expressed in Medicaid and Children's Health Insurance Program (CHIP) laws, regulations and policies apply to this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. The waiver and expenditure authority provided to Oregon through this demonstration promote the objectives of title XIX. Such deviations from Medicaid requirements are limited in scope to expenditures related to the following populations affected by the demonstration:

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project. Under the authority of section 1115(a)(1) of the Act, the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan beginning with the approval of this demonstration amendment through June 30, 2017. When the state amends its Medicaid state plan to include some or all of these populations after that date, the state will submit an amendment to the demonstration updating the populations that will be affected by the demonstration.

1. Statewideness/Uniformity **Section 1902(a)(1)**
42 CFR 431.50

To enable the state to provide benefits through contracts with managed care entities that operate only in certain geographical areas of the state. (Applies to all Medicaid state plan populations listed in Attachment D.)

2. Amount, Duration and Scope of Services **Section 1902(a)(10)(A)**
1902(a)(10)(B)
42 CFR 440.230-250

To enable the state to offer different benefits for individuals whose eligibility is determined based on modified adjusted gross income (MAGI) (other than children 0-1 years of age and pregnant women and individuals enrolled in an alternative benefits package benefits) which are consistent with a prioritized list of conditions and treatments, subject to certain exceptions for protected benefits.

3. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) — **Section 1902(a)(10)(A) and 1902(a)(43)(C)**

To allow the state to restrict coverage for treatment services identified during an EPSDT screening for individuals above age 1 to the extent that such services are not consistent with a prioritized list of conditions and treatments. (Applies to all populations, except population 23.)

4. Retroactive Eligibility — **Section 1902(a)(34)**

To enable the state to not provide three months of retroactive coverage. (Applies to all Medicaid state populations, except 7 and 8, listed in Attachment D.)

5. Freedom of Choice — **Section 1902(a)(23)(A) 42 CFR 431.51**

To enable the state to restrict freedom-of-choice of provider by offering benefits only through managed care entities (and other insurers) in a manner not authorized by section 1932 of the Social Security Act (the Act) because beneficiaries may not have a choice of managed care entities. This does not authorize restricting freedom of choice of family planning providers. (Applies to all Medicaid state plan populations listed in Attachment D.)

6. Disproportionate Share Hospital (DSH) Reimbursements — **Section 1902(a)(13)(A)**

To the extent necessary to allow the state to not pay disproportionate share hospitals payments attributable to hospital services furnished to managed care enrollees. (Applies to all Medicaid state plan populations listed in Attachment D.)

7. Prepaid Ambulatory Health Plan Enrollment — **Section 1902(a)(4) as implemented in 42 CFR 438.56(c)**

To enable managed care entities to permit enrollees eligible through Medicaid or the CHIP state plan, a period of only 30 days after enrollment to disenroll without cause, instead of 90 days. (Applies to all Medicaid state plan populations listed in Attachment D.)

Title XIX - Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) the Act, expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX state plan.

1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in an MCO.

2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.

3. Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.

4. Designated State Health Programs (DSHP). Subject to the conditions outlined in paragraph 52 and as described in section IX, a limited amount of expenditures for approved designated state health programs (DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. This expenditure authority will not be renewed or extended after June 30, 2017.

5. Uncompensated Care for Tribal Health Facility Program: Expenditures for supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority for uncompensated care costs of primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in OHP. This support promotes the objectives of title XIX by increasing access to, stabilizing, and strengthening the Oregon tribal health system and improves health outcomes for Medicaid and low income populations utilizing these facilities.

6. Hospital Transformation Performance Program (HTPP): Beginning July 1, 2014, through June 30, 2017, expenditures for incentive payments to participating hospitals for adopting initiatives for quality improvement of the Oregon health care system and the measurement of that improvement. The expenditures are limited to $150 million total computable for each demonstration year. HTPP expenditures are further limited pursuant to Section XI.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan

AWARDEE: Oregon Health Authority

I. PREFACE

The following are the special terms and conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115 (a) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to these STCs are the Oregon Health Authority (formerly Oregon Department of Human Services) (state) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These amended STCs are effective January 1, 2014, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The amended STCs are effective January 1, 2014, through June 30, 2017, unless otherwise specified.

The STCs have been arranged into the following areas:

I. Preface
II. Program Description, Objectives, Historical Context;
III. General Program Requirements;
IV. The Oregon Health Plan;
V. Delivery System Transformation;
VI. Capitation Rates and Performance Measures;
VII. Measurement of Quality of Care and Access to Care;
VIII. Calculating the Impact of Health Systems Transformation and Reductions in Designated State Health Program Funding;
IX. Designated State Health Programs;
X. Tribal Health Program for Uncompensated Care;
XI. Hospital Transformation Performance Program;
XII. General Reporting Requirements;
XIII. General Financial Requirements for Title XIX;
XIV. Monitoring Budget Neutrality for the demonstration;
XV. Evaluation of the demonstration; and
XVI. Additional attachments have been included to provide supplementary information and guidance for specific STCs.
1. Attachment A: Quarterly Report Guidelines
2. Attachment B: Evaluation Guidelines
3. Attachment C: Glossary of Terms
4. Attachment D: Summary Chart of Demonstration Populations

5. Attachment E: Menu Set of Quality Improvement in Focus Areas
6. Attachment F: CCO Services Inventory
7. Attachment G: DSHP Claiming and Documentation Protocols
8. Attachment H: Calculating the Impact of Health Systems Transformation
9. Attachment I: Tribal Health Program for Uncompensated Care Claiming Protocol
10. Attachment J: Hospital Metrics and Incentive Payment Protocol

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan (OHP) is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. OHP began in phases on February 1994. Phase I of the Medicaid demonstration Project started on February 1, 1994. Originally, the demonstration affected Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II added the aged, blind, disabled, and children in state custody/foster-care.

Objectives

Under the demonstration, Oregon strives to promote the objectives of title XIX by:

- Providing a basic benefit package;
- Insuring broad participation by health care providers;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Structuring benefits (what is covered), using a prioritized list of health care conditions and treatments.
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing the per capita costs of care for populations through such improvements.

- Providing financial support in the form of uncompensated care payments to Indian Health Service (IHS) or tribal health facilities operating under the ISDEAA 638 authority for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan). This support will increase access to, stabilize, and strengthen the Oregon tribal health system and improve health outcomes for Medicaid and low income populations utilizing these facilities.

Historical Context: Demonstration Extensions and Amendments

<u>1994 Initial Demonstration Approval</u>
CMS initially approved the Oregon Health Plan (OHP) section 1115 demonstration for a five-year period beginning February 1, 1994. Oregon sought to expand eligibility and manage costs

by using managed care and a Prioritized List of Health Services. This list is updated every 2 (two) years, whereby services are added, deleted, or moved to a different ranking within the list.

1998 Demonstration Extension
The OHP was extended by CMS for a 3 (three) year period through 2001.

2002 Demonstration Extension and Amendment
CMS approved Oregon's application to extend and amend OHP to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration for 5 (five) years through 2007. With this approval, Oregon was able to expand the demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

2005 Demonstration Amendment
CMS approved a demonstration amendment that changed coverage under the demonstration which placed a new emphasis on preventive care and chronic disease management in the recognition that the utilization of these services can lead to a reduction in more expensive and often less effective treatments provided in the crises stages of a disease.

2007 Demonstration Extension
CMS revised the structure of the populations within the demonstrations to reflect updated law and CMS policy. Uninsured adults not eligible for Medicaid or CHIP were removed from the title XXI expansion populations and moved into title XIX expansion populations. In addition, title XXI targeted low-income children (TLIC) in Oregon from ages 0 through 5 years with incomes from 133 percent to 185 percent of the FPL and ages 6 through 18 with incomes from 100 percent up to 185 percent of FPL, were made eligible under the CHIP state plan regardless of whether the child opts for CHIP direct state plan coverage (OHP Plus) or premium assistance (Family Health Insurance Assistance Program/FHIAP). In addition, it was clarified that mandatory pregnant women and children 0 to 1 year of age receive full Medicaid state plan benefits, subject to necessary pre-authorizations.

2009 Demonstration Extension and Amendment
CMS approved an amendment to the demonstration that restructured and expanded coverage for children through the "Healthy Kids," initiative. Healthy Kids provides coverage through its various components for otherwise uninsured children through age 18 in the state with family incomes from 0 up to and including 300 percent of FPL. The state also provides access to coverage for children above 300 percent of FPL, but does not receive FFP for this population. Healthy Kids includes four different program components: 1) Existing CHIP direct coverage (OHP Plus), 2) premium assistance through FHIAP, 3) Child-only premium assistance administered by the Office of Private Health Partnerships (Healthy Kids ESI), and 4) A private insurance component (Healthy KidsConnect). Through Healthy Kids, children from 0 up to and including 200 percent of the FPL have the choice between title XXI CHIP direct coverage, premium assistance through FHIAP, or Healthy Kids ESI. Children from above 200 up to and including 300 percent of the FPL have the choice between Healthy Kids ESI or coverage under Healthy KidsConnect.

In addition, the last CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed the methodology for use of a 'reservation list" to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance program; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

2012 Demonstration Amendment
As reflected in these STCs, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and a reduction of other benefits (reflected in 13 lines of the Prioritized List of Health Services for FFY12-13). This amendment is effective January 1, 2012.

2012 Demonstration Extension and Amendment
In July 2012, CMS approved an amendment and extension related to Oregon's Health System Transformation

The amendment and extension of OHP seeks to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve a three-part aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The design and implementation of the Oregon demonstration will be driven locally; overall, the amended 1115 demonstration seeks to achieve two equally important and inter-related goals:

- **Goal 1: Medicaid Statewide Spending Growth Reduction.** The demonstration will bend the Medicaid cost curve to achieve a 2 percentage point reduction in Medicaid per capita trend by June 30, 2015 of the demonstration. Progress toward and ultimate achievement of this goal will be measured by reviewing the state and federal cost of purchasing care for individuals enrolled in Coordinated Care Organizations (CCOs).

- **Goal 2: Improving Statewide Care Quality and Access.** Oregon Medicaid beneficiaries will experience improved access to care and quality of care over the five-year program period of July 2012 – June 2017, compared to a baseline level of performance.

The demonstration authorizes expenditures on certain Designated State Health Programs (DSHP), and in order to align incentives and support progress, if demonstration goals are not realized after interventions have been pursued to reorient progress, CMS will reduce DSHP funding as described in Section VIII.

Oregon seeks to achieve these goals without any diminution of eligibility or benefits. Instead, the state will pursue several different approaches, or "levers" to drive savings and quality improvement:

- Lever 1: Improved care management experienced by beneficiaries in CCOs
- Lever 2: Administrative efficiencies in CCOs
- Lever 3: Integration of physical and behavioral health for beneficiaries in CCOs
- Lever 4: Improved care coordination experienced by beneficiaries aligned with patient-centered primary care homes (PCPCH)
- Lever 5: Use of flexible services

Oregon plans to realize these goals through better care management, increased provider and community accountability, payment reform, administrative efficiencies, use of flexible services, promoting the provision of services by nontraditional health workers, and expanding access through improvements to the state's health care workforce.

2013 Demonstration Amendment

In October 2013, CMS approved an amendment to add tribal health programs supplemental primary care payments to the demonstration. The amendment allows the state to make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority: 1) for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) to pay for uncompensated care costs resulting from primary care services on the prioritized list provided to individuals not enrolled in Medicaid, Medicare, CHIP or other coverage who have incomes up to 133 percent of the Federal Poverty Level (FPL).

2014 Amendment

In December 2013, CMS approved amendments to align eligibility, populations, and benefits in the demonstration with provisions in the Affordable Care Act. The amendments reflect that the state has opted to expand Medicaid to adults under the Medicaid state plan, consolidates populations who will be covered under the Medicaid state plan, removes references to populations that will be covered by the title XXI CHIP state plan, and provides a uniform benefits package to all demonstration populations. Individuals who had previously been covered through the demonstration through either OHP-Standard or premium assistance will be covered through an Alternative Benefits Plan or referred to the state-based exchange for coverage on the Marketplace.

Additionally, CMS has approved a one-year extension of uncompensated care payments to IHS or tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority. Beginning January 1, 2014, through December 31, 2014, the state shall only make supplemental payments to these facilities for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for all populations enrolled in Medicaid (Oregon Health Plan).

2015 Amendment
CMS has approved another extension of the uncompensated care payments to IHS or tribal health facilities operating under the ISDEAA 638 authority. This program will operate through the remaining demonstration period of June 30, 2017.

2016 Amendment
CMS has approved an extension of the HTPP for one year, from July 1, 2016 through June 30, 2017.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the date such state legislation becomes effective, or the date such legislation was required to be in effect under federal law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, reservation list, sources of non-federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in the these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, required reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. Consistent with Oregon's community-focused health systems transformation approach, the state shall undertake a robust public process to ensure community engagement in the development and submission of amendments to the demonstration. Amendment requests must include, but are not limited to, the following:

    a. *Public Notice.* The state does not need to comply with the state public notice and comment process outlined in 42 CFR §431.408 until such time that CMS issues policy guidance to the contrary. However CMS encourages the state to do so in the event it seeks to amend the demonstration that modifies benefits, cost sharing, eligibility, or delivery system changes. CMS will post and accept public comments on all amendments.

    b. *Tribal Consultation.* The state must provide documentation of the state's compliance with the tribal consultation requirements outlined in STC 15. Such documentation shall include a summary of the tribal comments and identification of proposal adjustments made to the amendment request due to the tribal input;

    c. *Demonstration Amendment Summary and Objectives.* The state must provide a detailed description of the amendment, including what the state intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient

supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary;

d. *Waiver and Expenditure Authorities.* The state must provide a list waivers and expenditure authorities that are being requested or terminated, along with the reason, need and the citation along with the programmatic description of the waivers and expenditure authorities that are being requested for the amendment;

e. *A budget neutrality data analysis worksheet*. The state must provide a worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement, including the underlying spreadsheet calculation formulas. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group, or feature) the impact of the amendment;

f. *An allotment neutrality worksheet.* The state must provide an up-to-date CHIP (title XXI funding) allotment neutrality worksheet, if title XXI funds or populations are included in the demonstration; and

g. *Updates to existing demonstration reporting, quality and evaluation plans.* A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

    a. Compliance with Transparency Requirements at 42 CFR §431.412(c). As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements at 42 CFR §431.408 and 412 and the public notice and tribal consultation requirements outlined in STC 15.

    b. Temporary Extension of Demonstration. Upon application from the state or CMS determination that a temporary extension of the demonstration is necessary, CMS will temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Demonstration Transition and Phase-Out.** The state may only suspend or terminate this

demonstration in whole, or in part, consistent with the following requirements.

a. *Notification of Suspension or Termination*. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

b. *Transition and Phase-out Plan*. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c. *Transition and Phase-out Plan Requirements*. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available.

d. *Phase-out Procedures*. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

e. *Exemption from Public Notice Procedures 42.CFR Section 431.416(g).* CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

f. *Federal Financial Participation (FFP*. If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. Expiring Demonstration Authority and Transition. For demonstration authority that expires prior to the overall demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. *Expiration Requirements*. The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. *Expiration Procedures*. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

c. *Federal Public Notice.* CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR §431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. *Federal Financial Participation (FFP).* FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

11. CMS Right to Amend, Terminate or Suspend. CMS may amend, suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7 are proposed by the state.

    a. *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations*. In states with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    b. *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments*. In states with Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

    c. *Public Notice*. The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.
17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** Section 1903(r) of the Act requires that all states with Medicaid programs have approved mechanized claims processing and information retrieval systems that are compatible with claims processing and information retrieval systems used in the administration of Title XVIII of the Act. Those compatibility requirements include: 1) a uniform identification coding system for providers, other payees, and beneficiaries under Titles XVIII and XIX; 2) provisions for liaison between states and carriers and intermediaries with agreements under Title XVIII to facilitate timely exchange of appropriate data; 3) provisions for exchange of data between the states and the Secretary with respect to persons sanctioned under Titles XVIII or XIX; and 4) incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary . Additionally, effective for claims filed on or after January 1, 1999, a State's mechanized claims processing and information retrieval system will provide electronic transmission of claims data in the format specified by the Secretary and consistent with the MSIS (Medicaid Statistical Information System) including detailed individual enrollee encounter data and other information that the Secretary may find necessary. The claims data format for MSIS electronic transmission is specified in the State Medicaid Manual, Part 2, Section 2700 as may be updated by the Secretary from time to time. CMS released a letter to State Medicaid Directors on August 23, 2013, that discusses upcoming changes to the Medicaid Statistical Information System (MSIS), which will be known as Transformed MSIS or T-MSIS. CMS is implementing T-MSIS with states on a rolling basis, with the goal of having all states submitting data monthly by July 1, 2014. For more information, please refer to the letter, which is available online at http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html.

IV. THE OREGON HEALTH PLAN

18. **Overview of the Oregon Health Plan (OHP).** OHP provides health care coverage to low-income Oregonians through programs administered by the Division of Medical Assistance Programs (DMAP). Beginning January 1, 2014, all individuals eligible under the Medicaid state plan, including those eligible through mandatory and optional groups, will receive either the OHP-Plus benefit plan or the Alternative Benefits Plan approved in the Medicaid state plan, except that individuals eligible through the Breast and Cervical Cancer Treatment Program will receive full state plan benefits.

    a. **ACA Implementation.** Upon implementation of the ACA expansion to adults with incomes under 133 percent of the FPL on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII); benefits; and cost sharing will revert to the Medicaid state plan and comply with Medicaid regulatory and subregulatory guidance. Benefits under the Oregon Health Plan demonstration will include the provision of Essential Health Benefits identified in the Medicaid/CHIP state plan.

b. **OHP Populations.** The state will provide health care coverage through the OHP programs defined within these special terms and conditions (STCs) to the Medicaid mandatory and optional groups under the Oregon state plans, as defined in the "**Summary Chart of Demonstration Populations"** (Attachment D).

c. **Applicability of Medicaid Laws and Regulations.** All requirements expressed in Medicaid laws, regulations and policies apply to all the populations affected by this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration

d. **Summary of OHP Benefit Structure.** The Oregon Health Plan demonstration has two components, two offered directly through OHP Plus and the Alternative Benefits Plan. Most beneficiaries under either program receive services through managed/coordinated care delivery systems.

All beneficiaries other than low-income expansion adults (Population 23) and individuals eligible through the Breast and Cervical Cancer Treatment Program receive the OHP Plus benefit (populations 1, 3, 5, 6, 7, 8 and 21 in Attachment D) which consists of:

i. All benefits covered under the approved state plan that are also included on the prioritized list of health services (described in e. below);

ii. For children younger than 21 years old, all state plan and EPSDT covered services;

iii. For pregnant women, the entire Medicaid state plan Services Benefit Package, subject to necessary pre-authorization for services not in the prioritized list.

iv. Services of non-traditional health workers (see h. below);

v. Services of person centered primary care homes (see i. below); and

vi. The following Medicaid benefits to the extent otherwise provided under the state plan:

1. Mental Health Facility – DSH Adjustment Payments;
2. Long Term Care Services;

a. Nursing Facility Services
b. Home- and Community-Based Services
c. Community Supported Living Services

d. Programs of All-Inclusive Care Elderly

3. ICF/MR Services; and
4. Medicare Premium Payments and Medicare cost sharing.

e. **Prioritized List of Health Services.** One of the distinguishing features of the OHP demonstration is that OHP Plus benefits are based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services.

f. **Oversight -- The Health Evidence Review Commission (HERC)** - The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Office for Oregon Health Policy and Research. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse. The Health Evidence Review Commission performs a biennial review of the Prioritized List and will amend the List as required.

g. **Modifications to the Prioritized List**. Modifications to the Prioritized List require federal approval through submission of an amendment, as described in paragraph 7 in order to ensure the Prioritized List is comprehensive enough to provide Medicaid beneficiaries with an appropriate benefit package. A current version of the prioritized list of health services is maintained by the state of Oregon at the following website: http://www.oregon.gov/OHA/OHPR/HERC/Current-Prioritized-List.shtml. During the demonstration period and as specified below the state will not reduce benefits.

h. **Ordering of the Prioritized List.** The Prioritized List is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g. common colds); (b) are primarily cosmetic in nature (e.g. benign skin lesions); or (c) have no effective treatments available (e.g. metastatic cancers).

i. **Updating the Prioritized List**. The Commission is charged with updating the list for every biennial legislative session. The Oregon State Legislature determines how much of the list to cover (subject to federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.

j. **Non-covered Condition and Treatment Pairs**. In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

k. The state must adopt policies that will ensure that before denying coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the prioritized list of health services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, providers will be instructed to provide the specified treatment. The state shall provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

l. **Funding Line for the "2012-2013" Prioritized List of Health Services.**

i. Beginning January 1, 2012, the 2012-2013 Prioritized List of Health Services contains 692 lines. Lines 1-498 are funded to provide the OHP Plus and Standard benefit packages.

ii. The 2012-2013 Prioritized List will stay in effect until December 31, 2014.

iii. Beginning January 1, 2015, the 2014-2015 Prioritized List of Health Services will go into effect and will change the line number, structure and composition as a result of the biennial review conducted in anticipation of the conversion to ICD-10-CM. As implementation of ICD-10-CM was delayed, ICD-9-CM codes have been added back into the 2014-15 List to the best of the state's ability. As of the date of ICD-10-CM implementation, only ICD-10-CM codes will remain on the list. The state will maintain the funding line at the same position relative to the 2012-2013 List (currently between Chronic Sinusitis and Keratoconjunctivitis and Corneal Neovascularization) on the 2014-2015 List and for the remainder of the demonstration.

m. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

i. The state will maintain the cutoff point for coverage at the same position on the List relative to the 2012-2013 List for the remainder of the demonstration as noted above in subparagraph (g). For a legislatively directed line change to increase benefit coverage or a legislatively approved biennial list with substantive updating

of benefits due to new evidence, an amendment request (in compliance with paragraph 7) will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in Section XIV.

ii. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.

iii. For a change to the list not defined above that meets the terms of paragraph 6, an amendment request.

n. **Non Traditional Health Workers (NTHW).** NTHWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and doulas. NTHWs may serve individuals currently enrolled in Managed Care Entities (MCEs), and/or through the state's FFS delivery system.

o. **Patient Centered Primary Care Homes (PCPCH):** The state includes PCPCH services in the OHP Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement and obtaining agreement to participate. The state will work with CCOs to provide the enrollee with notice that s/he has been enrolled in a PCPCH. In addition this notice will provide the participant with information informing them of their right to opt out.

p. **Cost Sharing under OHP Plus**

i. For OHP Plus, individuals may be liable for nominal copayments. No copayment liability will be imposed on pregnant women or children under the age of 19.
ii. The approved copayments are included in the Title XIX state plan.
iii. Oregon uses the state plan amendment process to make changes to its OHP Plus copayment policies.

19. **Alternative Benefits Plan.** The mandatory state plan group, new adult group (Population 23 in Attachment D), will receive a benefits package provided through the state's approved alternative benefit plan (ABP) in the Medicaid state plan. The approved ABP includes at least all essential health benefits as defined using the required process, and other benefits that

are both: 1) covered in accordance with the traditional benefit package under the approved state plan and 2) included on the state's prioritized list, as approved by the Secretary.

20. **Breast and Cervical Cancer Treatment Program (BCCTP)**

a. The Breast and Cervical Cancer Treatment Program (BCCTP), formerly known as BCCM, provides medical assistance to women under the age of 65 who have been screened and diagnosed through the Breast and Cervical Cancer Treatment Program (BCCTP) and found to need treatment for breast or cervical cancer, or specific precancerous conditions, and are receiving such treatment. Such individuals are uninsured or underinsured with respect to necessary treatment.

b. Women determined to be eligible for BCCTP (population 21 in Attachment D) will be enrolled on the Oregon Health Plan for the duration of their treatment.

c. BCCTP Presumptive Eligibility

i. Any licensed health care provider qualified to diagnose cancer or pre-cancerous conditions can determine presumptive eligibility under the BCCTP.
ii. Presumptive eligibility provides immediate, temporary coverage for women who appear to meet basic eligibility criteria.
iii. Presumptive coverage lasts approximately a month before full determination of coverage through OHP.

d. Eligible individuals remain eligible for a period of 12 months. At the end of the 12 months:

i. A redetermination application is sent to the client;
ii. The client's provider verifies if patient still requires treatment and submits verification to OHP;
iii. If the client still needs treatment, coverage is extended for additional year;
iv. Not have creditable health insurance to cover her treatment; and
v. Be in need of treatment for breast or cervical cancer, including qualifying precancerous conditions.

V. DELIVERY SYSTEM TRANFORMATION

Description of the pre-Health System Transformation Managed Care Delivery System

21. **Pre-Health System Transformation Delivery Systems for OHP Plus and OHP Standard.** The majority of health care services under OHP Plus and OHP Standard are provided through a managed care delivery system. The managed care entities (MCEs) coordinate health care systems, including pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and comprehensive or targeted management of health services. The managed care services have been delivered through the entities in Table 1. Once the health

system transformation has been fully implemented the current managed care providers will be replaced by the Coordinated Care Organizations.

Table 1. Existing Care Delivery Systems

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Fully Capitated Health Plan (FCHP) (a managed care entity)	An organization contracted to provide physical health services and chemical dependency treatment services, including inpatient hospitalization. Oregon contracts with FCHPs throughout the state to provide health care services to Oregon Health Plan members.	FCHP contract ends if the FCHP reorganizes as a CCO in a particular service area.	No new FCHP contracts after July 1, 2014.
Physician Care Organization (PCOs) (a managed care entity)	An organization contracted to provide physical health services, excluding payment for inpatient hospitalization.	The two PCO contracts will end if they join a CCO in the PCO service areas.	No new PCO contracts after July 1, 2014.
Mental Health Organizations (MHOs) – (a managed care entity)	An organization contracted to provide outpatient and acute inpatient mental health services. Mental Health services are provided by stand-alone organizations that specialize in such services and are paid on a capitated rate basis	MHO contract ends if the MHO reorganizes as, or joins, a CCO in a particular service area. MHOs will continue to serve enrollees currently FFS for physical health care until 11/1/12. After that date, MHO contracts will end.	No new MHO contracts after July 1, 2014.
Dental Care Organizations (DCOs) – (a managed care entity)	An organization contracted to provide dental services, including preventive care, restoration of fillings, and repair of dentures. Dental services are contracted on a stand-alone basis through a DCO and are paid on a capitated rate basis to provide services to OHP members	CCOs will contract with DCOs in the CCO service area, but DCOs must be integrated into CCOs by July 1, 2014.	CCO/DCO contracts will be executed by July 1, 2014.

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Primary Care Manager (PCM)	A physician or other OHP approved medical provider responsible for providing primary care and maintaining the continuity of care, supervising and coordinating care to patients, initiating referrals to consultants and specialist care. PCMs are not under contract with a managed care organization; they provide health care services through a FFS system, and receive a nominal management fee on a per member per month basis. Compensation to PCMs for direct services is non-risk based and in accordance with the state plan.	Some PCMs will continue to exist for the small FFS population remaining. The state will be working with PCMs to meet PCPCH requirements.	Ongoing and parallel to CCO timelines.
Fee-For-Service/ Open Card	The OHP participants may also receive services through the fee-for-services delivery system. The OHP participant that receives service through FFS may be served through a PCPCH.	FFS open card will be maintained only for small number of exempted or excluded populations or those outside CCO service areas.	Ongoing
Patient Centered Primary Care Homes (PCPCH)	The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services.	The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system.	Ongoing Transition over 3-5 years as more PCPCHs become certified

Health System Transformation Transition

22. The state will transform its delivery system through a shift to the delivery of care from current specialized MCEs to Coordinated Care Organizations (CCOs) beginning in August

2012. Initially, CCOs will be required to provide both medical and behavioral health services (formerly provided under different MCEs). Dental services must be merged into the CCO by July 2014. The state's contracting with the CCO will result in the phase out of new Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), and Mental Health Organization (MHO) contracts by July 1, 2014 and CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. The CCOs initially will be phased into the delivery system over four monthly cycles (or "waves") beginning in August 2012 and ending in November 2012.

a. Transition of OHP Populations to CCOs

i. Existing enrollees of an MCE that has transitioned to a CCO will be given a 30 day notice and transitioned (rolled over) to the new CCO when certification and contracting is complete. This roll over will include currently enrolled tribal members and dual eligibles, who will be able to opt-out if they wish. Existing members who are receiving services from out-of-area or non-participating providers will be moved to a CCO when their MCE transitions. For these members, the CCO will be expected to cover out-of-network or non-participating provider services authorized by the member's care team, Medical Director of the MCO or the Medical Director of the Division of Medical Assistance Programs, for a transitional period until the CCO establishes a relationship with the member and is able to develop a medically appropriate care plan.

1. An MCO transitioning to become a CCO in any of the four initial contracting waves will retain its existing enrollees and those enrollees will be transitioned (rolled over) to the new CCO when certification and contracting is complete.

2. For an MCO not transitioning to become a CCO in any one of the four waves, enrollment of existing members will continue in the plan until the member chooses another plan as described below, or until the OHA determines on a case-by-case basis that members should be transitioned to other plans serving the geographic area.

ii. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.

1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.

2. All existing MCEs from Table 1 in paragraph 21 will be closed to new enrollment once sufficient capacity is determined to exist in the CCO(s) serving the area. If CCOs do not have sufficient capacity, new members may be enrolled only in MCOs on the path to becoming a CCO in one of the four waves until capacity in those plans is reached, then can be enrolled in any remaining MCOs.

iii. Individuals who are currently in FFS for physical health, other than dual eligibles and tribal members, will receive a 30 day notice and be required to enroll in CCOs by November 1, 2012 where sufficient capacity exists, and will be given their choice of plan.

1. Members not choosing a plan will be auto-assigned to a plan through an auto-enrollment process.

2. For members who are enrolled in an MHO for mental health services but otherwise receive physical health services through fee for service, if a CCO becomes operational in their area prior to November 1st, their mental health coverage will be through that CCO until they are enrolled in a CCO for both physical and mental health services in November.

iv. Tribal members and dually eligible individuals are both populations that must make an affirmative voluntary choice for CCO (and existing MCE) enrollment (i.e., cannot be auto-enrolled).

v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.

vi. OHA is planning member transition strategies for FFS members with special considerations:

1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:

- Care management requirements based on the beneficiary's medical condition;
- Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations;
- Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services);
- Availability of medically appropriate medications under the CCO formulary; and
- Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team.

2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.

Description of Delivery System Transformation

23. **Definition and Role of Coordinated Care Organizations**. CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the state. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR Part 438 unless a requirement has been specifically identified in the waiver authorities for this demonstration. CCOs will provide a governance structure to align the specialized MCE services under one managed care organization. CCOs will partner with OHA to further the state's implementation of PCPCH and utilization of Non-Traditional Health Workers (NTHWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

a. **CCO Criteria**. The CCOs are required to meet the following criteria:

i. **Governance and Organizational Relationships.**

1. Governance. Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see 2 below); and at least two members from the community at large to ensure that the organizations decision making is consistent with the community members' values.

2. Community Advisory Council (CAC). The CCOs are required to convene a CAC that include representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be ongoing bodies and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.

3. Clinical Advisory Panel. The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.

4. Partnerships. The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees

and with county health departments and other publicly funded providers for certain point-of-contact services.

5. Community Health Needs Assessment. Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The state encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

b. **CCO quality and access measurement.** CCOs will be accountable for metrics for quality and access as described in Section VII and Attachment E, including measures to track progress in the quality improvement focus areas, measures to track quality broadly, and measures to track access. Specific measures, timeframes, and CCO reporting requirements will be determined by the state and approved by CMS during the supplemental 120-day planning period.

i. Menu-set of CCO quality improvement focus areas. OHA will ensure that each CCO will commit to improving care in at least 4 of the following 7 focus areas, which have the significant potential for achieving the demonstration's goals of improving the patient experience of care, improving population health, and reducing per capita Medicaid expenditure trend. Three of these four projects may serve as a CCO's Performance Improvement Projects in accordance with 42 CFR 438.358 and 438.240. Attachment E provides further details on each of these focus areas. The state and CCOs may add to this menu of focus areas but should review Attachment E and provide a similar level of detail for anything not on the list below. The state will incorporate the PIP requirements into its CCO/MCE contracts within 120 days of the approval of the demonstration

1. Reducing preventable rehospitalizations.
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by "super-utilizers".
4. Integrating primary care and behavioral health.
5. Ensuring appropriate care is delivered in appropriate settings
6. Improving perinatal and maternity care
7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home model of care throughout the CCO network.

c. **Health Information Technology (Health IT).** The CCOs are directed to use HIT to link services and core providers across the continuum of care to the greatest extent possible. The CCOs are expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

i. Health IT:

1. CCOs must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the state's health information exchanges. If providers do not currently have this technology, there must be a plan in place for adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

2. In order for CCOs to fully realize years 2-3 performance incentives, the state must require that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The related incentives must take into account the costs incurred in order to facilitate adoption and meaningful use of EHRs, as well as the existing incentives available to eligible providers.

3. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. The state must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

4. All requirements must also align with Oregon's state Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

d. **Innovator Agents and Learning Collaboratives**. State shall utilize innovator agents to act as a single point of contact between the CCO and the Oregon Health Authority. Innovator agents will be assigned to each contracted CCO by January 15, 2013. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the demonstration's goals of improving quality and access while managing costs, within 120 days from the approval of the demonstration amendment the state will:

i. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.

ii. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as underperforming (as described above), the state will plan and execute intensified innovator/learning collaborative interventions.

iii. The information in (a) and (b) above will be incorporated into the CCO contracts by amendment.

24. **Alternate Delivery System**. The FFS delivery system applicable to some demonstration populations will continue under the health system transformation.

25. **Patient Rights and Responsibilities, Engagement and Choice.** The CCO is responsible for ensuring that its enrollee receives integrated person-centered care and services designed to provide choice, independence and dignity.

26. **Compliance with Managed Care Requirements.** The state must meet the requirements of 42 CFR Part 438 unless a requirement of part 438 has been identified in the waiver authorities for this demonstration.

27. **Managed Care Enrollment, Disenrollment, Opt Out and Transitions**

    a. **Mandatory Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive benefits pursuant to Sections –IV and V of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to 12 months. The Table below illustrates the mandatory and affirmative choice (i.e., "opt-in") populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given[1]
1, 3, 5, 6, 7, and 8	Individuals of the identified populations other than those footnoted. [2]	Mandatory; current FFS enrollees not transitioned for physical health until November 2012	Other CCO if available; MCO if no CCO in area; FFS with cause
21	Breast and Cervical Cancer Treatment Program Income: Up to 250% FPL Resource Limit: None	Not enrolled until November 2012, then Mandatory	Other CCO if available; MCO if no CCO in area; FFS with cause

[1] See (b) below for more information on disenrollment/plan change options and timelines.

[2] Exceptions include individuals who are: dually eligible for Medicare and Medicaid, American Indian or Alaska Native who are permitted to enroll, but not mandatorily enrolled. Current MCO enrollees will be rolled over to a CCO in November 2012, others may opt in. FFS populations who require special consideration (e.g., HIV/AIDs) will be transitioned in November 2012, after receiving individualized transition planning.

Population	Description	In/Out of CCOs	Disenrollment Options Given[1]
23	New eligible adults	Mandatory	Other CCO, if available; MCO if no CCO in the area; FFS with cause
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
1-11, 21	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid state plan	Individuals who are receiving non-OHP Medicare (QMB, SLMB, QI)	Out	N/A
Medicaid state plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A
Medicaid state plan	Individuals who are Transplant Rx only	Out	N/A

b. **Disenrollment.** The information in the table is applicable to all managed care enrollees.

Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR Part 438.
Eligibility Redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

28. **Network Adequacy and Access Requirements.** The state must ensure that any MCE and CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and services, considering the urgency of the service. Detailed standards for various levels of care

(e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the state's quality strategy required by 42 CFR 438.204.

29. **Required Notice for Change in CCO Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The state must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

30. **Contingency Planning.** In the event that a CCO contract is amended to significantly reduce its service area or the contract is terminated, the state will implement contingency planning in consultation with CMS to assure enrollee continuity of care.

31. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10(f)(4), 42 CFR 438.6(i) and 42 CFR 431.20, the state may allow the use of electronic methods for the beneficiary and provider communications as required by:

    - 42 CFR 438.10(b) – Special rule for mandatory enrollment states – timeframes for providing information;
    - 42 CFR 438.10(e) - Information for potential enrollees;
    - 42 CFR 438.10(f)(2), (3) and (6) - Right of enrollee to request and obtain information;
    - 42 CFR 438.10 (g)(2) and (3) – Other plan information, including PIPs;
    - 42 CFR 438.10(h)(2) and (3) - For PAHPs only - Other plan information, including PIPs;
    - 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
    - 42 CFR 438.102(b)(1)(ii) – state policies on excluded services.

    a. The state may allow the use of such electronic communications only if:

        i. The recipient has requested or approved electronic transmittal;
        ii. The identical information is available in written form upon request;
        iii. The information does not constitute a direct beneficiary notice related to an adverse action or any portion of the grievance, appeals, hearings or any other beneficiary rights or beneficiary protection process; and
        iv. Language and alternative format accommodations are available.
        v. Please note: All HIPAA requirements apply with respect to personal health information.

32. **Transparency/Public Reporting.**

    a. The state must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed

choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).

b. The state shall publish data regarding CCOs' performance on state-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the state's progress toward achieving the two primary goals of this demonstration.

33. **State Oversight of the CCOs.** The state Agency must have in effect procedures for monitoring the CCO operations, including, at a minimum operations related to the following: recipient enrollment and disenrollment; processing of grievance and appeals; violations subject to immediate sanctions, as set forth in sub part I of 42 CFR 438; violations of the conditions for FFP, as set forth in subpart J; and all other provisions of the contract.

VI. CAPITATION RATES AND PERFORMANCE MEASURES

34. **Principles for Payment Methods that Support the Three-Part Aim.** The state will employ the following concepts in its payment methods to CCOs:

a. The state will transition to a payment system that rewards health outcomes improvement and not volume of services.

b. The state will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services. The global budget will be phased in, but will eventually consist of two parts: 1) a capitated per member per month (PMPM) payment; and 2) a separate PMPM payment for services not included under the capitation rate.

Until January 2013, the global budget will include only capitated services (i.e., the first part above). After January 2013, the state will begin including additional services to the global budget (see Attachment F). These services may be included in the capitated portion of the global budget or in the separate PMPM payment methodology. The methodology for inclusion of additional services in the global budget will be mutually agreed upon by the state and CMS and phased in over the course of the demonstration. The state and CMS will finalize the methodology for inclusion of additional services within 120 days of this agreement.

No payment will be made for CCO enrollees to FCHPs, MHOs and, if dental services are included in the CCO benefit package, DCOs.

i. Attachment F provides a proposed schedule of inclusion of additional services into the CCO global budgets. Initial CCOs approved August through December 2012 will be at risk for Lines 1-8 through a PMPM global budget. The state intends to add service lines 9-22 to CCO global budgets over the course the demonstration. While the intent is to include as many services as possible within

the PMPM payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding these services to the global budget. Until services are added to the global budget either through the PMPM or another methodology, CCOs are not at risk for services other than 1-8 in Attachment F. If the state wishes to add any services included in lines 23-38 in Attachment F, the state will work with CMS to determine the most appropriate methodology for inclusion of the additional services within the CCO global budgets and amend the Section 1115 waiver if necessary.

c. The CCO contract language will require the CCOs to consider alternative non-state plan services (the constellation of these services includes services known as "in-lieu of services," "substitute services," "flexible services," and "non-encounterable services" and hereafter referred to as "flexible services" in order to capture the array of potential services). CCOs are always at liberty to offer any *additional* health-related services at their discretion, as allowed under 42 CFR 438.6(e). Since enrollees may need additional services that are not substitutes for state plan services, which could ultimately improve the enrollee's health, the CCOs should use this option as necessary.

i. The contract must not require specific, discrete service substitutions, but may require that the principle of "flexible services" (i.e., that CCOs look for more cost-effective services to replace or supplant the need for state plan services, as appropriate) be applied under the following circumstances:

1. An enrollee's request to have a state plan service rather than a flexible service must be honored when medically necessary.

2. All flexible services will be health related however the CCO will have broad flexibility in creating the array of services to improve care delivery and enrollee health. The state will report on the non-state plan services provided through the CCO contracts, including the effectiveness of the services in deterring higher cost care.

3. Flexible services will be accounted for in the administrative expenses part of the capitation rate. Although flexible service will not be included in the medical expenses portion of the capitation rate, utilization assumptions may be applied.

ii. The CCO contracts may levy performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. I.e., the more creative the CCOs are with flexible service delivery, health outcomes will improve and growth in per capita expenditures will decrease.

1. As CCOs provide health care services that are more cost-effective than state plan services (which is what the capitation rate is based on), the capitation per capita growth rate should gradually decrease over the waiver period. The state will offset

the decrease in capitation per capita rate growth with additional incentives outside of the capitation rate.

2. Over time, the per capita expenditure trend should be lower through decreased use of unnecessary and costly services. This will happen when: 1) Decreased utilization of unnecessary and costly services; 2) Financial reward of CCOs and their contracted providers for quality improvement, not volume of services; and 3) the health status of enrollees improves through coordination of care.

3. Success will be measured by and incentives paid based upon: 1) decreased rate of per capita Medicaid expenditure growth; 2) increased patient satisfaction with, and involvement in, care planning and quality of care; and 3) overall population health improvement.

d. In each year, the state and CCOs must track discrete services whether it is a state plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate.

35. **Structure.** Capitation rates and incentives for the Coordinated Care Organizations (CCOs) for each demonstration year (DY) will be structured as follows:

a. Demonstration Year 11:

i. Capitation rates. There will be no major changes in the currently approved rate-setting methodology for DY11.

ii. Incentives and Withholds. There will be no incentive payments made to CCOs or amount withheld from the CCOs.

iii. Special performance Standards. The state will apply special performance standards of timely and accurate data reporting in the first year.

b. Demonstration Years 12 through 15:

i. Capitation Rate Withhold. The first quarter of DY 12 will include a 1-percent capitation rate withhold that will be returned to CCOs successful in DY 11 performance metrics which reward timely and accurate data reporting A CCO that successfully meets the performance metrics of timely and accurate data reporting in DY 11 will receive the full capitation rate in this quarter. A CCO that does not meet the DY 11 performance metrics will not have the withhold restored, resulting in a 1-percent rate reduction. The state will determine the parameters for the special performance standards of timely and accurate data reporting within 120 days of this agreement.

ii. The state will have an additional 120 days after the agreement is in effect to address the details of DYs 12-15 so long as it is within the following parameters and subject to CMS approval:

1. Bonus Incentive Pool. The state will establish a separate bonus/incentive pool outside of the capitation rates (i.e., in addition to any capitation rate withholds). Incentives must be designed to reduce costs and improve health care outcomes. When developing the bonus pool, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing.

   a. The state will alert the CCOs that the bonus incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole bonus incentive pool amount will be at risk. The state will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark, and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance. Within 120 days of the demonstration approval, the state will submit and CMS will approve the specific requirements. The state will amend its CCO contracts to incorporate the changes immediately following the 120-day period.

2. CCO Provider Agreements. Incentives must be correlatively reflected in the CCO/provider agreements to insure that the incentives are passed through to providers to reflect the arrangement with the state-CCO contract.

iii. Each subsequent DY rates and incentives will be set in the DY preceding the implementation in order to apply program experience as the program matures (e.g., DY 13 rates and incentives will be set in DY 12). The state will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

VII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

36. **Overview.** Improving access and quality is a key component of the state health system transformation and measurement is necessary to determine whether the demonstration's goal of advancing the triple aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required.

37. **Metrics and Scoring Committee.** The state's strategy for a robust measurement includes the newly established Metrics and Scoring Committee. The Committee will review data and the relevant literature, determine which measures will be included in the CCO incentive program, and establish the performance benchmarks and targets to be used in this incentive program. The Committee will endorse/develop specifications for each measure. In future years, the Committee will review earlier decisions and make adjustments as needed. A

transitional Metrics and Scoring Committee recommended a set of metrics for the first program year, which were described in CCO RFA contracts. Going forward, the permanent Metrics and Scoring Committee will recommend metrics that will be used to determine financial incentives for CCOs.

38. **Additional Quality Measures and Reporting at the CCO Level.** CMS developed an additional list of requirements for the Metrics and Scoring Committee that should be incorporated into the measurement planning and financial incentive determinations. This should not supplant the work of this committee, but rather provide some strategic direction to reach the two goals of this demonstration. The CCOs will be required to collect and validate data and report to the state on the metrics listed in this section, which may be revised or added to overtime as the demonstration matures, but these metrics will remain constant for the first 2 years of the demonstration. CMS also encourages the CCOs to report on the core set of performance measures for children and adults in Medicaid and CHIP.

    a. **Metrics to track quality improvement focus areas:** Pursuant to paragraph 23.b.i), the state and CMS will ensure the collection and validation of measures to track progress in the quality improvement focus areas. (See Attachment E)

    b. **Core set of quality improvement measures**. The initial core measures will track the following:

        i. Member/patient experience of care (CAHPS tool or similar);
        ii. Health and functional status among CCO enrollees;
        iii. Rate of tobacco use among CCO enrollees;
        iv. Obesity rate among CCO enrollees
        v. Outpatient and emergency department utilization;
        vi. Potentially avoidable emergency department visits;
        vii. Ambulatory care sensitive hospital admissions;
        viii. Medication reconciliation post discharge;
        ix. All-cause readmissions;
        x. Alcohol misuse-screening, brief intervention, and referral for treatment;
        xi. Initiation & engagement in alcohol and drug treatment;
        xii. Mental health assessment for children in DHS custody;
        xiii. Follow-up after hospitalization for mental illness;
        xiv. Effective contraceptive use among women who do not desire pregnancy;
        xv. Low birth weight;
        xvi. Developmental screening by 36 months; and
        xvii. Difference in these metrics between race and ethnicity categories;

    c. **Access improvement measures based on CCO data.** The state and CMS will identify and agree to additional access measures by 120 days after the approval of this demonstration planning period. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.

i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
ii. Percentage of adults with any outpatient visit.
iii. Percentage of adults with a chronic disease w/any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.
v. Percentage of children with at least one dental visit.
vi. Fraction of physicians (by specialty) 'participating' in the Medicaid program.
vii. Change in the number of physicians (by specialty) participating in Medicaid
viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
ix. Percentage of CCO enrollees with access to a PCPCH.

d. **Access improvement measures based on state survey data.** The state will identify and CMS will approve additional access measures, particularly measures based on survey data, by 120 days after the approval of this demonstration planning period. Additional survey-based measures could include:

i. Percent of beneficiaries with a usual source of care.
ii. Percent of beneficiaries with a preventive visit in past year.
iii. Percent of beneficiaries with a dental visit in past year.
iv. Percent of beneficiaries with any unmet needs.
v. Percent of beneficiaries delaying/deferring care due to cost.
vi. Percent of beneficiaries delaying/deferring care due to lack of available provider.
vii. Percent of beneficiaries delaying/deferring care due to provider office being closed at time of illness.
viii. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

39. **Utilization of new services.** The state and CCOs must track discrete services whether it is a state plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement.

40. **Quality and Access Data Reporting from the State to CMS.** In accordance with paragraph 68, "Monitoring to Assure Progress in Meeting demonstration Goals," the state will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the state will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 120 days of the demonstration approval, the state will submit and CMS will approve a reporting format.

41. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**

    a. **Statewide quality, access, and expenditure monitoring and analysis.** The state, working with the CCO Innovator agents, shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The state must report to CMS any CCO issues impacting the CCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights

    b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the state shall intervene promptly within 30 days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to focused learning collaboratives and/or innovator agents, targeting underlying issues affecting outcomes, performance, access and cost.

    c. **Additional actions taken if goals are not achieved**. If the interventions undertaken pursuant to paragraph 41.b do not result in improved performance in identified areas of concern within 90 days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the state placing the CCO on a corrective action plan. The state must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the learning collaboratives and peer-support to the extent practicable.

42. **EQRO.** The state is required to meet all requirements found in 42 CFR 438, subpart E. The state will need to amend its current EQRO contract to require the reporting of outcomes information in the annual technical report related to performance measures and performance improvement projects. The state should generally have available its final EQR Technical Reports to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)]. In the first year of the transition to the CCO system and to a modified EQRO contract, CMS will use the quality and access data from the quarterly reports as identified in paragraph 40 to satisfy regulatory requirements.

43. **State Quality Strategy**. In accordance with CMS regulations, the state is required to submit a written strategy for assessing and improving the quality of managed care service offered by all managed care entities. This written strategy (also referred to as the "quality strategy")

must meet all of the requirements found in 42 CFR 438, subpart D. Before implementing a final, approved quality strategy, the state is required to submit a draft quality strategy to CMS for approval within 120 days of the approval date of the demonstration. The state will submit a revised strategy to CMS within 60 days, whenever significant changes are made. The state will submit annual reports to CMS on the implementation and success of the strategy, by means of the annual EQRO technical report or a separate annual report that assesses the implementation and effectiveness of the quality strategy.

VIII. CALCULATING THE IMPACT OF HEALTH SYSTEMS TRANSFORMATION AND REDUCTIONS IN DESIGNATED STATE HEALTH PROGRAM FUNDING

This section establishes the parameters by which the state and CMS will annually measure the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved. Data specified in this section shall be reported on a quarterly and annual basis as specified in paragraph 68.

There are three levels of baseline and actual expenditures that the state must calculate and provide to CMS that will be measured and monitored annually under this demonstration. These levels are:

- Level 1: the per member per month expenditure to the state to *purchase* identified global budget services for populations to be mandatorily enrolled in CCOs and voluntarily enrolled CCO populations,
- Level 2: the per member per month total expenditure to the state to *purchase* services across all Medicaid service expenditures for populations that are mandatorily required to enroll in CCOs and voluntarily enrolled CCO populations regardless of whether the services are included in CCO global budgets, and
- Level 3: The per member per month total expenditure to the state to *provide* care under Health System Transformation in Oregon.

44. The following section summarizes the specific populations, expenditures, and other variables that will be included in calculations of each of the expenditure levels described above.

a. **Level 1: Global Budget Expenditures**.

These expenditures are for services identified in Attachment F for all individuals enrolled in eligibility categories that are required to enroll in CCOs (mandatory populations) and for individuals that voluntarily enroll in CCOs that are in non-mandatory enrollment populations (voluntary populations). Expenditures would also include any incentive payments, shared savings payments made to CCOs as well as wrap-around or supplemental payments for services identified in the global budget and provided to these populations. This expenditure level is the level against which the health care cost trend targets and the associated funding consequences described in paragraph 52 will be based.

b. **Level 2: Medicaid Program Service Expenditures**

These expenditures are for all Medicaid services provided to all individuals enrolled in mandatory eligibility categories as well as those individuals enrolled in voluntary populations who voluntarily enroll in CCOs. This expenditure level includes all payments described in level 1 plus all other Medicaid payments for services provided under the demonstration or the state plan to individuals described in level 1 during a demonstration year. These additional expenditures would include services such as long term care services that are not included in the global budget service package but are provided to individuals described in level 1.

c. **Level 3: Medicaid Program Costs for Health System Transformation**

This expenditure measure will capture total costs to support Health System Transformation (HST) and will include all costs in level 1 plus all costs that the state incurs for supporting HST including activities such as learning collaboratives, innovation agents, and other activities performed or contracted by the state to implement and operate HST.

45. **Calculating Baseline Expenditures.** The baseline expenditures to the state without Health Systems Transformation of these services will be developed using expenditure information from 2011 for the full calendar year. The costs will be developed for each level of spending for each eligibility group. These baseline costs will be transformed into aggregate per member per month costs based on total member months in 2011. The groups are:

Population	**Enrollment**
Children	Mandatory
Non-disabled Adults	Mandatory
Disabled Adults	Mandatory
Dual Eligibles	Voluntary

The baseline PMPMs for each level will be developed as follows:

a. Level 1: The actual baseline PMPM will include all costs for global budget services plus all wrap-around payments for all populations whose enrollment is mandatory or voluntary (as defined in Table 2 in paragraph 27). The base costs for global budget services will be divided by the total applicable member months to create an aggregate PMPM.

The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the state and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

b. Level 2: The actual baseline PMPM will include all level 1 costs plus all other Medicaid service expenditures attributable to 2011 for all individuals in both mandatory and

voluntary populations. The total base costs for global budget services will be divided by the total applicable member months.

The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the state and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

c. Level 3: The actual baseline PMPM will include all level 1 costs by eligibility group and for the base year, should not differ from Level 1 expenditures as the additional costs in this category is expenditures supporting health system transformation.

The baseline PMPM in Level 1 will be the without Health System Transformation (HST) costs. The trend rate applied to the aggregate PMPM, which is based on the President's Budget estimates of the national rate of growth in Medicaid expenditures on a per member per month basis, is 5.4% for each year in the demonstration. If within the 120 day period following approval of the demonstration, the state provides analysis and data demonstrating that Oregon's trend differs substantially from this national average, and the Chief Actuary of CMS determines the difference to be valid and calculated reasonably and in accordance with general actuarial standards of practice, CMS will adjust this trend rate.

The PMPM calculation will be performed for each level (1, 2, and 3) described above in the aggregate.

46. **Calculating Actual Expenditures under Health System Transformation.** This measurement is based on actual DY expenditures for services and supports under HST. Actual HST PMPM expenditures will be calculated as follows:

a. Level 1: The actual HST expenditure PMPM will include all costs for global budget services plus all wrap-around payments.

For the mandatory populations, costs for global budget services will be included regardless of whether the CCO directly provided the services or not and whether or not individuals were enrolled in a CCO.

For voluntary populations, the costs for global budget services will be included regardless of whether the CCO directly provided the services or not. Expenditures and member months for individuals in the voluntary group will be included in this calculation only if they were enrolled in a CCO.

The state will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory populations and voluntary populations if they were enrolled in a CCO.

b. Level 2: The actual HST PMPM will include all Level 1 costs plus all other Medicaid service expenditures during the DY. For the mandatory populations, the total level costs

will include both global budget services and all other Medicaid services provided to individuals in the mandatory eligibility groups.

For voluntary populations, costs will include all Level 1 costs plus all other Medicaid service expenditures during the DY only for individuals actually voluntarily enrolled in CCOs. Individuals in the voluntary group will contribute their expenditures only if they were enrolled in a CCO.

The state will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory and voluntary populations.

c. Level 3: The HST PMPM will include all Level 1 costs by eligibility group and all costs incurred by the state for expenditures to support HST. The costs will include activities such as learning collaboratives, innovator agents, the quality and access metrics committee, and other administrative support the state may provide to facilitate the implementation and operation of CCOs and HST. The state will submit and CMS will approve within 120 days after the date of approval of the demonstration the activities and costs that will be included in the HST support expenditure category.

For mandatory and voluntary populations, the HST calculation will include Level 1 aggregate expenditures plus aggregate, identified HST support expenditures divided by total Level 1 mandatory and voluntary member months.

47. **Calculation of Trend Reduction Targets:** The state must beginning immediately following DY 12 to annually demonstrate the savings achieved under HST using the without HST PMPM and the HST PMPM for Level 1 expenditures each DY. The savings requirements and penalties are described in paragraph 52.

The PMPM savings percentages will be reported for each eligibility group and in the aggregate, although the savings reduction requirement will be applied only to the aggregate with and without HST expenditures. The aggregate HST PMPM must be below:

a. the 5.4% without HST trend rate by 1 percentage point in DY 12 (i.e. aggregate PMPM expenditures in DY 12 must be no more than a 4.4% increase over DY 11 aggregate without HST PMPM expenditures).

b. the 5.4% without HST trend rate by 2 percentage points in DY 13, 14 and 15 (i.e. aggregate PMPM expenditures in DY 13 must be no more than a 3.4% increase over DY 12 aggregate without HST PMPM expenditures).

48. **Return on Investment.** Annually, CMS will analyze the total return on investment in HST. The state must provide information (as part of the reporting requirements in paragraph 68) on total new federal funds claimed as DSHP as well as federal funds claimed using state funds repurposed as a result of DSHP relative to health savings achieved under the health transformation process. Elements in the analysis will include:

a. New federal funds drawn as match against DSHP programs.
b. New federal funds drawn as a result of DSHP. Under the state's proposal, this includes all federal funds drawn associated with state funds redirected from DSHP except DY1 rate stabilization.
c. Savings identified in the total cost of purchasing care in level 3 as described above (the total investment in HST).

49. **Evaluating Impact on Medicare and Medicaid Expenditures for Dual Eligibles.** In addition to expenditure estimates in paragraphs 45, 46, and 47, CMS and the state will examine total expenditures on individuals who are dually eligible for Medicaid and Medicare who are enrolled in CCOs.

50. **Measurement of Quality and Access Under the Demonstration.** The state will also monitor and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 68. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access. Within 120 days of approval of the demonstration, the state will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's Medicaid population as a whole. The state's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions) state quality and access reporting will take place on the same timeframes as the state's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

51. **Deliverables to be Negotiated Within 120 Days Post Approval:** Within 120 days of approval of the demonstration, CMS and the state will:

a. Finalize the benefit package for the global payment Level 1 analysis during the demonstration period (Attachment F).
b. Finalize the parameters of the total cost of care for levels 2 and 3 by identifying all payments and costs subject to inclusion in the costs of care calculation.
c. Finalize the annual per capita amount for the baseline period.
d. Finalize safe harbor language to limit risk to the state for increases in FQHC wrap-around payments for reasons that are not within the state's control for the purposes of Level 1 calculations. Valid reasons would include an increase in FQHCs in the state relative to the base year or changes in scope of service that actually effect the PPS rate.
e. Finalize a methodology for the treatment of long term care services and supports (LTSS) expenditures.

f. Finalize the return on investment formula template and the per capita reporting templates.
g. Finalize the calculation of cost shifting using Medicaid uncompensated care (shortfall) using DSH audit information.
h. Finalize the timing of and reporting format of the annual expenditure and savings calculations.
i. A plan for specific quality and access measures that the state and CMS will use to monitor access and quality during the demonstration, as well as methods for such measurement and reporting timeframes.
j. CMS will review, discuss with the state, and approve all of the above deliverables within 30 days after the 120 day period.

52. **Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets**

This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. **Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates**. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 47, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Table 3: Per Capita Expenditure Growth Reduction Targets and Associated DSHP Expenditure Authority Reductions for Failure to Meet Targets

Demonstration Year	**Per Capita Expenditure Growth Reduction Target** (measure following DY close)	**Reduction in DSHP Expenditure Authority** (reduce succeeding DY's DSHP expenditure authority)
DY11	NA	NA
DY12	1 percentage point	$54 million
DY13	2 percentage points	$68 million
DY14	2 percentage points	$68 million
DY15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the state in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the state has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. **Earn Back Option.** For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:

i. If the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year *and* significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.
ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.
iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

IX. DESIGNATED STATE HEALTH PROGRAMS

53. **Designated State Health Programs (DSHP).** To support the goals of health system transformation, the state may claim FFP for the following state programs subject to the annual limits and restrictions described below through June 30, 2017, unless otherwise specified. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment G. Subject to approval by the federal Office of Management and Budget, these expenditures can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of paragraph 52.

54. **Aggregate DSHP Annual Limits** – Expenditure authority for DSHP is limited to $704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by year as follows:

Table 4: Aggregate DSHP Annual Limits

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

DY 14	07/1/15-06/30/16	$ 68 M
DY 15	07/1/16-06/30/17	$ 68 M

55. **Restrictions on DSHP Programs.** Approved Designated State Health Programs for which FFP can be claimed are outlined below subject to the following funding limits by the four categories listed below. Prior to claiming funding for these programs, the state will submit and CMS will approve a DSHP claiming protocol. The state is not eligible to receive FFP until the protocol is approved. Upon CMS approval of the claiming protocol, state is eligible to receive FFP for the approved DSHP program expenditures beginning July 5, 2012.

Table 5. Limits on Allowable Designated State Health Programs

Expenditures by Type of Designated State Health Programs:	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**Total**
Oregon Medical Insurance Program	93	93	0	0	0	186
Workforce Training	69	69	40	0	0	178
Gero-Neuro	8	8	8	8	8	40
Other CMS Approved*	60	60	60	60	60	300
Total	**230**	**230**	**108**	**68**	**68**	**704**

*See Table 6 for all approved programs.

a. **Oregon Medical Insurance Program.** The state may claim FFP for expenditures related to the Oregon Medical Insurance Program only for DYs 11 and 12.

b. **Workforce Training.** To promote improved access and quality of care for Medicaid beneficiaries in the state by supporting the development of the health care workforce in the state and to the extent that such education promotes the rate of Medicaid participation among Oregon providers, the state may claim FFP for health workforce training programs and related supports at Oregon Health and Science University (OHSU), Oregon University System (OUS), and community colleges as follows; Blue Mountain, Clatsop, Linn Benton, Rogue, Umpqua, Central Oregon, Columbia Gorge, Mt Hood, Southwestern, Chemeketa, Klamath, Oregon Coast, Tillamook Bay, Clackamas, Lane, Portland, Treasure Valley. The state may only claim FFP for workforce training DSHP programs in DYs 11-13. The annual limit the state may claim FFP for workforce training programs is limited to direct and indirect costs and shall not exceed $69 million in each of DYs 11 and 12 and $40 million in DY 13.

i. **Loan Repayment:** To ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the State

shall commit to funding a primary care provider loan repayment program, with the following conditions:

By July 1, 2013, the state shall establish an annual funding level of $2,000,000 to provide assistance to providers who make written commitments to serving Medicaid populations in rural and underserved areas. If the state is unable to establish funding for this program at the amount specified in this term, the state's Workforce Development state designated health program expenditure authority must be reduced. The DSHP Workforce Development funding must be reduced by 25 percent of the difference between the $2,000,000 and the amount that the state is able to reinstate for the loan repayment program for Demonstration Years 12 and 13.

ii. **Training for Community Health Workers:** The state, through its Community Colleges, shall establish Community Health Worker curriculum that meets the core training elements established by the Oregon Health Policy Board. The state shall train 300 additional Community Health Workers by December 2015.

iii. **Increased Workforce/Provider Capacity.** The state must track the number of Medicaid primary care providers (including nurse practitioners, etc.). The state must submit to CMS within 180 days of the date of the demonstration amendment approval letter, a report detailing the number and types of primary care providers that are currently seeing Medicaid beneficiaries in the state of Oregon. In addition, the state must track where the graduates of these Educational Institutions are working and whether they become Medicaid providers beginning with DY 12 Quarterly and Annual Reports.

c. **Gero-Neuro.** The state may not begin claiming FFP for the Gero-Neuro program until the state begins the process to recertify the facility as an IMD meeting the inpatient hospital requirements as set forth in 42 CFR section 440.140 which include by reference requirements for the hospital conditions of participation at 42 CFR 482. Medicaid and CHIP citizenship rules apply as a condition for receiving FFP.

d. **Other CMS Approved DSHP.** For DYs 11-15, the state may claim FFP for expenditures related to state health programs specified in the "other" category of Table 6 in paragraph 56, subject to a 4.2% reduction on an annual basis. To the extent that the state identifies other programs in this category that support the health care needs of low-income, uninsured Oregonians, the state may submit to CMS for review and approval additional program expenditures for which expenditure authority may be provided. In the event of a shortfall in the "other" category, CMS will consider additional expenditures for OMIP if the state is able to document such expenditures. Additionally, subject to the aggregate annual DSHP limit, the state may exceed the amounts listed in Table 5 for the "other" category only in the event there is a shortfall in the remaining categories. The state must notify CMS in advance of the anticipated shortfall amount by category and the amount of funds to be redirected to either "OMIP" or "other" category. Upon approval, the state may only prospectively claim additional expenditures over the individual limits for OMIP and the "other" category. The state must not exceed the annual aggregate

limit. For any additional OMIP or other expenditures, the state must obtain prior CMS approval for the methodology used to claim any such additional expenditures, subject to the aggregate limit described in Table 5. Once all relevant approvals are obtained, CMS and the State will update the DSHP claiming protocol (Attachment G).

56. **Specified Designated State Health Programs (DSHP).** The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and limits described in section XIII of the STCs.

Table 6.

DSHP
OTHER
Non-Residential Adult (AMH1)
Child and Adolescent (AMH1)
Regional Acute Psychiatric Inpatient (AMH1)
Residential Treatment for Youth (AMH2)
Adult Foster Care (AMH2)
Older/Disabled Adult (AMH2)
Special Projects
Community Crisis
Support Employment (AMH1)
Homeless (AMH1)
Residential Treatment (AMH2)
Non-Residential Adult (Designated)
A & D-Special Projects (AMH3)
A & D Residential Treatment - Adult (AMH4)
Continuum of Care (AMH5)
System of Care (CAF1)
Community Based Sexual Assault (CAF2)
Community Based Domestic Violence (CAF3)
Family Based Services (CAF5)
Foster Care Prevention (CAF6)
Enhanced Supervision (CAF8)
Nursing Assessments (CAF11)
Other Medical (CAF13)
IV-E Waiver (Demo Project for Parenting, mentoring, enhanced supervision)
Personal Care (CAF17)
Oregon Project Independence
SE #150 Family Support (SPD3)
SE #151 Children Long-Term Support (SPD4)
Licensing Fee
General Microbiology

Virology
Chlamydia (PHD4)
Other Test Fees (PHD5)
State Support for Public Health (PHD6)
Newborn screening
Prescription Drug Monitoring Program (PHD7)
HIV Community Services (PHD8)
General Funds - HST (PHD9)
Sexually Transmitted Diseases
Mental Health Treatment
Drug and Alcohol
Formerly Medically Needy (Organ Transplant) Clients
Workforce Training To Promote Medicaid Provider Participation
Undergraduate and graduate health professions education
OMIP
State Hospitals (OSH and BMRC)
Gero-Neuro

X. TRIBAL HEALTH FACILITY PAYMENT PROGRAM FOR UNCOMPENSATED CARE

Through a tribal health program for uncompensated care, the state shall make supplemental payments to IHS and tribal health facilities operating under ISDEAA 638 authority: 1) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (OHP).

57. **Payments to IHS and tribal health facilities.** The state is authorized under expenditure authority of this demonstration to make payments to (IHS) and tribal health facilities subject to the following conditions:

    a. Individuals receiving care at these facilities would continue to receive acute care hospital and specialty care services as they do now through the IHS "Purchase and Referred Care" (formally the contract health service referral system). These services are not included for payment under this section.

    b. Services will continue to be provided in these tribal health facilities to non-IHS beneficiaries according to the eligibility policy currently set by the IHS or tribal health authorities in accordance with the Indian Health Care Improvement Act.

    c. Payment will be based on the approved methodology set forth in Attachment I, Tribal Health Facility Payment Program Claiming Protocol.

XI. HOSPITAL TRANSFORMATION PERFORMANCE PROGRAM

58. **Description.** Beginning July 1, 2014, through June 30, 2017, the state will establish a hospital incentive pool, the Hospital Transformation Performance Program (HTPP), to issue incentive payments to participating hospitals for adopting initiatives for quality improvement of the Oregon health care system and the measurement of that improvement. During the administration of the HTPP, CMS and the state will continue to explore options to strengthen incentives that will accelerate health system transformation at the provider-level within the state's CCO structure. Standard terms for the HTPP shall apply as follows:

    a. The non-federal share of payments to providers may be funded by a hospital reimbursement assessment compliant with the federal statute, regulation, and rules. All payments must remain with the provider and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

    b. The state must report to CMS on the funding of HTPP in a quarterly payment report, in coordination with the quarterly reporting required by STC 67 and 73, which must be submitted to CMS within 60 days after the end of the each quarter. The state shall update the Attachment A, quarterly reports, and submit to CMS for review and approval 30-days post-approval of the HTPP.

    c. When the state claims FFP for the HTPP, the state will make available to the CMS Regional Office appropriate supporting documentation in order to determine the appropriateness of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

    d. Changes to the HTPP are subject to amendment under STC 7.

59. **Expenditure limits:** Only to the extent that the state does not exceed the limits in Section VIII, the state may draw down up to the following expenditure limits in total computable expenditures:

    a. HTPP: Beginning July 1, 2014, the state may claim HTPP payments up to $150 million total computable.

    b. Annual Limits: The expenditure limits are calculated per year. Should the state be unable to exhaust the entirety of the annual limits, the funds cannot be rolled over into the following year.

60. **Qualifications:** Hospitals eligible to participate in the HTPP must meet the state's criteria for a diagnosis-related group hospital. Diagnosis-related group hospitals are urban hospitals with bed capacity of greater than 50.

61. **HTPP Payments:** The state shall make payments to participating hospitals for implementing and reporting on health system reform initiatives that the hospitals will initiate to improve reporting and tracking of important health indicators that will supply the state with data on the health status of Medicaid enrollees.

    i. Metrics: The state shall hold hospitals to the appropriate CCO and hospital-specific metrics outlined in Attachment J, Hospital Metrics and Incentive Payment Protocol.

    ii. Incentive Payment: In demonstration years 13, 14 and 15, the state shall make incentive payments to hospitals who have met the reporting and benchmark thresholds established by the state. Detail on incentive payment distribution methodology will be supplied through Attachment J, Hospital Metrics and Incentive Payment Protocol.

    iii. Trend Reduction: The state shall be held to the terms in Section VIII of the STCs. The state shall update Section B, Expenditure Tracking for the Trend Reduction Test, of Attachment H to reflect the inclusion of the HTPP payments towards the trend for review and approval 30-days after the approval of the HTPP including the HTPP 2016 amendment.

    iv. Oregon Hospital Performance Metrics Committee: The development of the hospital-specific metrics, which will be used to assess the HTPP payments, shall incorporate input from a state-convened committee, the Oregon Hospital Performance Metrics Committee. This committee comprised of members from the hospitals, coordinated care organizations, and researchers will work with the state and CMS to develop a set of hospital-appropriate benchmark metrics and targets for which the state can measure progress towards the state's health system transformation goals.

    v. Post-Approval Deliverable: Revised Attachment J, Hospital Metrics and Payment Protocol to CMS for review and approval by May 31, 2016. Approval of this attachment is needed before payments can be made. Attachment J will include, at a minimum, the following information:

        1. Metrics that will be used in DY 13, 14, and 15 and supporting narrative;
        2. Timeline for when performance targets will be set; and
        3. Timeline for when incentive payments will be made.

62. **Evaluation**: The state will conduct an interim independent evaluation of the HTPP to determine whether the goal, to accelerate health system transformation among targeted providers, has been met.

    a. The evaluation must include, but is not limited to, the following questions and comparisons:

        i. How have the DRG hospitals performed on all the HTPP metrics, as compared to

baseline?

ii. How have the DRG hospitals performed on the metrics that are also CCO metrics, as compared to hospitals not receiving HTPP payments?

iii. What contributed to the success of those hospitals successfully meeting the HTPP measurement goals;

iv. What barriers prevented the successes of any hospitals not meeting HTPP measurement goals;

v. What changes in hospital practice have been made as a result of HTPP ;

vi. What, if any, changes to the incentive structure for the CCOs by the state and by the CCOs for the providers is the state considering, as a result of lessons learned from HTTP.

vii. The interim evaluation will be due June 30, 2016.

XII. GENERAL REPORTING REQUIREMENTS

63. **General Financial Requirements.** The state shall comply with all general financial requirements under Title XIX set forth in these STCs.

64. **Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request, including revised budget and allotment neutrality spreadsheets consistent with these STCs.

65. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR Section 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

66. **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, CCO/MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, CCO/MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

67. **Quarterly Progress Reports.** The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter. CMS will provide the format for these reports in consultation with the state. The intent of these reports is to present

the state's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the OHP demonstration; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative activities, litigation status and other operational issues;

c. Action plans for addressing any policy, administrative, or budget issues identified;

d. Quarterly enrollment reports required under paragraphs 72 and 75; and

e. Evaluation activities and interim findings.

f. FHIAP Reporting inclusive of:

i. **Premium Costs (member share and state subsidy):** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

ii. **Subsidy Costs:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iii. **Enrollee Premium Contributions:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iv. **Employer Contributions:** By subsidy level, with a weighted overall average.

v. **Overall Premium Cost:** For individual and group, with a weighted overall average.

vi. **Overall Subsidy Cost:** For individual and group, with a weighted overall average.

68. **Monitoring To Assure Progress in Meeting Demonstration Goals:** The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the state's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of demonstration goals.

a. **Interim Reporting Format.** The state and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;
ii. Quality Improvement Metrics: Section VII;
iii. Access to Care measures: Section VII;

b. **Timeframe for Reporting.** The state will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.

c. **Data Sources:**

i. Goal 1:
1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with state);
2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;
3. Total Medicaid service spending per beneficiary; and
4. CCO provider spending per beneficiary.

ii. Goal 2:
1. Benchmarked metrics tied to incentive payments, including patient experience surveys;
2. Data from the all payer-all claims database;
3. Process Improvement Projects (PIPs);
a. EQRO studies;
b. Complaints and grievances;
c. Health risk assessment data;
d. Public health data;
e. Health risk assessment data;
f. Meaningful use attestation data;
g. State CCO monitoring reports; and
h. Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the duals demonstration.

d. **Final Annual Report:** The state shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The state will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.

e. **Penalty for Late Reporting:**

i. If the state fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The state may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that

prevents the state from reporting timely, the state can request an exception to these timeframes and penalties.

Percentage withheld of quarterly demonstration administrative funding	Days late
.2	15-30
.4	30-40
.8	41-50
1	51+

69. **Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration covering Medicaid. The draft report is also to include, at a minimum, the following:

    a. **FHIAP activity**: the names of all participating private individual insurance plans and carriers; any changes in participating individual insurance plans and carriers; the number of OHP eligible participants enrolled with each individual insurance plan or carrier; and the amount of premium subsidies paid each individual insurance plan and carrier.

    b. **Premium Assistance Evaluation Related to Cost Effectiveness.** Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the state's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The state provides limited wrap around services.

        i. The state will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:

            1. FHIAP's (populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies); to

            2. OHA direct coverage (populations 1 through 11 in Attachment D) overall pm/pm costs.

        ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in populations 12, 14, 16, 17, and 18 in Attachment D are based on maximum plan out of pocket costs (excluding premium share) to:

1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.[3]

iii. OPHP will monitor program expenditures for HK ESI (population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.

iv. OPHP will report average aggregate cost sharing for HK ESI plans (population 20 in Attachment D) based on maximum plan out of pocket costs (excluding premium share).

v. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

c. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its FHIAP children in the demonstration. DY 12 will be the last year that the state will include the reporting requirements for FHIAP and title XXI.

70. **Beneficiary Survey.** The state shall conduct surveys, at least every other year, of OHP enrollees and providers that assess the following information: enrollee health status; satisfaction with provider communication; and access to routine and specialty care. The surveys will be designed to allow analyses based on CCOs/MCOs and benefit plans. The state will also monitor and report on disenrollment requests and the reasons for the requests.

71. **Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act, and as specified in Section XV of these STCs.

72. **Enrollment Reporting.**

a. Through the end of the second quarter of FY 2014, each quarter the state will provide CMS with an enrollment report for the title XXI FHIAP population, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30-days after the end of each quarter. The data will be reported for the same groups, categories and in the same manner as the state reports enrollment data for CHIP state plan population as described in Section 457.740 of the CHIP Final Regulation. SEDS reporting is required for any title XXI-funded population, including populations, and is also required for title XIX Medicaid child enrollment.

[3] OHP Plus applies co-pays on an extremely limited basis: none for children, pregnant women, OAA and AB/AD clients with long-term care services, and only limited co-payments for other groups. Thus, they are not likely to provide a fair comparison with FHIAP and ESI cost sharing.

b. Enrollment reporting in the Quarterly and Annual Reports is required by Eligibility Group (EG) and Type for the title XIX and XXI state Plan and populations.

c. Quarterly Enrollment Reports. Within 60-days of the end of the quarter, the state shall provide CMS with an enrollment report by population showing the end of quarter actual and unduplicated enrollment. The state shall also report on the percent change in each category from the previous quarter and from the same quarter of the previous year. The state shall also report the number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA.

XIII. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

73. **Title XIX Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under section 1115 authority and subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIII and XI of these Terms and Conditions.

74. **Reporting Title XIX Demonstration Expenditures.** The following describes the reporting of title XIX expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures**. In order to track expenditures under this demonstration, Oregon must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual.

i. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver.

ii. Year 1 (DY 1) is defined as the year beginning October 1, 2002, and ending September 30, 2003. DY 2 and subsequent DYs are defined accordingly, through DY 9. DY 10 is defined as beginning November 1, 2011 and ending June 30, 2012. Beginning with DY 11, the Year is defined as beginning July 1, 2012 and ending June 30, 2013. DY 12 and subsequent DYs are defined accordingly. To simplify reporting, expenditures from the original Oregon Health Plan demonstration (11-W-00046/0) paid on or after October 1, 2002, shall be considered expenditures under OHP 2, and must not be reported on any Form CMS-64.9 Waiver or 64.9P Waiver for the original Oregon Health Plan demonstration.

iii. Up to and including the July-September 2008, QER, demonstration expenditures are to be reported on Forms CMS-64.9 Waiver and 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) in which payments were made for services.

iv. At the end of the demonstration, expenditures for which payment was made after the last day of the demonstration, but were for services or coverage provided during the demonstration period, are subject to the budget neutrality expenditure limit. These expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the demonstration project number assigned by CMS, with a project number extension equal to the DY number of the last year of the demonstration plus one. For example, if the last year of the demonstration is DY 8, the Forms CMS-64.9 Waiver and/or 64.9 P Waiver discussed here will bear the project number extension 09. The use of the last DY plus one as a project number extension is a reporting convention only, and does not imply any extension of the budget neutrality expenditure limit beyond the last DY.

v. All title XIX service expenditures that are not demonstration expenditures should be reported on the appropriate Forms CMS-64.9 Waiver/64.9P Waiver for another demonstration or waiver, if applicable, or on Forms CMS-64.9 Base/64.9P Base.

b. **Premium and Cost-Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the Eligibility Groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost-settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver schedules, and allocated to forms named for the different EGs described in (e) below, as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to populations shall be offset against expenditures.

e. **Use of Waiver Forms.** The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. "Current": Base 1 EG expenditures;
ii. "New": Expansion EG expenditures;
iii. "SSI": Base 2 EG expenditures.
iv. DSHP Expenditures
v. CCO Expenditures
vi. Indian Health Service or tribal health facility expenditures
vii. Hospital Transformation Performance Program

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to (1) all title XIX expenditures with dates of service between November 1, 2002 and the end of the OHP2 demonstration on behalf of individuals who are enrolled in this demonstration, net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse) and (2) expenditures with dates of service during the original Oregon Health Plan demonstration that are reported as OHP2 expenditures under paragraph 74.a.ii) above. However, certain Title XIX expenditures, as identified in paragraph 18.d.vi), are not subject to the budget neutrality expenditure limit. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit. Nevertheless, the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10 P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) for which the costs were expended.

h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the later 2-year period, the state must continue to separately identify net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 Waiver forms, in order to account for these expenditures properly to determine budget neutrality.

i. **Review of Past Expenditure Reporting and Corrective Action.** The state will conduct a review of title XIX expenditures reported on Form CMS-64 during the approval period for the OHP demonstration to ensure that expenditures subject to the budget neutrality expenditure limit have been reported appropriately, according to the instructions contained in this paragraph. The review will seek to verify that all demonstration expenditures have been reported on Forms CMS-64.9 Waiver, as required by the STCs, and not on any other CMS-64 form, and that no non-demonstration expenditures have been reported on Forms CMS-64.9 Waiver for the demonstration. The review will also ascertain whether demonstration expenditures have been reported under the correct DY. By the end of the second month following the date of approval of this extension, the state will submit a draft plan to the Project Officer for conducting the review, and for taking action to correct past reporting, subject to CMS approval. All corrective actions must be completed by October 31, 2009. At a minimum, the corrective action must result in the expenditures pertaining to the DY ending September 30, 2003 being identified as DY 01 expenditures, and correspondingly for subsequent DY. The state completed this corrective action on November 30, 2009.

75. **Reporting Member Months:** The following describes the reporting of member months for demonstration eligibles from October 1, 2002, forward:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 67 of these STCs, the actual number of eligible member months for all Medicaid and demonstration Member-Month Reporting Groups (MMRGs) defined in the table below. The state must submit a statement accompanying the quarterly report, which certifies the member-month totals are accurate to the best of the state's knowledge. These member month totals should include only persons for whose expenditures the state is receiving matching funds at the Title XIX FMAP rate. The state must also ensure that member-months reported as FHIAP member-months are also not simultaneously reported as direct coverage member-months. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

MMRG	Included Populations	Limitations
Base 1 - Direct Coverage		
AFDC	6	
PLM-A Pregnant Women	1	
PLM Children	3	
BCC Population	21	
Newly eligible adults	23	
Base II Direct Coverage		
OAA	7 (aged only), 8 (aged only)	
Blind/Disabled	7 (blind/disabled only), 8 (blind/disabled only)	
Foster Children	5	

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

76. **Standard Medicaid Funding Process.** The Standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

77. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section entitled "Monitoring Budget Neutrality For The demonstration" of these STCS.

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

    c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

    d. Tribal Health Program for Uncompensated Care to IHS and tribal health facility.

    e. Hospital Transformation Performance Program.

78. **Sources of Non-federal share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.
11.

d. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the state for premiums paid by beneficiaries shall not be used as a source of state match for FFP

XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

79. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in paragraph 74.

80. **Risk.** Oregon shall be at risk for the per capita cost (as determined by the method described below in this Section) for "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and "Expansion - Parents or Medicaid" population (as defined in paragraph 75(a) reporting of Member Months) enrollees under this budget neutrality agreement, but not for the number of such enrollees. By providing FFP for all "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and Expansion - Parents or Medicaid" enrollees, Oregon shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Oregon at risk for the per capita costs for these enrollees, CMS assures that the federal demonstration expenditures will reflect Oregon's estimates of savings from managed care, CCO implementation the priority list. Oregon will be at full risk for both enrollment and per capita cost for "Expansion – Childless Adults/Other" eligibles (as defined in paragraph 75(a)). Effective with the implementation of the ACA, these Expansion populations will become mandatory, and Oregon will no longer be at full risk for either enrollment or per capita cost.

81. **Budget Neutrality Ceiling.** The following describes the calculation of the yearly targets mentioned in paragraph 79. This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP through the end of the approval period.

a. The Base 1 Subtotal is calculated by multiplying the actual number of member-months for each "Base 1" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.
b. The Expansion Upper Limit is equal to the total number of Base 1 member months times the Oregon Ratio, which is equal to 46.86 percent.

c. Between October 2002, and October 2007, the following rules will govern calculation of the Expansion subtotal.

i. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is less than the Expansion Upper Limit, then the Expansion Subtotal is calculated by multiplying the actual number of member-months for each Expansion MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

ii. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is more than the Expansion Upper Limit, the Expansion MMRG totals are adjusted downward by multiplying them by the ratio calculated by dividing the Expansion Upper Limit by the actual total number of Expansion member-months. The adjusted member-month totals are then used in place of the unadjusted totals to calculate the Expansion Subtotal, following (c) above.

d. Beginning November 2007, and thereafter, the Expansion subtotal will be calculated by multiplying the actual number of member-months for each "Expansion - Parents or Medicaid" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together. The Oregon Ratio calculation will no longer be used after October 31, 2007.

e. The Base 2 Subtotal is calculated by multiplying the actual number of member-months for each Base 2 MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

f. The annual limit is calculated as the sum of the Base 1 Subtotal, Expansion Subtotal, and Base 2 Subtotal. The cumulative budget neutrality expenditure limit is equal to the sum of the annual limits over the entire period of the demonstration.

g. The following table gives the projected PMPM costs for the calculations described above.

i. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
AFDC	$420.74	6.2%	$446.83	$474.53	$504.08
PLM-A Pregnant Women	$1,605.08	6.1%	$1,702.99	$1,806.87	$1,917.16
PLM Children	$613.21	6.2%	$651.23	$691.61	$ 734.70
Individuals receiving treatment under the Breast and Cervical Cancer Medical (BCCTP) program		6.2%	$		$2504.78

ii. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Expansion Parents to 100% FPL	$326.31	6.1%	$346.21	$367.33	$391.86
FHIAP (Medicaid)	$294.48	6.2%	$312.74	$332.13	$352.72

iii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Old Age Assistance	$546.17	5.0%	$573.48	$602.15	$658.53
Blind/Disabled	$1,750.67	5.8%	$1,852.21	$1,959.64	$2179.61
Foster Children	$735.95	6.2%	$781.58	$830.04	$887.03

The following table gives the projected PMPM costs for demonstration years 12 through 15. For DY 12 (July 1, 2013 to June 30, 2014) a blended per member per month was created to account for 4 months of state historical rate and 8 months of 2013 President's budget trend rate.

a. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM 7/1/14-6/30/15	DY 14 PMPM 7/1/15-6/30/16	DY 15 PMPM 7/1/16-6/30/17
AFDC	$529.80	4.5%	$553.83	$578.95	$605.22
PLM-A Pregnant Women	$2018.86	4.9%	$2117.88	$2221.76	$2330.74
PLM Children	$768.80	3.8%	$798.32	$828.98	$860.81
BCCTP	$2631.69	4.5%	$2750.12	$2873.87	$3003.20

i. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Expansion Parents to 100% FPL	$658.53	4.9%			
FHIAP (Medicaid)	$352.72	4.9%			

ii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Old Age Assistance	$721.39	4.1%	$786.23	$855.19	$928.47
Blind/Disabled	$2419.85	5.1%	$2673.57	$2946.88	$3241.11
Foster Children	$934.56	3.8%	$977.06	$1021.43	$1067.77

Beginning 1/1/2014 MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
New mandatory adults	$522.00	7%	$559.88	$600.50	$644.07

82. **Future Adjustments to the Budget Neutrality Expenditure Limit.**

a. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under OHP. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903 (w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. Should the state submit a state plan amendment to expand coverage, the state must submit written notification to the Project Officer, including a proposal for how the new or expanded eligibility group will be incorporated into the budget neutrality test for OHP.

83. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the composite federal share. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process through an alternative mutually agreed to method.

84. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds shall be returned to CMS.

a. To perform the budget neutrality test, actual cumulative FFP received by the state on OHP demonstration expenditures are compared to the federal share of the cumulative OHP budget neutrality expenditure limit. The federal Share of the cumulative budget neutrality expenditure limit is equal to the cumulative budget neutrality expenditure limit calculated above (on a total computable basis) times the composite federal share, which is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by total computable demonstration expenditures for the same period. Actual expenditures are those reported on Form CMS-64, as described in paragraph 74 above. The state may include budget neutrality savings from the original Oregon Health Plan demonstration (11-W-00046/0) in its application of the budget neutrality test for OHP.

b. Should the demonstration be terminated prior to the end of the approval period (see paragraphs 9, and 13, the budget neutrality test (including calculation of the Composite federal share) will be based on the period in which the demonstration was active.

c. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite federal share may be used.

d. Interim Checks/Corrective Action Plan. If the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
DY 9	Cumulative budget neutrality cap plus:	0.25 percent
DY 10	Cumulative budget neutrality cap plus:	0.25 percent
DY 11	Cumulative budget neutrality cap plus:	0 percent
DY 12	Cumulative budget neutrality cap plus:	0.25 percent
DY 13	Cumulative budget neutrality cap plus:	0.25 percent
DY 14	Cumulative budget neutrality cap plus:	0.25 percent
DY 15	Cumulative budget neutrality cap plus:	0 percent

XV. EVALUATION OF THE DEMONSTRATION

85. **Evaluation Design.** In the 120 days following the date of approval of this demonstration, the state shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the state will consider the Evaluation Guidance in Attachment B. The evaluation will include:

a. A discussion of the demonstration hypotheses that will be tested, focusing on key areas of the state's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional demonstration outcome measures;

b. An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.
c. Any other information pertinent to the state's evaluative or formative research via the demonstration operations.
d. Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;
e. The draft plan shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation; and
f. Any other information pertinent to the state's evaluative or formative research via the demonstration operations
g. An interim evaluation of the uncompensated care payments provided to IHS and 638 tribal health facilities as described in 57 and Attachment I. The evaluation must address the following specific questions related to the uncompensated care payments:

    i. What changes in service utilization occur when uncompensated care payments are implemented (broken down by type of service as well as the population served)?

    ii. Do affected facilities make changes in staffing levels?

    Methods by which the state can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

h. The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 (Extension of the Demonstration) and paragraph 82 (Interim Evaluation Reports) should contain an addendum identifying the state's proposed measures. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. This is not an exhaustive list, and the state is free to include any other relevant data.

    i. Evaluation of eligibility determinations by type, application, redetermination, transfer to the Exchange.
    ii. Evaluation of Medicaid denial and termination reasons.
    iii. Evaluation of average application processing times and timeliness.
    iv. Evaluation of reasons for disenrollment and internal churn.
    v. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

86. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of Section 1115 (a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

87. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

88. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

Attachment A - Quarterly Report Guidelines

(updated December 18, 2012)

As written within these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. In particular, the reporting elements may change to take advantage of new reporting via automated data systems that will support the transmission of data through data portals and other electronic reporting channels.

A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided in Appendix D.

REPORT FORMAT

I. Introduction

A. Letter from the State Medicaid Director – overview of the report

B. Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

C. State Contact(s):

1. Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise concerning quarterly reports.

II. Title

Title Line One – Oregon Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 11 (7/1/2012 – 6/30/2013)

Federal Fiscal Quarter: 4/2012 (7/2012 – 9/2012)

III. Events affecting health care delivery during the current quarter

Table 1 – Overview of significant events across the state affecting health care delivery during the current quarter

Table 1 is a statewide overview of the effect, or impact, of changes – positive, negative or with neutral effect – happening in the current quarter that are noteworthy because they reflect trends, major policy modifications or planned or unforeseen occurrences that affect:

- **The demonstration goals** of better health, better care, and lower costs as reflected in measures of efficiency, value and health outcomes;
- **A substantial portion of the delivery system**; or
- **A substantial portion of beneficiaries**.

Each category identifies data sources and whether there is a documented impact on the delivery system or beneficiaries. This table also shows interventions, or actions, the state may take or require to remedy, sustain or improve an outcome, as appropriate.

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
A. Enrollment progress	Quarterly enrollment reports – Appendix A				
B. Benefits	Provider and member transmittals – online at: http://www.dhs.state.or.us/policy/healthplan/transmit/main.htm				
C. CCO Complaints and Grievances	Monthly/quarterly CCO logs submitted to OHA and presented with detail in Table 2				
D. Quality of care – CCO	CCO and Innovator agent reporting to OHA as reported in Table 3 and Appendix F				
D. Quality of care – MCO	MCO reporting to OHA as reported in QI monitoring reports				
D. Quality of care – FFS	OHA FFS reporting				

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
E. Access	CCO and Innovator agent reporting to OHA as reported in Appendix F				
F. Provider Workforce	OHA surveys, summarized in Table 4				
G. CCO networks	CCO and Innovator agent reporting to OHA as summarized in Table 5 and Appendix F				

Detail on impacts or interventions

C. Table 2 – Complaints and grievances – statewide report -- all categories of CCO complaints and grievances for the current quarter

See www.oregon.gov for quarterly reports of complaints and grievances for individual CCOs.

NOTE: Oregon defines a grievance as any written or verbal complaint by an enrollee or consumer, or the enrollee's representative, regarding the enrollee's quality and access of care, individual or system abuse or neglect, issues related to the health plan's compliance with the Medicaid Program rules, billing complaints related to rights and limitations as provided by 42 CFR §438 and complaints related to eligibility and/or enrollment.

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
ELIGIBILITY AND ENROLLMENT					
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.					
b) Plan unresponsive, not available or difficult to contact for appointment or information.					
c) Provider's office too far away, not convenient					
d) Unable to schedule appointment in a timely manner.					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
e) Provider's office closed to new patients.					
f) Referral or 2nd opinion denied/refused by provider.					
g) Unable to be seen in a timely manner for urgent/ emergent care					
h) Provider not available to give necessary care					
i) Eligibility issues					
j) Client fired by provider					
INTERACTION WITH PROVIDER OR PLAN					
a) Provider rude or inappropriate comments or behavior					
b) Plan rude or inappropriate comments or behavior					
c) Provider explanation/instruction inadequate/incomplete					
d) Plan explanation/instruction inadequate/incomplete					
e) Wait too long in office before receiving care					
f) Member dignity is not respected					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity.					
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity					
i) Lack of coordination among providers					
CONSUMER RIGHTS					
a) Provider's office has a physical barrier					
b) Abuse, physical, mental, psychological					
c) Concern over confidentiality					
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.					
e) No choice of clinician					
f) Fraud and abuse					
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)					
i) Differential treatment for Medicaid clients					
j) Lack of adequate or understandable NOA					
k) Not informed of consumer rights					
l) Complaint and appeal process not explained					
m) Denied member access to medical records					
CLINICAL CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.					
b) Testing/assessment insufficient, inadequate or omitted					
c) Medical record documentation issue					
d) Concern about prescriber or medication or medication management issues					
e) Unsanitary environment or equipment					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
f) Lack of appropriate individualized setting in treatment					
QUALITY OF SERVICE					
b) Delay, quality of materials and supplies (DME) or dental					
c) Lack of access to ENCC for intensive care coordination or case management services					
d) Benefits not covered (Right click on drop down for selection)					
CLIENT BILLING ISSUES					
a) Co-pays					
b) Premiums					
c) Billing OHP clients without a signed Agreement to Pay					

Trends related to Grievances and Complaints, to include:

- Rate of complaints and grievances per enrollee
- Rate of complaints and grievances per enrollee using services
- Trends across quarters, including year to date total complaints and grievances with percentages

C. Table 2.1 – Appeals and hearings – statewide report – all categories of CCO appeals and contested case hearings for the current quarter

NOTE: Appeals and Contested Case Hearings are based on "actions" or denials, limited authorization, reduction, termination or suspension of services; or when payment is denied for a service that has been provided or a CCO has failed to act within specified timeframes.

	CCO Appeals		Overturned at plan level		Decisions Pending		Contested Case Hearings from CCO Appeals		Overturned at hearing		Decisions Pending	
Category	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**
a) Denial or limited authorization of a requested service												
b) Single PHP service area, denial to obtain services outside the PHP panel												
c) Termination, suspension or reduction of previously authorized covered services												
d) Failure to act within the timeframes provided in § 438.408(b)												
e) Failure to provide services in a timely manner, as defined by the State												

f) Denial of payment for a service rendered												
TOTALS												

Trends (Narrative):

Interventions (Narrative):

D. Table 3 – Summary – Implementation of 1% withhold

Metric	Amount(s)	Quarterly	Annually
Actual amount paid of monthly PMPM capitation rate broken out by: - **Average/mean PMPM** - **Eligibility group** - **Admin component** - **Health services component** - **For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy)**		X	X
Actual amount paid in incentives monthly broken out by: - **Total by CCO** - **Average/mean PMPM incentive** - **The over/under 100% of capitation rate by CCO and by average enrollee PMPM**		X	X
Best accounting of the flexible services provided broken out by: - **Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers)** - **Services that are not reflected in encounter data (e.g., air-conditioners, sneakers)**		X	X
CCO sub-contractual payment arrangements – narrative - **Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network**			X

Metric	Amount(s)	Quarterly	Annually
Encounter data analysis - **Spending in top 25 services by eligibility group and by CCO** - **To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well**		X	X

E. Table 4 – Statewide Workforce development – Non-Traditional Health Workers (NTHW)

	Total Number Certified Statewide* (current quarter & cumulative)	Number of approved training programs (current quarter & cumulative)
Community Health Workers		
Personal Health Navigators		
Peer wellness specialists		
Other NTHW		

* Statewide NTHW registry anticipated to launch in fall of 2013. Quarterly reporting would be reasonable after that point.

Narrative detail on regional distribution of certified NTHWs and NTHW training programs; news about relevant recruitment efforts or challenges

Health professional graduates participating in Medicaid

Tracking method and reporting format in development. Current assumptions are that:

- Tracking and reporting will begin July 2013, per STC 57(b)(iii) and will continue through the period for which FFP is claimed.
- Tracking will include graduates of each health professional training program for which FFP is claimed, within Oregon Health & Science University, the Oregon University System, and select Community Colleges.
- Tracking and reporting will be done by program/professional type (e.g. reporting will distinguish between physicians, nurses, dentists, physical therapists, and so on) and by practitioner specialty to the extent possible.
- These data will be presented in a detailed annual report. Updates will be provided quarterly, as available.

F. Table 5 – Significant CCO/MCO network changes during current quarter

Type of Change	Specific change	Effect on delivery system	Effect on members	Number of CCOs affected	Number of CCO members affected
Approval and contracting with new plans					
Changes in CCO/MCO networks					
Rate certifications					
Enrollment/disen-rollment					
CCO/MCO contract compliance					
Relevant financial performance					
Other					

G. Table 6 – Transformation center

Innovator Agents – Summary of promising practices statewide during current quarter

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
Innovator agent training				
Learning Collaborative activities				
Assisting and supporting CCOs with Transformation Plans				
Assist CCOs with target areas of local focus for improvement				
Communications with OHA				
Communications with other Innovator Agents				
Community Advisory Committee activities				
Rapid-cycle Stakeholder feedback to identify and solve barriers; to assist with adapting innovations; to simplify and/or improve rate of adoption and to increase stakeholder engagement				
Data base implementation – Tracking of CCO				

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
questions, issues and resolutions in order to identify systemic issues				
Information sharing with public				
Other				

G. Table 7 – Innovator Agents – – Measures of effectiveness

Measure	Data published for current quarter? Type?	Web link to Innovator Agent quality data
1. Surveys rating IA performance		
2. Data elements (questions, meetings, events) tracked		
3. Innovations adopted		
4. Progress in adopting innovations *		
5. Progress in making improvement based on innovations *		
6. CCO transformation plan implementation		
7. Learning Collaborative effectiveness		
8. Performance on Metrics and Scoring Committee metrics		

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

H. Legislative activities during current quarter

I. Litigation status

J. 2 percent trend data are reported in Appendix D: This table shows expenditures, including services inside and outside capitation rates for all populations served by CCOs, as well as administrative expenditures and indicates progress in meeting spending growth reduction targets.

K. DSHP terms and status are reported in Appendix E: This table shows new federal funds drawn as match against DSHP programs; new federal funds drawn as a result of DSHP and savings identified in the total cost of purchasing care (as described in STC 48).

IV. Status of Corrective Action Plans (CAP) that address any policy, administrative, or budget issues identified by CMS, the State, or a regulatory entity that impacts the demonstration.

Table 8 – Status of Corrective Action Plans (CAP)

Entity (CCO or MCO)	Purpose and type of CAP	Start date of CAP	Action sought	Progress during current quarter	End date of CAP	Comments

V. Evaluation activities and interim findings

Primarily narrative section focusing on the levers that are expected to drive quality improvement and cost trend reduction under the waiver, and results available to date regarding progress toward demonstration goals.

Reporting and discussion will include both OHA and CCO actions and may make reference to data presented in other sections of the quarterly report or in other documents (e.g. Section III of quarterly report, 2% trend reporting etc.)

Table 9 – Evaluation activities and interim findings

Lever	Report and Discussion
Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient- centered primary care homes (PCPCH)	*Discussion to include any rapid-cycle improvement activities planned as a result of findings, and reports on previous improvement efforts.*
Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes	
Lever 3: Integrating physical, behavioral, and oral health care	

Lever	Report and Discussion
structurally and in the model of care	
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	
Lever 5: Implementation of health-related flexible services aimed at improving care delivery, enrollee health, and lowering costs	
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	

Discussion of progress to date on waiver goals: reducing per-member cost growth, and improving quality, access, member experience and health outcomes.

VI. Public Forums – For any public forums held during the quarter**,** include public comment and summary report

VII. Transition Plan, Related to Implementation of the Affordable Care Act (ACA) – Effective 4-1-13 and ongoing, submit state's transition plan on 4-1-13, report and update on changes to or implementation of the plan quarterly, as necessary. The plan will include how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible.

VIII. Appendices

A. Quarterly enrollment reports that report:

1. SEDS
2. State reported enrollment tables
3. Actual and unduplicated enrollment, showing:
    a) The percent change in each category from the previous quarter and from the same quarter of the previous year
    b) The number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

B. Complaints and Grievance reports by sub-categories

C. Neutrality reports:

1. Budget monitoring spreadsheet

2. CHIP allotment neutrality monitoring spreadsheet

3. Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state‘s actions to address these issues.

D. Two percent trend reduction tracking

E. DSHP tracking

F. Oregon Measures Matrix for Quarterly Reporting

IX. Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

The state may also add additional program headings as applicable.

Appendix F: Oregon Measures Matrix

NOTE: Measures with an asterisk (*) are those that are reported quarterly. All others are reported annually.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
Improving behavioral and physical health coordina-tion	*Alcohol or other substance misuse (SBIRT)	√	√			√	MN method** Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based intervention).	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based intervention).			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from	TBD			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
									predecessor organization.				
	*Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available by April 2013.	90% (Note: Benchmark based on Metrics & Scoring Committee consensus).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	90%			
	*Follow-up care for children prescribed	√			√	√	Oregon Medicaid baseline 2011:	Medicaid 2012 NCQA National 90th percentile:	Individual CCO baselines will be determined	Medicaid NCQA National 90th percentile:			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	ADHD meds (NQF 0108)						Initiation: 50% C&M: 57%	Initiation: 51% C&M: 63%	with 2011 data from predecessor organization.	Initiation: 51% C&M: 63%			
Improving perinatal and maternity care	* Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 89%			
	* Prenatal and postpartum care:			√		√	TBD (baseline data	2012 National Medicaid benchmark	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	postpartum care rate (NQF 1517)						available in Feb 2013)	75th percentile: 90th percentile: 74.7%					
	* PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could also use the 16% rate publically	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could	5% or below.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
							available from Joint Commissio n - Diane Waldo)		also use the 16% rate publically available from Joint Commission - Diane Waldo)				
Reducing preventabl e re-hospitaliza-tions	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	*Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm			
	*All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a			
Ensuring appropriate care is delivered in	*Ambulatory Care:	√	√		√	√	TBD (baseline data	TBD 2011 National	MN method with 3% floor.	2011 National Medicaid 90th percentile (ED			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
appropriate settings	Outpatient and ED utilization						available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	Individual CCO baselines will be determined with 2011 data from predecessor organization.	utilization): 44.4/1,000mm			
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5 year period based on trends in Medicare and	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from	2012 National commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								Commercial data).	predecessor organization.	Adjusted 75th percentile: 61.34 (Based on Metrics & Scoring Committee consensus)			
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
									on measure formula.	on measure formula.			
	*Developmen-tal screening in the first 36 months of life (NQF 1448)	√	√		√	√	Oregon baseline: 19.6% using admin data only.	50% (Metrics & Scoring Committee consensus)	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	50% (Metrics & Scoring Committee consensus)			
	*Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								90th percentile: 77.3%					
	*Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile: 56.9%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 75th percentile: 56.9%			
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data	2012 National Medicaid benchmark	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
							available in Feb 2013)	75th percentile: 90th percentile: 27.5%					
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a			
	Appropriate testing for children with				√	√	TBD (baseline data	2012 National Medicaid benchmark	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	pharyngitis (NQF 0002)						available in Feb 2013)	75th percentile: 90th percentile: 83.9%					
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
							or recommended medications with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)						
Deploying care teams to improve	*Ambulatory Care:	√	√		√	√	TBD (baseline data	TBD 2011 National	MN method with 3% floor.	2011 National Medicaid 90th percentile (ED			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
care and reduce preventable of unnecessarily costly utilization by super users	Outpatient and ED utilization						available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	Individual CCO baselines will be determined with 2011 data from predecessor organization.	utilization): 44.4/1,000mm			
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
geographic area by harnessing and coordinating a broad set of resources, including CHW.	*Comprehen-sive diabetes care: LDL-C Screening (NQF 0063)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 83.5%	n/a	n/a			
	*Comprehen-sive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 91.1%	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	TBD (baseline data available in Feb 2013)	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Pick percentile NCQA National Medicaid 90th percentile: 28% 75th percentile: 34%			
	* PQI 01: Diabetes, short term complication admission rate (NQF 0272)		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on Oregon's	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								data (2002-2011)					
	*PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)		√	√		√	416.9 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
	*PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								data (2002-2011)					
	*PQI 15: Adult asthma admission rate (NQF 0283)		√	√		√	178.7 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
Improving access to effective	CAHPS 4.0 – Adult questionnaire	√	√	√		√	**Access to Care**	**Access to Care**	**Access to Care**	**Access to Care**			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
and timely care	(including cultural competency and health literacy modules).						OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%	OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							
	Chlamydia screening in			√	√	√	TBD (baseline	2012 National	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	women ages 16-24 (NQF 0033)						data available in Feb 2013)	Medicaid benchmark 75th percentile: 90th percentile: 72.7%					
	* Cervical cancer screening (NQF 0032)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 78.5%	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	*Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a			
	Provider Access Questions from the Physician Workforce Survey: 1) To what extent is your primary practice accepting new Medicaid/					√	In 2009: 52.4% of Oregon's physicians accepted new Medicaid patients without limitations; 29.7% accepted with some	TBD	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	OHP patients? (include: completely closed, open with limitations, and no limitations). 2) Do you currently have Medicaid/ OHP patients under your						limitations; and 17.9% were completely closed. 84% of physicians have Medicaid patients. The statewide payer mix for Medicaid is 15%.						

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	care? 3) What is the current payer mix at your primary practice?												
	Screening for depression and follow up plan (see above)												
	*SBIRT (see above)												
	*Mental and physical health												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	assessment for children in DHS custody (see above)												
	*Follow-up care for children on ADHD medication (see above)												
	*Timeliness of prenatal care (see above)												
	Colorectal cancer												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	screening (see above)												
	PCPCH enrollment (see above)												
	* Developmen-tal screening by 36 months (see above)												
	* Adolescent well child visits (see above)												
Addressing patient satisfaction	CAHPS 4.0 – Adult questionnaire (including	√	√	√		√	**Satisfactio n with Care**	**Satisfaction with Care**	**Satisfaction with Care**	**Satisfaction with Care**			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
with health plans	cultural competency and health literacy modules).						OR adult baseline: 76% OR child baseline: 80% OR average: 78%	2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	OR adult baseline: 76% OR child baseline: 80% OR average: 78%	2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							
Meaningful Use	EHR adoption (Meaningful	√				√	TBD (Baseline data	TBD	TBD	TBD			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core	CMS CHIPRA Core Measures	Oregon Quality & Access	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	Use 3 question composite)						available in April 2013)		(Baseline data available in April 2013)				

* These measures are reported quarterly

**The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Attachment B – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS requires states with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; states, federal government, and individuals benefit from state conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to state and federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should states have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and
    - Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
    - Hypothesis or research questions to be investigated;
    - Goals, such as:
        - Increase Access
        - Impact of title XXI cost sharing waiver for children in premium assistance
        - Cost Effectiveness
        - Improve Care Coordination
        - Increase Family Satisfaction and Stability
    - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
    - The type of research design(s) to be included -
        - Pre/Post Methodology
        - Quasi-Experimental
        - Experimental
    - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
    - Enrollment and outreach records;
    - Medicaid claims data;
    - Vital statistics data;
    - Provide record reviews;
    - School record reviews; and
    - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
    - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
    - How findings will be incorporated into outreach, enrollment and education activities;
    - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
    - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the state and/or relevance to nuances of the demonstration intervention.

ATTACHMENT C
Glossary of Terms Related to title XIX and XXI funded Children

Effective with the implementation of the ACA, changes to the demonstration will require revision of the Glossary.

Exhibit 1: Glossary of Terms Related to title XIX and XXI funded Children

- **Healthy Kids*:*** Created by House Bill 2116 during Oregon's 2009 Legislative Session, *Healthy Kids* provides coverage for all uninsured children up to age 19 in the state. The plan offers comprehensive health care coverage that includes dental, vision, mental health and physical health care. The objective of *Healthy Kids* is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. *Healthy Kids* includes three different program components:

  1. Existing CHIP and Medicaid direct coverage (OHP Plus);

  2. Premium assistance administered by the Office of Private Health Partnerships (family coverage under FHIAP for children up to and including 200 percent of FPL, and Healthy Kids ESI child only premium assistance for kids up to and including 300 percent of FPL;

  3. A private insurance component, Healthy KidsConnect, which is provided under the CHIP state plan.

  The federal government will provide match for children up to and including 300 percent of the FPL. The state will also permit uninsured children above 300 percent of the FPL to purchase the plan under Healthy KidsConnect without state or federal match.

- **Family Health Insurance Assistance Program (FHIAP) for Families Enrolled in ESI or Individual Market:** The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA) administers FHIAP. The premium assistance program provides subsidies to help families and individuals pay for health insurance offered either through employer-sponsored insurance (ESI) or private health insurance carriers. Coverage provided by the insurance plans must meet or exceed the FHIAP benchmark criteria, which is approved at a level actuarially equivalent to federally mandated Medicaid benefits.

As of January 1, 2014: 1) Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP or Healthy Kids ESI components of this demonstration rather than enroll in the Medicaid or CHIP state plan, and 2) Parents and childless adults enrolled in FHIAP with income from 0 up to 133 percent of the FPL, will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP state plans. Individuals currently receiving premium assistance who, based on an initial screening evaluation, do not appear to be eligible under the approved

Medicaid or CHIP state plans will be afforded a full eligibility determination prior to termination. Individuals denied continued benefits will be offered the opportunity to have their information electronically transmitted to the state Affordable Insurance Exchange (Exchange) to be treated as an application for coverage and benefits through the Exchange.

- **Premium Assistance for children and families with incomes from zero up to and including 200 percent of FPL:** Subsidies are available to children in this income category through FHIAP or Healthy Kids ESI. Children determined eligible by DHS or OHA are referred to OPHP for enrollment and subsidy payment or go directly to OPHP and on the FHIAP reservation list. FHIAP pays premium subsidies ranging from 50 to 95 percent for adults. Both FHIAP and Healthy Kids ESI pay100 percent of the premium for children in this income group. Individuals (adults and children) who enroll in this program are subject to all other cost sharing provisions of the insurance plan. The children in this income group have the option of enrolling in FHIAP, Healthy Kids ESI, or CHIP direct coverage (OHP Plus), and children who choose FHIAP or Healthy Kids ESI can move back to state plan direct coverage at any time.

- **Healthy Kids ESI/Child Only Premium Assistance and Healthy KidsConnect for children in families with incomes above 200 up to and including 300 percent of FPL who have access to ESI:** Subsidies are available to children in this income category through ESI or the state's private insurance option, Healthy KidsConnect. Children in families with incomes above 200 percent FPL are not eligible for CHIP direct coverage (OHP Plus). Sliding scale subsidies are available for children who are able to enroll in the family's ESI.
  - Families with incomes above 200 up to and including 250 percent of FPL will receive state subsidies equaling about 90 percent of the child's monthly premium.
  - Families with incomes above 250 up to and including 300 percent of the FPL will receive state subsidies equaling about 80 percent of the child's monthly premium.
  - All other cost-sharing is subject to the cost of the employer plan.

- **Healthy KidsConnect:** This is a CHIP state plan direct coverage option provided under the state's separate child health program. Sliding scale subsidies are available to children who enroll in state-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP direct coverage (OHP Plus) benefit package.

- Families with incomes above 200 percent up to and including 250 percent of FPL will receive state subsidies equaling about 90 percent of the child's monthly premium; and
- Families with incomes above 250 percent up to and including 300 percent of the FPL will receive state subsidies equaling about 80 percent of the child's monthly premium.
- Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.

- **Oregon Health Plan (OHP) Plus:** OHP Plus is a CHIP state plan direct coverage option provided under the state's separate child health program. The state provides Secretary-approved coverage that is the same as coverage offered under the state's Medicaid program. The state's benefit package is based on the OHP Prioritized List of Health Services, which is a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration for its entire Medicaid population. Medically necessary services are defined in the Prioritized List. The benefit package includes mandatory services for children, including well-baby and well-child visits, immunizations and dental services. There are no premiums, co-payments, or deductibles for children in direct coverage.

- **FHIAP Reservation List:** Oregon uses reservation lists to manage enrollment in the premium assistance program. Only FHIAP-eligible families with income from 0 up to and including 200 percent of the FPL are subject to the reservation list.

  As of January 1, 2014 the FHIAP reservation list will no longer be applicable. Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP component of this demonstration rather than enroll in the Medicaid or CHIP state plan, and parents and childless adults enrolled in FHIAP with income below 133 percent of the FPL will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP state plans.

  - **The individual reservation list** is for applicants who do not have access to ESI.
    - Once approved, individuals may select an individual health plan from a list of approved FHIAP insurers.
    - Only plans that meet FHIAP's benchmark are offered to individual members.

  - **The group reservation list** is for applicants who have access to ESI.
    - ESI plans must meet FHIAP's benchmark.

Attachment D - Summary Chart of Populations Affected by or Eligible Under the Demonstration

ACA Implementation. As set forth in paragraph 13 and upon implementation of the ACA on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII) of the Act and the collapsing of certain eligibility groups will revert to the Medicaid state plan.

I. Mandatory Medicaid Populations*							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
1	Pregnant Women	Title XIX	Title XIX state plan and section 1115	Effective through December 31, 2013: 0% up to 133% FPL Effective January 1, 2014: 0% up to 185% FPL	None	OHP Plus	Base 1
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL** Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus	Base 1
4	Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	Effective through December 31, 2013: 0% up to 100% FPL Effective January 1, 2014: this	None	OHP Plus	Base 1

				population will be combined with population 3			
5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus	Base 2
6	Medicaid mandatory section 1931 low0income families. (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX	Title XIX state plan and Section 1115	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus	Base 2
21	Uninsured or underinsured women under the age of 65	Title XIX	Title XIX	0% up to 250% FPL	None	Limited – case-by-case basis	Base 1
23	Low-Income Expansion Adults	Title XIX	Title XIX	0% up to 133% FPL	None	ABP	Base 2

II. Optional Medicaid Populations* **							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
8	Aged, Blind, & Disabled	Title XIX	Section 1115 and Title XIX state plan	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus	Base 2

2	Pregnant Women	Title XIX	Section 1115 and Title XIX state plan	Effective through December 31, 2014: From 133% up to 185% FPL Beginning January 1, 2014, this group will be covered through population 1	None	OHP Plus	Base 1

**Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the state also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by federal regulations, since the state has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL.
***Optional Medicaid (OHP Plus) populations have the option of choosing FHIAP, in which case they would be in Population 14.
**** Unborn population is precluded from receiving the following services: abortion, death with dignity, sterilization, hospice services and postpartum services beyond the global rate

Attachment E: Menu Set of Quality Improvement in Focus Areas

The measures in bold would be the core measures for each focus area and would be required of any CCO selecting that focus area.[4] The purpose for these focus areas is to reduce costly, inappropriate, and unnecessary care where possible without decreasing the quality of care. The state may wish to add to this menu to account for how they will measure access and quality for individuals receiving care FFS—this should include populations receiving costly long term care and supportive services.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
1) Reducing rehospitalizations	**Hospital readmissions (across age groups); Plan all-cause readmissions**; hospital cost per patient and total cost of care per patient over specific time periods for patients enrolled in care transition programs; care plan for members with long-term care benefits; follow-up after hospitalization for mental illness; medication reconciliation post-discharge; timely transmission of transition record	Financial penalties for high rates of rehospitalizations and/or incentives for low rates (must remove the financial incentive to rehospitalize through incentives and penalties), care transition programs. Also see "super-utilizers" interventions
2) Addressing discrete health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers	These will vary depending on issue identified, but could include disease specific measures such as Diabetes Care measure, pediatric asthma hospitalization	Ideally these would include a wide range of activities by multiple entities such as pediatric community based asthma initiatives, enhanced by coordinated public health interventions to target tobacco cessation. Clinical diabetes care initiatives can dovetail with public health interventions such as outreach programs and community based obesity reduction programs
Reducing utilization by "super-utilizers"	Cost of care measures (total cost of care per patient over	Community-based outreach programs to better address

[4] The rest of the measurement strategy will be determined later but sample additional measures are included for discussion purposes.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	specific time period), and the **readmissions measures mentioned above, rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; and outpatient and ED utilization**	the needs of high utilizers. Successful programs have consisted of community-based outreach programs (including in person programs beyond telephonic case management), nurse care coordination, home visits, same day appointments, and data sources adequate to target the super utilizers. Oregon's proposal includes pieces of these, including community health workers to help beneficiaries navigate the system and access resources; coordination with long-term care case workers and providers for individuals receiving long-term care and/or developmental disabilities supports and services; CCO efforts to integrate information flow across providers. It is critical these services are appropriately targeted
Integrating primary care and behavioral health	Screening for clinical depression & follow-up plan; **screening and referral for alcohol or drug misuse**; initiation and engagement with alcohol and drug treatment; **follow-up after hospitalization for mental illness**; mental health assessment for children in DHS custody, mean cost for outpatient mental health and medications per patient; mean cost for inpatient	Global budget and single point of accountability for behavioral and physical health; co-location of mental health and primary care which includes collaborations between the mental health and primary care providers to develop and execute a shared treatment plan, including coaching and counseling, improved systems for records sharing

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	mental health and substance abuse care per patient	
Ensuring appropriate care is delivered in appropriate settings	**Rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization,** Hospital readmissions (across age groups); Plan all-cause readmissions, primary care access measures	Narcotics registries, programs to address "super-utilizers", targeted case management for frequent ED users, connect vulnerable patients with appropriate behavioral health and social services
Improving perinatal and maternity care	**Early elective delivery before 39 weeks**, preterm deliveries, perinatal measures such as screening for tobacco use, tobacco cessation counseling, breastfeeding at discharge	Collaboration with Strong Start program on early elective delivery, interconception care, home visiting programs for first time mothers
Improving primary care for all populations	Proportion of individuals with a patient-centered primary care home (PCPCH) and proportion of certified PCPCHs in a CCO's network, and level of certification; **rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization**; ratio of primary care spending to specialty & hospital spending over time, well-child visits, tobacco use screening and cessation counseling for patients >12 years old, BMI recorded (and appropriate counseling), drug-to-drug and drug allergy checks, and maintain active	CCO strategies to encourage their providers to attain highest levels of PCPCH recognition; development of community health workers to help increase access to culturally and linguistically appropriate primary care; CCO requirements for health assessments and person-centered care plans, certified EHR adoption and meaningful use; PCMH participation incentives; shared incentives across primary, specialty, long-term, and acute care; improved access (e.g., after-hours physician availability, 24/7 access to an NP or doctor); PHRs; open-access scheduling and sick hours.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	medication list (including allergies)	

Attachment F: CCO Services Inventory
(updated January 1, 2014)

This attachment provides the schedule for inclusion of new services into CCO global budgets and reflects OHA's planning as of December 2012. Oregon will notify CMS if contract amendment schedule is revised.

Pursuant to STC 36b, the inclusion of additional services in the global budget will be mutually agreed upon by the state and CMS and phased in over the course of the demonstration. Oregon will submit proposed changes to the Regional Office as part of draft CCO contracts or contract amendments at least 45 days in advance of their effective date. Services outlined in Attachment F will generally be included in CCO global budgets as capitated services. For any services not paid as capitation, the state will identify the rate (referencing the state plan methodology or describing the rate methodology to CMS) and the rates will be subject to CMS review and approval.

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
1	Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	X						Yes	Yes
2	Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities)	X						Yes	Yes
3	Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	X						Yes	Yes
4	Mental Health	Children's Statewide Wraparound Projects	X						Yes	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
5	Mental Health	Exceptional Needs Care Coordinators	X						Yes	Yes
6	Mental Health	Non-forensic intensive treatment services for children(Inpatient Psychiatric Facility Services for Individuals Under age 21)	X						Yes	Yes
7	Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	X						Yes	Yes
8	Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	X						Yes	Yes
9	Mental Health	Supported Employment and Assertive Community Treatment		X					Yes	Yes
10	Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating	X				Yes	Yes
11	Addictions	Youth residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X				Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring						Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
12	Addictions	Adult residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X				Yes	Yes
13	Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating			X		Yes	Yes
14	Targeted Case Management	HIV/AIDS Targeted Case Management					X		Yes	Yes
15	Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon					X		Yes	Yes
16	Maternity Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)		Optional where currently operating	X				Yes	Yes
17	Transportation	Non-Emergent Medical Transportation			X Pilot	X Partial Phase-in	X Complete		Yes	Yes
18	Mental Health	Adult Residential Mental Health Services					X		Yes	Yes
19	Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						X	Yes	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
20	Dental	OHP dental coverage	Optional	Optional	Optional		X		Yes	Yes
21	Mental Health	Young Adults in Transition Mental Health Residential			X				Yes	Yes
22	Mental Health	Personal Care 20 Client Employed Provider						X	Yes	Yes
23	Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)						X	No	Yes
24	Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)						X	No	Yes
25	Long Term Care	Long term care institutional and community supports						X	No	Yes
26	Mental Health	State Hospital Care - Forensic						X	No	Yes
27	Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations				X			No	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
28	Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)						X	No	Yes
29	Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB						X	No	Yes
30	Mental Health	OHP-covered mental health drugs						X	No	Yes
31	Other	Hospital Leverages: GME, Pro-Share, and UMG						X	No	Yes
32	Other	FQHC Full-Cost Settlements						X	No	Yes
33	Other	A & B Hospital Facilities Settlements						X	No	Yes
34	Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)						X	No	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
35	Targeted Case Management	Child Welfare Youth (Targeted Case Management)						X	No	Yes
36	Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)						X	No	Yes
37	Targeted Case Management	Tribal Targeted Case Management						X	No	Yes
38	Other	DSH						X	No	Yes
		Note: All services are state plan services with the overlay of the Section 1915(b) waiver for transportation and the Section 1115 demonstration that includes application of the Prioritized List of Health Services.								

Attachment G

Reimbursement and Claiming Protocol for Oregon Designated State Health Programs
Determination of Allowable DSHP Costs Per Waivers 21-W-00013/10 and 11-W-00160/10

Acronyms:

A & D – Alcohol and Drug
APD – Adults and People with Disabilities (formerly SPD)
AMH – Addictions & Mental Health
CAF – Children, Adults, and Families
CPMS – Client Process Monitoring System
DMAP – Division of Medical Assistance Programs
DSHP – Designated State Health Programs
eXPRS – Express Payment and Reporting System
OSPHL – Oregon State Public Health Lab
OMIP – Oregon Medical Insurance Pool
PHD – Public Health Division
SFMA – Statewide Financial Management System
SPD – Seniors and People with Disabilities

To support the goals of health system transformation, the state may claim federal Financial Participation (FFP) for the following state programs subject to the annual limits and restrictions described in the Standard Terms and Conditions (STCs) # 55 -58 of Oregon's Health Transformation Waivers 21-W-00013/10 and 11-W-00160/10 through June 30, 2017. This attachment contains the protocol for such determination of cost.

Office of Management and Budget (OMB) Circular A-87 (2 CFR Part 225), Cost Principles for state, Local and Indian Tribal Governments, section C.4. requires federal grants be provided net of any applicable credits. The state is required to offset all revenues received relating to eligible expenditures identified under this attachment.

For purposes of this protocol, CMS will recognize as allowable costs under this demonstration the total amounts expended by the state without reduction to FFP to reflect revenues in the form of premiums and tuition paid by program enrollees that might be otherwise treated as applicable credits. This exception is only available for approved expenditures associated with the Oregon Medical Insurance Pool through June 30, 2014, and for approved education expenditures associated with for Workforce Training at the State of Oregon's public colleges and universities through June 30, 2015.

All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding. For purposes of expenditures claimed under this protocol, the state cannot utilize provider-related donations as a source of the non-federal share.

Below are descriptions of each DSHP program that was approved under waivers 21-W-00013/10 and 11-W-00160/10. The following programs have been arranged based on program groups.

PROGRAM GROUP: AMH—Addictions and Mental Health

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the AMH non-contract program group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure.

For each program in this group that involves contractual services, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual services delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the AMH Contractual Services Program Group is R-Base.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the AMH R-Base data base system (R-Base), a contract database subsidiary system for accounting data to the SMFA accounting system, the official 'book-of-record' for the state. The R-Base system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state Funds only will be so identified. Coding tables in R-Base are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. Data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

Program: Mental Health (MH) Non-Residential Adult Services

- **Brief Description:** MH services delivered to persons diagnosed with serious mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. The following services are provided via this program:

  - Vocational and social services
  - Medication and medication monitoring
  - Counseling for emotional support
  - Individual/family and group counseling and therapy
  - Support to locate and obtain housing
  - Coordination of care services

  Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Adults 18 years or older with serious mental illness who do not qualify for Medicaid.

Program: MH Children and Adolescent

- **Brief Description:** Mental health services for children and adolescents with primary mental, emotional or behavioral conditions. The following services are provided via this program:

  - Provision of screening
  - Assessment and Level of Service Intensity
  - Referral and care coordination services
  - Skills training

- Crisis planning
- Respite care
- In-home support.

Services may be delivered, as appropriate, in a clinic, home, school or other settings familiar and comfortable for the individual receiving such services. Other settings may be aftercare/daycare, county case manager office, mental health clinic, and primary care clinic.

Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Individuals under age 18 who have primary mental, emotional or behavioral conditions and are not eligible for Medicaid.

Program: MH Regional Acute Psychiatric Inpatient

- **Brief Description:** Stabilize, control or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the individual to a less restrictive environment. The following services are provided via this program:

    - Ancillary services such as regional coordination and enhancements to County, Community Mental Health Program (CMHP) ; treatment plan development that include identification of goals, strengths, target behaviors, methods for change; coordination of care, evidence-based interventions with families, advocates, representatives of community agencies; and medication management; individual and group therapy that addresses issues identified in the treatment plan.
    - Services that serve to expedite the movement (including secure transportation) of individuals into and out of facilities where inpatient psychiatric services are delivered and to divert persons from acute care services, collaboration with families, parenting support, crisis planning, skills training for client and family members, continuum of care plan to move client to less restrictive settings.

- **Eligible Populations:** Individuals in need of inpatient psychiatric services who are uninsured and/or indigent and are not eligible for Medicaid. These are individuals who suffer from an acute mental illness, or other mental or emotional disturbance posing a danger to the health and safety of the individual or others.

Program: MH Residential Treatment for Youth

- **Brief Description:** Services for individuals needing continued long-term services to avoid hospitalization. The following treatment services are provided via this program:

    - Medication and Medication monitoring supervision)
    - Vocational and social services
    - Individual and family group counseling
    - Counseling emotional support
    - Coordination of care services
    - Services delivered on a 24-hour basis.

Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Residential Treatment for Youth: Young adults through age 25 who are eligible, under ongoing review of the jurisdiction of the Juvenile Psychiatric Review Board or in the Youth and Young Adult in Transition Program, with mental or emotional disorders who

have been hospitalized or are at immediate risk of hospitalization, who need continuing services to avoid hospitalization or who are a danger to themselves or others or who otherwise require long-term care to remain in the community. These individuals are not eligible for Medicaid.

Program: MH Adult Foster Care

- **Brief Description:** This program includes continuing services, including ongoing supervision, which are provided to adults to avoid higher level services or hospitalization. The following services are provided via this program:
    - Clinical assessment
    - Develop individual plan of care that addresses clients MH diagnosis
    - In-home case management
    - Counseling (individual and family group)
    - Coordination of care services
    - Skill training
    - Transition support to move to the next step to independent living.
    - These services are delivered in family home or facility.
- **Eligible Population:** Adults 18 years old or older who are in need of continuing services to avoid hospitalization, or who have been hospitalized, or who pose a danger to the health and safety of themselves or others, and who are unable to live by themselves without supervision. These individuals are not eligible for Medicaid.

Program: MH Older and Disabled Adults

- **Brief Description:** This program includes specialized geriatric mental health services delivered to older and disabled adults with mental illness. The following services are provided via this program:
    - MH services
    - Medication management
    - Follow-up services.
    - Medical condition follow-up (many of these clients have ongoing medical conditions).
    - Coordination of care
- **Eligible Populations:** Older and disabled adults with mental illness needing mental health services. These individuals are not eligible for Medicaid.

Program: MH Special Projects

- **Brief Description:** These are projects that provide enhanced services, services to enable service delivery expansion, peer delivered services, and, educational and employment support services. The following services are provided via this program:
    - Peer delivered services (PDS): is the social, emotional and instrumental support offered or provided by persons with a mental health condition, to others who share a similar mental health condition in order to bring about a desired social or personal change. This overall service includes an array of agency or community-based services and supports provided by peers and peer support specialists.

Included is assistance for people with Serious Mental Illness (SEMI) to meet their education and/or recovery goals and/or become gainfully employed through the education and training acquired during postsecondary education.
    - Skill training
    - Counseling for emotional support
    - Community integration
    - Crisis support

- **Eligible Population:** Adults and Children with mental illness in unique condition situations who need special mental health services. These individuals are not eligible for Medicaid.

Program: MH Community Crisis

- **Brief Description:** This program provides immediate MH crisis intervention (24/7) and assessment; triage and intervention services (psychological treatment services and crisis counseling services) delivered to individuals experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. This program also includes the following psych services which can be rendered at a hospital or a non-hospital facility. Services are of limited duration and are intended to stabilize the individual and prevent further serious deterioration in the individual's mental status or mental health condition.

- **Eligible Population:** Adults and Children in a crisis situation who are not eligible for Medicaid.

Program: MH Support Employment

- **Brief Description:** This program includes the following services which are delivered to individuals to enable them to obtain and maintain employment:

    - Supervision and job training
    - On-the-job visitation
    - Consultation with the employer
    - Job coaching
    - Counseling
    - Skills training
    - Transportation
    - Transitional employment services: On-the-job skills development for the next level—to obtain a better job, job counseling.

- **Eligible Population:** Individuals 18 years or older with chronic mental illness needing to obtain and maintain employment. These individuals receive non-residential adult services and need evidence-based supported employment services. These individuals are not eligible for Medicaid.

Program: MH & Alcohol and Drug (A & D) Homeless

- **Brief Description:** This program provides transitional services to a supported environment, i.e., treatments services, housing/living environments that maintain and reinforce the client's recovery efforts. This program provides a broad range of transition services that include:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation and rehabilitation services
- Community MH services, A&D treatment services
- Staff training
- Case management services
- supportive and supervisory services in residential settings
- Referrals for primary health services
- Job training
- Educational services
- relevant housing assistance services (locating and securing housing)

Room and board is not considered in the amounts that will be claimed for this program

- **Eligible Population:** Individuals with serious mental illness that may have co-occurring substance abuse use disorders and who are homeless or at risk of being homeless. These individuals are not eligible for Medicaid.

Program: MH Residential Treatment for Adults

- **Brief Description:** This program includes crisis stabilization and intervention services, including:

  - Behavior management
  - Daily living activity coordination
  - Crisis stabilization services
  - Crisis intervention services
  - Residential treatment services determined upon individualized assessment of treatment needs and development of plan of care
  - Management of personal money and expenses
  - Supervision of daily living activities
  - Life skills training
  - Administration and supervision of medication
  - Provision or arrangement of transportation
  - Management of behavior
  - Diet management.

- Services are delivered on a 24-hour basis to individuals who need continuing services to remain in the community and to avoid higher levels of services or hospitalization or who are a danger to themselves or others or who otherwise require continuing care to remain in the community.

  Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Adults 18 years or older who are determined unable to live independently without supervised intervention, training or support, and who do not qualify for Medicaid.

Program: MH Non-Residential, Designated

- **Brief Description:** These individuals in this program have low frequency, high intensity needs above the standard non-residential structure. Services include:

    - Vocational and social services
    - Support to obtain and maintain housing (locating and securing housing)
    - Medication and medication monitoring
    - Emotional support
    - Individual, family and group counseling and therapy
    - Case management services

- **Eligible Population:** Adults 18 years old or older, who are uninsured needing mental health services delivered to designated persons (adults) diagnosed with serious, chronic mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. These individuals are not eligible for Medicaid.

Program: A & D Special Projects

- **Brief Description: This program includes the following** treatment enhancement activities:

    - Early screening and assessment for alcohol and drug problems
    - Facilitation of collaboration between schools and partner agencies in developing and maintaining screening and referral processes
    - Outreach
    - Case management

- **Eligible Population:** Youth at high risk of problems with alcohol and drugs and their families. These are Non-Oregon Health Plan individuals or may pay for services not provided by OHP. This program is specifically designed for families at risk of Temporary Assistance for Needy Families (TANF) involvement or in the TANF program.

Program: A & D Residential Treatment, Adults

- **Brief Description:** This service is to support, stabilize and rehabilitate individuals and to permit them to return to independent community living. Services provide a structured environment for an individual on a 24-hour basis consistent with chemical dependency placement, continued stay and discharge criteria Level III-services (twenty-four hour supervision is needed using a structured 7-day-a-week therapeutic environment to achieve rehabilitation). The services within this program address the needs of diverse population groups within the community. This program helps people stabilize physically and mentally so they are able to transition to a lower level of care including self-directed recovery management.

- **Eligible Population:** Individuals 18 years of age or older who are unable to live independently in the community and cannot maintain even a short period of abstinence and are in need of 24-hour supervision, treatment and care. These individuals are for non-OHP eligible and must be indigent status with income at 100 percent or lower of the federal Poverty Level (FPL). These individuals are not eligible for Medicaid.

Program: A & D Continuum of Care

- **Brief Description:** This program provides outpatient substance abuse disorder treatment including medication-assisted treatment (primarily methadone). This program also includes non-hospital detoxification, case management and wrap around services such as:

- Peer mentoring
- Child care
- Transportation
- Relapse prevention
- Healthy eating and wellness counseling
- Connection to social support groups

Services build upon resilience, assisting individuals to make healthier lifestyle choices and to promote recovery from substance use disorders. Services consist of case management, clinical care and continuing care delivered when therapeutically necessary and consistent with the developmental and clinical needs of the individual, Level I (Outpatient), Level II (Intensive Outpatient), Level III (Non-medical Detoxification, and Intensive Treatment and Recovery Services).

- **Eligible Population:** Services delivered to youth and adults with substance use disorders. These are individuals who are indigent with no OHP or insurance coverage. These individual are not eligible for Medicaid.

PROGRAM GROUP: Children, Adults and Families (CAF)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the CAF program group is Oregon Kids System (OR-KIDS).
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the OR-KIDS, an interface sub-system for accounting data to the state accounting system official 'book-of-record' SFMA. The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the OR-KIDS system as they are then authorized for service payments to providers providing the designated client care services. The system checks the client eligibility status then matches to the appropriate fund source based on the client eligibility status. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state funds only will be so identified. Only those services funded with state funds only are allowable for DSHP match. Coding tables in OR-KIDS, are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: System of Care

- **Brief Description:** This program consists of purchased services provided to meet the individualized needs of children and parents involved with Child Welfare. This program is only applicable to services not rendered by any other state program. The following services are provided via this program:
  - Wrap-around planning services
  - Healthcare services for uninsured parents
- **Eligible Population:** Children and families being served by Child Welfare where caseworkers have identified needs for supports and services unmet by any other state resource.

Program: Community Based Sexual Assault

- **Brief Description:** This program consists of contracted services for Sexual Assault Counselors to provide counseling and support services to victims of sexual assault.

- **Eligible Population:** Victims of sexual assault who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Community-based Domestic Violence

- **Brief Description:** This program consists of contracted services for Domestic Violence Advocates to provide support and treatment services to victims of Domestic Violence.

- **Eligible Population:** Victims of domestic violence brought to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Family Based Services

- **Brief Description:** This program consists of services to provide in-home safety and reunification services. As a result of this program, families remain together while safety supervision and parenting support/coaching are provided. Services include:

    - Parent training
    - Therapeutic support
    - Supportive remedial day care.

- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Foster Care Prevention

- **Brief Description:** This program consists of Child Welfare services for families with children at risk of out-of-home placement. The following services are provided via this program:

    - Therapeutic supports
    - In-home case management
    - Counselling
    - Referrals to families to help them transform their lives.

- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Enhanced Supervision

- **Brief Description: This program consists of** one-on-one supervision services to children in out-of-home care to assure their safety or the safety of those around them. These are children that have emotional, behavioral or medical issues. This program involves assessment services to identify services needed, and the supervision of the process by which the client receives those services.

- **Eligible Population:** Children placed in out-of-home care due to allegations of abuse and/or neglect requiring additional supervision to assure safety.

Program: Nursing Assessments

- **Brief Description:** This program involves Individualized assessments provided by a Registered Nurse to determine the need for Personal Care services to be provided to a child in an out-of-home care setting.
- El**igible Population:** Children placed in out-of-home care that may have medical needs requiring ongoing care in a home setting.

Program: Other Medical

- **Brief Description:** This program consists of contracted services for assessments and evaluations deemed necessary for the comprehensive and coordinated care planning needed for children and families involved with Child Welfare.
- **Eligible Population:** Parents and children who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: IV-E Waiver Demonstration Project

- **Brief Description:** This program consists of additional supports in the form of Peer Mentoring or Relationship Based Visitation for parents and children being served by Child Welfare. These supports are in addition to traditional child welfare programs that provide services for prevention and reunification (of families). Traditional services and community supports include mental health counseling, parenting training, and assistance navigating the process (e.g., court processes) for victims of domestic violence.
- **Eligible Population:** Parents and children served by Child Welfare, not receiving Medicaid or services via any other federal program.

Program: Personal Care:

- **Brief Description:** This program consists of the provision of medical services including skilled services delegated by a Registered Nurse under Oregon's Nurse Practice Act, identified in an individual care plan and provided to eligible children in a family foster care setting. Services provided in this program can include: medication supervision and monitoring assistance, assistance with activities of daily living, specific medical procedures (e.g. trachea support), and incontinence management procedures.
- **Eligible Population:** Children served by Child Welfare that must be in out-of-home care due to allegations of abuse and/or neglect, and have medical needs requiring an individualized care plan approved by the state.

PROGRAM GROUP: Adults and People with Disabilities (APD) (formerly SPD—Seniors and People with Disabilities)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> > **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-systems for the APD (formerly SPD) Program Group are the House Keeper System for Oregon Project Independence, and the CPMS and eXPRS interface sub-systems for Family Support and the Children's Long-Term Support programs.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- **House Keeper System :** The process of the determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients, and entry of the data into the House Keeper system as they are then authorized for service payments to providers providing the designated client

care services. In the Housekeeper system, the status identifies the client for Oregon Project Independence (OPI) services and the system generates provider payments. The system assigns SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) that identify the clients' services and related costs attributable for DSHP. Payment data is interfaced to the state SFMA system from which payment (expense) reports are produced. The accounting reports pull data directly from the SFMA system, and/or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **eXPRS System:** Payment source data is from the eXPRS system, an interface sub-system for accounting data to the SFMA accounting system, the 'book-of-record' for the state. The eXPRS system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state funds only will be so identified. Coding tables in eXPRS are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **CPMS System:** The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the CPMS system. A report is pulled from CPMS source data and reconciled on a quarterly basis with the payment as authorized by the eXPRS System and paid by SFMA. Only those services funded with state funds only are allowable for DSHP match.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Project Independence (OPI)

- **Brief Description:** OPI provides in-home services to seniors who require the same level of care as people in nursing homes, but who do not qualify for Medicaid. Services can be received in their own homes, and include personal assistance, nursing tasks and help with housekeeping. Services may also include help with activities of daily living, memory and confusion, mobility and transfers, housekeeping and laundry, meal preparation or delivery, shopping and transportation, medical equipment, assistance with medications.

- **Eligible Population:** Eligibility for OPI is age (60 years of age or older or under 60 with a diagnosis of Alzheimer or related dementia) and a Client Assessment & Planning System assessment evidencing a service priority level (SPL) of 1-18. These services are provided statewide through Area Agencies on Aging local offices. Clients with net incomes between 100 percent and 200 percent of federal Poverty Level (FPL) are expected to pay a fee toward their service, based on a sliding fee schedule. Families with net incomes above 200 percent FPL pay the full hourly rate of the service provided.

Program: Family Support

- **Brief Description:** Services are provided for eligible children with developmental disabilities, in their parents' or relatives' home. Through this program, families determine what they need most. Families have the flexibility to choose services and providers. Families and service coordinators work to develop a plan revolving around the child and family needs. In some

cases, a family may access family support for a brief time while other families may need an on-going family support plan. The program strives to help children and families remain independent, healthy and safe. The service coordinator and family work to identify all available resources from the family and community. These might include people, support-groups, public and private programs, private insurance, and many other resources. Services include assistance in determining needed supports, respite care, purchase of adaptive equipment; services are proactive, and are intended to help prevent families from going into crisis.

- **Eligible Population:** Families who have children with developmental disabilities. It is a capped program ($1,200 per eligible child per year) with a current caseload of approximately 500. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and have tried to get access to funds to cover their needs prior to submitting request for Family Support. These individuals are not eligible for Medicaid.

Program: Children Long-Term Support

- **Brief Description:** This program provides supports to a child with a developmental disability at risk of out-of-home placement (foster care, residential, etc.). Children are assessed for level of service by the local Community Developmental Disability Program Service Coordinator. With the family, the Service Coordinator assists in plan development that identifies supports needed for the child to stay in the home. Supports include:
  - In-Home Supports
  - Respite
  - Behavior Consultation
  - Family Training
  - Environmental Adaptations
  - Specialized Medical Equipment and Supplies.
- **Eligible Population:** Families who have children with developmental disabilities who are at risk for out of home placement. This is a capped program with a current caseload of approximately 180. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and meet a crisis criteria of risk of out of home placement. These individuals are not eligible for Medicaid.

PROGRAM GROUP: Public Health Division (PHD)

- **Funding Sources:** State General Funds, Other Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Public Health Division Program Group is the Oregon Statewide Payroll (OSPS) system.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service that is eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with state funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All PHD expenditures are processed directly in the SFMA system.

- **Payroll System**: Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses (OPE) directly to the PHD programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one

program, a different Index/PCA combination is entered to ensure their time is properly allocated to DSHP. Coding tables in OSPS are accessed that assign an SFMA coding structure and are interfaced to SFMA system.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

Program: PHD Licensing Fee (Health Care Regulation and Quality-HCRQI)

- **Brief Description:** The Health Care Regulatory & Quality Improvement Section (HCRQI) is statutorily mandated to regulate, inspect, license and provide certification approval for the following entities and individuals: Ambulatory Surgical Centers, Birthing Centers, Dialysis Facilities, Hemodialysis Technicians, Home Health Agencies, Hospice Agencies, Hospitals, In-Home Care Agencies, Special Inpatient Care Facilities, Trauma Hospital designations.
  HCQRI is responsible for the entire licensure and certification processes for each of the above-listed individuals or entities. HCRQI also provides licensing information to the public and other agencies. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

- **Eligibility:** HCRQI does not provide direct care to Oregonians so there are no eligibility criteria. However, the ultimate beneficiaries are Oregonians who are able to find access to safe, high-quality and patient-centered health care because of HCRQI's efforts. All Oregonians benefit from having a wide access to health care. The program ensures that the health care will be safe, of high quality, and meet or exceeds and federal standards.

Program: PHD, Oregon State Public Health Lab (OSPHL) General Microbiology Testing Program

- **Brief Description:** The OSPHL General Microbiology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitters. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: PHD OSPHL Virology/Immunology Testing Program

- **Brief Description:** The OSPHL Virology/Immunology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitter. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: State Support for Public Health

- **Brief Description:** This program consists of services rendered by Local Public Health Departments (LPHA) to operate a Communicable Disease control program This program includes the following components: (i) epidemiological investigations that report, monitor and control Communicable Disease, (ii) diagnostic and consultative Communicable Disease services, (iii) early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases, (iv) appropriate immunizations for human and animal target populations to control and reduce the incidence of Communicable Diseases, and (v) collection and analysis of Communicable Disease and other health hazard data for program planning and management. LPHAs must operate its Communicable Disease program in accordance with the Coalition of Local Health Officials (CLHO) Standards for Communicable Disease Control and the requirements and standards for the Control of communicable disease set forth in Oregon Revised Statutes (ORS) Chapters 431, 432, 433 and 437 and Oregon Administrative Rule (OAR) Chapter 333, Divisions 12, 17, 18, 19 and 24, as such statutes and rules may be amended from time to time. As part of its Communicable Disease control program, LPHAs must, within its service area, investigate the outbreak of Communicable Diseases, institute appropriate Communicable Disease control measures, and submit to the Oregon Health Authority as prescribed in the Oregon Health Authority Communicable Disease Investigative Guidelines.

- **Eligibility:** All Oregonians benefit from the communicable disease control program provided to Local Health Departments. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: PHD Laboratory Northwest Regional Newborn Screening (NBS) Program

- **Brief Description:** The Northwest Regional Newborn Screening Program conducts screening of all newborn infants to prevent mental retardation and premature death in children through early detection and treatment of congenital disorders by: screening and testing for selected diseases and conditions; serving as the regional center for newborn screening; contracting for the medical consultation needed for the initial clinical follow-up; and maintaining a data base of all screened infants for use in follow-up, tracking, and monitoring disease incidence. Oregon designates practitioners as being responsible for specimen collection. The definition of "practitioner" includes physicians, nurses, and midwives who deliver or care for infants in hospitals, birth centers or homes. Also, parents are responsible to ensure that their infants are tested.

- **Eligibility:** Newborn screening activity is not divided among specific eligibility groups within Oregon newborn infants. It is a population-based service applicable to all newborn infants in the state. Oregon statutes require that every infant be tested. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees and driven by volume or amount of tests received by the Lab for which they receive test fee revenues.

Program: Prescription Drug Monitoring Programs (PDMP)

- **Brief Description:** Oregon-licensed pharmacies are required to report to the Oregon Health Authority PDMP system all Schedule II – IV controlled substances dispensed to patients. The system must be accessible by healthcare providers and pharmacists 24/7. The intent behind the

PDMP is to help improve patient management particularly among pain patients. Health improvements include pain care, addictions treatment and reduced overdose.

- **Eligibility:** Services are provided to any Oregonian who requests a copy of their own patient record. Services are provided to any authorized PDMP system user that can include any Oregon-licensed healthcare provider who prescribes controlled substances or any Oregon-licensed pharmacist who dispenses controlled substances. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: HIV Community Services

- **Brief Description:** The HIV program provides case management and support services (case managed, treatment and support plan) for people already tested and living with an HIV diagnosis.

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: General Funds – HIV, Sexually Transmitted Disease, Tuberculosis (HST)

- **Brief Description:** The HST program works with local health authorities and community based organizations to provide guidance on the delivery of services to the populations impacted by HIV, STD, and TB. This program is administered by local health authorities that primarily screen, treat or control the transmission of those diseases. As well, this program provides support administration, prevention, TB case management and medications for STD's and TB

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable STD's TB or HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: Sexually Transmitted Disease

- **Brief Description:** The program provides Clinician Training for the clinician workforce in Oregon. The training is a two-day didactic training designed for clinicians. Training is intended to provide an update on HIV, HPV, Cervicitis, Chlamydia, Gonorrhea, Syphilis and other STD's.

- **Eligibility:** Clinicians workforce in Oregon to provide training on reducing and detecting STD's.

PROGRAM GROUP: Oregon Youth Authority (OYA)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the OYA Program Group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services. The Waiver approval for DSHP included mental health and A & D treatment services funded through state funds only. The Protocol identifies the allowable state fund only funding stream(s) for these DSHP allowable services and expenditures for non-Medicaid eligible youth. The youth receiving and benefiting from these services (mental health and A & D) may be placed in the custody of the OYA, but are not incarcerated in a close custody setting. DSHP does not allow nor include expenditures for services rendered to youth in a close custody setting, in other words, for incarcerated youth. Expenditures for which DSHP is claimed are community based, delivered in the youth's place of residence or in a licensed professional provider's office or clinic. Youth are living at home or in an out-of-home non-secure placement (not a residential treatment facility), where youth are free to leave the premise. The youth are

not incarcerated, not associated with the prison system, not in secure facilities operated by OYA and are not in the physical custody of OYA. The youth may be in the custody of OYA, e.g. adjudicated youth served by county probation or diversion programs, are not Medicaid eligible, and are receiving mental health and A & D treatment funded by state funds only.

- Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with state Funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OYA contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the R*STARS accounting database. Code and expenditures will be displayed.

Program: Alcohol & Drug Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Alcohol and drug abuse treatment provided to youth in community settings occurs through community service contracts for non-Medicaid eligible youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: alcohol and drug abuse treatment services in the community include: assessment, group treatment, individual treatment, individual care coordination, recovery, maintenance and relapse prevention.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for alcohol and drug treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

Program: Mental Health Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Mental health services provided to youth in community settings occurs through community service contracts for non-Medicaid eligible youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: mental health treatment services in the community include: assessment of mental health needs,

psychotropic medication management, group treatment, individual treatment, individual care coordination, crisis intervention and family therapy.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for mental health treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

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PROGRAM GROUP: DMAP – Division of Medical Assistance Programs

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 - Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the DMAP Program Group is MMIS.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests that funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the MMIS data base system that contains the requirements (i.e., edits) for processing claims for this population. MMIS is a subsidiary system for accounting data to the state SFMA accounting system, the 'book-of-record' for the state. From client and related payment data entered in MMIS, payments to providers are produced. The payment/expenditure data is interfaced to SFMA from which provider payments and expense reports are produced that identify the relevant category in which the DSHP allowable expenditure is incurred. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly. The SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) identifies the program, funding, and client are entered with the MMIS data. The coding is mapped to specific service tables that include each service funding source, thereby isolating the claims and associated payments for this population. The coding generated by the MMIS interfaces to SFMA. For this program, those services that match to state Funds only, will be allowable for FFP. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Formerly Medically Needy (Organ Transplant) Clients

- **Brief Description:** The program provides limited drug coverage for individuals receiving post-transplant services, formerly eligible for the Medically Needy program, which ended in 2003. Oregon Administrative Rule (OAR) 461-13-120-1195, chapter 461 filed with the Secretary of State, 9-30-2011, defines the population and covered services. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds and limited to 22 identified individuals.

- **Eligible Population:** This program provides services for 22 identified individuals receiving post-transplant services who were participating in the formerly Medically Needy program, as of January 31, 2003.

PROGRAM GROUP: Workforce Development and Education

- **Funding Sources:** State General Funds, Tuition and Fees

Expenditures for DSHP allowable Workforce Development Training expenditures are defined in the Waiver agreement, as those incurred by universities, colleges, and community colleges in the course of workforce training of health professionals in fields likely to benefit Medicaid beneficiaries. Source data elements are used to support the expenditures and payments of DSHP allowable Workforce Development Training and for the certification of DSHP allowable expenditures. The source data elements are:

- **Audited Financial Statements**
- **Invoices**
- **Payroll data**
- **Funding Source (ensures restriction to state only funds through the accounting elements and structure)**

Each university/college entity uses an integrated accounting system. Though they are not all the same system, they accumulate, process, and employ coding structures in similar formats for reporting and audit processes. These systems are the 'book of record' for each entity. They are complete systems with modules devoted to accounting, purchasing, accounts payable, fixed assets, grants, and budget development. The charts of accounts structures have these primary coding structure elements: Fund, Organization, Account, and Program. Transactions in the systems require these coding structures to store, process, and report out expenditures for all programs, including DSHP. The coding structure elements are hierarchical and roll up from lower data entry levels to higher summary levels. The DSHP expenditures roll into the regular monthly and annual final statements. Typically these types of expenses are tracked at a lower level of the accounting system coding structure and while they are not visually displayed in annual financial reports, they are included in the respective Instruction line displays in the financial statements.

For each Workforce Development Training program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #57(b). The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – Original source data is identified where data from the source documents is reviewed, and approved for coding and entry into the appropriate financial accounting sub-system for each Workforce Development Training program (e.g., accounts payable, payroll-personnel).

Step 2 – The financial data accumulation begins with initial entry into source data systems for the following:

- Invoices received for services and set up in the accounting system accounts payable module: invoices reviewed, services received verified, payment amounts approved, specific coding verified for programs and unique projects (e.g., DSHP - Instruction)

- Employee data set-up in the payroll system: Personnel payment data, pay rates, default cost center to be charged, etc.. Specific coding identified for additional programs/projects to where employee work time should be charged. Time sheet data, for time and effort recording, including proper employee and supervisory verifications/authorizations.

Step 3 – Source data systems access internal data and coding tables, and based on entry data, assigns to expenses the accounting coding element structures (i.e., codes: Fund, Organization, Account, Mission, Object). ***See Table 1,*** below.

TABLE 1 – Coding Elements

Oregon Health Sciences University

- *Fund code:* University General Fund 0151
- *Organization code:* Identifies the Schools: Medicine 54000-54999, Nursing 58000-58999, Dentistry 60000-69999.
- *Mission code:* Non-Sponsored Instruction & Training 11; Student Admin and Services
- *Object code:* Functional description of expenditures, Wages 5100-5199; Supplies 5300-5399; Cost of goods 5400-5499; Purchased services 5500-5599

A combination of the above codes identifies DSHP allowable expenses.

Oregon University System

- *Fund code:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Department of Community Colleges and Workforce Development

- *Fund Type:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code/Account Type:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Step 4 – Source data systems compile data during the system scheduled maintenance runs for interface to the financial accounting system, the 'book-of-record', source for all financial audits (e.g. general; A-133; other audits).

Step 5 – Accounting system processes are compiled, interfaced data configured according to the system processing design and the internally established chart of accounts. It matches the coded expense data to the internal chart of accounts (See ***Table 3 – OUS Example*** below). At period end close, the Overhead Cost Allocation module is run, charging indirect cost expenses (e.g. Administration and General (A & G)) to revenue producing cost centers, based on standard, approved cost allocation principles **(See *Table 2 – Cost Allocation***, below**)**. Closed period end financial data is downloaded to a database system (e.g., a financial services 'datamart') that can be queried using specific general ledger established accounting coding elements to pull out DSHP expenditure data (see ***Table 1 –Coding Elements above***).

TABLE 2 – Cost Allocation

DSHP approved program expenditures can include direct charged costs as well as indirect costs (i.e., a cost necessary for the functioning of the organization as a whole, but which cannot be directly assigned to one service or product, and therefore must be allocated). Very similar to the Medicare cost finding principles, cost allocation is a process, to identify common costs (e.g., A & G—executive staff, accounting, legal, human resources, etc.) to the courses of health care professionals in fields likely to benefit Medicaid recipients. The entity can determine those costs that can be accurately direct charged, or charge them to an allocation cost center for charging via the allocation process. --Medicare Reimbursement Manual form 2552-10, 40-93

Step 6 – Report queries are run against the financial services datamart using the coding element structures unique to the DSHP program/project. (***See Table 1, Coding Elements above***)

Step 7 – Expense Reports for DSHP expenditures are run after the accounting period end close. Accounting period close may be monthly, quarterly or annually.

Step 8 – Certification of Public Expenditures (CPE) form, certifying allowable DSHP expenditures per STCs #55 – 58 are represented in the expense reporting, will be sign by the appropriate and authorized college or university authority and provided to the State.

If an expenditure made under DSHP Workforce Training Program Group is found, in a future audit or financial review requiring corrective action, the prior period transaction(s) will be reconciled in the current DSHP claiming period using CMS 64 established guidelines. The CMS 64 reporting will reflect this reconciliation.

Accounting System, DSHP Expense Report Crosswalk to Financial Statements: DSHP Workforce Training expenditures, processed through the respective accounts payable and/or payroll systems are coded with organization department and instruction program coding elements (described in the preceding individual protocol narratives) that will identify DHSP allowable expenditures, per STCs # 55-58.

DSHP expenditures are a small subset of the overall individual operation of each university, college and community college. Expenditures to be claimed as DSHP, per STCs #55-58, are included in the annual year end audited statements as specific amounts at a lower level than displayed on the Instruction report line. These expenditures can be audited down to individual transactions for which original source documents can be pulled. Table 3 below illustrates this process.

Agreements will be in place between OHA and workforce entities to include allowance for audit by OHA of DSHP allowed expenditures. DSHP Expense Reports will be certified, and the amounts on the DSHP expense reports can be directly tied to the individual university, college and community college audited financial statements.

The total computable amount to be claimed to the federal government begins with the amount recorded for Instruction within the university, college or community college's audited financial statement. The financial statements may include the amount applicable to Instruction for one institution, or multiple institutions, depending on the structure of the university/college system.

In support of the total computable amount to be claimed under DSHP, supporting documentation will include the university's/college's expenditure report/account detail. The expenditure report classifies expenditures (as detailed in Table 1 – Coding Elements) by code, including fund code, organizational code, mission code and object or program code. The organization and fund type level codes will be primarily used to distinguish between aggregate expenditures applicable to Instructions and expenditures applicable to Instruction eligible under DSHP, per STCs #55-58.

Categorical Examples of Workforce Development Training DSHP allowable programs
School of Medicine
School of Nursing
School of Dentistry
Clinical Laboratory Science
Radiologic Technology/Diagnostic Imaging
Respiratory Care
Clinical Care
Medical Assistant
Dental Assistant/Dental Hygienist

EMT/Paramedic
Nursing Education/Certified Nursing Assistant
Pharmacy Technician

The examples above are not intended to be an exhaustive list of each course offered by the individual college or university. Rather, they an example by category of the type of DSHP allowable graduate and undergraduate workforce training programs available at the colleges and universities.

Upon receipt of the specific college and university expenditure report, OHA will verify the expenses reported are for health-care and health-care related fields of education and training. The specific listing of the DSHP allowable health-care and health-care related course offerings will be made available to OHA by each college or university, and will become a part of the DSHP report to CMS Region X for purposes of claiming via the CMS 64 Report. By keeping the specific list(s) apart from, yet referenced herein Attachment G, as a college or university changes, adds or deletes a DSHP allowable course, it would not be necessary to amend Attachment G.

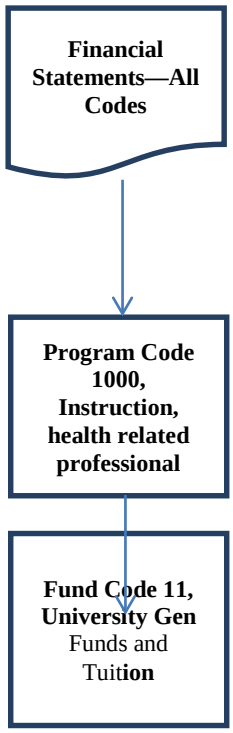
Verification of the DSHP allowable course may be accomplished in a three-fold manner using the 1) published course offering/calendar of the college or university; 2) through enrollment information, and; 3) through the college and university expenditure reports.

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for Workforce Training will be computed without taking into account program revenues from tuition. However, to the extent the above universities and colleges receive funds that are directly used to support Workforce Training applicable offsets will be made to the amount claimed to the federal government as an allowable DSHP expenditure per the above referenced STCs.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the Workforce entities accounting systems databases. Codes and expenditures will be displayed

Table 3 – OUS Example

Highest Level -- Financial Statements: Includes all accounting data codes. To reconcile to financial statements, the report query would not restrict to specific codes; all would be pulled.
Program Codes: Report query, restrict codes to program code 1000 for Instruction Courses of health care professionals in fields likely to benefit Medicaid recipients.
Funds: Further restrict report query to fund code 11, university general funds (incl tuition).



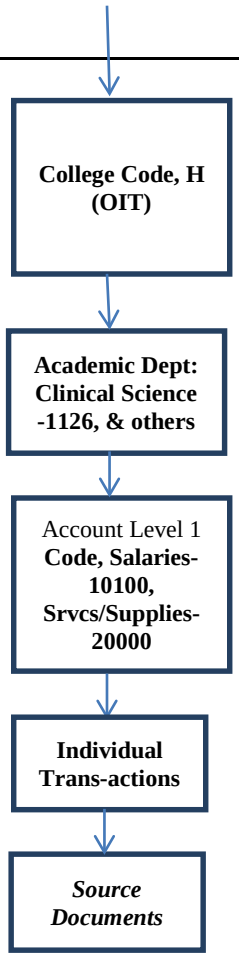
College Codes: Further restrict report query to college code H for OIT

Organization Codes: Further restrict report query to academic codes, 1126 & others.

Functional Codes: Further restrict report query to account level one codes for personnel, materials & supplies, etc.

Lowest Level -- Transactions: Further restrict to the lowest level Transactions that identify vendor/payee and personnel/ staff payee.

Documents Level -- Based on the transaction list pulled (i.e., showing the amounts entered, vendor, other identifying data; payroll time & effort data) supporting documents can be pulled.



PROGRAM GROUP: Oregon Medical Insurance Pool (OMIP)

- **Funding Sources:** State General Funds

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for the Oregon Medical Insurance Program will be made without considerations for high risk pool healthcare premiums.

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

Step 4a—There is no interface sub-system for the OMIP Program Group as services paid for are a direct charge into SFMA.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OMIP contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Medical Insurance Pool

- **Brief Description:** The Oregon Medical Insurance Pool (OMIP), administered by the state Office of Private Health Partnerships (OPHP), is the high-risk health insurance pool for the state established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions. OMIP also enables continuance of insurance coverage for those who exhaust COBRA benefits and have no other options. The funding for OMIP comes from two sources. Premiums paid by enrollees currently cover about 52% of program costs. Statutory requirements for establishing premiums limit them to no more than 125% of average market premiums for comparable benefits. The remaining 48% of the costs are funded from assessments the OMIP Board charges the licensed Oregon commercial health insurers on a per covered life basis.
-
- **Eligibility:** Enrollees must be residents of Oregon when they enroll and, once enrolled, they must demonstrate that they have lived in Oregon for at least 180 days during each benefit year. It does have a six-month pre-existing condition waiting period for which enrollees can get credits if they have had prior comparable coverage. To be eligible for portability coverage, they must not have access to a commercial portability insurance plan.

PROGRAM GROUP: Oregon State Hospital (Gero-Neuro)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Oregon State Hospital Program Group is the Oregon Statewide Payroll (OSPS) system.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All Hospital expenditures are processed directly within the SFMA system.
- **Payroll System:** Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses (OPE) directly to the various Hospital programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination can be entered to ensure their time is properly allocated to DSHP.
    - The Hospital is accounted for as an enterprise fund where all costs for the program are recorded as one fund source. However, any resources from insurances (e.g., Medicaid, Medicare, Private pay) are identified to the various wards and are subtracted to record the State Only Fund expenditures that are allowable under the DSHP Waiver amendment. Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Coding and expenditures will be displayed.
-

Program: Gero-Neuro Wards at the Oregon State Hospital (MH, Psychiatric)

- **Brief Description:** This program is for patients who require a hospital level of care for dementia, organic brain injury or mental illness. Patients in this program require physically secure, 24-hour care that is not available through community programs. These patients often have significant medical issues. Some are either civilly committed or voluntarily committed by

a guardian because they are a danger to themselves or others, or are unable to provide for their own health and safety needs. Some patients who require significant medical care come through the criminal court system. Those admitted under criminal commitments are excluded, are not approved for DSHP federal Funds Claiming. The program's goal is for everyone to return to a community-care setting. From the day of admission, the treatment team works with the patient toward this goal. The program uses the following treatments:

- Sensory and behavioral therapy
- Recreation
- Coping and problem-solving skills learned through group and individual therapy in the treatment mall setting.

- Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.

- **Eligibility:** Elderly persons with a mental health diagnosis that requires hospital level of care, or all ages with special needs due to related neurological impairment. Inpatient services are available to older adults who have major psychiatric disorders and adults older than 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive community care nursing home system environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical-surgical hospital.

Attachment H: Calculating the Impact of Health Systems Transformation
(updated December 18, 2012)

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State of Oregon

Attachment H: Calculating the Impact of Health Systems Transformation -

Oregon's Accountability Plan and Expenditure Trend Review

Attachment H: Calculating the Impact of Health Systems Transformation

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Executive Summary

Oregon has a long history of choosing innovative means of managing its Medicaid program. Yet, Oregon has faced a number of challenges in recent years familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and government (both state and federal); cost growth that far outpaces the state's general fund revenue; and a system focused on volume, not value. For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical.

Instead of responding to these challenges with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon chose a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon developed a coordinated care model for this transformation built on the three-part aim of better health, better care and lower costs. In alignment with that aim, the two overarching goals of Oregon's 2012-2017 demonstration are to reduce the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

This document contains Oregon's Accountability Plan, a multi-pronged strategy to achieve the three-part aim and methodology for the two percent trend reduction test. The document represents a shift toward a new model of care encouraging continuous learning and transformation, increased transparency, and clear expectations and incentives for improvement along with a significant investment in measurement, analytics, and evaluation.

Attachment H is divided into two sections: Oregon's Accountability Plan (Section A) and the Expenditure Trend Review (Section B).

Section A: Oregon's Accountability Plan is divided into three parts:

Part I: Coordinated Care Organization Quality Strategy

Part I of the Accountability Plan (pages 9-66) contains Oregon's Coordinated Care Organization (CCO) quality strategy, which describes the process by which the CCOs will work towards the three-part aim. The CCOs will be held accountable for spending through a comprehensive capitated per-member-per-month payment (PMPM). Under this capitated arrangement, beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures.

CCOs will also be rewarded for improving quality. At the start of the demonstration, two percent of the PMPM budget will form a quality incentive pool and will be available to CCOs that achieve specific quality goals. The percent assigned to this pool will increase over the course of the demonstration, subject to approval from CMS where necessary. By holding CCOs responsible for spending as well as quality, and by shifting incentives towards outcomes over time, the CCO model will increasingly reward value and outcomes rather than utilization.

A key part of the strategy is changing the way care is delivered in key focus areas. Each focus area was chosen because of prior evidence suggesting that improvement in these areas can achieve the three-part aim. Each CCO will address four of seven quality improvement areas:

- Reducing preventable re-hospitalizations;

- Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services and aligned federal and state programs;
- Deploying care teams to improve care and reduce preventable, unnecessary and costly utilization by frequent utilizers;
- Integrating primary care and behavioral health;
- Ensuring appropriate care is delivered in appropriate settings;
- Improving perinatal and maternity care; and
- Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness.

The state will support CCO efforts with a wide array of resources and supports:

- **The Oregon Transformation Center:** Once launched in 2013, the Oregon Transformation Center will act as the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state. The center will provide support mechanisms that include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a range of topics including health equity. A patient-centered primary care home (PCPCH) technical assistance institute, that is already operational, will coordinate with the Oregon Transformation Center's learning collaboratives once launched.
- **Innovator agents:** Innovator agents will be assigned to each CCO. They will be a single, constant point of contact between the CCO and OHA and will help champion and share innovation ideas in support of transformation, within either the CCOs or the state agency. The state's innovator agent plan is included in this master document.
- **Non-Traditional Healthcare Workers:** These workers include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems
- **Patient-Centered Primary Care Homes:** The adoption of patient-centered primary care homes (PCPCH) is integral to transforming the health system. The primary care home model of care is defined by Oregon's statewide PCPCH standards and measures. These measures call for a patient-and-family-centered approach to all aspects of care, wellness and prevention. This includes

culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner.

- **Evidence-based clinical decision tools:** Disseminated through the Oregon Transformation Center, these tools, based on extensive research and expertise on treatment effectiveness in achieving meaningful clinical outcomes, will provide guidance to providers and CCO clinical advisory panels in delivering clinically and cost-effective care.

- **Transparency:** Quarterly public reporting on a wide range of quality, access, and beneficiary experience measures, via CCO dashboards, will synthesize performance data to make it clear and understandable to all stakeholders, most importantly Medicaid beneficiaries.

- **Timely feedback:** Feedback will be presented to CCOs about progress, opportunities, and areas for improvement through a robust measurement strategy and analytics infrastructure.

Part II: Statewide Quality and Access Tests and Evaluations

Part II of the document (pages 67-97) provides information about statewide activities to support and incent quality and access, including an annual statewide test of quality and access required by CMS to assure that the demonstration's cost control goal is not being achieved at the expense of quality. The tests are structured to encourage improvement in quality, but if quality and access significantly diminish, a Designated State Health Programs (DSHP) penalty specified in the demonstration special terms and conditions (STCs) will apply. Part II of the Accountability Plan also includes demonstration evaluation plans to support continuous quality improvement as well as a summative evaluation as required by the STCs.

The goal for these tests and evaluations is to create a new paradigm of accountability between CMS and the state. The key elements of this are:

- **Structured access and quality test:** Not only is the state required to meet the expenditure test outlined in Section B of this document, but in years where it meets that test, it is also required to meet a structured access and quality test to ensure that cost containment goals are not achieved at the expense of access or quality. The quality and access test consists of two parts: a relatively simple initial comparison of annual performance on a broad set of metrics against a baseline; and a more complex analysis of the associated between transformation activities and performance on access on quality, to be conducted only if the state fails part one of the test.

- **Formative, midpoint, and summative impact evaluations:** Building on the measurement strategy described in the first part of this document, the state will track and report regularly on OHA and CCO actions, the "levers" for health system transformation described in the STCs, and progress toward the goals of the three-part aim. The formative evaluation will provide timely and

actionable feedback to CCOs, the state, and CMS. The midpoint and summative evaluations will be conducted by external, independent contractors and will employ more sophisticated analytic methods in order to determine whether changes in quality and outcomes resulted from the state's transformation activities.

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. The expansions and delivery reforms under this demonstration are intended in part to bridge the transition to implementation of the ACA, making monitoring the changes in 2014 an essential part of the state's efforts. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the quality and access tests will apply no differently in 2014 than in other demonstration years, except that the midpoint assessment is designed to provide analytical insight into progress as of 2014.

Part III: Measurement Strategy

Part III of the document (pages 98-170) describes the measurement strategies to support both CCO level quality activities in Part I as well as statewide quality activities in Part II.

Performance for all of these metrics will be made transparent, and will be reported by race, ethnicity and language to the extent possible, to ensure improved outcomes for all communities. CCO level dashboards will also be created to assist in rapid cycle improvement.

Metric groups:

- **Oregon CCO Incentive Measures:** The state's Metrics and Scoring Committee is responsible for identifying and adopting metrics for a program that establishes CCO financial incentives for improved outcomes. The Committee has identified an initial set of 17 metrics.
- **Oregon Demonstration Core Performance Measures:** Oregon's 1115 demonstration also includes ten additional measures that represent a broad snapshot of the Medicaid program.
- **CMS Adult Core Set for Medicaid**: These are the core set of measures recommended by an expert panel and established by CMS to track quality of care for the adult Medicaid population.
- **CMS Child Core Set for Medicaid and the Children's Health Insurance Program**: These are the core set of measures established by CMS for the pediatric population, also recommended by an expert panel. Both core sets will be part of the reporting format to the extent feasible, even as the sets evolve.

There is considerable overlap among these metric groups. The CCO incentive measures will determine the disbursement of the CCO-level quality pool and will serve as a strong incentive for quality improvement. The other measure sets, to the degree they are not included in the incentive measures, will serve as a broad snapshot of the Medicaid program in order to ensure that there is no degradation

in some areas as the CCOs focus on the quality improvement areas represented by the incentive measures.

The statewide tests for quality and access that can trigger DSHP penalties include a very broad set of measures from all of these metric groups.

Section B: Expenditure Trend Review (pages 168- 188)

The expenditure trend review provides the methodology and template for measuring the required two-percentage point reduction in the rate of growth of Oregon Health Plan per capita expenditures. The test consists of three levels that capture growth in: 1) CCO global budget services; 2) total Medicaid expenditures for CCO enrollees; and 3) new administrative costs that may accrue to Medicaid in order to provide care under health system transformation in Oregon.

Along with submitting the expenditure trend review data quarterly, the state has agree to conduct an exploratory stakeholder process regarding opportunities, barriers, and strategies to integrate long term care into CCO global budgets. The state will also augment the expenditure review test reporting in March of each year with trends on hospital uncompensated care in the state for monitoring purposes.

Conclusion

The overall purpose of this demonstration is to help support fundamental changes in the delivery system. These changes can in turn help not only achieve the three-part aim, but also to prepare the state for the transition to 2014 when more of its population will be enrolled in CCOs.

Oregon's Accountability Plan and Expenditure Trend Review memorialize agreements negotiated between the state and CMS to ensure robust monitoring of the state's innovative health system transformation activities. Through regular reporting and rapid cycle improvement activities, both CMS and Oregon hope to learn lessons that can be applied to other payers and perhaps in other states.

Part I

Coordinated Care Organization (CCO)

Quality Strategy for the Oregon Health Plan 2012

CCO Quality Strategy Table of Contents

I. Introduction

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

For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical. Nationally, it is estimated that about 30 percent of care provided is either unnecessary or does not lead to patient health. For racial and ethnic minorities, access to care and health status are worse than for the general population. For example, 35 percent of minority women in Oregon have no regular care provider, compared to 18 percent for Caucasian women, and the life expectancy for African Americans and American Indians/Alaska Natives in Oregon is two years less than for Caucasians. People of color disproportionately represent one in four covered lives in the Medicaid population. Native Americans have lower utilization rates of preventive services for children (birth through 10 years old), when compared to Caucasians, Latinos, and Asian Americans. African Americans and Native Americans have high rates of ambulatory care sensitive condition hospitalizations than Caucasians, Latinos and Asian Americans. Oregon's Action Plan for Health issues a call for action to address racial and ethnic health disparities. Addressing these disparities will go a long way toward improving Oregon's health system.

Instead of responding to trends over the last several years with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon has chosen a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon has developed a coordinated care model for this transformation that is built on the three-part aim of better health, better care and lower costs, and is being implemented in Oregon's Medicaid program through Coordinated Care Organizations (CCOs).

The coordinated care model was the logical next step for Oregon's health reform efforts that began in 1994 with the creation of the Oregon Health Plan (OHP). The coordinated care model grew out of recognition that the services people need are not integrated, leading to poorer

health and higher costs. Physical health, mental health, substance abuse, and oral health, services are fragmented and are insufficiently tailored to meet the diverse needs of Oregon's population. There is a sense of urgency in the state to rein in these costs or they will continue to overwhelm state, business and personal budgets.

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

Oregon's first eight Coordinated Care Organizations were certified to begin enrolling new members as of August 1, 2012. As of December 2012, there are 15 CCOs extending across every county in the state and approximately 90 percent of the Medicaid enrollees *(See attached map in Appendix 1.A)*.

As in the past, Oregon will continue to develop and maintain a quality strategy to assess and improve the quality of CCO services and to ensure compliance with standards. Section A, Part 1 of this Accountability Plan (the current section) satisfies both STC 45 and 42 CFR Part 438, subpart D requirement for a state quality strategy. Oregon will continue its robust monitoring of system performance and will continue to assure that standards of access, program operation, and quality are met. Although many oversight mechanisms used today will continue in the future, the transition from managed physical and mental health care to CCOs has greater implications for quality assurance and performance improvement focus areas than for methods of oversight.

CCO accountability measures and related incentives will be core elements of the state's quality strategy. These measures will allow the Oregon Health Authority (OHA) to set clear expectations for care delivery and health systems transformation and to monitor CCOs' performance against those expectations. OHA will institute a system of progressive shared accountability that maximizes the opportunity to succeed but also protects the public interest.

OHA will perform periodic reviews of the quality strategy to determine the need for revision and to assure CCOs are in contract compliance and have committed adequate resources to perform internal monitoring and ongoing quality improvement activities.

II. Improvement Strategies

To meet the goals of the three-part aim, Oregon's coordinated care model and FFS delivery systems rely on six key levers to generate savings and quality improvements and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that the Oregon Health Authority will take in the form of the stimuli and supports described below, they comprise a roadmap for achieving Oregon's vision for better health, better care and lower costs.

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

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

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

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

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

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 Oregon Transformation Center

OHA will employ a variety of stimuli to promote the action of the levers and supports to enhance their effectiveness. *See the theory-of-action visual in Appendix 1.B for more details on the interaction between these levers and supports.*

STIMULI

Contractual requirements

One of the hallmarks of Oregon's health system transformation is local governance and flexibility, which requires a unique approach to a quality strategy in that it must recognize that each organization is unique in its approach to a model of care that meets the three-part aim. To that end, the state has included in its contracts a requirement that each CCO submit a draft

transformation plan for approval by OHA by January 15, 2013. These plans must incorporate all the contractual requirements of transformation, including milestones and benchmarks in each of the following areas:

- The model of care that the CCO will adopt;
- Their strategies for integrating behavioral, physical and oral health;
- The use of flexible services;
- How they will coordinate care;
- How they will adopt alternative payment methodologies for compensating providers;
- How they will work with diverse community partners and their Community Advisory Council;
- How they will reduce health disparities and advance health equity for culturally and socially diverse communities;
- How they will employ non-traditional healthcare workers and health care interpreters; and
- How they will address four of the seven focus areas in the STCs, three of which will be addressed as performance improvement products (PIPs). See below for a detailed discussion.

OHA will negotiate the content of the transformation plans with the CCOs and the final plans will become part of the CCO contracts as addenda. *See also section V of the Quality Strategy for further discussion of contract compliance and the repercussions for CCOs of non-compliance*.

Global budgets for CCOs (STC 36b)

CCO global budgets integrate previously separated funding streams – physical, mental and, beginning in 2013, oral health – and represent the total cost of care for all services a CCO is responsible. CCOs are held accountable for managing the total array of services, either through a capitated per-member-per-month (PMPM) payment or though payment for outcomes. In addition to reducing administrative overhead and promoting administrative simplification by combining the infrastructure and function of previously separate organizations, global budgets require coordination of care across all services and promote accountability. By shifting some services away from capitation and toward payment for outcomes (subject to CMS approval

where necessary), Oregon is moving toward a system that increasingly pays for value rather than utilization.

This global budget is neither a per-capita cap nor a global cap. Beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures. Per person spending trends will be measured to assure the demonstration is on track to save state and federal funds, but do not in any way serve as a cap on federal funding for medical assistance provided to Oregon's Medicaid beneficiaries.

Transparency

Beginning in January 2013, data supporting measures of cost, quality, access, experience of care, and health status will be collected by OHA over all delivery settings and populations. These measures include the core performance measures listed in the Oregon demonstration; others will be drawn from the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measures, the Medicaid adult core set, and a set of measures specifically addressing the needs of the severely and persistently mentally ill (SPMI) population. (*See Oregon's Measurement Strategy in Part III for the complete listing of metrics*). Data to track these measures will also be collected by race, ethnicity and language, to ensure improved outcomes for all communities. These measures will be reported publicly beginning June 2014 and will be updated either quarterly or annually depending on the measure. In addition, CCO dashboards will be created that will synthesize performance data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries.

Financial Incentives

A legislatively mandated stakeholder group, the Metrics and Scoring Committee, identifies metrics for financial incentives and makes recommendations to OHA about the design of the incentive structure. Incentive payments linked to metrics recommended by the Committee will form the basis of a fully-at-risk quality pool. The quality pool is a bridge strategy to move CCO payments from utilization to value. Over time, the proportion of a CCO's global budget based on capitation is expected to decrease as the proportion based on incentives tied to improvements in outcomes and efficiency increases, with prior CMS approval as needed.

The Oregon Metrics and Scoring Committee has worked with national experts to create the appropriate metrics and incentives that are aligned with the state's Medicaid quality strategy. Beginning July 2014, incentives will be linked to each CCO's performance on quality, cost and access measures as well as electronic health record adoption. In addition, in order to maximize the potential for achieving quality goals, CCOs will be required to align their provider incentives with the quality pool incentives; that requirement is reflected in CCO contracts. Timelines and

milestones for implementation of alternative payment methodologies that further align CCOs and their providers with health system transformation objectives are addressed as part of CCO transformation plans (drafts due January 15, 2013). *See Oregon's Measurement Strategy in Part III and the Quality Pool Structure in Appendix 1.C for a fuller description of financial incentives*.

One Percent Administrative Withhold

In accordance with STC 37b.i., OHA will withhold one percent of capitation revenue from CCOs in each year of the demonstration in order to ensure timely and accurate data submission. CCOs will forfeit up to the full one percent if they do not meet Oregon's standards for timely and accurate submission of encounter data. The specific contractual requirements are reflected in Oregon's January 2013 CCO contract amendments.

Quality Improvement Focus Areas

As required by contract and STC 25b.i., each CCO must address four of the quality improvement focus area issues, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific problem identified,
- Implement the action plan,
- Study its effects, and
- Refine the intervention.

Three of the focus areas will be conducted as performance improvement projects (PIPs). In Demonstration Year 11 (DY11), one of the three required PIPs will focus on integrating primary care and behavioral health, and will be conducted statewide. The quality improvement focus areas are:

1. Reducing preventable re-hospitalizations;

2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs;

3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers;

4. Integrating primary care and behavioral health;

5. Ensuring appropriate care is delivered in appropriate settings;

6. Improving perinatal and maternity care; and

7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. Finally, Attachment E of the demonstration's STCs outlines example measures that would be required of any CCO selecting specific focus areas.

SUPPORTS

The Oregon Health Transformation Center

In 2008 the Oregon Health Fund Board recognized the need for an infrastructure to stimulate system innovation and improvement. The Oregon Health Policy Board directed OHA in creating "Oregon's Action Plan for Health" to provide necessary supports for success of the model of coordinated care. As an important support, Oregon is forming a Transformation Center in the winter of 2013 to support the rapid learning and improvement necessary to implement the coordinated care model and to make any required mid-course corrections quickly. In Oregon's vision, the Oregon Transformation Center is the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state.

The activities of the Transformation Center will be aimed at creating the optimal conditions for the rapid spread of the key elements of the coordinated care model. Everett Roger's Diffusion of Innovation theory suggests that there are eight critical components in the successful spread of innovation.[5] In accordance with this work, the Transformation Center will conduct activities aimed at identifying or achieving:

- **Change leaders:** respected individuals who can serve as key messengers for the innovations;

- **Active learning networks:** peer-to-peer networks, collaboratives and other communication channels that enable stakeholders (CCOs and other payers, their

[5]Everett M. Rogers, *Diffusion of Innovations*, Fifth Edition 2003, Free Press, New York

providers, communities and consumers) to engage in learning and sharing information about the innovations;

- **Relative advantage:** stakeholders believe that the innovations are an improvement over current practice and their benefits outweigh the risks;
- **Compatibility:** stakeholders understand how the innovations fit in with their current system and community needs;
- **Simplicity:** innovations are as easy as possible to implement;
- **Trialability:** stakeholders are able to try out an innovation with minimal investment before moving to full implementation;
- **Observability:** stakeholders see demonstrated evidence that an innovation works; and
- **Reinvention:** stakeholders can appropriately adapt innovations to serve local community needs.

The specific tools and support mechanisms to be provided by the Transformation Center include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a variety of topics including advancing health equity. Timely data and targeted analytic tools are among the most important supports that the Transformation Center will provide. In order to make sustainable progress towards integrating and coordinating care, CCOs and other health system partners will need better tools and stronger incentives to improve performance.

In cooperation with OHA's Office of Health Analytics, the Transformation Center will provide, both through Innovator Agents (described below) and directly to CCOs:

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

See Part III for descriptions of data sources and measurement details.

Learning Collaboratives

The Oregon Health Authority will establish a CCO learning collaborative as required by STC 25d within the Transformation Center, the purpose of which is to promote innovations and activities that will contribute to the objectives of health system transformation and accountability for achievement of the three-part aim of better health, better health care and lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. In addition to learning collaborative areas of focus to be defined by OHA, CCO learning collaborative members will work together to decide upon additional focus area(s) of the collaborative and work with OHA to develop appropriate performance measures.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract. Also established by contract is a requirement that when a CCO is identified by OHA as underperforming in access, quality or cost against established metrics, the CCO will be required to participate in an intensified innovator/learning collaborative intervention.

Innovator Agents

STC 25d. and Senate Bill 1580 require OHA to provide CCOs with "innovator agents" who will act as a single point of contact between the CCO and OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation's three-part aim: better health, better care, lower cost. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight. (*See section V for additional details on contract monitoring and oversight*).

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication and allowing streamlined reporting, reducing the duplication of requests and information.

- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports.
- Assist the CCO in managing and using data to accelerate quality improvement.
- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The innovator agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other innovator agents, CCOs, community stakeholders and/or OHA.

Innovator agent performance will be assessed annually through a "360" review process that includes input from the Community Advisory Councils, CCO management, OHA partners and other relevant stakeholders.

For more details on innovator agents and the Transformation Center, see the innovator agent plan, Appendix 1.D.

Community Advisory Councils (STC 25a)
Community Advisory Councils (CACs) are statutorily and contractually required of each CCO to ensure that the health care needs of the consumers and the community are being addressed. At least one member of the CAC sits on the governing board of the CCO, and the CCO's assigned innovator agent is required to attend CAC meetings. The council must:

- Include representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership;
- Meet no less frequently than once every three months; and
- Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the CCO and members of the governing body of the CCO.

The duties of the council include, but are not limited to:

- Identifying and advocating for preventive care practices to be utilized by the CCO;

- Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization; and
- Annually publishing a report on the progress of the community health improvement plan.

Community Advisory Council members will be surveyed annually to assess their satisfaction with the level and quality of their engagement with the functions of the CCO board.

Community Health Assessments and Community Health Improvement Plan (STC 25a)
Community health assessments and the resulting community health improvement plan are required annually of each CCO. The community health assessment and community health improvement plan serve as a strategic population health and health care system service plan for the community served by the CCO.

The community health improvement plan adopted by the CAC should describe the scope of the activities, services and responsibilities that the CCO will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- Health policy;
- System design;
- Outcome and quality improvement;
- Integration of service delivery;
- Reduction of health disparities; and
- Workforce development.

Non-Traditional Healthcare Workers (STC 18j)
Non-Traditional Healthcare Workers (NTHW) include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems, including reaching fee-for-service members. NTHWs take health care beyond the four walls of

clinics and hospitals, out into homes and the community, supporting healthcare transformation in a variety of ways.

By focusing on culturally sensitive and linguistically appropriate approaches, NTHWs support adherence to treatment and care plans, coordinate care and support system navigation and transitions, promote chronic disease self-management, and foster community-based prevention. In order to build a health care workforce for the future, Oregon will:

- Establish systems for certifying NTHWs and certify 300 new community health workers by December 2015;
- Establish infrastructure to accelerate the certification of health care interpreters and certify 100 interpreters by June 2016; and
- Establish a curriculum within the Transformation Center learning collaboratives that supports best practices in using this new workforce to improve access and outcomes.

Patient-Centered Primary Care Home (PCPCH) Adoption (STC 18k, 25, 40c.viii, ix)
The Patient-Centered Primary Care Home (PCPCH) is integral to health systems transformation, and is defined by Oregon's statewide PCPCH standards and measures[6], developed through a public process to advance the three-part aim. These PCPCH standards call for a focus on patient-and-family-centered approach to all aspects of care, wellness and prevention, culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner. PCPCHs are available for both CCO and FFS members alike.

Practices are recognized to meet the criteria for one of three tiers, with tier one being the basic level, tier two an intermediate level, and tier three a more advanced level of practice. There is a crosswalk so that practices that are NCQA-certified medical homes can use that as a portion of their requirement for designation. Health plans and other payers can then use the tiers to determine payment to incent and support the model.

Through a state plan amendment, OHA is currently providing tiered payments to recognized clinics for care to Medicaid enrollees with specific chronic diseases using federal funding

[6]See:http://www.oregon.gov/oha/OHPR/pages/HEALTHREFORM/PCPCH/standards.aspx

through the Affordable Care Act's Section 2703. Several private payers are also paying an incentive payment to certified clinics based on the Oregon PCPCH standards, including those in partnership with the state and Medicare through the Centers for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care Initiative to 70 Oregon clinics.

House Bill 3650 (the enabling legislation for health system transformation) calls for CCOs to provide access to services through PCPCHs to the greatest extent possible. Through its contracts with CCOs, Oregon will encourage CCOs to use alternative payment methodologies that support PCPCH functions. Oregon will assess the implementation of PCPCHs through the statewide PCPCH recognition process, CCO performance monitoring, and by assessing the percentage spent on primary care services and numbers of enrollees attributed to PCPCHs over time.

CCOs will demonstrate how they will use PCPCH capacity to:

- Partner with and/or implement a network of PCPCHs to the maximum extent feasible;
- Require other contracting health and services providers to communicate and coordinate care with PCPCHs in a timely manner using HIT/HIE technologies;
- Incent and monitor for comprehensive transitional care;
- Assure that beneficiaries receive integrated, person-centered care and are fully informed partners in transitioning to this new model of care;
- Assure that beneficiaries are informed about access to non-traditional providers as they are available through the CCO. Non-traditional providers may include personal health navigators, peer wellness specialists, and community health workers; and
- Assure that the primary care team provides culturally and linguistically appropriate assistance to beneficiaries in accessing needed services.

To further support the development of PCPCH capacity in Oregon, with funding from the Northwest Health Foundation and the Health Resources and Services Administration (HRSA) State Health Access Program, OHA awarded a $1.3 million contract to the Oregon Health Care Quality Corporation (Quality Corp) to establish a public-private partnership focused on supporting primary care transformation. The PCPCH Institute will provide technical assistance to Oregon clinics looking to improve care and gain recognition as patient-centered primary care homes.

Quality Corp will facilitate a collaborative and open process to establish the PCPCH Institute, beginning with the appointment of an expert oversight panel. The panel will include practicing providers with PCPCH knowledge and experience, experts in PCPCH learning techniques,

behavioral health experts, public and private health system representatives, Independent Physicians Association representatives, and OHA staff. The Institute will invite proposals from interested technical assistance providers and organizations and the expert panel will oversee the selection process.

Once organizations are selected for providing specific services, a broad array of technical assistance will dramatically expand the quality and capacity of resources available to primary care clinics in Oregon including:

- The PCPCH learning collaborative
- A comprehensive, interactive learning system website
- Online learning modules and webinars
- Practice facilitation or "coaching" services
- Quality improvement training via a train-the-trainer model.

The Oregon Health Authority, Northwest Health Foundation, and Quality Corp will also be working to sustain the PCPCH Institute as an ongoing vehicle to support the patient-centered care model that will result in significant improvements in health care quality and outcomes in Oregon.

The Public Health Division (PHD) and the Office for Oregon Health Policy and Research are collaborating on the implementation and oversight for the PCPCH Program evaluation site visits in order to maintain the integrity and outcomes of the Program. PHD will train site evaluators that will conduct site visits in order to assist PCPCHs in identifying areas of strength and improvement.

In addition to these supports, the quality pool for CCOs will include an incentive for member enrollment in PCPCHs. *See Part III and Appendix 1.C for more details on Oregon's Measurement Strategy and Quality Pool Structure.*

Health Information Technology (HIT) is another tool that will support transformation; see the discussion of HIT initiatives at the end of Section IV, under the heading Health Information Technology.

Coordination with Other State Agencies

Public Health Division

Many of the factors that lead to chronic disease and disability, including unhealthy behaviors, are caused by social conditions beyond the immediate control of a single individual or Coordinated Care Organization—such as persistent mental illness, addiction, homelessness, unemployment, lack of transportation and lack of quality education. Community interventions are needed to address the systemic barriers and root causes of poor health outcomes as well as corresponding risk factors such as tobacco use, poor nutrition and physical inactivity. Oregon's healthcare transformation initiative specifically delineates expectations that CCOs will address these root causes through the community needs assessment, community health improvement plan, the Community Advisory Council and collaboration with state and local public health agencies and community partners.

Through the Transformation Center, the state's Public Health Division will work with local health departments to collaborate in developing training and technical assistance for CCOs that includes webinars, group training, individual coaching, and sharing of best practices, related to health promotion and disease prevention. This would include topics such as:

- The development and implementation of evidence-based cessation services, including benefits, referral systems, tobacco use as a vital sign, and integrating cessation support into electronic health records.
- The development of tobacco-free campus/worksite policies.
- The development of nutrition standards for hospital campuses, worksites and health care settings.
- USPSTF clinical preventive services recommendations for colorectal, breast, and cervical cancer screening, with specific emphasis on the importance of evidence-based colorectal cancer screening.
- The development and implementation of evidence-based chronic disease self-management programs, including referrals through electronic health records.

OHA will also be establishing a prevention policy committee that spans its operating divisions, including mental health, Medicaid, and public health to ensure that the OHA's policies support prevention in healthcare settings, extend prevention linkages between healthcare settings and communities, and integrate a variety of programmatic and professional approaches. This policy committee will consider issues related to supporting the CCOs, including operational policy issues and payment policy issues to support the three-part aim through prevention, and will review and make recommendations upon the request of the OHA Director. Issues the committee might consider include facilitating payment mechanisms for evidence-based chronic disease self-management programs such as Living Well with Chronic Conditions that are known to reduce the burden and costs associated with chronic diseases.

Office of Equity and Inclusion (OEI)

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain communities. These communities are often less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider. It is critical to address equity in these areas that impact a person's health. The connections among the CCO, its Community Advisory Council, community health workers, and local community health and community advocacy organizations will further this goal.

Through the Transformation Center, the Office of Equity and Inclusion (OEI) will assist in developing a curriculum for CCOs and Medicaid providers that will include webinars, group training, individual coaching, information sharing, and technical assistance related to health equity. This would include topics such as:

- Language access services such as interpretation, translation, signage, web sites.
- Job descriptions, training, recruitment and retention of community health workers and other non-traditional health workers.
- Diversifying the health care workforce.
- Diversity and inclusion best practices.
- Diversifying community advisory boards.
- Including equity and diversity in CCO community health assessments and improvement plans.
- Cultural competence continuing education for all staff.
- Race, ethnicity, and language data collection, analysis, and reporting for quality improvement, and
- Community outreach and partnership with trusted culturally competent community and faith based organizations.

Early Learning Council and Oregon Department of Education

Early investments in human capital that improve skill and health formation are critical to ensure long-term health outcomes and cost-savings for Oregon. Concurrent with its health reform efforts, Oregon is undergoing education system reform from preschool through higher education. Specific attention has been given to the reorganization of Oregon's early learning services for children ages 0-6.

Oregon's Early Learning Council (ELC) is legislatively charged with developing and overseeing a unified system of early childhood services centered on improving child outcomes. In order to redesign and integrate existing services into a high functioning early learning system, adaptive change across multiple sectors is required. OHA is coordinating with the ELC to ensure that a broad view of early learning is adopted, one that encompasses more than traditional pre-school environments, but rather includes all settings where children are served from childcare to health and human services. Working together, the ELC and OHA are seeking shared opportunities for coordination of services, workforce training, data sharing, quality measurement, and accountability for child outcomes.

Oregon Patient Safety Commission
OHA will partner with the Patient Safety Commission to make the Commission's Breakthrough Series Collaboratives available to CCOs, and to bring learnings from the work of the commission to improving patient safety throughout the Medicaid population.

III. Oregon's Goals

Oregon is engaged in multiple efforts to achieve the three-part aim. Through specific objectives, ideal behaviors, supportive stimuli, and through an infrastructure of learning systems to support rapid cycle improvement, the state can achieve lower costs, improve quality of care and improve the patient experience.

A. Lower Costs

In the past two decades, Oregon's health care expenditures have been increasing exponentially. It is one of the sectors of Oregon's economy with the highest growth rate, averaging 7.6 percent annually. Medicaid served 14 percent of the Oregon population in 2010. Its expenditures, at $3.3 billion, represented 12 percent of the total healthcare spending in 2010, and per capita Medicaid expenditures were $6,049.[7]

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as $10 billion in the FY 2017-2019 biennium with more than 900,000 individuals enrolled in the program. This figure includes approximately over 200,000 newly eligible under federal health reform expansion provisions that take effect in 2014.

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

With healthcare costs increasing unsustainably, a key goal of healthcare transformation in Oregon is to reduce the growth in statewide PMPM Medicaid spending by one percentage point in demonstration year two and by two percentage points over demonstration years three, four, and five.

Specific objectives:

1. Decrease trend rate by two percentage points as evidenced by total cost PMPM.
2. Meet or exceed 90th percentile national Medicaid benchmark for ED visit rates.
3. Meet or exceed national Medicaid benchmark for all cause readmissions

LOWER COST			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	Align provider financial incentives to achieve the Three-part aim Take meaningful action to reduce administrative waste Be creative with deploying flexible services Be creative with deploying caregivers directly when appropriate	Global budget creates incentive to coordinate care and eliminate redundant organizational structures Transparency: o Avoidable ED visits o ED utilization o PQI o Re-admissions to hospital o % of service dollars for enabling services for SPMI populations o Length of stay in various care settings for SPMI population Incentives:	• Analytic support: quarterly analysis of: o PQI o Avoidable ED visits o Expenditures per CCO o High utilizers • Innovator agents work with CCO to use results of analysis to determine most efficacious interventions in rapid cycle improvement (RCI) • Innovator agents recommend and provide information regarding best practices, innovative models, to address issues in RCI, e.g.: o Financial models, including alternative payment methodologies o Financial tools, such as groupers

LOWER COST			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
		o Follow-up after hospitalization for mental illness o EHR adoption o ED utilization Contract requirements for: • Flexible services • NTHWs • APMs	o Models for administrative simplification • Transformation center provides TA and tools related to the "starter set" of promising alternative payment models (APMs) including: o Bundled payments o Risk and gain sharing arrangements o Global payments o Service agreements aligning primary and specialty care incentives
Providers:	• Coordinate care with other providers • Coordinate care with community resources and services • Offer after-hours help and alternatives to the emergency department • Avoid duplicative and unnecessary services	Alternative payment methodologies Flexible services	• PCPCH adoption • Case managers and NTHWs • Support with community health solutions • Innovator agents work with CCO to share data analyses with PCPs • Transformation Center supports innovative strategies such as community health workers to address needs of high utilizers; use of flexible services

B. Better Care: Quality of Care

An in-depth examination of Oregon managed care organizations' (MCOs) historical performance on a number of measures of quality of care reveals significant areas where performance should improve to equal the national Medicaid average. In other measures, Oregon performs at the national average. In either case, it is important to maintain the level of quality and strive to improve it. Thus, Oregon set objectives to meet or exceed national Medicaid averages where they are available, focusing on areas that are closely aligned with the overall goals of health system transformation. For some measures, an Oregon baseline has not yet been calculated, but it is believed that the measure is critically important to evaluating the quality of care provided.

Specific objectives:

1. Improve developmental screening by 36 months to align with Oregon Early Learning Council objectives (no national baseline available).

2. Meet or exceed the 75th percentile of the national Medicaid average on HEDIS timeliness of prenatal care visits, 69.4%, using administrative data only.

3. Meet or exceed the March of Dimes goal of <5% rate of elective deliveries before 39 weeks. Establish baseline in DY11.

4. Meet or exceed the 75th percentile national Medicaid benchmarks for diabetes care (HbA1C poor control). Pay for measurement and reporting in DY12 and DY13, pay for performance beginning in DY14. Access to the challenge pool will be based on pay for performance beginning in DY13.

5. Meet or exceed the 75th percentile national Medicaid average for controlling hypertension (HEDIS). Establish baseline in DY11. Pay for measurement and reporting in DY12 and DY13; pay for performance in DY14. Access to the challenge pool based on pay for performance beginning in DY13.

6. Maintain or improve colorectal cancer screening. Set target at 49% (based on improvement across Oregon's Medicaid plans since 2002).

7. Improve substance abuse screening (SBIRT): Establish baseline in DY11 and set benchmark for DY12.

8. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.

9. Maintain or improve to meet or exceed the 90th percentile of the national Medicaid average for follow up after hospitalization for mental illness.

10. Improve mental health and physical health assessment in children in DHS custody. Establish baseline in DY11 and set benchmark for DY12.

11. Improve screening for clinical depression and follow up plan. Establish baseline in DY11 and set benchmark for DY12. Pay for measurement and reporting in DY12 and DY13, pay for performance beginning in DY14. Access to the challenge pool based on pay for performance beginning in DY13.

12. Meet or exceed the 90th percentile national Medicaid benchmarks for follow up care for children on ADHD medication

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to improve care coordination, including behavioral health • Encourage providers to exceed benchmarks for meaningful use and participate in HIE • Engage meaningfully with community, including culturally and linguistically diverse communities, to address its health needs • Encourage members to take an active role in their care	Global budgets provide stimulus for integrating and coordinating care Financial incentives: • Screening for addiction, brief intervention and referral to treatment (SBIRT) • Follow up after hospitalization for mental illness • Diabetes control • Colorectal cancer screening • Hypertension control • Elective delivery before 39 weeks • Timeliness of prenatal care visits	• Learning collaboratives that target areas of concern • Provide TA as needed on PIPs • Innovator agents champion and share ideas • Transformation Center supports analysis of data by race, ethnicity and language to assure equitable quality of care • Support and encourage employment of NTHWs through registry of workers, establishment of certification criteria, and partnerships with community colleges • Transformation Center shares best practices, evidence-based interventions, and care models

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
		• Developmental screening by 36 months • Mental health and physical health assessment for children in DHS custody • EHR adoption Transparency: Quality measures will be tracked and posted on the OHA website. See Part III for the complete listing. Contract requirements for: • Focus areas (PIPs) • Community needs assessment • Community Advisory Council • Transformation plan	across communities • Public health supports through evidence-based interventions to improve population health • Work with Oregon Patient Safety Commission to bring information about best practices and evidence-based interventions to improve patient safety to CCOs
Providers:	• Strive for tier 3 PCPCH status • Coordinate care with other providers • Coordinate care with community resources and services • Help patients navigate the healthcare system • Encourage patients activation • Show respect to patients and families	• Incentives for PCPCH status • Incentives for EHR adoption • Payment methodologies that incentivize performance	• Community support through public health • Utilization of NTHWs • Transformation Center and Innovator agents share best practices and resources • Feedback on performance measures

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
	• Adhere to clinical guidelines • Use data to ensure timely follow up, prevention, and interventions • Increase healthcare workforce diversity, including non-traditional health care workers • Access cultural competency continuing education		

C. Better Care: Access to Care

Oregon exceeds national Medicaid benchmarks in some measures of access, particularly for access to primary care and ambulatory care visits. For Consumer Assessment of Healthcare Providers and Services (CAHPS) measures, Oregon is often just below national Medicaid CAHPS measures of access. For adolescent well care visits, Oregon is below national Medicaid average and our goal is to improve it to meet that standard.

Specific objectives:

1. 100% of beneficiaries will have access to a certified PCPCH.
2. 75% of PCPCH sites will be certified as tier 3.
3. Meet or exceed the AHRQ national in patient sample rates for primary care sensitive admissions (PQI).
4. Rates for avoidable ED visits will meet or exceed (i.e., be lower than) national Medicaid averages.
5. Dental visits for children (after 2014) will meet or exceed national Medicaid averages.

6. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.

ACCESS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to meet level 3 PCPCH certification • Care about and take action to increase access • Encourage use of NTHWs • Support culturally and linguistically specific outreach and engagement to promote access • Support availability and use of culturally and linguistically appropriate materials	Transparency: Access measures will be tracked and reported on the OHA website. See Part III for additional details. Contractual requirements for: • Transformation plan must incorporate model of care that addresses access issues • Community needs assessment must address access • Community Advisory Council provides ongoing feedback on access to CCO Financial incentives: • CAHPS survey questions about access • ED utilization • Access to PCPCH • Adolescent well visits	• Support for NTHW, who help increase access by helping members navigate the healthcare system and advocating for them as needed • Data analytic support on measures of access • Innovator agents bring resources on best practices and innovations to increase access • Learning collaboratives focus on improving access • Support from Office of Equity and Inclusion to promote culturally competent care that is welcoming to all and increases access
Providers:	• Offer after-hours help and alternatives to the emergency room • Help patients navigate the healthcare system • Diversify the workforce	PCPCH financial incentives	• Learning collaboratives • NTHWs and HCIs

D. Better Care: Experience of Care

Patient-centeredness is the key component of the care Oregon aspires to provide to Medicaid beneficiaries. By encouraging feedback from patients about their experience of care, OHA learns how to make significant improvements in the quality of the care provided and build a model of care that meets their needs. In Oregon, CAHPS scores for patient experience of care measures for individuals are slightly lower than the national Medicaid average for adult members reporting getting needed care and positive communication with a doctor, but slightly higher for getting care quickly.

Specific goal:
Meet or exceed the 75th percentile of the national average for Medicaid CAHPS (for both adults and children) experience of care tools for specified composite measures that focus on areas critical to Oregon's goals for health system transformation:

- Access to care composite, for both children and adults

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
CCOs:	• Adopt value-based purchasing • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care	Transparency: OHA will post on its website: • CAHPS survey results • Performance metrics by race and ethnicity. Financial incentives: CAHPS survey questions are included in quality pool metrics: ▪ Composite: Health plan's customer service gave information or help you needed ▪ Composite: Getting care quickly Contract requirements include quarterly reporting	• Data from CAHPS and other surveys used to identify learning needs • Innovator agents : o support improvement with learning collaboratives, peer-to-peer learning o Collaborate with the OHA Ombudsman to monitor emerging trends in complaints and appeals assigned CCOs. o Provide feedback to assigned CCOs and identify needs for peer-to-peer and learning collaboratives to address problems as they arise. • Community Advisory Council monitors patient experience and works with CCO to improve in identified areas

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
		of grievances and appeals by CCOs (*see section IV)*	• Office of Equity and Inclusion supports provision of culturally competent care which will improve the patient experience
Providers:	• Help patients navigate the healthcare system • Are accessible • Put patients first • Encourage patients to play an active role in their care • Show respect to patients and their families	Value-based purchasing and provider incentives encourage providers to address needs of patients	• Community support through public health • NTHWs support members in navigating healthcare system and getting needed services • Best practices and sharing of resources (e.g. Quit Line)

E. Better Health

The ultimate test of the effectiveness of a healthcare system is the health of the people who use it. While pursuing the goals of lower cost and better experience of care, it must be assured that at the very least health and healthcare are not degraded, and aim to improve them.

To improve population health and lower costs, Coordinated Care Organizations must address the increasing burden of chronic diseases. Chronic diseases account for 75 cents of every health care dollar spent. Eighty percent of health care resources are spent on 20 percent of members,[8] most of whom have multiple chronic conditions that are complex to manage. Chronic diseases that remain undetected untreated and poorly managed result in increased hospitalizations, costly medical interventions, lower productivity and, most importantly, lower quality of life for Oregonians.

[8] Agency for Healthcare Research and Quality

Health status: Oregon's baseline data for Medicaid, taken from the 2011 Medicaid Adult CAHPS survey, reveals health status responses that are below national averages as well as health status of Oregon's general population as reported on the 2010 BRFSS:

	Oregon CAHPS (Medicaid)	National Average CAHPS (Medicaid)	Oregon BRFSS Adult General Population
Excellent	7%	11%	19%
Very good	16%	22%	33%
Good	33%	32%	30%
Fair	29%	24%	13%
Poor	14%	10%	5%

Obesity: Oregon's 2010 BRFSS data reveal an adult Medicaid obesity rate of 38.3 percent, compared to 27.7 percent of the general population in Oregon. *(Note: the Medicaid data are not age adjusted, while the general population data are)*.

Tobacco: The current adult Medicaid rate of tobacco use is 31 percent (CAHPS 2011), compared to 23 percent in the general population in Oregon (BRFSS 2010). Oregon Medicaid is below the national average of 37 percent (Medicaid CAHPS), but tobacco use is a major driver of long-term health risks.

Specific objectives:

1. Reduce the proportion of beneficiaries who report their health status to be poor to 10 percent by 2017**.** Oregon will initially assess health status through the use of the CAHPS survey. It is expected that health status will be evaluated through a self-assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

2. Obesity as calculated from self-reported height and weight will not exceed 41 percent over course of the demonstration. Oregon will initially assess obesity through the use of the CAHPS survey. It is expected that a self-assessment tool will be available as part of a new online enrollment system projected to come on line in 2014. Enrollees will be asked to state their height and weight, from which a BMI can be calculated.

3. Decrease tobacco use in the Medicaid population to 25 percent over the course of the demonstration. Oregon will initially assess tobacco use through the use of the CAHPS survey. It is expected that tobacco use status will be determined through a self-

assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

4. Reduce ethnic and racial disparities over the course of the demonstration. Establish baseline in first year of the demonstration. Use enrollment data, which identifies race, ethnicity, and foster child status to compare these groups for health status, obesity and tobacco use. In the first year of the demonstration, develop strategy to identify disabled and Serious and Persistent Mental Illness (SPMI) populations, and establish baseline for disparities among all groups.

HEALTH STATUS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Care about and take actions to guarantee strong member outcomes • Use value-based purchasing to improve outcomes • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care • Focus on health equity	Contract requirements: • CCOs must perform a community health assessment in the first year • CCO's transformation plan must reflect the community health assessment • Community Advisory Council (CAC) will guide the development of the community health assessment, connect the CCO with the community, and hold it accountable to improving the health of beneficiaries enrolled Financial incentives for PCPCH adoption Transparency: publish health outcomes data by	The Transformation Center will provide data and analytic support to CCOs for race/ethnicity composition of their population and inequities in performance metrics and the community health assessment Innovator agents work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work, champion and share ideas. Office of Equity and Inclusion will support CCOs in designing culturally appropriate strategies to improve health

		CCO on the OHA website. Relevant performance measures include: • Health and functional status among CCO enrollees; • Rate of tobacco use among CCO enrollees; • Obesity rate among CCO enrollees • Reduction of disparities: differences in these metrics among race and ethnicity categories Community Advisory Council Community Needs Assessment PCPCH incentives	
Providers:	• Encourage patients to play an active role in their care	PCPCH incentives	• The Public Health Division will work with local health departments to support the implementation of evidence-based community interventions • Support for the employment of NTHWs through a registry of workers, establishment of certification criteria, and partnerships with community colleges

IV. Assessment

To monitor how well Oregon's coordinated care model is achieving its goals of access and quality improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have a robust measurement and reporting strategy and mechanisms to monitor and assess all Medicaid delivery systems (including Coordinated Care Organizations and Fee-for-Service). Full details on how the Oregon Health Authority will measure quality of and access to care for the Oregon Health Plan population are available in Part III: Oregon's Measurement Strategy. The format for the state's required quarterly reporting to CMS on quality, access, and many other elements of the demonstration can be found in STC Attachment A, Quarterly Report Guidelines. This section describes Oregon's assessment program, available data sources, requirements for credentialing, and an overview of health information technology.

Performance Monitoring

As required by CFR 438.202(d), the state assesses how well the Coordinated Care Organizations and Managed Care Organizations are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees and consumer satisfaction data described in Part III. Oregon's evaluation plans, described in Part II, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries.

In addition, OHA monitors plans activities on an ongoing or periodic basis for the level of contract compliance. Assessment program components are described below:

On-site operational reviews – Operational reviews are conducted on a regular basis. These reviews are designed to supplement other state monitoring activities by focusing on those aspects of CCO performance that cannot be fully monitored from reported data or documentation. These reviews focus on validating reports and data previously submitted by the CCO through a series of review techniques that include an assessment of supporting documentation and conducting a more in-depth review of the CCO's quality assurance activities.

On-going focused reviews – Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through the routine monitoring processes and grievance and appeal reporting. These reviews will also provide more detailed information on areas of particular interest to the state such as emergency department visits, behavioral health, utilization management, and data collection problems. Another example of a focused review is an on-going review of plans' provider networks to determine if physicians are

being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

Appointment and availability studies – The purpose of these studies is to review managed care and FFS provider availability/ accessibility and to determine compliance with contractually defined performance standards. To conduct these studies, state and External Quality Review Organization (EQRO) staff attempt to schedule appointments under defined scenarios, such as a pregnant woman requesting an initial prenatal appointment.

Marketing and materials reviews – Managed care contractors are contractually required to submit all marketing materials, marketing plans, and certain member notices to the state for approval prior to use. This process ensures the accuracy of the information presented to members and potential members.

Quarterly and annual financial statements – In order to monitor fiscal solvency of plans, plans are contractually required to submit Quarterly and Annual Financial Statements of Operations.

Complaint, grievance and appeals reports – On a quarterly basis, plans must submit a summary of all complaints registered during that quarter, along with a more detailed record of all complaints that have been unresolved for more than 45 days. A uniform report format has been developed to ensure that complaint data is consistent and comparable. OHA uses complaint data to identify developing trends that may indicate a problem in access, quality of care, and/or education. Complaint, grievance and appeals reports also identify FFS provider trends.

Fraud and abuse reports – The plan must submit Complaints of Fraud or Abuse that are made to or identified by the plan which warrant preliminary investigation. The plan must also submit the following information on an ongoing basis for each confirmed case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees, or any other source:

- The name of the individual or entity that committee the fraud or abuse;
- The source that identified the fraud or abuse;
- The type of provider, entity, or organization that committed the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data or information as requested.

Concerns related to FFS provider networks are identified through ongoing Provider Services and Client Services reviews.

Data Sources

Oregon assesses the quality and appropriateness of care through the collection and analysis of data from many sources. The state has developed many systems to collect data from plans and plans are required to have information systems capable of collecting, analyzing, and submitting the required data and reports. Data sources include:

Administrative Data – All CCOs, managed care plans, and FFS providers are required to submit encounters to the Medicaid Management Information System (MMIS) and the All Payer All Claims data system (APAC). MMIS and APAC data provide a source of comparative information and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, monitoring and developing quality and performance indicators, studying special populations and priority areas, and cost effectiveness analysis.

In the MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Ethnicity is currently defined as Hispanic/non-Hispanic. Oregon does not have data on multiple races. Oregon only has data on preferred household language, not language spoken by an individual client.

Community Health Assessment – CCOs are contractually required to submit the community health needs assessment to OHA. For additional detail on the community health assessment, see section II, above.

Enrollment Data – Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

As the state moves to an online enrollment system in 2014, data collection on race, ethnicity, and language will be improved and additional data will be collected through this system, including tobacco use status and body mass index (BMI). All enrollment data is shared with the plans.

Member Satisfaction Surveys – Oregon, in conjunction with its external quality review agent (EQRO), conducts statewide-standardized surveys of patients' experience of care (satisfaction). These surveys allow for plan-to-plan comparisons. Plans are required to participate, as appropriate, in the performance of such surveys. Plans whose results are meaningfully and

statistically below acceptable thresholds may be required to develop a corrective action plan that the state will review and monitor. The results of the surveys are made available to Medicaid beneficiaries to assist them in the processes of selecting an appropriate plan. Survey results are shared with plans and reports are published on the OHA website.

Participating provider network reports – Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turn over.

Focused clinical studies – Focused clinical studies, conducted by the state and EQRO, usually involve medical record review or surveys and focus groups. Plans and FFS providers are required to participate in mutually agreed upon focused clinical studies. Results of focus studies are distributed to plans and reports are published on the department website.

Credentialing

Managed care plans must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider's National Practitioner Data Bank profile. FFS providers are also enrolled through the state's Provider Enrollment Unit, which confirms that Medicaid, Medicare or other state agencies have not sanctioned providers. The Provider Enrollment Unit also checks providers' National Practitioner Data Bank Profile.

CCOs must also work with OHA through the Addictions and Mental Health Division and Public Health Division to assure proper credentialing of Mental Health Programs, associated providers and non-traditional health care workers. *See Appendix 1.E for a list of contractual elements and associated OARs.*

Health Information Technology

Adoption of Electronic Health Record Technology and Meaningful Use (STC 25c)

The Medicaid Electronic Health Record (EHR) Incentive Program provides incentives to certain providers who adopt and demonstrate meaningful use of certified electronic records. The program began in 2011 and concludes in 2021. Initial participation by eligible professionals (EPs) may begin any time until 2016. Oregon requires that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The Metrics and Scoring Committee is developing measures and benchmarks that will demonstrate CCO commitment to exceed the federal standards for EHR adoption. *See Part III for details on measures and benchmarks.*

Information Sharing

Health information exchange activities are critical for central elements of this demonstration, including reporting of quality metrics, progress with meaningful use of electronic health records, meaningful care coordination, and real-time data assessments. CMS has made funds available, at state request, for the Medicaid portions of the health information exchange infrastructure. These funds could help support the HIE provisions outlined in STC 25(c).

The Health Information Technology Oversight Council (HITOC), created legislatively in HB 2009, has guided the development of Health Information Exchange (HIE) work in Oregon. HIE is not a single technical solution, but rather includes any solutions that allow health information to be made available to the provider at the right time and in the right place to meet patient needs. For Oregon's first phase of HIE, HITOC selected the standards for secure, HIPAA-compliant electronic messaging developed by the Direct Project through the Office of the National Coordinator for Health Information Technology (ONC). Using these standards, statewide Direct Secure Messaging was developed through the Oregon Office of Health Information Technology (OHIT) and launched in May 2012 under the brand CareAccord™. OHIT is tracking the number of Direct addresses in use and number of Direct messages being sent through CareAccord™ as one way to measure growth in information exchange.

Direct Secure Messaging is not the totality of HIE, and currently Oregon is in the process of gathering stakeholder input from within the state, from CCOs, from patient groups, and others to determine the right path for the development of further HIE services.

Recommended measures start with those that ONC has published in a program information notice (PIN) for HIE which established that states report the following measures annually:

- Percent of pharmacies participating in e-prescribing
- Percent of clinical laboratories sending lab results electronically and in structured format
- Percent of providers and hospitals sharing patient care summaries electronically
- Percent of state health programs within the Oregon Department of Health electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results

In addition, each CCO is contractually obligated to meet standards in foundational areas of health IT. This includes facilitation of providers' adoption and meaningful use of EHRs and ensuring that every provider either is registered with a statewide or local Direct-enabled health information service provider (HISP), or is a member of a health information organization (HIO) that enables electronic sharing of information with other providers in the CCO's network. Also, each CCO must develop a transformation plan that demonstrates, among other elements, how

it will develop EHRs, HIE and meaningful use. The Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) are also investigating the inclusion of measures for HIE in future contracts.

These developments in EHR adoption and HIE support better collection of timely, actionable data to enable quality measurement and improvement.

Trailblazer State Project

The HIT Trailblazer Project is a new technical assistance award from ONC and supported by the National Academy for State Health Policy (NASHP) for a small number of states that are leading the nation in health system transformation. An action plan will be developed by March 2013 for the technical infrastructure for statewide quality reporting and feedback. Part of the assistance that the federal partners will be providing Oregon is an understanding of the federal vision for quality measures and how those can be aligned with the state measures to reduce the burden on providers for reporting while providing metrics that are meaningful to Oregon's specific implementation of health system transformation.

V. Contract Compliance

Standards for Managed Care Contracts

As required by CFR 438.204(g), Oregon must establish standards for all managed care contracts regarding access to care, structure and operations, and quality measurement and improvement. Appendix 1.E outlines each required component of the federal regulations and identifies the section of the model coordinated care organization, dental care organization, fully capitated health plan, and provider service organization contracts, and/or Operational Protocol where this requirement is addressed.

Delivery System Performance Monitoring

Oregon has developed a comprehensive program to assess all aspects of the delivery system. As described in section IV, above, this program involves routine analysis and monitoring of delivery system performance and consumer satisfaction data; comprehensive on-site operational reviews; and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews.

Accountability Team Reviews

The OHA accountability teams meet monthly to review contract compliance issues across all delivery systems in aggregate and quarterly to review performance metrics described in section IV above.

On an annual basis, OHA prepares a compendium of plan-specific descriptive data reflecting their performance metrics. This analysis includes information on trends in plan enrollment, provider network characteristics, performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies, and other on-site survey findings, focused clinical study findings, and financial data. Each of the data files helps prepare a profile for each plan, including a summary of plan strengths and weaknesses. These reports also provide a concise summary of critical quality performance data for each plan, as well as the EQRO's assessment of strengths and opportunities for improvement.

Each year, the state reassesses each plan's progress in addressing and improving identified problem areas. If any deficiencies are identified through the operational review, the plan will be issued a Statement of Deficiency (SOD), which specifically identifies areas of non-compliance. The plan will be required to submit a Plan of Correction (POC), which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up visits may be conducted as appropriate to assess the plan's progress in implementing its POC.

External Quality Review Organization Activities

OHA has contracted with Acumentra Health to serve as its external quality review organization (EQRO). In compliance with federal regulations, the scope of work includes all mandatory activities: compliance reviews every three years, validating health plan Performance Improvement Projects; and performance measure validation including information system capability assessment (-ISCA), and preparing an EQRO Technical Report for each Medicaid managed care plan.

The contract also ensures the ability to negotiate optional activities, including encounter data validation, the conduct of Focused Studies and/or PIPs, PM calculations described above and beyond what the state and/or plans calculate, and administration and/or validation of consumer and provider satisfaction surveys.

Technical Report

The technical report provides a feedback loop for ongoing quality strategy directions and development of any technical assistance training plans. In addition to the Statement of Deficiencies and resulting Plans of Correction, findings from the operational reviews may be

used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

Quality Management Plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance. These Quality Management Plans (QMPs) are reviewed, along with documentation of the activities and studies undertaken as part of the QMP during both the certification process and ongoing EQRO reviews.

Enforcement

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance and reports for monitoring. If a plan cannot meet a reporting deadline, a request for an extension must be submitted in writing to the Division. The Division will reply in writing as well, within one week of receiving the request. Plans that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: (1) contact the Division within one week with an acceptable extension plan; or (2) submit the information within one week.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. If these efforts are not producing results, a corrective action plan may be jointly developed and the plan monitored for improvement. More aggressive enforcement options that OHA may apply include restricting enrollment, financial penalties and ultimately, non-renewal of contracts. A list of conditions that may result in sanctions can be found in Appendix 1.F.

VI. Review of CCO Quality Strategy

The Quality Strategy shall be reviewed annually by OHA. This annual review and update will begin each August and shall be completed by December of each year. The Quality Strategy update will be provided to CMS in December of each year upon significant changes.

The OHA Quality Committee shall have overall responsibility to guide the annual review and update of the Quality Strategy. The review and update shall include an opportunity for both

internal and external stakeholders to provide input and comment on the Quality Strategy. Key stakeholders shall include, but are not limited to:

- AMH Planning and Management Advisory Council (PAMAC)*
- Medicaid Advisory Committee*
- DMAP/AMH Executive Team
- OHP Medical Directors
- OHP Contractors
- OHP Quality Management Coordinators
- Local Government Advisory Committee*
- DHS Internal Stakeholders
- Health Equity Policy Committee*

** Committees including consumer representatives*.

The Quality Strategy and subsequent updates will be posted online for a two-week public comment period before they are submitted to CMS for approval. Final versions will be posted on the OHA website.

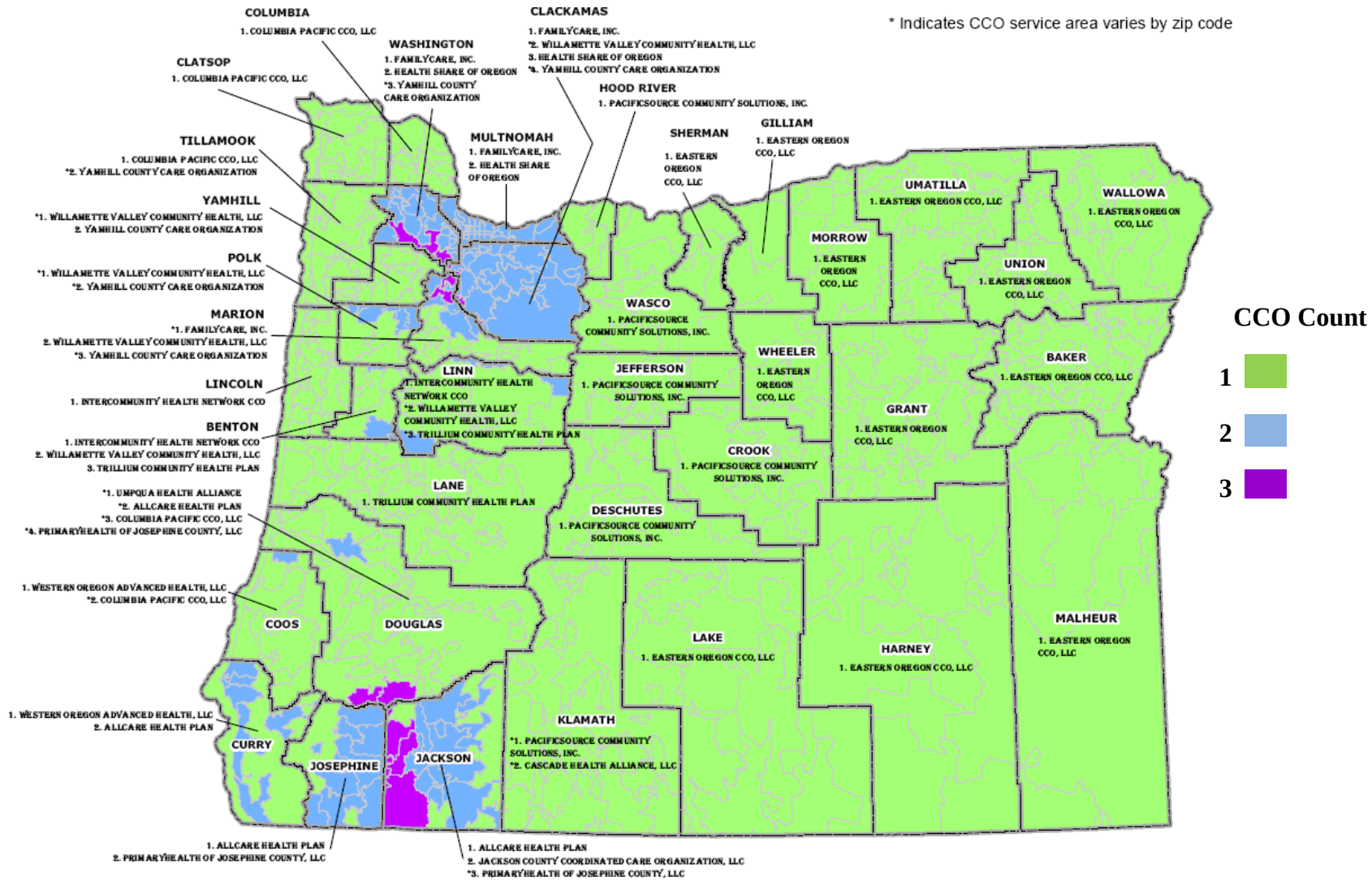
VII. Achievements and Opportunities

Passage of House Bill 2009 and HB 3650 are important achievements for the state and present a significant opportunity for Oregon to expand work already in progress to improve population health and increase access to high quality, efficient, and cost effective health care.

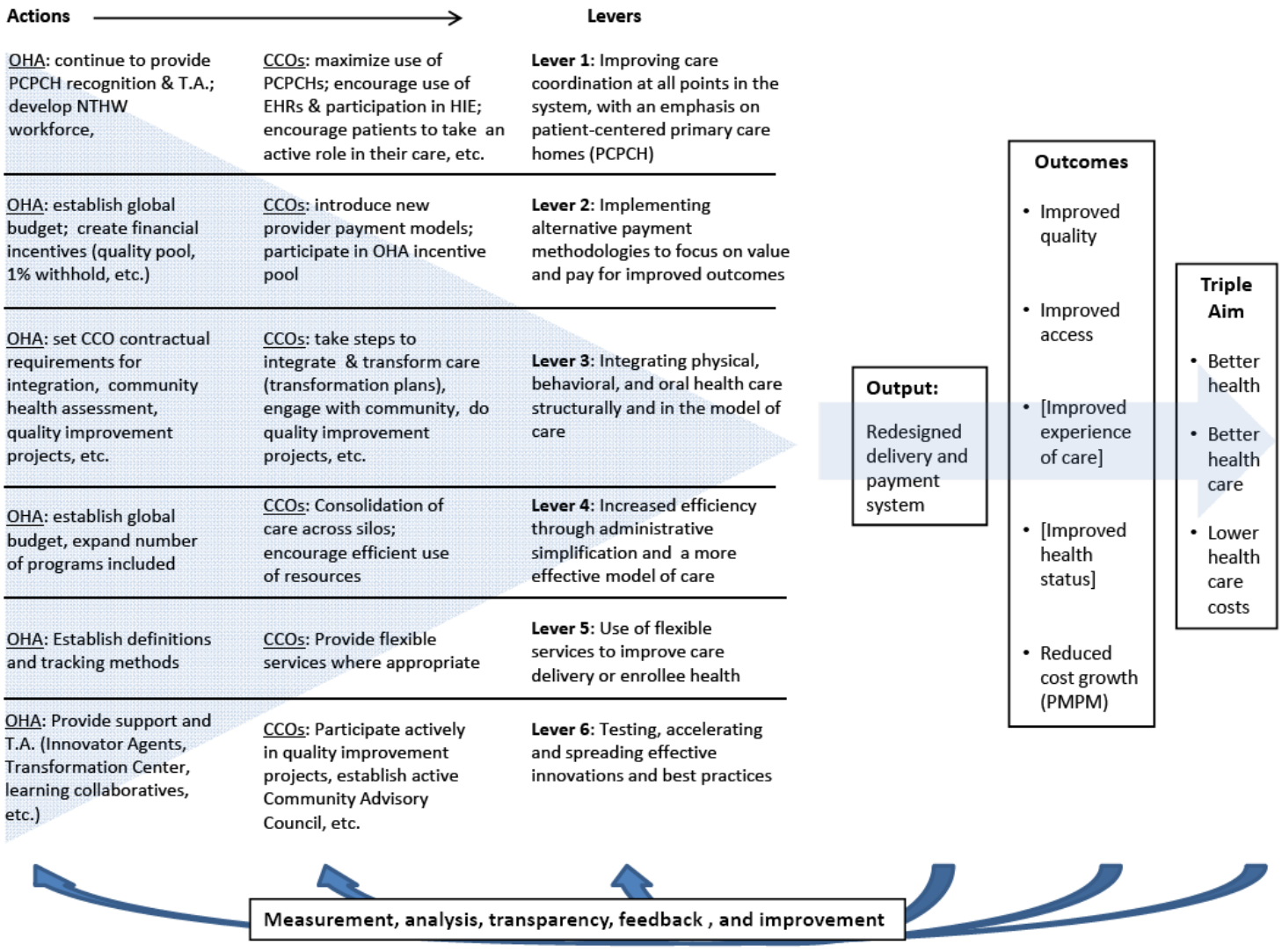
Oregon has a strong foundation for future health system transformation based upon the 20-year history of the Oregon Health Plan, and the extensive knowledge and experience developed during that time, including the unique use in Oregon of the Prioritized List of Health Services under the Health Services Resource Commission.

With the creation of the Oregon Health Authority consolidating all state health agencies in Oregon, there is further opportunity for increased focus and support for the Quality Strategy, including alignment with other quality and health improvement initiatives.

Appendix 1.A: Coordinated Care Organization Service Area Density



Appendix 1.B: Theory of Action Model


Actions
Levers
OHA: continue to provide PCPCH recognition & T.A.; develop NTHW workforce,
CCOs: maximize use of PCPCHs; encourage use of EHRs & participation in HIE; encourage patients to take an active role in their care, etc.
Lever 1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)
OHA: establish global budget; create financial incentives (quality pool, 1% withhold, etc.)
CCOs: introduce new provider payment models; participate in OHA incentive pool
Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes
OHA: set CCO contractual requirements for integration, community health assessment, quality improvement projects, etc.
CCOs: take steps to integrate & transform care (transformation plans), engage with community, do quality improvement projects, etc.
Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care
OHA: establish global budget, expand number of programs included
CCOs: Consolidation of care across silos; encourage efficient use of resources
Lever 4: Increased efficiency through administrative simplification and a more effective model of care
OHA: Establish definitions and tracking methods
CCOs: Provide flexible services where appropriate
Lever 5: Use of flexible services to improve care delivery or enrollee health
OHA: Provide support and T.A. (Innovator Agents, Transformation Center, learning collaboratives, etc.)
CCOs: Participate actively in quality improvement projects, establish active Community Advisory Council, etc.
Lever 6: Testing, accelerating and spreading effective innovations and best practices
Output:
Redesigned delivery and payment system
Outcomes
• Improved quality
• Improved access
• [Improved experience of care]
• [Improved health status]
• Reduced cost growth (PMPM)
Triple Aim
• Better health
• Better health care
• Lower health care costs
Measurement, analysis, transparency, feedback , and improvement

Appendix 1.C: Quality Pool Structure (STC 37b.ii)

Introduction

Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. By establishing a quality incentive pool as required by STC 37b.ii, the state is taking the first step in this process. It is expected that over time, savings accruing from the restructuring of delivery systems and improved models of care will allow reductions in capitation rates and the growth of incentive payments that reward outcomes rather than volume of services.

OHA's Strategy for Annually Setting the Amount of CCO Payment at Risk for Performance

OHA's strategy is to annually increase the percentage of CCO payment at risk for performance over the term of the demonstration. OHA believes that unless CCOs have a meaningful percentage of their payment at risk for performance, they are unlikely to take the steps necessary to achieve significant performance improvement and affect transformative change in care delivery. OHA also believes that it must be careful to not make the at-risk amount so large as to threaten the financial viability of a CCO should it not perform well relative to the contractual targets.

Because performance-based contracting is new to both OHA and CCOs, OHA anticipates the need to annually assess the experience, with CCO and Metrics and Scoring Committee input, and then determine both a) changes to the quality incentive pool methodology, and b) the desired level of CCO financial risk for the next contract year.

OHA recognizes that while a substantive incentive payment will provide meaningful motivation for CCOs, research has shown that fear of loss is a greater motivator than is the potential for gain.[9] For this reason, OHA intends to increase the at-risk amount by a percentage point each year of the demonstration—meaning poor performance could result in a loss of margin–although not a loss so large as to threaten the CCO's stability.

OHA's Planned Approach for Defining the At-Risk Amount for the DY12 Contract Year

OHA plans to finance the Quality Pool for the demonstration year 12 (DY12) contract year

[9]Kahneman, D. and Tversky, A. "Choices, Values, and Frames." American Psychologist39 (4): 341–350 (1984) and Kahneman, D., Knetsch, J., & Thaler, R. "Experimental Test of the endowment effect and the Coase Theorem" *Journal of Political Economy* 98(6), 1325-1348 (1990).

at two percent of the aggregate value of the per member per month (PMPM) CCO budget. Specifically, OHA will make disbursement of these funds contingent on measurement and reporting activities for three specific measures: diabetes control, hypertension control and depression screening and CCO performance relative to both absolute (benchmark) targets and improvement targets on the remaining measures.

Using OHA's planned methodology, there will be two rounds of funding distributions. In Round One, each CCO will have a maximum amount of Round One dollars from the incentive pool for which it is eligible in any particular contract year. This pre-determined amount will be calculated by multiplying a common PMPM value by the CCOs' beneficiary average monthly member count for the contract year. Seventy-five percent of the "pay for measurement and reporting" funds (for the three pay for measurement metrics only) will be disbursed upon OHA's acceptance of a technology plan for collecting and reporting the three specified measures, with an end of year adjustment if the monthly average monthly member count differs from that used at the time of disbursement of the "pay for measurement and reporting" funds. The remaining twenty-five percent of the "pay for measurement and reporting" funds will be dispersed upon the CCO's reporting of the three measures. OHA plans, however, to set a floor such that regardless of enrollment, each CCO shall be eligible to earn at least $1 million dollars, assuming maximal performance, through the incentive pool. OHA has adopted this strategy in order to ensure that small CCOs have sufficient grounds for making necessary investments in quality improvement.

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs in a second round of funding distribution called the "challenge" round. The challenge funds will be distributed to those CCOs that meet the performance (or measurement) targets on a subset of four incentive measures described in this document as "challenge measures." A complete description of the challenge measures and the distribution of challenge funds are provided below.

CCOs will only be rewarded for attaining performance (or measurement) targets ***or*** improving performance; there will be no penalties assessed related to performance in DY12.

OHA believes this strategy is appropriate for the first year for the following reasons:

- CCOs will view an incentive pool equivalent to the aggregate size of the rate increase to be sizeable, particularly given the large rate cuts experienced previously by the predecessor MCOs. The CCOs will be motivated to achieve this potential reward.

- This approach has been used by commercial health plans with providers with positive results.[10]
- Use of a challenge pool will allow CCOs to give special attention to those aspects of performance that are most important to OHA for DY12.
- The CCOs have never been measured or been held accountable for performance relative to many of the adopted measures. Neither OHA nor the CCOs can be absolutely certain regarding the feasibility of CCO target attainment. As CCOs develop experience with the measures and with implementing efforts to generate improvement to attain targets, they will be better prepared to accept higher levels of risk.

For the above reasons, a first-year approach that offers a meaningful incentive appears appropriate as OHA and the CCOs transition to a new method of contracting and doing business.

Timeline for Distribution of Funding in DY12

The incentive funds will be distributed on an annual basis. The incentive period will run for one calendar year (January – December 2013); there will be an additional three-month period following the incentive period to account for the time lag to obtain complete claims data and conduct any needed chart reviews, with the incentive payments to be made by June 2014.

The baseline measurement year for each of the incentive metrics will be 2011 and will be derived from combining the predecessor organizations (MCO + MHO) metrics in each service area. In areas where there is no predecessor MCO, the statewide average will be applied.[11]

The first measurement year and reporting period for the incentive measures will be 2013. Results will be available in early 2014, in time for the first quality pool distribution in the second quarter of 2014. The year two data measurement and reporting period for incentive measures will be 2014. Using this timeline, the final incentive payments of the demonstration program will not be paid until several months after the end of the demonstration period.

Process for Distributing Incentive Pool Dollars in Round One

The Metrics and Scoring Committee has selected an initial set of 17 measures, listed below. OHA will be collecting baseline data for these measures and conducting some statistical testing

[10]Richard Weisblatt, Harvard Pilgrim Health Care, personal communications, March 8, 2011 and October 24, 2012.

[11] Most CCOs have predecessor MCO organizations. In every case, they have structurally and organizationally restructured to adopt the CCO business model as well as the coordinated care model.

to determine if the selected measures and performance targets are feasible. Any revisions to the measure set will be made in coordination with the Metrics and Scoring Committee.

Measures selected by the Oregon Metrics and Scoring Committee as of Oct. 22, 2012 and negotiated with CMS as of December 12, 2012:

Prevention

1. Developmental Screening in the first 36 months of life (NQF 1448)
2. Assessment of Children in DHS Custody within 60 days (mental health and physical health)
3. Adolescent Well Care Visits
4. Colorectal Cancer Screening

Access and Patient Satisfaction and Access

5. Rate of Patient-Centered Primary Care Home enrollment (*Challenge Measure*)
6. CAHPs composite "Getting Care Quickly" (adult and child)
7. CAHPs composite "Health Plan Satisfaction" (adult and child)

Chronic Illness Management

8. Diabetes Control: HbA1c >9% (*Challenge Measure*) (NQF 0057)
9. Controlling High Blood Pressure (BP less than 140/90) (NQF 0018)

Behavioral Health

10. Screening for Clinical Depression and Follow-up Plan (*Challenge Measure*)
11. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT) (*Challenge Measure*)
12. Follow up for children prescribed ADHD medications (NQF 0108)
13. Follow-up after Hospitalization for Mental Illness (NQF 0576)

Maternal Care

14. Timeliness of Prenatal Care (NQF 1517)
15. Reducing Elective Delivery Before 39 weeks (NQF 0469)

Overuse

16. Ambulatory Care: Outpatient and Emergency Department Utilization

EHR Adoption and Use

17. Rate of EHR adoption and Meaningful Use among eligible Medicaid and Medicare providers.

In order to access the incentive pool, CCOs will be measured against a specified benchmark for each measure. CCOs that don't meet the benchmark for a given measure will be assessed against an improvement from baseline target. The benchmark and improvement targets for each measure are described in detail in Part III. The target levels of performance and improvement are the same for all CCOs, regardless of geographic region and patient mix. All of these measures are independent from one another such that a CCO can receive an incentive payment if performance on a specific measure warrants it, regardless of overall performance.

All of the measures are valued equivalently in the algorithm. For all measures except for the Patient-Centered Primary Care Home (PCPCH) measure, performance is treated on a pass/fail basis. For example, if the benchmark is met or minimum improvement level achieved, the CCO receives all of the credit available for that measure. If neither target is met, the CCO does not receive any credit for the measure.

For the PCPCH measure, performance is measured according to the following formula known as the "tiered formula." This formula multiplies the number of members enrolled in each tier (1, 2 and 3) with the level of the tier (if 100 people are enrolled in tier 3, multiply 100 by 3), adds the totals and divides by the total number of members enrolled in the CCO multiplied by 3. The goal is to have all members enrolled in a tier 3 PCPCH so the result of the tiered formula provides a sense of where the CCO is relative to the goal. The formula is below.

$$\frac{(\#\text{ of members in Tier 1})*1 + (\#\text{ of members in Tier 2})*2 + (\#\text{ of members in Tier 3})*3}{\text{The total number of members enrolled in the CCO}*3}$$

For the three "pay for measurement and reporting" metrics in DY12, CCOs will hav e the opportunity to earn seventy-five percent of the quality pool funds tied to these metrics (e.g. 3/17ths of the quality pool) upon OHA's approval of a technology plan for electronic collection and reporting of the three specified measures. CCOs must submit their technology lan by February 1, 2014. Requirements for the technology plan are under development in collaboration with the Office of Health Information Technology and the Technical Advisory Workgroup (TAG) of the Metrics & Scoring Committee.

OHA will conduct an end of year adjustment if the monthly average member count differs from that used at the time of disbursement of these funds. The remaining twenty-five percent of the

quality pool funds tied to these three metrics will be disbursed upon CCO submission of "proof of concept" data for these three metrics by May 31, 2014. In DY12, the proof of concept data submission must comprise at least 10 percent of the CCO enrollees. If CCOs are unable to demonstrate "proof of concept" data, they will not be eligible to receive the remaining twenty-five percent of the quality pools tied to these three measures and the remaining funds will be re-distributed through the challenge pool (described below).

For DY13, OHA will apply the same approach for the three "pay for measurement and reporting metrics" for Round One, with updated requirements for the DY13 technology plan and more robust data reporting expectations, to be developed in collaboration with the Office of Health Information Technology and the Technical Advisory Workgroup (TAG) of the Metrics and Scoring Committee.

Once OHA has calculated how much incentive funding each CCO is eligible to receive and determined each CCO's level of performance against the measure targets and reporting requirements, then it will calculate the amount of the incentive funds each CCO will receive based on its level of performance.

For the three "pay for measurement and reporting" metrics, OHA will hold out 3/17ths of the total quality pool and distribute these funds based on the technology plan and "proof of concept" data criteria described above the DY12 and DY13. Funds left over if CCOS do not meet the technology plan and "proof of concept" criteria will be included in the challenge pool. In DY14 and after, the three "pay for measurement and reporting" metrics will become pay for performance metrics with benchmark and improvement targets. A statewide baseline will be collected for DY12 and DY13 by OHA using a sampling strategy and chart review.

For the remaining fourteen measures, there are ten performance tiers ranging from 10 percent to 100 percent of the remaining quality pool funds. As the CCOs meet more benchmarks or improvement on these fourteen measures, they receive a higher payment. If the CCO attains the benchmark or the improvement target on at least seventy-five percent of the remaining measures (10.6 measures) and met or exceeded the benchmark or improvement target for the EHR measure, then the CCO will receive 100 percent of the remaining incentive funds.

If the EHR measure is not met, then the maximum incentive payment that the CCO can receive is equivalent to the second tier of incentive payment. If the CCO gets fewer than 1 measures, then the CCO does not receive any of the remaining incentive funds. A detailed definition of the tiering methodology is provided in Table 1 below.

Table 1: Example of Initial Round Quality Pool Distribution

Tier	Percent of targets met (benchmark or improvement)	Number of targets met (benchmark or improvement)	Percent of total incentive payment for which the CCO is eligible
1	74.12-100% (with EHR)	At least 10.6 (with EHR)	100%
2	68.57%	At least 9.6 (does not require EHR)	90%
3	61.43%	At least 8.6	80%
4	54.29%	At least 7.6	70%
5	47.14%	At least 6.6	60%
6	40%	At least 5.6	50%
7	32.86%	At least 4.6	40%
8	24.71%	At least 3.6	30%
9	18.57%	At least 2.6	20%
10	11.42%	At least 1.6	10%
Nothing	Less than 7.14%	Fewer than 1	No incentive payment

Process for Distributing Incentive Pool Dollars in the Challenge Round

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs that met the benchmark or improvement target for one or more of the following measures:

1. Rate of Patient-Centered Primary Care Home Enrollment (PCPCH)
2. Screening for Clinical Depression and Follow-up Plan (Depression)
3. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT)
4. Diabetes Control: HbA1c > 9%

In the challenge round, OHA will determine the aggregate number of instances in which a CCO achieves either the benchmark or improvement target for each of the four challenge measures (Diabetes Control, Depression, PCPCH, SBIRT). For the two "pay for measurement and reporting metrics, CCO achieve the target in DY12 if they report the "proof of concept: data. In

DY13 and after, access to the challenge pool for these two measures will be "pay for performance." Since the PCPCH measure does not have a benchmark, OHA will assume that all of the CCOs achieved the target. OHA will then calculate the base amount for achieving the target on this measure by dividing the challenge pool funds into equal portion equivalent to the total number of challenge targets met (e.g. if all 16 CCOs met a PCPCH target, 5 CCOs met an SBIRT target, 6 met a Depression target, and 3 met a Diabetes Control target, then the incentive fund would be divided into 30 equal portions (the "base payment").

For the Diabetes, Depression, and SBIRT measures, OHA will calculate the payments for each CCO that achieved a target on each challenge measure by adjusting the "base payment" described above based on the CCO's enrollment relative to the mean for those CCOs that met a specific challenge measure's target. This calculation will be performed separately for each of the three measures. An example of this calculation is detailed in Table 2 below.

Table 2. Example of Challenge Fund Distribution for Standard Measures (Diabetes, depression, SBIRT)

CCO Name	Base Payment	Member Months (MM)	CCO's ratio of MMs to total MM	Adjusted Challenge Fund Payment
CCO A	$ 1,666.67	29,588	1.459	1,666.67*1.459= $ 2,432.26
CCO B	$ 1,666.67	23,343	1.151	1,666.67*1.151= $ 1,918.90
CCO C	$ 1,666.67	22,788	1.124	1,666.67*1.124= $ 1,873.27
CCO D	$ 1,666.67	18,014	0.889	1,666.67*.889= $ 1,480.83
CCO E	$ 1,666.67	16,394	0.808	1,666.67*.808= $ 1,347.66
CCO F	$ 1,666.67	11,521	0.568	1,666.67*.568= $ 947.08
	$10,000 (Total pool for measure #1)	121,648 (Total MM)		$ 10,000 (total)
		20274.67 (Mean MM)		

For the PCPCH measure, the funding will be distributed to the CCOs based on a combination of results of the tiered formula and overall enrollment. For each CCO, OHA will multiply the result of the tiered formula with the total number of member months for the CCO to get an adjusted number of member months. OHA will then multiply this adjusted enrollment with an

adjustment factor (the adjusted member months relative to the mean) and multiply that by the "base payment" described above to determine the total incentive payment amount for PCPCH. An example of this calculation is detailed in Table 3 below.

Table 3: Example of Challenge Fund Distribution for PCPCH

	Base Payment	Result of Tiered formula	Member Months	Adjusted Member Months	Adjusted Member Months Relative to the Mean		Adjusted challenge fund payment (PCPCH)
CCO A	$ 1,666.67	0.4 *	29,588	=11,835.2	0.969	$ 1,666.67*.969=	$ 1,615.21
CCO B	$ 1,666.67	0.5 *	23,343	=11,671.5	0.956	$ 1,666.67*.956=	$ 1,592.87
CCO C	$ 1,666.67	0.6 *	22,788	=13,672.8	1.120	$ 1,666.67*1.120=	$ 1,866.00
CCO D	$ 1,666.67	0.7 *	18,014	=12,609.8	1.033	$ 1,666.67*1.033=	$ 1,720.92
CCO E	$ 1,666.67	0.8 *	16,394	=13,115.2	1.074	$ 1,666.67*1.074=	$ 1,789.90
CCO F	$ 1,666.67	0.9 *	11,521	=10,368.9	0.849	$ 1,666.67*.849=	$ 1,415.10
	$10,000 (Total pool for PCPCH measure)			73,273 (Total adjusted member months)			$ 10,000.00 (total)
				12,212 (mean adjusted member months)			

Appendix 1.D: Innovator Agent Plan

Innovator agents and Learning Collaboratives

Learning Collaboratives (STC 25d)

The Oregon Health Authority will establish a CCO learning collaborative, the purpose of which is to promote innovations and activities that will contribute to the goals of health system transformation and accountability for achievement of the three-part aim of better health, better health care and lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. CCO learning collaborative members will work together to decide upon the area(s) of focus of the collaborative and work with OHA to develop appropriate performance measures. OHA reserves the right to select some of the learning collaborative topics.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract as will a requirement that when a CCO is identified by OHA as underperforming in access, quality or cost against metrics established by the OHA Metrics and Scoring Committee, the CCO will be required to participate in an intensified innovator/learning collaborative intervention.

Role of the Innovator agents (STC 25d)

Senate Bill 1580 requires OHA to provide CCOs with "Innovator agents" who will act as a single point of contact between the CCO and the OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation's three-part aim of better health, better care and lower cost.

The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability for achieving the three-part aim. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight.

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication; allowing streamlined reporting and reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports
- Assist the CCO in managing and using data to accelerate quality improvement.
- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other Innovator agents, CCOs, Community Stakeholders and/or OHA.

Tasks to be performed by innovator agents:

- Complete OHA innovator agent training (training will be developed in consultation with national experts and based on other national models, such as the CMMI Innovation Advisory program training).
- Assist and support the CCOs in developing and implementing their transformation plans.
- Assist the CCO with gathering and interpreting data to target areas of local focus for improvement.
- Gather input on CCO performance from other state agency staff working directly with the CCO, primarily the Quality Improvement Coordinator and Health Plan Coordinator.
- Communicate at least every other week with all other innovator agents (and meet in person at least once each quarter) to discuss ideas, projects and creative innovation planned or undertaken by their assigned CCO.
- Attend Community Advisory Committee meetings and provide input into Community Health Assessment process.
- Participate in innovator agent learning collaborative; Participate and/or convene in other learning collaboratives as appropriate (CCOs, providers, etc.).
- Ensure rapid-cycle stakeholder feedback to identify and solve barriers; to assist with adapting innovations to simplify and/or improve rate of adoption; and to increase stakeholder engagement.

- Track questions / issues from CCOs and the answers/resolution, establishing a database not only to serve as the basis for a FAQ and information sharing among innovator agents, but also to identify potential systemic issues.
- Participate in information sharing through an interactive website, sharing documents, communicate, collaborate, and developing resources to share with the team.

Innovator Agent Reporting Requirements:

- Monthly reports on CCO progress toward the implementation of the CCO's transformation plan.
- Monthly reports about CCO progress toward achieving "ideal behaviors".
- Quarterly reports on promising practices and/or innovations occurring within the CCO.

Methods for Sharing Information

A critical role of the innovator agents will be to share information with OHA, the CCO, other innovator agents and community stakeholders. Information will be shared through the following mechanisms:

- Weekly in-person meetings and/or phone conversations with OHA and other innovator agents.
- Daily contact with the CCO and/or community stakeholders.
- Community meetings and/or forums.
- Secure website with a database into which the Innovator Agent will log all CCO/ Community Stakeholder questions and answers.
- Not less than once every calendar quarter, all of the innovator agents must meet in person to discuss the ideas, projects and creative innovations planned or undertaken by their assigned coordinated care organizations for the purposes of sharing information across CCOs and with OHA.

Measures of Effectiveness

The success and effectiveness of innovator agents will be measured in a variety of ways, but initially will focus on measures of the IAs level of engagement with the CCO and the community it serves as well as shared accountability for CCO outcomes, including:

- Survey rating innovator agent's performance to be completed by CCO leadership, Community Advisory Council members, and other relevant stakeholders.
- Number of questions answered (tracked in online database as outlined above) and number of meetings/ events an innovator agent has in the community.
- Number and success of innovations adopted by a CCO.
- Rate at which CCOs test new ideas and improve.
- Successful implementation of CCO's transformation plan, the measures for which will be developed upon completion of the CCO's transformation plan.
- The measures used to gauge the effectiveness of learning collaboratives (number of meetings, level of engagement, etc.) may also be used to measure efficacy of innovator agents.
- CCO performance on metrics as identified by the Metrics and Scoring Committee: improved access and quality, decreased per capita costs.

Appendix 1.E: Contract Compliance

The following table itemizes where the federal requirements of CFR 438.204(g) are addressed in the Medicaid model contracts.

Required Component	Contract Provision
438.206 - Availability of services • Delivery network, maintain and monitor a network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled. • Provide female enrollees direct access to women's health specialists. • Provide for a second opinion. • Provide out of network services when not available in network. • Demonstrate that providers are credentialed. • Furnishing of services, timely access, cultural competence.	Model Contract: • Exhibit B, Part 4, Subsection 3.a. • Exhibit G,1.b. • Exhibit B, Part 4, Subsection 2.m. • Exhibit B, Part 4, Subsection 3.a. (6) • Exhibit B, Part 4, subsection 3.b.(1) • Exhibit B, Part 4, subsection 3.a.(1)
438.207 - Assurances of adequate capacity and services • MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment. Submit the documentation in a format specified by the state at time of contracting and any time there is a significant change.	Model Contract • Exhibit B, Part 3.a.(1)
438.208 - Coordination and continuity of care • Each MCO must implement procedures to deliver primary care to and coordinate health care services to enrollees.	Model Contract: • Exhibit B, Part 4, 2.i. • Exhibit B, Part 4, 2.e.

Required Component	Contract Provision
• State must implement procedures to identify persons with special health care needs. Special health care needs are defined as: high health care needs, multiple chronic conditions, mental illness or substance use disorder and either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care. • MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions. • State must have a mechanism to allow persons identified with special health care needs to access specialty care directly, (standing referral).	
438.210 - Coverage and authorization of services • Service authorization process.	Model Contract: • Exhibit M, subsection 7
438.214 - Provider selection • Plans must implement written policies and procedures for selection and retention of providers. • State must establish a uniform credentialing and recredentialing policy. Plan must follow a documented process for credentialing and recredentialing. • Cannot discriminate against providers that serve high risk populations. • Must exclude providers who have been excluded from participation in federal health care programs.	Model Contract: • Exhibit B, part 4, 3.b.
438.218 - Enrollee information • Plans must meet the requirements of 438.10	Model Contract: • Exhibit N

Required Component	Contract Provision
438.224 - Confidentiality • Plans must comply with state and federal confidentiality rules.	Model Contract: • Ex. B, Part 4, Section 5.b.(3)
438.226 - Enrollment and disenrollment • Plans must comply with the enrollment and disenrollment standards in 438.56.	Model Contract: • Ex. B, part 3, subsection 6
438.228 - Grievance systems • Plans must comply with grievance system requirements in the federal regulations.	Model Contract: • Ex. B, part 3, subsection 5
438.230 - Subcontractual relationships and delegation • Plan is accountable for any functions or responsibilities that it delegates. • There is a written agreement that specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor's performance is inadequate.	Model Contract • Exhibit D, section 18
438.236 - Practice guidelines • Plans must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically. • Guidelines must be disseminated. • Guidelines must be applied to coverage decisions.	Model Contract: • Ex. M, subsection 6
438.240 - Quality assessment and performance improvement program • Each MCO and PIHP must have an ongoing improvement program. • The state must require that each MCO conduct performance measurement, have in effect mechanisms to detect both underutilization and overutilization, have in effect a mechanism to assess the quality and	Model Contract: • Ex. B, Part 9

Required Component	Contract Provision
appropriateness of care furnished to enrollees with special health care needs. • Measure and report to the state its performance using standard performance measures required by the state. Submit data specified by the state to measure performance. • Performance improvement projects. Each plan must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the state the results of each project. • The state must review at least annually, the impact and effectiveness of the each program.	
438.242 - Health information systems • Each plan must have a system in place that collects, analyzes, integrates, and reports data and supports the plan's compliance with the quality requirements. • Collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system. • The plan should ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the state and CMS.	Model Contract: • Exhibit B, Part 7

Appendix 1.F: List of Conditions that can result in Sanctions

1. Fails substantially to provide Medically Appropriate services that the Contractor is required to provide, under law or under its Contract with OHA, to a Member covered under this Contract;

2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medical Assistance Program;

3. Acts to discriminate among Members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of Enrollment or refusal to reenroll a Member, except as permitted under the Medical Assistance Program, or any practice that would reasonably be expected to discourage Enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;

4. Misrepresents or falsifies any information that it furnishes to CMS or to the state, or its designees, including but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this Contract, encounter data or other information related to care of services provided to a Member;

5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;

6. Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210 and this Contract;

7. Fails to comply with the operational and financial reporting requirements specified in this Contract;

8. Fails to maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services under this Contract;

9. Fails to maintain an internal Quality Improvement program, or Fraud and Abuse Prevention program, or to provide timely reports and data required under Exhibit B, Part 1 through Part 9 and Exhibit L, of the model contract;

10. Fails to comply with Grievance and Appeal requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, and record keeping and reporting requirements;

11. Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services required under this Contract;

12. Fails to follow accounting principles or accounting standards or cost principles required by federal or state laws, rule or regulation, or this Contract;

13. Fails to make timely Claims payment to Providers or fails to provide timely approval of authorization requests;

14. Fails to disclose required ownership information or fails to supply requested information to OHA on Subcontractors and suppliers of goods and services;

15. Fails to submit accurate, complete, and truthful encounter data in the time and manner required by Exhibit B, Part 8, Section 7;

16. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information;

17. Fails to comply with a term or condition of this Contract, whether by default or breach of this Contract. Imposition of a sanction for default or breach of this Contract does not limit OHA's other available remedies;

18. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations;

19. Fails to submit accurate, complete and truthful pharmacy data in the time and manner required by Exhibit B, Part 8, Section 7; or

20. Violates any of the other applicable requirements of 42 USC §1396b(m) or 1396u-2 and any implementing regulations.

Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluations

Evaluation Design and Quality and Access Tests

Table of Contents

Preface

The prior part of this document describes the Oregon quality improvement strategy, and primarily addresses the interactions between the state and the CCOs as part of this demonstration.

Part II describes the efforts to monitor and assess quality and access at a statewide level to ensure that statewide quality and access are improving over the course of the demonstration.

The relevant special terms and conditions relating to evaluation, monitoring, and statewide tests are listed below.

Oregon Special Terms and Conditions 52, 54, 64, 86, and 88

Oregon's special terms and conditions (STCs) for the Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115(a) Medicaid demonstration extension ("demonstration"), contain the following provisions related to monitoring quality and access (STC 52) and standards of quality and access, including the standard that must be met for purposes of DSHP expenditure authority (STC 54):

52. ***Measurement of Quality and Access Under the Demonstration***. The state will also monitor *and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 64. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.*

Within 120 days of approval of the demonstration, the state will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's Medicaid population as a whole. The state's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). state quality and access reporting will take place on the same timeframes as the state's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

54. ***Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets.*** *This demonstration authorizes time-limited expenditures on certain Designated State Health Programs*

(DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 49, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Demonstration Year	**Per Capita Expenditure Growth Reduction Target** (measure following DY close)	**Reduction in DSHP Expenditure Authority** (reduce succeeding DY's DSHP expenditure authority)
DY 11	NA	NA
DY 12	1 percentage point	$54 million
DY 13	2 percentage points	$68 million
DY 14	2 percentage points	$68 million
DY 15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the state in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the state has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. Earn Back Option. For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:

i. If the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year

and significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.

ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.

iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

Quarterly reporting requirements are outlined in STC 64 and are an integral part of monitoring the demonstration:

64. Monitoring To Assure Progress in Meeting Demonstration Goals: *The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the State's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of demonstration goals.*

a. ***Interim Reporting Format.*** *The state and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:*

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;

ii. Quality Improvement Metrics: Section VII;

iii. Access to Care measures: Section VII;

b. ***Timeframe for Reporting.*** *The state will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.*

c. ***Data Sources:***

i. Goal 1:

1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with state);

2. *CCO Medicaid billing per beneficiary within eligibility and service subgroups;*

3. *Total Medicaid service spending per beneficiary; and*

4. *CCO provider spending per beneficiary.*

ii. *Goal 2:*

1. *Benchmarked metrics tied to incentive payments, including patient experience surveys;*

2. *Data from the all payer-all claims database;*

3. *Process Improvement Projects (PIPs);*

   a. *EQRO studies;*
   b. *Complaints and grievances;*
   c. *Health risk assessment data;*
   d. *Public health data;*
   e. *Health risk assessment data;*
   f. *Meaningful use attestation data;*
   g. *State CCO monitoring reports; and*
   h. *Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the Duals Demonstration.*

d. ***Final Annual Report:*** *The state shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The state will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.*

e. ***Penalty for Late Reporting:***

i. *If the state fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The state may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that prevents the*

state from reporting timely, the state can request an exception to these timeframes and penalties.

Percentage withheld of quarterly demonstration administrative funding	***Days late***
.2	*15-30*
.4	*30-40*
.8	*41-50*
1	*51+*

The STCs also include the following language specific to Evaluation Design and Final Evaluation Design and Implementation:

86. ***Evaluation Design.*** *In the 120 days following the date of approval of this demonstration, the state shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the state will consider the Evaluation Guidance in Attachment B. The evaluation will include:*

    a. *A discussion of the demonstration hypothesis that will be tested, focusing on key areas of the State's health system transformation, including its impact on the patient experience of care,*

population health, and reduction in cost growth and additional demonstration outcome measures;

b. *An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.*

c. *Any other information pertinent to the State's evaluative or formative research via the demonstration operations.*

d. *Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;*

e. *The draft plan shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation; and*

f. *Any other information pertinent to the State's evaluative or formative research via the demonstration operations.*

88. ***Final Evaluation Design and Implementation.*** *CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the state shall submit its final design within 60 days after receipt of CMS comments. The state shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 after the expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after the receipt of CMS comments.*

Introduction

The statewide assessments of quality and access serve multiple functions for the demonstration.

First, the assessments help CMS determine the impact of the demonstration on quality and access, consistent with STCs 52 and 54. The state must pass these "tests" in order to avoid financial penalties as per STC 54. The first section of this Part II describes how these "tests" will function.

The second section of this Part II describes three types of evaluations. Each evaluation examines a specific set of questions. Although the analyses may be similar with regard to method, the demonstration evaluation is distinct from the quality and access “tests” associated with designated state health program (DSHP) expenditure authority under STC 54. The results of demonstration evaluation activities—including the midpoint assessment—have no bearing on the state’s DSHP authority.

Quarterly reports, as described here and as required by STC 64, will provide frequent feedback in order to inform ongoing operations. Elements of the quarterly reports are part of the "formative evaluations." These formative evaluations are intended to provide frequent feedback in order to ensure that course corrections are made, and that the results from those course corrections are understood in a timely fashion so as to continue the feedback cycle.

At the midpoint of the demonstration, a broader effort to learn from the demonstration will be conducted, called here the "midpoint assessment." This type of statewide assessment will provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

Finally, the state will conduct a "summative evaluation," which is required by STC 86 and 88 and is intended to summarize the experiences to ensure that this innovative demonstration is fully analyzed to determine whether it has been successful in achieving the stated goals.

As with the prior section, the measurement strategy is more fully described in Part III of this overall document.

Demonstration Overview

Demonstration Context

Health care costs are increasingly unaffordable. Despite the success of the Oregon Health Plan (OHP), which Oregon estimates has saved the state and federal government an estimated $16 billion since its inception in 1994, the growth in Medicaid expenditures in Oregon far outpaces the growth in General Fund revenue. And while health plan performance is generally strong, the growth in expenditures has not been matched by improvement in health outcomes. There are still significant opportunities to enhance access to care, improve care delivery, and advance health outcomes at the community level.

The structure of separate managed care organizations, mental health organizations and dental care organizations limits Oregon's ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. OHP clients face a sometimes dizzying array of plans and rules and the current payment system provides little incentive for the prevention or disease management actions that can improve health and lower costs.

Demonstration Goals

The July 2012 amendment and extension of Oregon's 1115 demonstration seeks to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve the demonstration goals of reduced Medicaid spending growth and improved health care quality and access. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The current demonstration aims to accomplish two equally important and inter-related goals: reducing the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

These two goals form **the hypotheses to be tested as part of this demonstration**:

I. Oregon will reduce the growth in statewide PMPM Medicaid spending by 1 percentage point in demonstration year two and by 2 percentage points in demonstration years three and beyond; and

II. Over the course of the demonstration, Oregon will achieve control of PMPM cost growth while improving access to and quality of care for Oregon's Medicaid

beneficiaries.

Reflecting the state's commitment to the three-part aim, Oregon also proposes to evaluate the impact of Medicaid transformation on beneficiary experience of care and health outcomes.

Medicaid Transformation, Theory of Change

The Coordinated Care model, as implemented in Medicaid through Coordinated Care Organizations (CCOs), begins to address the health system shortcomings described above using several different approaches, or levers, to drive savings and quality improvement:

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on patient- centered primary care homes (PCPCHs)
- Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care
- Lever 4: Increased efficiency through administrative simplification and a more effective model of care
- Lever 5: Implementation of flexible services to improve care delivery or enrollee health
- Lever 6: Testing, accelerating and spreading effective innovations and best practices

These levers are described in more detail in Part I: Oregon's Quality Strategy, above, and are aligned with Oregon's quality improvement focus areas.

The OHA and CCO actions (including "ideal" behaviors) that power those levers are shown above in Appendix 1.B: theory of action model.

OHA and the CCOs will work toward improvement in specific focus areas (as outlined in Attachment E and elsewhere in this document) that can result in achievement of the three-part aim.

Statewide Quality and Access Test

Overview

The following section lays out the details of a "quality and access test" (the test), which will be applied each program year that the state achieves its cost control goal to determine whether Oregon's Health System Transformation (HST) has caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen. "Failing" the test results in reductions in a portion of DSHP funding to the state, as described in STC paragraph 54.

The quality and access test consists of two "parts," both described in detail below and in satisfaction of STCs 52 and 54. In brief, part 1 of the quality and access test 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 comparison of program period quality and access to a counterfactual level of quality and access that would exist had HST not been undertaken. Part 2 of the quality and access test is required only if the state fails part 1, and Oregon fails the test for that year if and only if it fails both part 1 and part 2.

Seeking to balance the need for accurate and complete information against timeliness, CMS and the state have negotiated a streamlined reporting structure to monitor the goals of the demonstration while meeting the analytic requirements specified in STC 52 on an annual basis. This document memorializes CMS and the state's agreement to an annual test to assess whether unadjusted metrics for quality and access under the demonstration have stayed constant or, in later years, have improved. For the first two years, this first order test is passed if the score for the quality or access metrics remains constant or improves as compared to the historical baseline. After that, the first order test is passed only if the quality and access test shows improvement. If the State does not pass the first order test in any year to which it is applied, the state will undertake, and submit to CMS, a more detailed counterfactual analysis (as prescribed by STC 52 and conducted by an independent, third party evaluator) to determine whether quality and access have significantly diminished in a manner attributable to the state's efforts under the demonstration. If this counterfactual analysis indicates a significant diminishment in quality and access under the demonstration in a given year (or is not completed according to the timeframes specified below), CMS will apply the five percent DSHP

reduction to the FFP claimed in the year immediately following the year for which the determination was made as specified in STC 54. As described, after two demonstration years, Oregon will also undertake a robust midpoint analysis that will provide more detailed information about achievement of the demonstration's goals.

If the state has met its per capita expenditure growth target in any year, as described in Attachment H, Section B, but fails to achieve its quality and access goal as determined by the analysis conducted pursuant to STCs 52 and 54, beginning at the end of DY 12, the STCs give CMS the authority to prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year. Recognizing that data lags will prevent CMS from determining Oregon's satisfaction of yearly demonstration goals until several months after the close of the demonstration year, the prospective reduction will be applied at the beginning of the next succeeding demonstration year, as follows:

- Oregon may begin each new demonstration year claiming DSHP up to the full amount authorized in that year but will be at risk for a penalty of five percent of that year's DSHP allotment should CMS subsequently verify through the required reporting that, in the demonstration year in question, Oregon achieved a cost trend reduction at the expense of quality and access, or that the analyses were not submitted in accordance with the STCs.

- Once CMS has made such a determination and informed OHA of the rationale and the amount of expenditure reduction which it is subject to, Oregon must refund the funds identified as the agreed upon DSHP expenditure reduction in the quarter following the CMS determination.

- If the state does not voluntarily refund these funds, CMS may exercise the option of taking a deferral or disallowance for the amount.

Part 1 Quality and Access Test

A single "aggregate" indicator will be constructed using a number of "component" quality and access measures. A test result will be generated based on the difference between performance on this aggregate indicator in the current period (using the most recent full demonstration year) and a baseline period (calendar year 2011).

Component Measures

Oregon and CMS determined the component measures that will be used to construct the single quality and access aggregate indicator.

This approach relies on as broad a set of measures as possible, using measures for which data collection is already planned, because a broad set of measures encourages broad-based improvement and tends to increase the precision of the aggregate. Measures included in the CCO incentive measure set are particularly attractive candidates, as the objectives of CCOs should be aligned with those of the state as much as possible. In general, measures for which the state is already planning to collect data should be included in the aggregate unless there is good reason to exclude that measure. Good reasons to exclude a measure are: no data are available for that measure in the baseline period; that measure would contribute so much uncertainty to the aggregate that judgments about the aggregate would be affected; it is not possible to establish a functional benchmark for the measure; or there is a lack of consensus at the state level about the value of the measure. For the three CCO incentive "pay for measurement and reporting" metrics where CCOs qualify for the incentive pool in DY12 and DY13 by obtaining OHA approval of the a technology/measurement plan and reporting "proof of concept" data, the state will report the measure a the statewide level by conducting chart review.

The component measures to be used in constructing the quality and access aggregate measure, as well as baseline and benchmark information for as many measures as possible are indicated on the *Oregon Measures Matrix* in Part III, below.

Aggregation of Component Measure Results

Because component measures may be in different units, on different scales, for different populations, and at different levels of performance compared to an ideal target, each component measure will be "translated" to a common scale, reflecting the fraction of the performance gap between baseline and ideal performance closed since the start of Medicaid system transformation. The algorithm for generating these translated measure values is as follows:

1. For each measure, Oregon and CMS will agree to a "target" level of performance, reflecting the best possible performance that Oregon would be able to achieve as a high performing program. Where possible, these targets are aligned with the CCO incentive benchmarks.

2. For each measure, where possible, the baseline (calendar year 2011 as described above) level of performance will be calculated.

3. For each measure, for each program period, the translated level of performance for the measure will be calculated as the difference between current and baseline performance divided by the difference between target and baseline performance. (Note that this formula applies whether or not the component measure has improved or worsened over time compared to a baseline.)

4. The translated value for each component measure takes the form of a percentage.

For each of the quality and access subtests, the aggregate measure is then constructed by taking the average of the component measures' translated values and rounding to the nearest first decimal place, i.e., to the nearest tenth of a percentage.

Metrics may be modified over time in the manner described in Part III of this document, regarding Oregon's Measurement Strategy.

Definition of Passing

Subject to CMS review and approval of reported findings and calculations, Oregon will be considered to have passed part one of the quality and access test for the DSHP performance periods of DYs 12 and 13 if the aggregate measure value for this test, rounded to the nearest tenth of a percentage, is greater than or equal to zero percent. In subsequent years (DYs 14 and 15), Oregon will be considered to pass a subtest only if the aggregate measure value, rounded to the nearest tenth of a percentage, is strictly greater than 0.

Timing and Deadlines

The statewide quality and access test applies only in years when the state meets its target for cost growth reduction. The first target is a one percentage point reduction for DY 12 (July 2013 – June 2014), so, allowing for data lag, the earliest point at which the test might be performed would be 6 months after the end of the end of the demonstration year in question, or early 2015. To align with quarterly reporting deadlines, the state will report test data and results to CMS in February 2015. However, the state will also calculate and report the aggregate measure to CMS in late fall 2013 on a practice basis only, using as much DY 11 performance data as is available at the time. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a

report to CMS by the August following the end of the demonstration year in question (see Timeline).

The quality and access test for any year in which Oregon has met the cost growth reduction target will be based on measurements from the most recent full demonstration year, as follows:

DSHP Quality and Access Test Data Periods
DY 12 (7/1/13-6/30/14)
DY 13 (7/1/14-6/30/15)
DY 14 (7/1/15-6/30/16)
DY 15 (7/1/16-6/30/17)

2014

As described above, the period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the part 1 quality and access test will not be any different for 2014 in order to reflect the expectation that the demonstration will continue to provide high quality care and to preserve the simplicity of the part 1 quality and access test approach. Nevertheless, it would not be surprising if part 2 of the quality and access test were to be necessary for this year and the part 2 quality and access methodologies should specifically account for the particular circumstances in this year.

Subpopulation Subtests

Due to potential technical challenges, and the increased risk of false-negative test results associated with a substantial increase in the number of comparisons, CMS will not require Oregon to demonstrate any minimum level of quality and access performance for beneficiary subpopulations as part of part one quality and access test.

However, these analyses should be included in evaluation analyses, and performance of metrics for subpopulations should be made transparent in a similar fashion to the core performance metrics. See Part III: Oregon's Measurement Strategy below for additional details about planned subpopulation analysis and public reporting.

Part 2 Quality and Access Test

As described above, if Oregon fails to pass part one of the quality and access test, a more complex analysis will be undertaken to determine whether the performance decline compared

to baseline was attributable to the state's transformation efforts. Methodologically, part 2 of the quality and access test will largely follow the rigorous independent analysis of the association between state transformation activities and changes in access and quality (controlling for external forces) that is described under Midpoint Assessment. (There is one exception: part two of the quality and access test will not include any subgroup specific analysis.) Practically, however, the part 2 test and any evaluation activities differ in both cause and consequence:

- Part 2 of the quality and access test is only triggered if the state does not pass part one of the test for a particular year. Formative, midpoint and summative evaluations will occur as planned, regardless of the state's performance related to cost growth reduction targets or part one of the test.
- Evaluation activities have no bearing on DSHP expenditure authority. In other words, if part 1 of the quality and access test is passed in a particular year, the state passes the test for that year and incurs none of the DSHP penalties described in STC 54, even if a concurrent rigorous analysis may be occurring as part of a formative, midpoint, or summative evaluation.

Definition of Passing

Oregon will be deemed to have passed the part 2 quality and access test if access and quality have not significantly diminished relative to changes in a comparison group or counterfactual scenario across the same time period. Thus, Oregon will pass as long as the difference between CCO members and the comparison group does not significantly change to the detriment of CCO members.

Responsibilities of Oregon

Oregon will issue a Request for Proposal for and contract with an independent evaluator or evaluators, which will be responsible for performing the part one and, if necessary, part two analyses in all required years. The state will convene a review group consisting of key state partners and independent scientific experts with appropriate expertise to review and score all proposals. The evaluator's responsibilities will include:

- Develop a detailed methodology for the execution of each part of the test, in advance of their use;
- For each required program year, review the relevant raw data, verify its accuracy, and, if necessary, clean the data;

- Produce the part one quality and access test —and, if necessary—part two quality and access test results described above.

- Deliver a package to CMS and Oregon containing (1) the cleaned datasets; (2) the detailed methodology; and (3) any results produced, by the required deadlines

Allowing for data lag, the state will submit the part one of the quality and access test to CMS in the February following the end of each demonstration year in which the test applies (see Timeline below). Failure to submit the required data also will result in application of the DSHP withhold specified in STC 54, as well as invoke the penalties for late reporting that are described in STC 64. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a report to CMS by the August following the end of the demonstration year in question (see Timeline).

Responsibilities of CMS

CMS will fully review the data, methods, and results produced for each year's test to ensure that calculations were made appropriately. Upon such a determination, CMS will notify the state that the DSHP penalty authorized by STC 54 shall not apply. If the state fails the test, the DSHP penalty described earlier will apply.

Evaluation

This section contains four parts: evaluation objectives; contextual considerations; research questions, data sources, and analytic approaches; and plan development.

Evaluation Objectives

This evaluation has three objectives:

(1) To perform a formative evaluation of Medicaid transformation that seeks to provide timely and actionable feedback on the initiative's progress, in terms of both outcomes and implementation activities. The formative evaluation will track and report regularly on OHA and CCO actions, progress toward achieving a health care system characterized by the key transformation levers; and progress toward achieving the primary goals of Medicaid transformation.

(2) To perform a midpoint assessment of Oregon's Medicaid transformation to provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

(3) To perform a summative assessment of Oregon's Medicaid transformation describing changes in Medicaid per capita expenditure trend and quality and access outcomes, as well as other outcomes of interest, and to identify the changes in outcomes resulting from transformation activities.

Note that there will be some overlap in the research questions, data sources, and measures used to fulfill these three objectives. In particular, early and medium-term results for certain questions will be addressed in a midpoint assessment in the third year of the demonstration, but may also be addressed in a formative or summative evaluation.

Contextual Considerations

Analytic challenges

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act will take effect. Expansion of Medicaid eligibility is expected to extend additional benefits to some adults already enrolled in the demonstration and bring more than 200,000 new individuals into the program and on to CCOs' membership rolls. These individuals, many of whom will have been uninsured previously, may need and utilize Medicaid services differently than the previously eligible group. In addition, all other large scale reforms—the individual mandate, guaranteed issue, tax subsidies for coverage through the Exchange etc.—are likely to have a significant impact on the capacity of the delivery system. The expansions and delivery reforms under this demonstration are intended to help bridge the transition to this new challenge, and so monitoring the changes in 2014 is an essential part of the efforts. The transitions in 2014 create a few inter-related analytic challenges for assessing the impact of Oregon's Medicaid transformation, most notably:

- How to account for any effect the needs and experiences of the newly eligible group might have on aggregate trends of quality, access, and cost for Medicaid populations over the 5 years of the demonstration;
- How to account for any effect that the delivery system's response to health care reforms outside of Medicaid may have on measures of access, quality, and cost for Medicaid populations;
- How to isolate the impact of Oregon's Medicaid transformation activities from contemporaneous trends in quality, access, and cost.

Oregon will contract for independent analysis that includes a triangulated approach to addressing these analytic challenges including tracking outcomes for the expansion population separately, development of a sound comparison group, and in-depth or complex mixed methods analyses. On some questions, it will also be useful to compare Medicaid enrollees to those with other sources of coverage (via the state's All-Payer All-Claims data system or population surveys such as BRFSS), although there are likely to be some spill-over effects given that almost 85 percent of Oregon's health care providers serve Medicaid clients. A difference-in-differences design may also be helpful as part of this triangulated approach to compare changes over time among Medicaid CCO enrollees to an appropriate comparison population, at the mid- and end-points of the demonstration period. Together, these should provide a reasonable picture of the success of Oregon's Medicaid transformation against its stated goals.

External evaluations

Oregon has an active and engaged health services research community and a history of sophisticated, policy-relevant research on the Oregon Health Plan including the landmark Oregon Health Study (OHS). The Oregon Health Research & Evaluation Collaborative (OHREC) serves as a point of collaboration and connection between state staff researchers from a variety of organizations. Two OHREC-affiliated research projects have already received funding from a mix of foundation, government, scientific, and philanthropic sources:

- The Robert Wood Johnson Foundation-funded SHARE grant is a mixed-methods study building on the OHS to assess what CCOs in Oregon actually do, how they impact health care access, use, quality, costs, and health outcomes, and how each CCO's outcomes are associated with its individual design. The partners in the study are the Office for Oregon Health Policy and Research in the Oregon Health Authority, Portland State University, Oregon Health & Sciences University and the Center for Outcomes Research at Providence Health System.

- An NIH-funded economic study focuses on the impact of spending reductions implemented through the CCO global budgets and the financial integration of behavioral specialty care and primary health care. The study includes cross-state comparisons, and also includes a qualitative component. This study is being conducted by researchers at Oregon Health & Sciences University, Portland State University, and the University of Colorado Denver.

Other proposals are currently under review at different funding agencies.

The state will use results from these and future independent evaluations to supplement its own demonstration evaluation work and provide independent analysis on the demonstration hypotheses. In addition to taking advantage of related research, Oregon intends to issue a request for proposals (RFP) and to contract directly with independent evaluators for two products: a midpoint assessment of quality and access (described in more detail shortly); and a summative evaluation at the end of the demonstration that will address the major research questions described under Summative Assessment below, synthesizing and summarizing findings from earlier evaluation and research.

The demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. Among the characteristics of rigor that will be met for the midpoint and summative evaluations are use of best available data; controls for and reporting of the limitations of data

and their effects on results and the generalizability of results. Treatment and control or comparison groups will be used, except (in the common circumstance) where randomization is difficult, in which case appropriate methods will be used to account and control for confounding variables. The evaluation design and interpretation of findings will include triangulation of various analyses, wherein conclusions are informed by all results with full explanation of the analytic limitations and differences.

An independent third party, selected by some means other than sole source contracting, following applicable state procurement, selection and contracting procedures, will conduct the midpoint and summative evaluations. The third party selected for the evaluation shall be screened to assure independence and freedom from conflict of interest. The assurance of such independence will be a required condition by the state in awarding the evaluation effort to a third party.

STC 88 requires that the state will provide to CMS within 120 days after expiration of the demonstration a draft summative evaluation report. Recognizing data lags and complexity of the analyses that comprise the midpoint and summative evaluations, we have agreed that CMS will not hold the state to be out of compliance with the timing requirements of STC 88 if the state provides to CMS its draft summative evaluation report within 180 days after the end of demonstration Year 15. In addition, CMS will not hold the state to be out of compliance for the draft midpoint analysis if submitted to CMS 180 days after the close of the initial review period, July 1, 2012 through June 30, 2014.

For both reports, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the state or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the contractor.

Draft reports related to the midpoint and summative evaluations will not be routinely released except as required by state and federal law. Until the later of the following two dates – July 1, 2019 (two years after the end of the demonstration) or 12 months from the date that the final reports for these evaluations are provided to CMS, CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the contractor or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS

will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

In light of the flexibility that CMS has offered in enforcing these evaluation deadlines, Oregon has agreed that in each demonstration year, when draft and final midpoint and summative evaluation reports are due, it will reduce claimed DSHP expenditures by one half of one percent (0.5) for the year to follow if any of these reports are not provided or are found by CMS to be unacceptable because they do not represent adequate rigor and independence and do not adequately implement the final evaluation design. The claimed expenditures withheld by CMS would be authorized only if revised reports are provided and found by CMS to be acceptable within a year of their original due dates under STC 88. The penalties related to quarterly and annual reporting submission deadlines, as specified in STC 64(e), continue to apply as specified in the STCs.

Research Questions, Data Sources, and Analytic Approach

Formative Evaluation

The formative evaluation will track and report regularly on: (1) OHA actions; (2) CCO actions; (3) progress on the "levers" intended to drive savings and quality improvement; and (4) progress toward achieving the primary demonstration goals. (See the Quarterly Report Guidelines—Attachment A of the STCs—for details on who information from the formative evaluation will inform the state's quarterly reports.) The formative evaluation is designed both to provide actionable information for quality improvement and to help inform/explain the summative assessment and will therefore include analysis by individual CCO, as well as in the aggregate.

Data and findings resulting from all stages of the evaluation—formative, midpoint, or summative—will be shared widely as part of the state's commitment to feedback and continuous improvement. Key pathways for dissemination and use of evaluation findings beyond the required reporting to CMS include:

- The Oregon Transformation Center, which will act as the state's hub for innovation and improvement. The CCO learning collaboratives to be convened by the Transformation Center will be a primary venue for sharing evaluation information, posing additional analytic questions, and sharing best practices or potential solutions to problems;
- The state's innovator agents, who are expected to help CCOs review their own data and identify opportunities for improvement;

- Formal publications and presentations (primarily for midpoint or summative evaluations) aimed at a variety of different audiences, including service providers, beneficiaries, and communities and their members; and

- Internal reporting for OHA leadership and program personnel.

The data sources identified to address specific evaluation questions will provide relevant information on several important aspects of the demonstration operations, for example: measures of beneficiary experience of care and provider engagement with Medicaid will feed into monitoring and policy development for network adequacy; and assessments of CCOs' actions to improve care coordination and integration will inform interpretation and resolution of grievances or appeals.

Table 1 shows the relevant formative research questions for the four topics listed above, as well as proposed measures and data sources. Note: rows shaded in light grey indicate research questions to be addressed in both the formative assessment and the midpoint assessment, described later in this section.

Table 1 – Formative Evaluation (shaded rows will be addressed in midpoint as well as formative)

Topic Area	Related Research Question(s)	Measures or data source(s)
OHA actions	To what extent has OHA effectively taken action to support transformation? For example: • Set expectations and monitor for care management • Develop global budget and quality incentive pool • Establish robust quality measurement and improvement strategy • Provide technical assistance and support, including Innovator Agent program • Patient-centered primary care home recognition, certification system for non-traditional health workers • Tracking method for flexible services	OHA documentation is the data source for most of these questions. Specific measures might include: • Incorporation of CCO transformation plans into individual contracts • Amount paid to CCOs in the form of quality incentives, vs. capitation • Attendance/participation rate at learning collaboratives • Measures of effectiveness from innovator agents document

Topic Area	Related Research Question(s)	Measures or data source(s)
CCO actions	To what extent have CCOs – in aggregate and individually – taken action to transform care delivery & payment? For example: • Encourage use of EHRs and participation in HIE • Use alternative payment mechanisms with providers • Maximize use of PCPCHs • Support and encourage providers to improve care coordination • Use quality metrics • Take action to reduce administrative waste • Provide flexible services where appropriate • Engage meaningfully with communities	• CCO Transformation plan tracking • Innovator agent contact database and monthly reports (see Innovator Agent document) • Office of Health IT tracking of EHR adoption and HIE participation (surveys) • Data from CCO quality assurance and oversight processes (monthly accountability team reviews, on-site operational reviews, etc., see Quality Strategy) • Surveys of CCO leadership and CCO Community Advisory members (see Innovator Agent document) • Tracking of flexible services • Qualitative information from independent evaluations – SHARE and McConnell NIH study
	• To the extent that some CCOs have not taken actions for transformation, what has prevented them from doing so? • To the extent that some CCOs have been successful in taking action, what have been their keys to their success?	As above
Levers for transformation	To what extent are CCO members experiencing improved care coordination, with emphasis on PCPCH?	• PCPCH enrollment by tier • Metrics from *Oregon Measures Matrix* related to integrating primary care and behavioral health, reducing preventable hospitalizations, and reducing preventable and costly utilization
	To what extent have OHA and CCOs implemented payment methods that focus on value not volume?	• Which CCOs do and which do not use alternative payment methods internally? • What is the distribution of available incentive funds across CCOs? (OHA admin data)

Topic Area	Related Research Question(s)	Measures or data source(s)
		• *Potentially:* measures from soon-to-Catalyst for Payment Reform scorecard
	To what extent have CCOs integrated physical, behavioral, and oral health services? Other services?	• CCO Transformation plan tracking • Metrics from *Oregon Measures Matrix* related to integration, e.g. SBIRT, follow-up after hospitalization for mental illness, etc.
	To what extent have CCOs achieved administrative efficiencies?	• CCO financial reporting requirements, including OHA-developed Exhibits (see CCO core contract) • Office of Health IT tracking of EHR adoption and HIE participation • CCO Transformation plan tracking • CCO participation in statewide administrative simplification efforts (e.g. common credentialing)
	To what extent are beneficiaries using flexible services?	• TBD – tracking method for flexible services is still in development • CCO Transformation plan tracking
	To what extent are best practices being tested and disseminated?	• CCO participation in learning collaboratives and other technical support opportunities • Innovator agent monthly reports; Number and success of innovations adopted by a CCO; rate at which CCOs test new ideas and improve (see Innovator Agent document) • Successful implementation of CCOs' transformation plans, the measures for which will be developed upon completion of the plans
Demonstration / Medicaid Transformation Goals	Have CCOs– in aggregate and individually • Improved quality of care for members? • Improved access to care? • Improved members' experience of care? • Improved members' health status?	See impact assessment table

Topic Area	Related Research Question(s)	Measures or data source(s)
	Has Oregon reduced per-member cost growth?	See summative assessment table

Midpoint Assessment

The midpoint assessment will analyze activity through the midpoint of calendar year 2014, with a report due to CMS no later than August 2015. In addition to summarizing findings to date on select research questions from the formative and summative evaluations (indicated by shaded rows in Table 1 and Table 2), the midpoint assessment will connect the two via an explicit examination of the coordinated care model on changes in access and quality. (Access and quality should be read here to include experience of care.) The report will also include a high-level summary of expenditure and cost data, based on 2 percent test reporting described in Attachment H, Section B. The state anticipates contracting with independent researchers (as described above) to perform a rigorous analysis of the association between state transformation activities and changes in access and quality, controlling for external forces.

For instance, a contractor could employ a difference-in-differences analysis, assessing the average changes in scores over time from the baseline year among CCO enrollees and subtracting out the average changes among a comparison group of matched individuals from a non-CCO, fee-for-service comparison group in order to arrive at the "net" impact of transformation, as follows:

- **Measures**: Measures of access and quality (including care coordination and beneficiary experience of care) would be drawn from the *Oregon Measure Matrix* listed in Part III, below. Measures of access and quality for future consideration are also listed in Part III, below. Because this is an evaluative assessment rather than a “test,” there is no need to create an aggregate access or quality measure. The results of the formative evaluation to date will provide contextual information about the extent to which the transformation “levers” have been implemented.

- **Study Groups**: Contractors will provide for an adequate comparison group. Potential contractors will describe a plan for specifying the control group and specify criteria for case-matching or other adjustments to account for potential changes in group

composition over time, as well as plans for the treatment of individuals who disenroll during the study period.

- **Data Years**: The contractor's plan should also address the appropriate data years for both study and comparison groups to identify to the extent possible any underlying movement in the scores that was occurring prior to implementation.

- **Statistical Approach**: Contractors will describe a statistical plan that accounts for the distribution of the dependent variables and uses appropriate modeling techniques. The state will work with the contractor to insure that the model is appropriately pre-specified while being sensitive to model choices that must account for the distribution of the data.

- **Strategies to Account for Potential 2014 Expansion**: If the state expands its Medicaid program to 133 percent FPL in accordance with the Affordable Care Act in 2014, the contractors will describe specific strategies to account for the effects of this expansion on access and quality and separate them from the impacts of Medicaid system transformation. (A DiD design is robust against such changes provided the expansion impacts both groups in the same way, but if expansion impacts CCO and comparison group members differently, the model's ability to identify the specific impacts of Medicaid transformation will be compromised.) Contractors will propose methods to account for the impacts of the expansion (with respect to both expanded eligibility and the availability of more expansive coverage for some adults previously eligible for the demonstration) and extract those impacts from the estimates of CCO effects. Separate tracking of new eligibles, described in the analytic approach column of Table 1, will produce information that may be of use to contractors in accounting for expansion effects.

- **Subgroup Analysis**: Contractors will describe a plan that provides results separately for vulnerable populations or subgroups of interest and compares those results to the overall trends to identify differences in effects by subgroup. Depending on the degree of variation across the state or among CCOs and the stability of enrollee populations, it may also be possible to compare trends in access and quality across beneficiaries experiencing "low-dose" and "high-dose" transformation.

The midpoint assessment will produce a more nuanced picture of trends than the summary scores of the DSHP quality and access "tests." It will also provide the state and CMS with a sophisticated assessment of the relationship between the state's actions and beneficiary outcomes well in advance of the end of the demonstration period.

Finally, the midpoint assessment will include a narrative section regarding the progress of Oregon towards streamlining its reporting processes, including whether there are reports and/or evaluations the state would recommend combining, and specifically regarding progress towards use of automated data systems that will support the transmission of data through data portals and other electronic reporting channels, and progress towards an HIE infrastructure.

Summative Assessment

The impact assessment focuses on the outcomes depicted in the theory of action: reduced PMPM cost growth (demonstration goal 1), improvement or maintenance of quality and access (demonstration goal 2), and improvement or maintenance of beneficiaries' experience of care and health status. Table 2 lists the research questions associated with each outcome, as well as proposed measures and data sources and analytic approaches for addressing the question. The research questions should be read as including both CCO enrollees and those beneficiaries for whom services will be provided on a fee-for-service basis even after January 2013. Note: rows shaded in light grey indicate research questions to be addressed in both the summative assessment and the midpoint assessment, described earlier in this section.

Table 2 – Summative Assessment (shaded rows will be addressed in midpoint as well as summative)

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
Per capita Medicaid spending	How does annual change in per-capita Medicaid spending during demonstration period compare to projected trend?	state Medicaid program expenditure data Presidents' budget for projected trend	Align with methodology for expenditures for 2% test (including adjustment for 2014).
	Which beneficiary subpopulations* deviate from the statewide trends?	state Medicaid program expenditure data	Subpopulation analysis of expenditures by demonstration year.
	How does spending change for behavioral health compare to overall trends and physical health spending changes?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.
	How does spending change for primary care services compare?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
	Are "flexible services" deterring higher-cost care?	TBD – tracking method for flexible services is still in development.	Depending on tracking method, approach may include: Estimation of the value of flexible services provided, by category Estimation of costs deterred Case studies of variation by CCO in flexible services offered
Quality of care	Is quality of care for Medicaid beneficiaries improved or at least maintained over time?	Quality measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Is coordination of care for Medicaid beneficiaries improved or at least maintained over time?	Care coordination measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in the quality of care or care coordination for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved quality of care or care coordination?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g. PQIs using HCUP data) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation assessing changes in quality for those enrolled in CCOs vs. not enrolled.

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
			Incorporate results of independent McConnell NIH study of changes in "contracted" and "non-contracted" quality measures For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group
Access to care	Has access to care for Medicaid beneficiaries improved or at least maintained over time?	Access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Has the rate of change in access to behavioral health kept pace with physical health access improvements?	Behavioral health access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Comparison of change over time in access measures by service type
	Have there been variations in any of the access to care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved access to care?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g. care delayed due to cost) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation comparing changes in access for those enrolled in CCOs vs. not enrolled.

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
			Incorporate results of independent McConnell NIH study assessing impact to CCOs on probability of members accessing care, by provider type For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group and analysis of provider survey data on Medicaid acceptance by primary care v. subspecialty
Member experience of care	Has beneficiary experience of care improved or at least maintained over time?	Experience of care measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in experience of care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved experience of care?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of externally-conducted SHARE evaluation comparing changes in experience of care for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
			enrollees to change in an appropriate comparison group
Health Status	Is beneficiary health status improved or at least maintained over time?	Health outcome or status measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in health status measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved health status?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures, BRFSS) Incorporate results of externally-conducted SHARE evaluation comparing changes in health status for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group

* Categories of interest for sub-population analysis include:

- Beneficiary race and ethnicity
- Beneficiary primary language
- Individuals eligible for Medicare and Medicaid
- Individuals with mental illness

- Disability status
- Rural vs. non-rural location

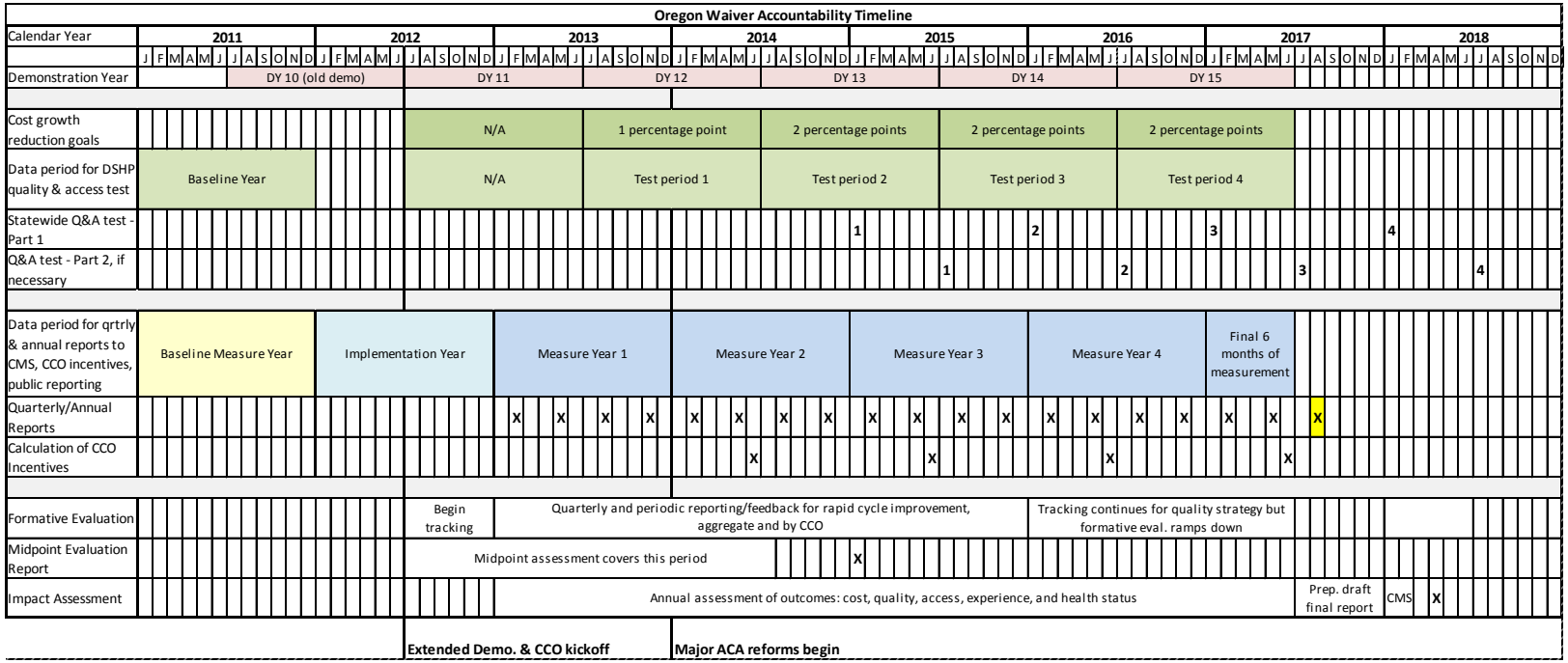
Ability to analyze outcomes by beneficiary sub-population will be dependent on the specific measure and data source. Provider measures for access will also be analyzed by subtype of provider.

Evaluation Plan Development

This plan was developed by a cross-division of OHA staff with experience in evaluation research and demonstration planning and reviewed by OHA leadership. External expertise and consultation was provided by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, as well as CMS staff. Because of the close connection between the formative evaluation plan described here and the state's Quality Strategy, the demonstration evaluation design will be reviewed annually along with the Quality Strategy.

Timeline

This figure depicts the timing of key deliverables under STCs 52, 54, 64, 86 and 88.



Part III: Oregon's Measurement Strategy 2012

Introduction

Oregon's Measurement Strategy (STCs 38, 39, 40, 42) outlines how the Oregon Health Authority will measure quality of care and access to care for individuals enrolled in Coordinated Care Organizations and for the Oregon Health Plan population as a whole. The metrics are also integral to the effort to monitor and correct pathways towards improvements in the quality of care and access to care for Medicaid beneficiaries under health system transformation efforts, as described in the Statewide Quality and Access Tests section above.

OHA Measurement Framework

Oregon has identified over 100 potential measures of cost, quality, access, patient experience, and health status that could be tracked over delivery settings and populations during the demonstration period. These measures come from several measure sets.

- Oregon CCO Incentive Measures
- Oregon Demonstration Core Performance Measures
- CMS Adult Core Set for Medicaid
- CMS Child Core Set for Medicaid and the Children's Health insurance Program

Oregon has committed to collecting and reporting on the CCO Incentive Measures and the Demonstration Core Performance Measures. Many of the CMS Adult Medicaid Quality Measures and CHIPRA Measures overlap with these measure sets, and Oregon has also committed to reporting on these two core sets even as they evolve to the extent feasible. *See Appendix 3.A for a listing of these measures by population and by domain.*

Oregon has submitted an application for an Adult Medicaid Quality Grant for the *Oregon CMS Adult Measures Project*, which would develop additional capacity for standardized collection and reporting of the CMS Adult Medicaid Quality Measures. Through this project, Oregon would test and evaluate methods for collection and reporting of the measures, improve measures so they are reliable, and develop capacity to report the data, analyze, and identify opportunities to improve health care quality for Medicaid beneficiaries. Work funded through this grant would inform the collection and reporting of the Demonstration Core Performance and CCO Incentive Measures.

Through participation in the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Program, Oregon has also collected all 24 CHIPRA measures and developed an understanding of standardization and comparability for these measures. Oregon

will continue to participate in this program and collect and report on selected CHIPRA measures through 2015.

From these measure sets, Oregon has identified access measures, including CCO-level access improvement measures, and survey-based access measures. *These measures are also identified in the tables in Appendix 3.A.*

Incentive Measures

The Oregon Metrics and Scoring Committee have identified the year one incentive measures that will be tied to the quality pool as required by STC 37b.ii.[12] See Appendix 1.C: Quality Pool Structure above for a detailed description of the quality pool design and funding algorithm. Building on work completed by their predecessor committee, the Oregon Health Policy Board Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics[13], the Committee considered several core principles when selecting these measures. Among other principles, any selected measures should:

- Meet standard scientific criteria for reliability and face validity;
- Help drive system change;
- Successfully communicate to consumers what is expected of CCOs;
- Align with evidence-based or promising practices;
- Be nationally validated, a required reporting element in other health care quality initiatives, or align with national or other benchmarks for performance; and
- Usefully distinguish between different levels of CCO performance.

The majority of incentive measures selected overlap with Oregon's Demonstration Core Performance Measures, CMS Adult Medicaid Quality Measures, and CHIPRA Measures, ensuring that the incentive program is aligned with existing state and national quality measures. Selected incentive measures do strongly align with Oregon's quality improvement focus areas and all incentive measures have been included in the set of quality and access "test" measures. Specifications and data sources for the year one incentive measures can be

[12] http://www.oregon.gov/oha/pages/metrix.aspx

[13] http://www.oregon.gov/oha/OHPB/pages/health-reform/workgroups/outcomes-quality-efficiency.aspx

found in Appendix 3.C and more detailed rationale for each of these incentive measures can be found in Appendix 3.D.

Through a public process, the Metrics and Scoring Committee established improvement and performance targets that a CCO must meet on the selected incentive metrics to be eligible for receiving funds from the quality pool. These targets are listed in Appendix 3.B.

Oregon has also established benchmarks for the statewide quality and access test described below. Oregon's baseline data (2011) and benchmarks are included in Appendix 3.B.

Ensuring Continuous Quality Improvement

Incentive Measures

The Metrics and Scoring Committee will likely consider additional measures, either as part of the Oregon Health Authority's overall measurement framework or as incentive metrics in future years. The Committee will be reviewing CCO performance data, improvement over baseline, and distribution of the quality pool to determine if the initial incentive metrics selected were the right combination of measures to improve quality and access for the Oregon Health Plan population. Incentive measures may be added in subsequent years and it is likely that other measures will be retired from the list, either due to measurement concerns or progress. CCO performance may improve significantly enough on select measures that the Committee refocuses efforts to different areas needing improvement.

The Committee is charged with revisiting not only the selected incentive measures, but also the performance and improvement targets. It is critical that these targets take future CCO improvement into account and continue to provide stretch goals that CCOs must meet to be eligible for the quality pool. CCOs will not be allowed to coast on early success, or demonstrate improvement in just one domain.

Specifically, the initial decision by the Metrics and Scoring Committee was to reward improvement in incentive metrics as compared to a historical baseline, rather than to the prior year's performance. This structure may not be adequate to provide ongoing incentives for continued improvement and may be reexamined by the Metrics and Scoring Committee in consultation with CMS and the state as part of the midpoint assessment.

Likewise, the Oregon Health Authority will be revisiting selected quality and access measures in future years of the demonstration to ensure that quality of care and access to care are being tracked appropriately. A subset of quality and access test measures has already been identified for consideration in demonstration year 3. These are listed in Appendix 3.E.

OHA will also be exploring National Quality Forum (NQF)-endorsed and other healthcare disparities and cultural competency measures for inclusion in the measurement framework. As new measures are identified, potentially through the CMS Adult Core Quality Measures Grant, or endorsed, through NQF or Meaningful Use Stage 2, OHA will add and retire measures from the overall measurement framework.

Modification of Metrics for Statewide Quality and Access Test

Consistent with the recognized need for flexibility to modify plans over time and take into account evidence and learning over time, as well as for unforeseen circumstances or other good cause, a CCO, CMS, or the state may request prospective changes to metrics or targets for any achievements that are well above or below the established targets based on progress to date through a modification process. CMS and the state must agree to modify the metrics; CMS retains the authority for final approval of such changes, which will be reflected in the quality strategy. Examples of when requests for changes may be appropriate are:

a. **Difficult metrics:** The CCO, CMS, or the state may suggest re-targeting of metrics in instances in which it appears that statewide targeted performance will not be achieved over the life of the demonstration.

b. **Topping out on metrics:** During any given year, the CCO, CMS, or the state may suggest re-targeting in instances in which targets have been achieved or surpassed. However, it appears that there is still substantial room for growth on selected projects (e.g., percentage improvement or volume metrics for subsequent years were already met because the original estimates were too low, but data suggest that more improvement could be done.)

c. **Mismatched metrics:** The CCO, CMS, or the state may suggest new metrics that better reflect local concerns when it is determined that the existing metrics are inadequate.

Data Collection

The Oregon Health Authority will be responsible for collecting data on all measures selected. Data sources for incentive measures are included in Appendix 3.B and descriptions of data sources are also included in section IV of the Quality Strategy. An external quality review organization (EQRO) will play a role in data collection and analysis where necessary, assisting with measures that require chart reviews and/or validation of information submitted by a CCO.

OHA will contract with the Oregon Health Care Quality Corporation (Quality Corp) for assistance in data cleaning and analysis, third party validation, and reporting. As a Robert Wood Johnson Foundation *Aligning Forces for Quality* grantee, Quality Corp is experienced in ensuring the production of transparent data and analytics that are highly valued and actionable.

Measurement Year

The first measurement year for the CCO incentive measures will be calendar year 2013. Results will be available in June 2014, in time for the first quality pool distribution by June 30, 2014. The second measurement year for incentive measures will be 2014. Medicaid adult quality and CHIPRA measures will be calculated during the same period. A detailed timeline for the formative and summative assessments, and quarterly reporting as required by STC 64, is included in the Evaluation Plan above. Of note, the measurement period for the statewide quality and access tests will be the demonstration year, which runs from June to July, and so is offset from the measurement period for the CCO incentive measures by six months.

Data Analysis

OHA will also be responsible for conducting data analysis on these measures. Where possible, measures will be aggregated by the CCO and analyzed for trends, issues, areas of concern and areas of innovative improvement. Data will also be analyzed by racial and ethnic groups, in addition to vulnerable populations such as people experiencing homelessness and people with specific diagnoses (disabling conditions, SPMI, chronic conditions, addictions).

Where possible, measures will also be reported for the fee-for-service (FFS) population. For example, all measures from the Consumer Assessment of Health Plans and Systems (CAHPS) survey will be reported for the remaining FFS population.

Other subpopulations of interest for analysis include beneficiary primary language, individuals eligible for Medicare and Medicaid, and rural versus non-rural locations. OHA will involve data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders in clearly defining selected subpopulations for analysis before the measurement year begins in January 2013.

This data will be used to track program goals, address disparities, and drive quality improvement through the financial incentives, performance reporting, and rapid cycle feedback processes described in Part I (Oregon's CCO Quality Strategy). Data from selected measures will also be used to inform the evaluation questions described in Part II (Statewide Evaluations and Tests).

Data Reporting

The Oregon Health Authority has committed to transparency in health system transformation efforts: all selected measures will be reported publicly through reports made available on the Oregon Health Authority website. At a minimum, data will be reported publicly on an annual basis; however a subset of information will be reported more frequently to track patterns of utilization and highlight potential issues with performance. This will also allow OHA to work frequently with CCOs on metrics and possibly make course corrections prior to annual reports. Additional details on reporting are included in the Evaluation Plan timeline above.

Where possible and appropriate, measures will be reported by race and ethnicity, disability, and a where there is a diagnosis of serious and persistent mental illness (SPMI). Measures will be reported by CCO, and in aggregate. In addition, CCO dashboards will synthesize performance data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries. OHA will not disclose any information otherwise protected by law.

Appendix 3.A: Measure Sets by Population and Domain

Table I: CCO Incentive Measures	Population		Domain					
Measures	**Adult**	**Child**	**Access**	**Cost**	**Quality**	**Health Outcomes**	**Patient Experience**	**Systems**
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√			√	√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√	√	√			
Mental and physical health assessment within 60 days for children in DHS custody (state measure)		√	√		√			
Follow up care for children on ADHD medication (NQF 0108)		√	√		√			
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Elective delivery before 39 weeks (NQF 0469)	√				√			
ED utilization without an admission per 1,000 member months (HEDIS)	√	√		√				
Colorectal cancer screening (HEDIS)	√		√		√			
Patient-Centered Primary Care Home (PCPCH) (state enrollment (state measure)	√	√	√	√				
Developmental screening by 36 months (NQF 1448)		√	√		√			
Adolescent well child visits (HEDIS)		√	√		√			
Controlling hypertension (NQF 0018)	√		√	√		√		
HemoglobinA1c poor control (NQF 0059)	√			√		√		
Access to Care: Getting Care Quickly (CAHPS Composites)	√	√	√				√	
Health Plan Satisfaction: Customer Service (CAHPS Composites)	√	√					√	

Table I: CCO Incentive Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient Experience	Systems
EHR adoption (composite – 3 questions)	√							√

Table II: Oregon Core Performance Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Getting needed care and getting care quickly (CAHPS Composites)	√	√	√				√	
Member health status, adults (CAHPS health status)	√	√				√		
Rate of tobacco use among CCO enrollees (Medicaid BRFFS, CAHPS)	√					√		
Rate of obesity among CCO enrollees (state measure)	√					√		
Ambulatory Care: Outpatient and emergency department visits (HEDIS)	√	√	√					
Potentially avoidable ED visits (Medi-Cal approach)	√	√		√				
Ambulatory-care sensitive hospital admissions (PQI #1: NQF 272; PQI #14: NQF 638)	√		√		√			
Medication reconciliation post-discharge (NQF 0554)	√				√			
All-cause readmissions (NQF 1789)	√			√				
Alcohol or other substance misuse (SBIRT)	√				√			
Initiation and engagement in alcohol and drug treatment (NQF 0004)	√		√		√			
Mental health assessment for children in DHS custody		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Effective contraceptive use among women who do not desire pregnancy (BRFFS)	√		√		√			

Table II: Oregon Core Performance Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Low birth weight (NQF 0278, PQI 9)					√	√		
Developmental screening by 36 months (NQF 1448)		√	√		√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√		√			

Table III: CHIPRA Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Frequency of Ongoing Prenatal Care (NQF 1391)	√	√	√		√			
Low birth weight (NQF 1382)		√			√	√		
Childhood immunization status (NQF 0038)		√	√		√			
Immunizations for adolescents (NQF 1407)		√	√		√			
Developmental screening by 36 months (NQF 1448)		√	√		√			
Chlamydia screening for women (NQF 0033)	√		√		√			
Well-child visits in the first 15 months of life (NQF 1392)		√	√		√			
Well-child visits in the 3rd, 4th, 5th and 6th years of life (NQF 1516)		√	√		√			
Adolescent Well-Care Visit (NCQA)		√	√		√			
Child and adolescent access to Primary Care Practitioner (NCQA)		√	√		√			

Table III: CHIPRA Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Appropriate testing for children with pharyngitis (NQF 0002)		√			√			
Ambulatory Care: ED Visits (NCQA)	√	√	√	√	√			
Annual % of Asthma Patients with 1 or more Asthma-related ED visits (ages 2-20)		√	√	√	√			
Follow up Care for Children prescribed ADHD medication (NQF 0108)		√	√		√			
Annual pediatric hemoglobin A1C testing		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Mental health assessment for children in DHS custody		√	√		√			
CAHPS Health Plan Survey (child version with chronic conditions supplemental items)	√	√	√	√	√			

Table IV: Medicaid Adult Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Cervical cancer screening (NQF 0032)	√		√		√			
Medical assistance with smoking and tobacco use cessation (NQF 0027)	√		√	√	√			
Screening for clinical depression and f/u (NQF 0418)	√		√		√			
Plan All-Cause Readmissions (NCQA)	√	√	√	√	√			
Diabetes short-term complications admission rate (NQF 0272; PQI 01)	√		√	√	√			
COPD Admission Rate (NQF 0275, PQI 05)	√		√	√	√			
CHF Admission Rate (NQF 0277, PQI 08)	√		√	√	√			

Table IV: Medicaid Adult Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Adult Asthma Admission Rate (NQF 0283, PQI 0283)	√		√	√	√			
Chlamydia Screening in Women age 21-24 (NQF 0033)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√				√			
Elective delivery before 39 weeks (NQF 0469, PC-01)	√			√	√			
Controlling hypertension (NQF 0018)	√			√	√	√		
Comprehensive Diabetes Care: LDL-C Screening (NQF 0063)	√		√	√	√			
Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF 0057)	√		√	√	√			
Antidepressant Medication Management (NQF 0105)	√		√		√			
Adherence to antipsychotics for individuals with schizophrenia (CMS-QMHAG)	√			√	√			
Annual monitoring of patients on persistent medications (NQF 0021)	√		√		√			
CAHPS Adult Survey (including NCQA Supplemental) (NQF 0006 and 0007)	√		√		√			
Prenatal and Postpartum Care: Postpartum Care Rate (NQF 1391)	√		√		√			

Appendix 3.B: Oregon Measures Matrix

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
Improving behavioral and physical health coordination	Alcohol or other substance misuse (SBIRT)	√	√			√	MN method[14] Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused,

[14] The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore, the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								focused, evidence-based intervention).		evidence-based intervention).
	Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from predecessor organization.	TBD

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available by April 2013.	90% (Note: Benchmark based on Metrics & Scoring Committee consensus).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	90%
	Follow-up care for children prescribed ADHD meds (NQF 0108)	√			√	√	Oregon Medicaid baseline 2011: Initiation: 50% C&M: 57%	Medicaid 2012 NCQA National 90th percentile: Initiation: 51% C&M: 63%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid NCQA National 90th percentile: Initiation: 51% C&M: 63%
Improving perinatal and maternity care	Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data	2012 National Medicaid 75th percentile: 89%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
									from predecessor organization.	
	Prenatal and postpartum care: postpartum care rate (NQF 1517)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 66% 90th percentile: 71%	n/a	n/a
	PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per Oregon Association of Hospitals and Health Systems (OAHHS), could also use the	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per	5% or below.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							16% rate publically available from Joint Commission)		OAHHS, could also use the 16% rate publically available from Joint Commission)	
Reducing preventable re-hospitalizations	Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 90th percentile: 68%
	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013)	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							ED utilization baseline (2011): 56 / 1,000 mm		predecessor organization.	
	All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a
Ensuring appropriate care is delivered in appropriate settings	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5-	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data	2012 National commercial data, unadjusted 75th percentile: 65.76

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								year period based on trends in Medicare and Commercial data).	from predecessor organization.	Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile: 61.34 (Based on Metrics & Scoring Committee consensus)
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.
	Developmental screening in the	√	√		√	√	Oregon baseline: 19.6%	50%	MN method.	50%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	first 36 months of life (NQF 1448)						using admin data only.	(Metrics & Scoring Committee consensus)	Individual CCO baselines will be determined with 2011 data from predecessor organization.	(Metrics & Scoring Committee consensus)
	Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 77.3%	n/a	n/a
	Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile: 56.9%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from	2011 National Medicaid 75th percentile: 56.9%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
									predecessor organization.	
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 27.5%	n/a	n/a
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a
	Appropriate testing for children with pharyngitis (NQF 0002)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 76%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								90th percentile: 84%		
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed or recommended medications with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
Deploying care teams to improve care and reduce preventable of unnecessarily costly utilization by super users	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and coordinating a broad set of	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%
	Comprehensive diabetes care: LDL-C Screening (NQF 0063)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 80%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
resources, including CHW.								90th percentile: 84%		
	Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 86% 90th percentile: 90%	n/a	n/a
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	TBD (baseline data available in Feb 2013)	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%
	PQI 01: Diabetes, short term complication		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	admission rate (NQF 0272)							Oregon's data (2002-2011)		
	PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)		√	√		√	416.9 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 15: Adult asthma admission rate (NQF 0283)		√	√		√	178.7 (2011)	10% reduction from baseline Benchmark set based on	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								Oregon's data (2002-2011)		
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	**Access to Care** OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%	MN method with 2% floor Access to Care OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	Average of the 2012 Medicaid 75th percentile for the adult and child rates. Access to Care 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√				

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 63% 90th percentile: 69%	n/a	n/a
	Cervical cancer screening (NQF 0032)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 74% 90th percentile: 79%	n/a	n/a
	Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a
	Provider Access Questions from the Physician					√	In 2009: 52.4% of Oregon's	TBD	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Workforce Survey: 4) To what extent is your primary practice accepting new Medicaid/OHP patients? (include: completely closed, open with limitations, and no limitations). 5) Do you currently have						physicians accepted new Medicaid patients without limitations; 29.7% accepted with some limitations; and 17.9% were completely closed. 84% of physicians have Medicaid patients. The statewide payer mix for Medicaid is 15%.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Medicaid/OHP patients under your care? 6) What is the current payer mix at your primary practice?									
	Screening for depression and follow up plan (see above)									
	SBIRT (see above)									
	Mental and physical health assessment for children in DHS									

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	custody (see above)									
	Follow-up care for children on ADHD medication (see above)									
	Timeliness of prenatal care (see above)									
	Colorectal cancer screening (see above)									
	PCPCH enrollment (see above)									
	Developmental screening by 36 months (see above)									

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Adolescent well child visits (see above)									
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules)- report on identified Access to Care and Satisfaction with Care composites for incentive, waiver and test.	√	√	√		√	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	MN method with 2% floor. Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average: 78%	Average of the 2012 Medicaid 75th percentile for the adult and child rates. Satisfaction with Care 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items)- report on identified Access to	√	√		√	√				

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Care and Satisfaction with Care composites for incentive, waiver and test.									
Meaningful Use	EHR adoption (Meaningful Use 3 question composite)	√				√	TBD (Baseline data available in April 2013)	TBD	TBD (Baseline data available in April 2013)	TBD

Appendix 3.C: CCO Incentive Measure Specifications

Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)

This is a non-standard measure based on recommendations from SAMHSA and CMS. The measure is modeled after the screening for depression and follow up measure, without the chart review component.

Numerator

- Individuals screened using SBIRT as indicated by billing codes: 99408, 99409, and 99420

Denominator

- All individuals age 18+

Exclusions

- No exclusions noted.

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
A very low rate of claims submitted in a 12 month period (using CPT codes or H codes). Assume 0% baseline.	n/a	n/a

Follow up after hospitalization for mental illness

NQF Measure #0576. Measure Steward: National Committee for Quality Assurance.

This measure tracks the percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment (had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner) within seven days of discharge.

Numerator

- Clients seen for a non-inpatient visit for mental health services within seven days of discharge for a psychiatric hospitalization defined by relevant DRG codes.

Denominator

- Discharges for psychiatric hospitalization with principal mental health diagnosis.

Exclusions

- If discharge is followed up by another hospitalization for any cause within seven days of discharge, the discharge should be excluded from denominator.
- If it can be determined that the client was transferred to Oregon State Hospital or Blue Mountain Recovery Center, the discharge should be excluded from the denominator. This should be signified by disenrollment from OHP.

Notes

HEDIS specification also defines a metric for 30 day follow up. Continuous enrollment specifications in HEDIS metric take this longer follow up period into account. In addition, the clinics that qualify for follow up visits are too prescribed within HEDIS specifications. It is recommended that OHA adapts to include visits to any setting for mental health services. HEDIS calls for a mental health practitioner to see the person within 7 days. HEDIS definition for MH practitioner includes practically all practitioners allowed to encounter a mental health service in Oregon.

Data Source(s) Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
51%	68% (2012)	58% (2012)

Screening for depression and follow up plan

NQF Measure #0418. Measure Steward: Centers for Medicare and Medicaid Services

This measure tracks the percentage of clients age 18 and older screened for clinical depression using a standardized tool and with a documented follow-up plan

Numerator

- Individuals screened for clinical depression using an age appropriate tool with follow-up plan documented.

Denominator

- All individuals age 12+.

Exclusions

A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.

Notes

This is a metric that will have initial specifications for CMS Adult Quality Measures Grant. It is not currently defined in NQF, despite notation.

Data Source(s)

- Administrative data and chart review.

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Assume 0% baseline.	n/a	n/a

Mental and physical health assessment for children in DHS custody

This is a non-standard measure that tracks the percentage of children in DHS custody who receive a mental and physical health assessment with 60 days of initial custody date

Numerator

- The number of children brought into DHS custody within a given quarter that received a mental health assessment within 60 days of custody date. Mental Health assessment is defined through the following procedure codes: H0031; H1011; 90801; 90802; 96101; and 96102.
- The number of children brought into DHS custody within a given quarter that received a physical health assessment (procedure codes to be defined) within 60 days of custody date.

Denominator

- The number of children age 4+ taken into custody within a given timeframe (month, quarter or year) who remained in DHS custody for 60 days.

Exclusions

- Children must be continuously enrolled for the 60 day follow up period.
  Notes

Current agreed upon procedure codes (with predecessor Mental Health Organizations) may need to be updated with CCOs.

Committee proposed expanding this measure to include oral health screening in future years

Data Source(s)

- Administrative data and child welfare records (ORKids)

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
58% (Mental Health assessment)	n/a	n/a

Follow up care for children prescribed ADHD medication

NQF #0108. Measure Steward: NCQA

The measure tracks the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

2. *Continuation and Maintenance (C&M) Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Numerator

- Rate 1: Members from the denominator with one face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date.

- Rate 2: The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Denominator

- Members 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an attention deficit/hyperactivity disorder (ADHD) medication during the 12-month Intake Period.

Exclusions

- Initiation Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis or DRG for mental health or substance abuse during the 30 days after the IPSD.
- Continuation and Management Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis of mental health substance abuse during the 300 days after the IPSD.
- Patients diagnosed with narcolepsy (ICD-9-CM Code: 347) should be excluded from the denominators.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
2011 rate 1: 49.96%	2012 rate 1: 51%	2012 rate 1: 44%
2011 rate 2: 57.09%	2012 rate 2: 63%	2012 rate 2: 53%

Prenatal and Postpartum Care: Timeliness of prenatal care

NQF #1517. Measure Steward: NCQA

This measure tracks the percentage of deliveries of live births that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Numerator

- Number of live birth deliveries that received a prenatal care visit as a member of the CCO in the first trimester or within 42 days or enrollment.

Denominator

- Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Exclusions

- None.

Notes

Must be enrolled for 43 days prior to delivery with no gaps.

From July 1, 2009, managed care plans received global payments for prenatal, delivery, and postpartum services in addition to capitation rates: a significant portion of ambulatory services may not generate a claim. This could be addressed through chart review.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
30.4% (administrative data only)	92% (2012)	89% (2012)

Elective delivery before 39 weeks

NQF #0469. Measure Steward: The Joint Commission

This measure tracks the percentage of patients with elective vaginal deliveries or elective cesarean sections at >=37 and <39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).

Numerator

- Individuals with elective deliveries with ICD-9-CM principal procedure code or ICD-9-CM other procedure codes for one or more of the following: Medical induction of labor, Cesarean section while not in active labor or experiencing spontaneous rupture of membranes.
- Procedure codes are defined in Appendix A, Table 11.05 and 11.06 available online at http://manual.jointcommission.org

Denominator

- Patients delivering newborns with >= 37 and < 39 weeks of gestation completed.

Exclusions

- ICD-9-CM Principal Diagnosis Code of ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07.
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
0.8% (2012)		

Emergency Department Utilization

This measure summarizes emergency department utilization and is half of the HEDIS measure "outpatient and ED utilization."

Numerator

- Number of ED visits (multiple visits on one day are counted as one visit).

Denominator

- Per 1,000 member months.

Exclusions

- Emergency Department visits that result in hospital admission.
- HEDIS does not include mental health or chemical dependency if diagnoses are listed as primary.

Notes

Recommend OHA reports total utilization for all covered diagnoses per 1,000 member months, as well as grouping for physical health, mental health, and chemical dependency.

Each group should be reported by recommended race and ethnicity categories. Each group should also be broken out by the following age categories: 0-12; 13-17; 18-20; 21-64; 65-74; and 75+.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
56/1,000mm (2011)	44.4/1,000mm (2011)	55.2/1,000mm (2011)

Colorectal cancer screening

NQF #0034. Measure steward: NCQA

The measure tracks the percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Numerator

- Individual who had an appropriate screening if a submitted encounter / claim contains appropriate CPT code.

Codes used to identify (2012 HEDIS Specifications)

FOBT	CPT CODES: 82270, 82274 HCPCS: G0328 LOINC: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2
Flexible sigmoidoscopy	CPT CODES: 45330-45335, 45337-45342, 45345 HCPCS: G0104 ICD-9 CM PROCEDURE CODES: 45.24
Colonoscopy	CPT CODES: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 HCPCS: G0105, G0121 ICD-9 CM PROCEDURE CODES: 45.22, 45.23, 45.25, 45.42, 45.43

Denominator

- All eligible members meeting enrollment criteria and age 50-75 during measurement year.

Exclusions

- Continuous enrollment for measurement year and prior year. No more than one gap of up to 45 days.
- Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review.

Codes used to identify exclusions (2012 HEDIS specifications)

Colorectal cancer	HCPCS: G0213-G0215, G0231 ICD-9 CM DIAGNOSIS CODES: 153, 154.0, 154.1, 197.5, V10.0
Total colectomy	CPT CODES: 44150-44153, 44155-44158, 44210-44212 ICD-9 CM PROCEDURE CODE: 45.8

Notes

Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy. The diagnosis must have occurred by December 31 of the measurement year.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
30.5% (administrative data only)	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 90th percentile: 71.67.	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 75th percentile: 65.76
	Adjustment factor for Medicaid: 4.12	Adjustment factor for Medicaid: 4.42
	Adjusted 90th percentile: 67.55	Adjusted 75th percentile: 61.34

Patient-Centered Primary Care Home (PCPCH) enrollment

This measure identifies the number of members enrolled in patient-centered primary care homes by tier.

Numerator

- The number of PCPCH enrolled members by tier:
    - # of enrollees in tier 1 x 1
    - # of enrollees in tier 2 x2
    - # of enrollees in tier 3 x 3

Denominator

- All enrolled members x 3

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	n/a	n/a

Developmental screening in the first three years of life

NQF #1448. Measure Steward: Oregon Health & Sciences University

This measure tracks the percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Numerator

- Children in the relevant denominator who had a claim/encounter with CPT code 96110 (developmental testing, with interpretation and report) by their birthday.

Denominator

- The children in the eligible population who turned one during the measurement period
- The children in the eligible population who turned two during the measurement period
- The children in the eligible population who turned three during the measurement period

Children must be covered by Medicaid/CHIP program continuously for 12 months between last birthdate and this birthdate, regardless if they had a medical/clinic visit or not during the measurement period.

Exclusions

- Children with more than one 45 day gap in enrollment for 12 months prior to birthday are excluded.

Notes

Measure could be collapsed into one across described denominators.

If using hybrid methodology, OHA may need to accept other forms of evidence. This would need to be defined and standardized across plans. Hybrid methodology would lose comparison to national benchmarks.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
19.6% (administrative data only)		

Adolescent well child visits

This HEDIS measure tracks the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Numerator

- Members 12-21 years of age who received at least one comprehensive well-care visit during the measurement year.

Codes used to identify well-child visits (2012 HEDIS Specifications)

Well Child Visits	CPT CODES: 99381, 99382, 99391, 99392, 99432, 99461 HCPCS: G0438, G0439 ICD-9 CM DIAGNOSIS CODES: V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Denominator

- Members 12-21 years of age continuously enrolled in a specific health plan, FFS, or primary care management for the measurement year, with up to one 45-day gap in enrollment allowed.

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
26.7%	64.1% (2011)	56.9% (2011)

Controlling high blood pressure

NQF #0018. Measure Steward: NCQA

This measure tracks the percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator

- The number of patients in the denominator who's most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.

Denominator

- Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Exclusions

- Exclude from the eligible population all patients with evidence of end-stage renal disease (ESRD) (including dialysis or renal transplant), all patients who are pregnant, and all patients who had an admission to a non-acute inpatient setting on or prior to December 31 of the measurement year.
- Individual must be continuously enrolled during the measurement year with no more than one month gap in coverage.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	66% (2012)	60% (2012)

Diabetes: HbA1c Poor Control

NQF #0059. Measure Steward: NCQA

This measure tracks the percentage of adult patients with diabetes ages 18-75 years with most recent hemoglobin A1c level greater than 9.0% (poor control)

Numerator

- The number of patients in the denominator with HbA1c levels greater than 9.0% during the measurement year.

Denominator

- Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Exclusions

- Patients with a diagnosis of polycystic ovaries who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.
- Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
TBD	28% (2012)	34% (2012)

Access to Care: Getting Care Quickly

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: getting care quickly (adult) and getting care quickly (child).

The measure reports on the ease with which the members can access care quickly. The composite score is the overall percentage of members who responded "always" or "usually" to the following questions:

- In the last 6 months, when you needed care right away, how often did you get are as soon as you thought you needed? (Adult)
- In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? (Adult)
- In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed? (Child)
- In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 79%	Adult (2012):85.59%	Adult (2012): 83.63%
Child (2011): 88%	Child (2012):92.16%	Child (2012): 90.31%
Average (2011): 83.5%	Average (2012): 88.88%	Average (2012): 86.97%

Satisfaction with Care: Health plan information and customer service

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: health plan information and customer service (adult) and health plan information and customer service (child).

This measure reports members' customer service experiencing when contacting the health plan. The composite score is the percentage of members who responded "always" or "usually" to the following questions:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed? (Adult)
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? (Adult)
- In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed? (Child)
- In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 76%	Adult (2012):86.67%	Adult (2012): 83.19%
Child (2011): 80%	Child (2012): 88.99%	Child (2012): 84.71%
Average (2011): 78%	Average (2012): 87.83%	Average (2012): 83.95%

Electronic Health Record (EHR) Adoption

This measure is a composite of three Eligible Professional (EP) Meaningful Use Core Measures.

- #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)
- #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology).
- #5: Active Medicaid List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

Notes

Data Source(s)

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
TBD	n/a	n/a

Appendix 3.D: Rationale for Incentive Measures

Incentive Measures[15]	Brief Description	Rationale for Measure
Screening for clinical depression and follow-up plan	Percent of members age 12+ screened for clinical depression using an age-appropriate standardized tool and follow-up plan documented in chart.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Alcohol and Drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	Percentage of members age 18+ with routine visit in the measurement year screened for substance abuse and referred as necessary.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Bundled measure: mental health and physical health assessment for children in DHS custody	Percentage of children age 4+ who receive a mental health assessment and/or physical health assessment within 60 days of DHS custody date.	Oregon's baseline for mental health assessments for children in DHS custody is 58%. As this assessment is a requirement for the foster program, the rate should be much closer to 100%. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

[15] These measures will be publically reported by CCO, by race and ethnicity, and by other subpopulations where possible and appropriate, including people who are dually eligible, people with serious and persistent mental illness, people with disability, and people with special health care needs (e.g., chronic conditions, homelessness). Other analysis may include looking at beneficiary primary language, or rural versus non-rural locations.

Incentive Measures[15]	**Brief Description**	**Rationale for Measure**
Follow up care for children prescribed ADHD medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed	Oregon's baseline for follow-up care for children prescribed ADHD medication is 49.96% (rate 1) and 57.09% (rate 2). This is between the 2012 National Medicaid 75th and 90th percentiles. This measure addresses coordination of behavioral health and physical health care, as well as an emerging issue for children.
Follow-up after hospitalization for mental illness	Percentage of members age 6+ and mental health diagnosis with a follow-up visit within 7 days after hospitalization.	Oregon's baseline for follow-up after hospitalization for mental illness is 52%, between the 50th and 75th percentiles nationally (54% and 58%, respectively, 2012 Medicaid Benchmarks). Research has found patient access to follow-up care within 7 days of discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmissions.[16] In addition to potential cost savings from reducing readmissions, focusing on the integration between physical and behavioral health is a key component of Oregon's Health System Transformation. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

[16]Fortney J, Sullivan G, Williams K, Jackson C, Morton SC, Koegel P. Measuring Continuity of Care for Clients of Public Mental Health Systems. *Health Services Research*.2003; 38: 1157-1175.

Incentive Measures[15]	**Brief Description**	**Rationale for Measure**
Prenatal care initiated in the first trimester	Percentage of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan.	Oregon's baseline for prenatal care is 30.4% based on administrative data, compared to the 25th percentile nationally of 77% (2012 Medicaid Benchmarks). However, ongoing measurement issues, including bundled payments for pre- and post-natal services, create an artificially low rate when just using administrative data. While Oregon's baseline is likely much higher than 30.4%, improving prenatal care is widely acknowledged as the most cost-effective way to improve the outcome of pregnancy for all women and infants.[17] As 43% of babies born in Oregon are covered by Medicaid (2009),[18]Oregon can achieve significant cost savings and better health outcomes by improving prenatal care. This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Reducing elective delivery before 39 weeks	Patients with elective vaginal deliveries or elective cesarean sections at >=37 and < 39 weeks of gestation completed.	The Leapfrog 2011 hospital survey indicates that rates of elective deliveries in Oregon range from 3.9 – 18.2%, compared to the recommended national benchmark of 5%. Complications for infants delivered by early cesareans include infections, five days or more of hospitalization, and the need for CPR. Additionally, babies born earlier average

[17] A California Medi-Cal study found that women with no prenatal care were four times as likely to give birth to a baby of low birth weight and more than seven times as likely to give birth prematurely (2000). And a Missouri Medicaid study found a cost-savings of $1.49 for every $1 spent on prenatal care (1992).
[18] http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF

Incentive Measures[15]	Brief Description	Rationale for Measure
		more visits during the first year of life compared to full-term babies (nine visits versus six, respectively). [19] Total first year costs after initial hospitalization have been found on average to be three times higher for late preterm infants (>37weeks, <39 weeks) than for full-term infants. [20] This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Developmental screening by 36 months	The percentage of children with documentation that they were screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.	Oregon's baseline for developmental screening by 36 months is 19.6%. National survey for children's health indicates a range of 9% - 52% for developmental screening rates across the country. 52% was the highest performing state in the nation. Early developmental delays are often not identified until kindergarten entry or later – well beyond the period in which early intervention is most effective. Early identification and treatment of developmental delays leads to improved outcomes and reduced costs. This measure will help inform the quality improvement focus area: improving primary care for all populations.
Adolescent well care visits	The percentage of enrolled members age 12-21 who had at least on comprehensive well-	Oregon's baseline for adolescent well care visits is 26.3% (2010), well below the 25th percentile nationally of 39.7% (2011 Medicaid National Benchmark) and lower than the

[19] http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Maternity_Care.pdf
[20] McLaurin KK, Hall CB, Jackson EA, et al. Persistence of morbidity and cost differences between late-preterm and term infants during the first year of life. *Pediatrics*. 2009;123:653-659.

Incentive Measures[15]	Brief Description	Rationale for Measure
	care visit with a PCP or an OB/GYN practitioner during the measurement year.	general population (in 2011, just over half of Oregon's 8th and 11th graders reported a well care visit in the past year – Oregon Healthy Teens). Youth who can easily access developmentally appropriate, evidenced-based preventive health services are more likely to be healthy.[21] This measure will help inform the quality improvement focus area: improving primary care for all populations.
Diabetes care: HemoglobinA1c poor control	Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control)	Addresses quality of care for a disease that impairs health and function in the individual and results in high costs due to complications and hospitalizations. By measuring HbA1c control, Oregon will assess the effectiveness of diabetes care. This measure will help inform the quality improvement focus area: Addressing discrete health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers.
Controlling hypertension	Percentage of patients age 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year (2013).	According to 2010 BRFSS data, 39.4% of Oregon Health Plan adult enrollees have high blood pressure, compared to 31% of the general population. While baseline data for OHP members with controlled high blood pressure is not available, Oregon is likely below the

[21]Haas, S.A. & Fosse, N.E. (2008). Health and the educational attainment of adolescents: Evidence from the NLSY97.*Journal of Health and Social Behavior, 49,* (2), 178-92.

Incentive Measures[15]	Brief Description	Rationale for Measure
		25th percentile nationally of 47% (2012 Medicaid Benchmarks) as studies indicate that as many as two thirds of those with hypertension are either undertreated or untreated.[22][23] This measure will help inform the quality improvement focus area: Addressing discrete health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers.
Colorectal cancer screening	Percentage of individuals age 50-75 who had appropriate screening for colorectal cancer, defined as: • Fecal occult blood test (FOBT) during the measurement year (2013); • Flexible sigmoidoscopy during the measurement year (2013) or the four years prior to the measurement year; or	Oregon's baseline for colorectal cancer screening is 30.5%, well below the 25th percentile of 51% (Regions 9 & 10, commercial population) and the overall screening rate in Oregon (63%)[24] Colorectal cancer is Oregon's second leading cause of cancer deaths.[25] Numerous studies have found that colorectal cancer screening is cost-effective or even cost-saving compared with no screening.[26] This measure will help inform the quality improvement focus area: improving primary care for all populations.

[22] *Trends in prevalence, awareness, treatment, and control of hypertension in the United States, 1988–2000.* JAMA. *2003; 290: 199–206*
[23] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6135a3.htm?s_cid=mm6135a3_w
[24] 2008 BRFSS data. Screening is defined as fecal occult blood test within one year, sigmoidoscopy within 5 years, or colonoscopy within 10 years.
[25] www.oregon.gov/DHS/ph/oscar/arpt2006/colorectal06.pdf
[26] Cost-effectiveness of Colorectal Cancer Screening. *Epidemiol Rev (2011) doi: 10.1093/epirev/mxr004* First published online: June 1, 2011 http://epirev.oxfordjournals.org/content/early/2011/06/01/epirev.mxr004.full#abstract-1

Incentive Measures[15]	Brief Description	Rationale for Measure
	• Colonoscopy during the measurement year (2013) or the nine years prior to the measurement year.	
ED Utilization	Number of Emergency Department visits, calculated per 1,000 member months	Oregon's baseline for Emergency Department utilization is 56 visits/1,000 member months (2011), close to the 75th percentile nationally of 55.2/member months (2011 Medicaid Total Population National Benchmarks). Reducing ED utilization will result in cost savings.
Rate of PCPCH enrollment:	Percentage of members enrolled in patient-centered primary care homes, calculated by tier.	The Oregon Health Policy board estimates that up to $44 million in 3 years and up to $190 million in 10 years can be saved by implementing integrated health homes for Oregon Health Plan beneficiaries with chronic and/or comorbid conditions. Further savings will be possible when PCPCHs are expanded to public employees and other privately insured Oregonians.[27] This measure will help inform the quality improvement focus area: improving primary care for all populations.

[27] http://www.oregon.gov/OHA/OHPR/HFB/docs/Final_Report_12_2008.pdf

Incentive Measures[15]	**Brief Description**	**Rationale for Measure**
CAHPS Composite: Getting Care Quickly Getting Needed Care	Percentage of members who responded "Always" or "Usually" to four CAHPS survey questions about getting needed care as soon as needed and getting appointments at a doctor's office or clinic as soon as needed. •	Improving access to effective and timely care has the potential to improve the overall quality of care and help reduce costs. [28] It is necessary to assess for the availability and proximity of providers, as well as barriers to access such as lack of transportation, or long waits to get an appointment.[29]Measuring access to care can also identify disparities based on race/ethnicity, gender, or geography.
CAHPS Composite: Health plan information and customer service	Percentage of members who responded "Always" or "Usually" to four CAHPS survey questions about how often a health plan's customer service gave needed information or help and how often a health plan's customer service treated members with courtesy and respect.	Member satisfaction is a critical component of quality analysis, from NCQA's HEDIS to the American Medical Association's Accreditation Program. Patient satisfaction is considered a key result of patient care. Healthier members tend to report better satisfaction with their health plan; although this has not been demonstrated conclusively, patient satisfaction could be used as a partial proxy for health status, particularly for managed care members.[30]

[28]Steinbrook R. Easing the shortage in adult primary care -- Is it all about money? N Engl J Med. 2009;360:2696-2699; Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff. April 7, 2004: w4.184-197.
[29] Hall A, Harris Lemak C, Steingraber H, et al. Expanding the definition of access: It isn't just about health insurance. J Health Care Poor Underserved. 2008;19:625-638

[30] http://www.dssresearch.com/Download/PSATwithHCHP_RG.pdf

Incentive Measures[15]	Brief Description	Rationale for Measure
		Addressing patient satisfaction with health plans covers a number of variables, including patient interactions with individual providers, which may be less under the control of the health plan, but also the quality of communication of rules and benefits, and overall customer service provided by the plan.
EHR Composite (3Qs)	1. Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.) 2. Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.) 3. Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen	Creating a composite score from three Meaningful Use core measures will serve as a measure of EHR adoption across Oregon. The three MU measures selected address both quality and coordination of care, a critical component of the Coordinated Care model.

Incentive Measures[15]	Brief Description	Rationale for Measure
	by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	

Appendix 3.E: Measures for Consideration in Demonstration Year 3

Quality Improvement Focus Area	Measures
Reducing preventable rehospitalizations	• Pediatric central line associated bloodstream infections – Neonatal intensive care unit and pediatric intensive care unit
Addressing discrete health issues	
Reduce preventable and costly utilization	• Medication reconciliation post-discharge (NQF 0054) • Care transition – transition record transmitted to health care professional (NQF 0648)
Integrate primary care and behavioral health	• Antidepressant medication management (NQF 0105) • Behavioral health risk assessment for pregnant women (AMA PCPC1) • Depression remission at 12 months (NQF 710)
Improving access to timely and effective care	• Total eligible who received dental treatment services (ages 1-20) • Total eligible who received preventive dental services (ages 1-20) (NQF 1334)
Improving perinatal and maternity care	• Percentage of live births weighing less than 2500 grams (NQF 1382) • Prenatal and postpartum care: postpartum care rate (NQF 1391) • Behavioral health risk assessment for pregnant women (AMA PCPC1)
Improving primary care for all populations	• Annual monitoring of patients on persistent medications (NQF 0021)

Section B: Expenditure Tracking for Trend Reduction Test

The following is a description of the elements within the expenditure workbook and the underlying assumptions regarding the calculation of costs as required by STC 46, 47, 48, and 49.

Description of Costs

Level 1: The per-member-per-month expenditure to the state to purchase identified global budget services for populations to be mandatorily enrolled in CCOs and voluntarily enrolled CCO populations.

- All capitated services, prospective global budget services, incentive payments, and FQHC/RHC wrap around payments are enumerated in this part of the expenditure-tracking sheet. At that point of inclusion in the global budget, the services will no longer be tracked separately.

- As specified by the STCs, expenditures for the mandatory CCO populations (children, non-disabled adults, disabled adults) are included in the Level 1 calculations and only expenditures for the voluntary dual eligibles who are actually enrolled in CCOs. Breast and cervical cancer treatment adults are included in the non-disabled adult's category.

- This category includes all PPS rates or costs included in payments to CCOs regardless of when the RHC/FQHCs were established. In addition, wrap payments associated with RHC/FQHCs established prior July 1, 2011 are included in the two percent test. Wrap payments paid to RHC/FQHCs established on or after July 1, 2011 are not included in this category of expenditure but will be separately documented on the Tab entitled New FQHC/RHC and included in Level 2 tracking. In addition, any incremental increases in wrap payments associated with a change in scope after July 1, 2011 will also be tracked in this Tab and included as part of Level 2 tracking.

Level 2: The per-member-per-month total expenditure to the state to purchase services across all Medicaid service expenditures for populations that are mandatorily required to enroll in CCOs and voluntarily enrolled CCO populations regardless of whether the services are included in CCO global budgets.

- This level includes all CCO and non-CCO service expenditures for:

    1. all individuals in mandatory population groups, and

    2. individuals in voluntary populations enrolled in a CCO.

- Expenditures associated with voluntary populations who are not enrolled in CCOs are not included in Level 1 or 2, including those for non-enrolled duals, individuals with third party coverage, and tribal members.

- Wrap payments for RHC/FQHCs established on or after July 1, 2011 as well as incremental increases in wrap payments for any RHC/FQHCs due to an increase in the scope of services will be included in this category of expenditure.

Level 3: The per-member-per-month total expenditure to the state to provide care under Health System Transformation in Oregon.

On the tracking template, there are three administrative cost categories. For the first two on HIT and internal IT costs, specifically the costs funded by Medicaid AND undertaken exclusively to help make CCOs successful are included. The third, the transformation center and related supports, OHA will report the full budget and parse out the Medicaid funding share of that work. This will provide a full picture of the funds needed to support transformation directly. The following provides a more detailed description of the three administrative cost categories and what would be included:

1. **HIT/Interoperability Costs**

    - This category would include administrative expenditures by the state to implement and further statewide HIT/Interoperability *specific to CCOs*.

    - These expenditures would not include anything activities that are the responsibility of the CCOs and providers paid through the CCO global budget.

    - A couple examples of these state costs could include:

        - State monitoring and measuring the CCO progress in increasing EHR adoption rates within their networks

        - State evaluation of the HIT/HIE portions of the CCO Transformation Plans and measuring progress of those plans in those areas

2. **Internal IT system changes**

    - This category would include administrative costs to implement health system transformation that are above and beyond the intensity, frequency, or complexity of normal system changes and are undertaken for the sole purpose to successfully implement CCOs.

- Examples would include:
    - Personal services focused on HST project direction, management, coordination.
    - Hardware and software purchased to establish a new function or service (such as SharePoint for the CCO portal and collaboration)
    - Contracted resources to assist with workload (such as documentation of business requirements, making system changes, implementation of new function/service, etc.)
    - System changes needed to accommodate both transfer of pertinent data between the state and the CCOs, but also the changes required to support metrics, performance and quality measures and the payment processing attached to those requirements.

3. Transformation Center costs

- This would include the full cost of the transformation center, with Medicaid's share delineated.
- Medicaid's share could include analytic support, staff training, and other related administrative costs that are not funded by other grant funds.

Other Cost Treatment

- **Long-Term Care services**: Oregon has agreed to conduct an exploratory stakeholder process that would result in a report to CMS regarding the integration of DHS Medicaid-funded long-term care for the aged or people with disabilities into CCO global budgets. The report will identify opportunities, barriers, and strategies for integrating long term care, and address issues of scope, process and timeline for integration. The report will be submitted to CMS no later than December 31, 2013.
- **Uncompensated Care Costs:** CMS and OHA acknowledged that DSH audit reports have a significant lag between the review year and date of the actual audit report. State and CMS agree to use data from the most recently filed Medicare cost reports to evaluate the year-to-year trend in hospital uncompensated care. Most recently filed Medicare cost reports are available through the Healthcare Cost Report Information System (HCRIS) maintained by CMS. Six months following the end of the state fiscal year (beginning with SFY 2013), the state would extract HCRIS data for each of the two previous state fiscal years, calculate an

aggregate year-to-year trend of uncompensated care and report it to CMS as a component of the quarterly report ending March 31 of each year.

To the extent uncompensated care is increasing more quickly than other health care costs, the state and CMS will attempt to identify underlying factors for the increase and to what extent the state and CMS have influence to affect such factors in the future.

Treatment of Populations within the Workbook after January 1, 2014

The attached spending growth reduction template is now populated with actual expenditure data and caseload for CY 2011. Expenditure data is extracted from the OHA accounting system based on date of payment.

CMS has proposed a methodology for accounting for the influx of new enrollees in 2014 with the ACA Medicaid expansion. In discussions with the state, CMS has identified three particular populations that are identified in the waiver and subject to the two percent test for some portion of the expenditures for health care (also known as Level 1 service expenditures). The populations are:

A. State plan eligibles currently receiving the OHP Plus benefit package

B. Demonstration population that currently receives the OHP Standard benefit package but will move to the OHP Plus package on January 1, 2014 (approximately 60-70k enrolled individuals)

C. Newly covered individuals in the new section 1902(a)(10)(A)(i)(VIII) group (estimated at 220k individuals)

The current STCs require that the state begin achieving savings in state fiscal year 2014 (July 1, 2013 – June 30, 2014) for populations A and B based on calendar year 2011 base year expenditures for services identified as in the global budget. By June 30, 2014, the state is required to document a one percent savings for all groups covered in the demonstration. However, populations B and C will have major expenditure effects associated with mid-year changes attributable to implementation of ACA Medicaid expansions.

- Population A will not be affected as their benefit package will remain the same and the base year expenditures are still the relevant measure against which savings are determined.

- Population B will experience an increase in expenditures as of January 1, 2014, due to the expansion of their benefit package. CMS proposes that the state measure savings at the

two percent level for the OHP Standard benefit package for the full 2014 period. The contracts in place with the CCOs would identify the capitated rate paid for the first half of the year. The state should document the proportion of the rate for the remainder of the demonstration year that is associated with the expanded (Plus) benefit package. The additional benefits available after January 1, 2014, are not subject to the spending growth reduction test for this demonstration year. For the subsequent demonstration year, the expenditures incurred over the final 6 months of the SFY 2014 demonstration year will be used to develop a new SFY 2014 base (full expanded benefit package) against which SFY 2015 demonstration year (DY 13) will be measured.

- Population C will be new as of January 1, 2014 and therefore, expenditures from January 1 – June 30, 2014 will become the base against which SFY 2015 demonstration year (DY 13) expenditures are measured. The first year that the two percent will be applied is 2015 expenditures.

- If during demonstration year 2015 or 2016, the state is required to modify the rates for the expansion population based on actual experience of the CCOs due to a demonstrable difference in health status or a significant and identifiable increased pattern of utilization, the state will need to provide both of the following:

    1. Analyses that indicate population C has a higher case mix acuity requiring rates that are increased to reflect this higher "sicker population". The state will use the Chronic Illness and Disability Payment System Model (CDPS) to document this case mix and acuity differential and modify the base against which savings will be measured. The documentation must clearly demonstrate that the new population is clearly more expensive due to actual differences in population acuity (health) rather than simply increased utilization of services, poor management in CCOs, or other volume and care management issues.

    2. Analysis that population C has a significantly higher pattern of utilization when compared to the other Medicaid populations (rate groups). Significant increases in utilization that can be isolated to the expansion population are the result of either missed assumptions in the rate setting process or the result of untreated pent up demand. This state will demonstrate this discrepancy by documenting the base utilization assumptions used in setting the capitation rates for the expansion population and then compare those assumptions to the actual experienced utilization for specific services and activities identified prior to the population receiving services in 2014.

The state must provide the actual baseline service data, utilization assumptions, and health status indicators being targeted for review and analysis within the models employed under (1) and (2) for CMS approval prior to the population being enrolled in 2014. CMS understands that the contracts for this population will be negotiated between June and September of 2013 and would expect that the state would begin sharing this information during that period. If the detailed information described in this paragraph is not provided to CMS for review and approval, the state will not be able to request a change in the base for these populations.

Any modification to the base year would need to be agreed upon by CMS and Oregon through the underlying documentation and only for this specific population.

Return on Investment: The return on investment analysis focused on the federal investment represented by total federal financial participation (FFP) in DSHP claims plus additional FFP drawn by the state because it has additional state dollars in the same amount as the FFP drawn against the DSHP claims. This amount represents the total new federal investment into Oregon to support their delivery system transformation under the 1115 demonstration. This amount will be measured against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Description of Elements in the Work Book

Tab 1: PMPM Target – includes 2011 base year per member per month expenditures as developed using OHA expenditure information based on actual date of payment expenditure for 2011. The chart creates spending targets by inflating expenditures forward using the agreed upon without transformation trend rate of 5.4 percent and the year by year reduction targets of one percent by the end of 2014 and two percent by the end of 2015. Expenditures are developed by using aggregate service expenditures from Tab 2, Expenditures Target divided by caseload information in Tab 5, Caseload to create PMPMs.

Tab 2: Expenditure Targets – includes 2011 base year aggregate expenditures derived from Tab 8. CY 2011. Subsequent year expenditures for Tab 2 will be derived by multiplying trended target PMPMs from Tab 1 by Tab 5, Caseload.

Tab 3: PMPM Actuals – includes actual PMPMs as available for each year of the demonstration calculated from total expenditure data for each year in Tab 4: Expenditure Actuals and Tab 5, Caseload. Annual estimates will be updated quarterly based on the combination of actual and projections available each quarter.

Tab 4: Expenditure Actuals – includes actual aggregate expenditures derived from Tabs 8 through 13 as yearly data is available.

Tab 5: Caseload – provides caseload by year and by population category (children, non-disabled adults, disabled adults, dual eligibles, and ACA/Standard) for calculation of PMPMs.

Tab 6: New FQHC-RHC – provides a tracker of wrap payments made to FQHCs/RHCs established after 7/01/2011 and incremental increases in wrap payments due to increases in scope of service made after 7/01/2011. These calculations then feed into the FQHC/RHC wrap line items in Tabs 10-14.

Tab 7: ROI – includes calculations for the return on investment analysis outlined in STC 50 and above measuring the total DSHP investment against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Tabs 8-13: Yearly tabs that track actuals for the CY 2011 base year and each year of the demonstration by population category. These tabs form the basis for the PMPM summary sheets (Tabs 3 and 4) along with Tab 5: Caseload. For each current demonstration year, the full year will be estimated, updated with actuals as they are available.

PMPM WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGET

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
	Without HST Baseline Growth (Per ST&Cs)	Base Year	5.40%	5.40%	5.40%	5.40%	5.40%
	Without HST Baseline Growth PMPM	$ 400	$ 421	$ 444	$ 468	$ 493	$ 520
	With HST Spending Reduction Growth Target	Base Year	5.40%	4.40%	3.40%	3.40%	3.40%
Level 1: Global Budget	**Capitation:**						
	Total Managed Care						
	Total Fee For Service (for equivalent CCO services)						
	Incentive Payment Pool						
	Total Capitation PMPM	$ 368					
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						
	Youth residential alcohol and drug treatment (OHP carve out)						
	Adult residential alcohol and drug treatment (OHP carve out)						
	Nurse Home Visiting program: Babies First! And CaCoon						
	Non-Emergent Medical Transportation						
	Adult Residential Mental Health Services						
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
	Young Adults in Transition Mental Health Residential						
	Targeted Case Management						
	Federally Qualified Health Center Wrap						
	Primary Care Case Management						
	Global Budget PMPM	$ 400	$ 421	$ 440	$ 459	$ 484	$ 510
Level 2: Total Expenditt	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**						
	Mental health remaining in fee-for-service						
	Long Term Care						
	School Based Health Services						
	Behavioral Rehabilitative Services (BRS)						
	Personal Care 20 Client Employed Provider						
	FQHC Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system costs						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

1. PMPM Targets 12/14/2012 1

TOTAL EXPENDITURES WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGETS

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget	**Capitation:**						
	Total Managed Care	$ 2,140,213,391					
	Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
	Incentive Payment Pool						
	Total Capitation	**$ 2,519,153,853**	**$ -**				
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030.00					
	Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
	Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
	Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
	Non-Emergent Medical Transportation	$ 43,416,273					
	Adult Residential Mental Health Services	$ 71,019,309					
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
	Young Adults in Transition Mental Health Residential	$ 376,116					
	Targeted Case Management	$ 9,846,177					
	Federally Qualified Health Center Wrap	$ 67,458,838					
	Primary Care Case Management	$ 153,133					
	Total Global Budget - No HST	**$ 2,733,284,427**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation						
	Mental health remaining in fee-for-service						
	Long Term Care						
	School Based Health Services						
	Behavioral Rehabilitative Services (BRS)						
	Personal Care 20 Client Employed Provider						
	FQHC Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system changes						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Total Administrative Expenses						

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

PMPM ACTUALS UNDER HEALTH SYSTEM TRANSFORMATION

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget	**Capitation:**						
	Total Managed Care						
	Total Fee For Service (for equivalent CCO services)						
	Incentive Payment Pool						
	Total Capitation PMPM	**$ 368.32**					
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing						
	Parents with Children under Age 18 (Targeted Case Management)						
	Youth residential alcohol and drug treatment (OHP carve out)						
	Adult residential alcohol and drug treatment (OHP carve out)						
	Nurse Home Visiting program: Babies First! And CaCoon						
	Non-Emergent Medical Transportation						
	Adult Residential Mental Health Services						
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
	Young Adults in Transition Mental Health Residential						
	Targeted Case Management						
	Federally Qualified Health Center Wrap						
	Primary Care Case Management						
	Global Budget PMPM	**$ 399.63**					
Level 2: Total Expendit	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**						
	Mental health remaining in fee-for-service						
	Long Term Care						
	School Based Health Services						
	Behavioral Rehabilitative Services (BRS)						
	Personal Care 20 Client Employed Provider						
	FQHC Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system changes						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

3. PMPM Actuals 12/14/2012 3

TOTAL ACTUAL EXPENDITURES UNDER HEALTH SYSTEM TRANSFORMATION

	BASE TOTAL CY 2011	TOTAL SFY 2013	3.4% TOTAL SFY 2014	3.4% TOTAL SFY 2015	3.4% TOTAL SFY 2016	3.4% TOTAL SFY 2017
Level 1: Global Budget						
Capitation:						
Total Managed Care	$ 2,140,213,391					
Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
Incentive Payment Pool	$ -					
Total Capitation	**$ 2,519,153,853**					
Services Outside of Capitation + Subject to Evaluation						
ADDITIONAL SERVICES:						
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030					
Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
Non-Emergent Medical Transportation	$ 43,416,273					
Adult Residential Mental Health Services	$ 71,019,309					
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
Young Adults in Transition Mental Health Residential	$ 376,116					
Targeted Case Management	$ 9,846,177					
Federally Qualified Health Center Wrap	$ 67,458,838					
Primary Care Case Management	$ 153,133					
Total Global Budget	**$ 2,733,284,427**					
Level 2: Total Expendi						
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation						
Mental health remaining in fee-for-service						
Long Term Care						
School Based Health Services						
Behavioral Rehabilitative Services (BRS)						
Personal Care 20 Client Employed Provider						
FQHC Wrap for new centers and change of scope after 7/01/2011						
Services Outside of Capitation + NOT Subject to Evaluation						
PMPM						
Level 3: Admin						
Administrative Expenses						
HIT/Interoperability costs	$ -					
Internal IT system changes	$ -					
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Ar	$ -					
Total Administrative Expenses	**$ -**					

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

4. Expenditure Actuals 12/14/2012 4

Base Year Caseload and Projected Caseload								
	HST Population Groups	Base CY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Total PLUS		5,533,161						
Total Standard	ACA/OHP Standard	838,738						
Total ACA Expansion	ACA/OHP Standard							
Total CHIP	Child	816,558						
Total Plus, Standard, ACA and CHIP		**7,188,457**						
Cawem Prenatal	Non-disabled adult	16,324						
Breast and Cervical Cancer Program	Non-disabled adult	6,309						

Footnote for discussion:

[1]AB/AD w/o Medicare and AB/AD w/Medicare populations include disabled children

Less Duals Non-enrollees	**286,450**
Less TPL Caseload	**68,761**
Total Caseload not including Cawem Prenatal	**6,839,555**

TPL Caseload:

kids	**9896**
Non-Dis	**4571**
Dis	**2842**
Duals	**50306**
Standard	**1146**
Total TPL	**68761**

FQHCs and RHCs who were either established after 7/01/2012 or have a change of scope since the CY 2011 baseyear

Note: these calculations will be fleshed out and linked to expenditure pages for FQHC payments lines.

Health Centers Established after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

DMAP Provider ID	FQHC/RHC Name	Type	Began	PPS Rate	CY 2011 Wrap	SFY 2012 Wrap	SFY 2013	SFY 2014
500637389	Women's Health Center	RHC	7/13/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637337	Ocean Medical Clinic	RHC	8/17/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637480	Naselle Clinic	RHC	8/17/2011	$86.32	$0.00	$0.00	$0.00	$0.00
544642552	MMoreCare	RHC	11/1/2011	$206.70	$0.00	$0.00	$0.00	$0.00
500640302	Centennial Medical Group	RHC	12/1/2011	$128.11	$0.00	$63,358.13	$0.00	$0.00
500642552	St. Charles Health Sys. Inc.	RHC	1/1/2012	$207.53	$0.00	$0.00	$0.00	$0.00
500646533	Firwood- Legacy Clinic	RHC	8/1/2012	$193.46	$0.00	$0.00	$0.00	$0.00
	Total				$0.00	$63,358.13	$0.00	$0.00

Incremental increases in wrap payments due to rate change effective after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

							SFY 2013		SFY 2014	
DMAP Provider ID	FQHC/RHC Name	Type	Pre-7/1/12 PPS Rate	New PPS Rate	Incremental Rate Change	Effective Date for New Rate	Total	Incremental Increase	Total	Incremental Increase
xxxxxxxxxxx	Example	FQHC	$ 200	$ 225	$ 25	1/1/2013	$ 2,250,000	$ 250,000		
	Total						$ 2,250,000	$ 250,000		

ROI Analysis

	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17
FFP DSHP Claimed (FMAP X TC)					
a. High Risk Pool					
b. Higher Education					
c. State identify Health Programs					
Total Claimed					
New FFP Available on Non-Federal Share {Total DSHP Claimed (line 7)/(1-FMAP)}-DSHP claimed					
Total Federal Investment (Line 7 + Line 9)					
Total Actual Savings (% reduction in Level I & 2 savings realized by the state X Level 1 & 2 spending)					
ROI (line 12/line 14)					

Global Budget	CY 2011 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
	Capitation:							
	Total Managed Care	$ 647,342,558	$ 489,607,766	$ 530,789,880	$ 105,277,560	$ 367,195,627		$ 2,140,213,391
	Total Fee For Service (for CCO equivalent services)	$ 115,182,230	$ 48,275,516	$ 165,007,384		$ 50,475,332		$ 378,940,462
	Incentive Payment Pool							$ -
	Total Capitation	$ 762,524,788	$ 537,883,283	$ 695,797,264	$ 105,277,560	$ 417,670,958	$ -	$ 2,519,153,853
	Services Outside of Capitation + Subject to Evaluation							
	ADDITIONAL SERVICES:							
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						$ 1,206,030	$ 1,206,030
	Youth residential alcohol and drug treatment (OHP carve out)						$ 3,010,303	$ 3,010,303
	Adult residential alcohol and drug treatment (OHP carve out)						$ 9,982,229	$ 9,982,229
	Nurse Home Visiting program: Babies First! And CaCoon						$ 227,973	$ 227,973
	Non-Emergent Medical Transportation						$ 43,416,273	$ 43,416,273
	Adult Residential Mental Health Services						$ 71,019,309	$ 71,019,309
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						$ 7,434,193	$ 7,434,193
	Young Adults in Transition Mental Health Residential						$ 376,116	$ 376,116
	Taregeted Case Management						$ 9,846,177	$ 9,846,177
	Federally Qualified Health Center Wrap						$ 67,458,838	$ 67,458,838
	Primary Care Case Management						$ 153,133	$ 153,133
	Total Global Expenditures	**$ 762,524,788**	**$ 537,883,283**	**$ 695,797,264**	**$ 105,277,560**	**$ 417,670,958**	**$ 214,130,575**	**$ 2,733,284,427**
	Total Caseload	**4,146,385**	**858,410**	**603,435**	**393,733**	**837,592**		**6,839,555**
	PMPM	**$ 183.90**	**$ 626.60**	**$ 1,153.06**	**$ 267.38**	**$ 498.66**		**$ 399.63**
	Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
	Mental health remaining in fee-for-service	$ 13,891,529	$ 8,376,740	$ 61,414,236	$ 816,989	$ 10,748,475		$ 95,247,969
	Long Term Care						$ 812,827,021	$ 812,827,021
	School Based Health Services						$ 25,174,125	$ 25,174,125
	Behavioral Rehabilitative Services (BRS)						$ 3,663,118	$ 3,663,118
	Personal Care 20 Client Employed Provider						$ 988,176	$ 988,176
	FQHC Wrap for new centers and change of scope after 7/01/2011						$ -	$ -
	Total Services Outside of Capitation + NOT Subject to	**$ 13,891,529**	**$ 8,376,740**	**$ 61,414,236**	**$ 816,989**	**$ 10,748,475**	**$ 842,652,439**	**$ 937,900,408**
	Administrative Expenses							
	HIT/Interoperability costs							$ -
	Internal IT system changes							$ -
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							$ -
	Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

C:\Documents and Settings\OR0181264\Local Settings\Temporary Internet Files\Content.Outlook\N9G5S3E3\[Attach H Exp Trend Review Template 121412.xls]1. PMPM Targets

	SFY 2013 DETAIL						
	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service							
Long Term Care							
School Based Health Services							
Behavioral Rehabilitative Services (BRS)							
Personal Care 20 Client Employed Provider							
FQHC Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

	SFY 2014 DETAIL						
	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service							
Long Term Care							
School Based Health Services							
Behavioral Rehabilitative Services (BRS)							
Personal Care 20 Client Employed Provider							
FQHC Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

	SFY 2015 DETAIL						
	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service							
Long Term Care							
School Based Health Services							
Behavioral Rehabilitative Services (BRS)							
Personal Care 20 Client Employed Provider							
FQHC Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

	SFY 2016 DETAIL						
	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
Global Budget: ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service							
Long Term Care							
School Based Health Services							
Behavioral Rehabilitative Services (BRS)							
Personal Care 20 Client Employed Provider							
FQHC Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

	SFY 2017 DETAIL						
	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service							
Long Term Care							
School Based Health Services							
Behavioral Rehabilitative Services (BRS)							
Personal Care 20 Client Employed Provider							
FQHC Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

13. SFY 2017 12/14/2012 13

Attachment I – Tribal Health Program for Uncompensated Care Claiming Protocol

The methodology outlined, as required by STC 57, below has been approved for structuring supplemental payments to IHS and tribal health facilities from the date of CMS approval of the amendment to this demonstration through December 31, 2017.

Using the methodology, the state shall make supplemental payments to IHS and tribal health facilities operating under ISDEAA 638 authority: 1) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010, for non-pregnant adults enrolled in OHP.

Provider Claiming Methodology

1. Participating IHS or tribal health facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The service provided;
    b. Whether the service was provided to an IHS eligible individual;
    c. Whether the service was provided to an individual who is later found to not meet the eligible criteria to receive care at the facility;
    d. Whether the service was provided to a OHP beneficiary that is IHS eligible; and
    e. The service date.
2. Qualifying encounters shall not include encounters for which any payment was made under OHP at the IHS published rate.
3. Participating IHS and tribal health facilities shall maintain existing policies for pursuing third party liability, and shall have procedures to ensure that individuals who have a source of third party liability are not considered uninsured.
4. Participating IHS and tribal health facilities shall submit to Oregon Health Authority (OHA), on a quarterly basis, the number of qualifying uncompensated encounters, broken down by type of qualifying uncompensated service (primary care services above and below the funding line on the prioritized list), type of individual and status of individual as IHS-eligible (American Indian or Alaskan Native, or non-IHS).
5. Participating IHS and tribal health facilities shall submit to OHA, on a quarterly basis, the amount of third party payments received for OHP beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.

State Payment Process

6. OHA will process the reports from participating IHS and tribal health facilities and submit to CMS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1) specifying the number of qualifying

uncompensated encounters for each IHS/tribal health facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, OHA shall submit a certification, signed by the Director of Medical Assistance Plan (DMAP) of OHA that the information contained therein is current, complete, and accurate.
8. The state shall make supplemental payments to each participating facility based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the rate as established in the Oregon Medicaid state plan, offset by any third party payments received by each IHS or tribal health facility for uncompensated encounters involving OHP beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other OHP payments to the facility by the amount of such payments.
9. The state must maintain documentation sufficient to support the claims for supplemental payments and provide to CMS upon request.
10. The state may claim federal matching funding for supplemental payments to IHS and tribal health facilities at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated primary care services which fall below the funding line of the prioritized list to individuals who are both Medicaid-enrolled and status as IHS-eligible.

Exhibit 1

Facility Name	IHS Eligible Individuals	
	Uninsured: non-OHP beneficiaries	OHP beneficiaries
Total Number of Encounters		
IHS Encounter rate		
Total Expenditures		
Less: Any other payments received		
Total Net Expenditures		

Attachment J: Hospital Metrics and Incentive Payment Protocol

Introduction

Oregon's Hospital Measurement Strategy (STC 62) outlines how the Oregon Health Authority (OHA) will make payments to participating Diagnosis-Related Group (DRG) hospitals for implementing and reporting on health system reform initiatives within a three year program. The metrics are integral to the effort to monitor and correct pathways towards improvements in the quality of care and access to care for Medicaid beneficiaries under health system transformation efforts. The work in this area forms Oregon's Hospital Transformation Performance Program (HTPP).

Hospital Performance Metrics Advisory Committee

In 2013, Oregon House Bill 2216, Section 1, established the nine-member Hospital Performance Metrics Advisory Committee, appointed by the Director of OHA. The Committee is comprised of four hospital representatives, three health outcomes measurement experts, and two representatives of Coordinated Care Organizations (CCOs). The Committee was charged with using a public process to identify three to five performance standards (incentive measures and targets) for DRG hospitals that are designed to advance health system transformation, reduce hospital costs, and improve patient safety.

Incentive Measures

The Oregon Hospital Performance Metrics Advisory Committee has identified hospital-specific metrics, which will be used to assess the HTPP payments through 2017 from a share of Oregon's hospital assessment revenue. See Appendix A: Hospital Quality Pool Structure for a detailed description of the hospital quality pool design and funding algorithm. Building on work completed by the Metrics and Scoring Committee, the Hospital Performance Metrics Advisory Committee considered several core principles when selecting these measures. Among other principles, any selected measures should:

- Meet standard scientific criteria for reliability and face validity;
- Help drive system change;
- Be aligned with health system transformation underway by CCOs;
- Align with evidence-based or promising practices;
- Be nationally validated, a required reporting element in other health care quality initiatives, or align with national or other benchmarks for performance; and

- Be able to accomplish change in the measure within three years.

The hospital quality measures are captured in two overarching focus areas, hospital-focused and hospital-CCO coordination-focused. These focus areas are comprised of domains and measures, many of which overlap with the state test for quality and access measures (Attachment H). There are six domains, comprised of 11 measures. Table 1 below shows the incentive measures selected by the Hospital Performance Metrics Advisory Committee and agreed by OHA and CMS. All measures but follow-up after hospitalization for mental illness relate to patients from all payer-types; follow-up after hospitalization for mental illness, however, relates only to Medicaid patients enrolled in a CCO. Specifications, benchmarks, and improvement targets for the incentive measures can be found in Appendix B will be updated by May 31, 2016. A more detailed rationale for each of these incentive measures can be found in Appendix C.

Table 1: Agreed Domains and Measures

Focus Area	Domains	Measures
Hospital focus	1. Readmissions	1. Hospital-Wide All-Cause Readmission
	2. Medication Safety	2. Hypoglycemia in inpatients receiving insulin 3. Excessive anticoagulation with Warfarin 4. Adverse Drug Events due to opioids
	3. Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166) 6. HCAHPS, Staff gave patient discharge information (NQF 0166)
	4. Healthcare-Associated Infections	7. CLABSI in all tracked units (adapted from NQF 0139) 8. CAUTI in all tracked units (adapted from NQF 0754)
Hospital-CCO collaboration focus	5. Sharing ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits
	6. Behavioral Health	10. Follow-up after hospitalization for mental illness (adapted from NQF 0576) 11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department

Benchmarks and Improvement Targets

The Hospital Performance Metrics Advisory Committee worked with OHA and CMS to develop a set of hospital-appropriate benchmarks and improvement targets for which the state can

measure progress towards the state's health system transformation goals. In year one, hospitals will receive payment for submitting baseline data to OHA (pay for reporting). In years two and three, hospitals will only receive payment for submitting data to OHA *and* achieving the established benchmarks or improvement targets. In years two and three, hospitals that do not meet the benchmark for a given measure will be assessed against their improvement from their prior year's performance ("improvement target"). If hospitals meet either the benchmark or their improvement target on a given measure, they will be awarded the quality pool funds associated with that measure[31]. As HTPP is meant to foster continuous improvement across all measures for all hospitals, all benchmarks in year two will be evaluated against year one baseline data and amended as appropriate to ensure continuous improvement. All benchmarks in year three will be evaluated against year two data. Details on the hospital measures, benchmarks, and improvement targets can be found in Appendix B.

[31] OHA will use the methodology established for the CCO improvement targets in calculating the hospital improvement targets. These improvement targets are based on the Minnesota Department of Health's Quality Incentive Payment System (hereafter referenced as the "MN method"). This method requires at least a 10 percent reduction in the gap between the baseline and the benchmark to be eligible for incentive payments. Detailed specifications on the improvement target calculations used can be found here: http://www.oregon.gov/oha/CCOData/Forms/AllItems.aspx.

Appendix A: HTTP Quality Pool Structure

Hospital Quality Pool Funding

The total funding allocated for the Hospital Transformation Performance Program quality pool will be equivalent to the federal match of state dollars generated by one percent of the Hospital Provider Tax Program, limited to a maximum of $150,000,000 per year or the maximum allowed under the 2% test. The total quality pool funding available to be earned through achievement of the performance metrics may therefore vary based upon the amount available from the Hospital Provider Tax Program. All funds will be distributed each year; there will be no carryover.

Hospital Quality Pool Timing

HTPP funds will be distributed three times, with three measurement years spanning the federal fiscal year. The first measurement period is October 1, 2013 – September 30, 2014, which is the federal fiscal year 2014. For this period, hospitals will receive payment based on baseline data submission of all measures for that period. Year one data must be submitted to OHA by February 28, 2015, and OHA will issue the first payment by April 30, 2015.

The second measurement year will cover the period October 1, 2014 – September 30, 2015. Hospitals will submit data to OHA by March 31, 2016, and OHA will issue the second payment by June 30, 2016. Year two payment will be contingent upon performance across the hospital quality measures.

The third year measurement year will cover the period October 1, 2015 – September 30, 2016. Hospitals will submit data to OHA by March 31, 2017, and OHA will issue the third payment by June 30, 2017. Year three payment will be contingent upon performance across the hospital quality measures.

Ensuring Continuous Improvement

OHA is committed to continuous improvement. The fact that the HTPP is only a three year program precludes changes to the measure set itself over those three years; however, OHA in consultation with CMS will be reviewing hospital performance in relation to the established benchmarks to ensure that improvement targets and benchmarks are set to a standard that ensures continued quality improvement. When baseline data for year one are submitted, the measures and any pre-existing benchmarks for year two performance will be reassessed to ensure that hospital performance must be appropriately stretched in order to receive the year two performance payments. When data for year two are submitted, the benchmarks and improvement targets for year three performance will be assessed to ensure that hospital performance must be appropriately stretched in order to receive the year three performance payments. The Hospital Metrics Advisory Committee may be reconvened as required to provide guidance in this area. In addition, the hospital measures which overlap with the CCO incentive measures will need to be

aligned with any changes that occur in the CCO measure specifications. Furthermore, as HTPP is meant to foster continuous improvement across all measures for all hospitals, all benchmarks in year two will be evaluated against year one baseline data and amended as appropriate to ensure continuous improvement. All benchmarks in year three will be evaluated against year two data to ensure continuous improvement.

While the years two and three benchmarks may be amended as needed to ensure quality improvement, the measure set itself will not be amended within the three years of the HTPP.

Allocation Methodology

OHA has set a floor such that each hospital will be eligible to earn $500,000 in each year of the program, contingent upon maximal performance, defined as achieving credit for at least 75% of the measures (9 of 11). This strategy ensures that hospitals have sufficient motivations for making necessary investments in quality improvement. As with the funding available for HTPP as a whole, the availability of floor funds is subject to the amount allowed under the 2% test. The funds remaining after allocation of the possible $500,000 per hospital floor will be allocated to each domain based upon weighting agreed with CMS (detailed further below). After this, the amount each hospital achieving a measure will actually receive will be weighted according to its Medicaid volumes, as below:

- Fifty percent will be based upon each hospital's total Medicaid discharges for the 12 months ending September 2012 as a percent of all DRG hospital for that 12 month period
- Fifty percent will be based upon each hospital's total Medicaid patient days for the 12 months ending September 2012 as a percent of all DRG hospitals for that 12 month time period.

The discharge data are from the Hospital Inpatient Discharge Data hospitals are required to submit to OHA. This weighted distribution will be held constant for the three years that the hospital quality pool is in effect. Holding the weighted distribution constant avoids penalizing hospitals that reduce Medicaid discharges and/or inpatient days proportionally better than other hospitals, which would decrease their share of total Medicaid discharges and inpatient days.

Though the methodology for determining the estimated amount a hospital can earn will be held constant for the three years of the program (to ensure there is no disincentive for hospitals making quality improvement efforts to appropriately decrease Medicaid discharges and hospital days), the amount available for each hospital to earn will vary based upon the final total hospital quality pool availability, changes in the number of DRG hospitals in the HTPP program, and how each hospital performs against the quality metrics. Hospitals will only receive quality pool payments for providing baseline data (in year one), or attaining benchmarks or improvement targets in years two and three.

This allocation methodology has been chosen as it is felt it is the most equitable in terms of hospital effort, performance, and size in terms of use by Medicaid members. OHA bases this on its experience with the CCO incentive metric pool. The inclusion of the improvement targets (in

addition to the benchmarks) for the CCO incentive pool allowed CCOs which engaged in quality improvement activities to successfully achieve the measures and receive incentive payments. In the first performance year, all CCOs saw improvement on at least some measures, and 11 of 15 CCOs earned 100% of their quality pool. Furthermore, at least half of the CCOs met either the benchmark or the improvement target on most of the CCO incentive measures. OHA expects a similar experience with hospital performance and quality pool distribution.

Quality Pool Distribution

The quality pool distribution method occurs in two phases, for both the hospital focused and the hospital-CCO collaboration focused domains. Phase 1 involves determining whether a hospital is eligible for the $500,000 floor (earned by achieving at least 75% of the measures [9 of 11]). Phase 2 involves allocating the remaining funds to hospitals based upon performance against each measure.

In cases in which a hospital does not have the relevant ward (e.g., hospitals which do not perform deliveries for the early elective deliveries measure, or hospitals without psychiatric wards for the follow-up after hospitalization for mental illness measure), OHA will utilize an attribution methodology in which the CCO rate will be applied to relevant hospitals during the pay-for-performance years two and three.

Phase 1: Floor Allocation

The first step in distributing the hospital quality pool funds involves determining the number of instances in which a hospital has achieved a measure. In year one, achieving the measure is defined as submitting baseline data that meets OHA approval, and in years two and three it means achieving the improvement target or benchmark. Hospitals achieving at least 75% of the measures [9 of 11] will be allocated a $500,000 floor. Phase I allocation is pass/fail; hospitals will not receive partial credit. Hospitals must achieve at least 75% of the measures (9 of 11) to be allocated the floor payment. This will impact the amount remaining in the pool for Phase II allocation. Table 1 illustrates how Phase 1 works:

Table 1: Example of Phase 1 Floor Allocation

Total HTPP available funds – one year	$133 million
Available funds – floor for 27 hospitals (assuming all achieve at least 75% of the measures) ($500,000 * 27)	$13.5 million
Remaining to earn in Phase 2 allocation (payment per measure achieved) (Total – floor)	$119.5 million

Phase 2: Allocation per Measure Achieved

The portion of Phase 2 quality pool funds that a hospital receives is based on the number of measures on which it reports baseline data (in year one), or the number of measures on which it achieves an absolute benchmark or demonstrates improvement over its own baseline ("improvement target") in years two and three. The benchmarks are the same for all hospitals, regardless of geographic region and patient mix (see Appendix B for measures and benchmarks).

Hospital performance on these measures is treated on a pass/fail basis and all measures are independent from one another. In year one, if data are submitted and accepted by OHA for a particular measure, the hospital receives all credit for that measure, regardless of submission of data for the other measures. In years two and three, if the benchmark is met or the improvement target reached for a specific measure, the hospital receives all of the credit available for that measure, regardless of performance on other measures.

Once OHA has determined each hospital's level of performance against the measure targets and reporting requirements, then OHA will calculate the amount of the Phase 2 incentive funds each hospital will receive. The number of measures achieved by hospitals will impact the 'base amount' that each measure is worth after the Phase 1 floor allocation. In Phase 2 the base amounts are computed after any floor allocations are subtracted from the quality pool. The proportions in Table 2, below, will be applied to the remaining hospital quality pool funds. The proportions may shift if all measures are not achieved by at least one hospital. The base amount for each measure will then be allocated to the hospitals achieving that measure based upon the proportion of Medicaid discharges and patient days at each hospital that achieved the target, 50% based on discharges and 50% based on patient days.

Table 2: Share of Available Funds by Measure by Year after Floor Payment Allocation

Domains	Measures	Share of Available Funds by Year*		
		YR 1	YR 2	YR 3
Readmissions	1. Hospital-Wide All-Cause Readmission	18.75%	18.75%	18.75%
Medication Safety	2. Hypoglycemia in inpatients receiving insulin	6.25%	6.25%	6.25%
	3. Excessive anticoagulation with Warfarin	6.25%	6.25%	6.25%
	4. Adverse Drug Events due to opioids	6.25%	6.25%	6.25%
Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166)	9.38%	9.38%	9.38%
	6. HCAHPS, Staff gave patient discharge information (NQF 0166)	9.38%	9.38%	9.38%
Healthcare-Associated Infections	7. CLABSI in all tracked units (modified NQF 0139)	9.38%	9.38%	9.38%
	8. CAUTI in all tracked units (modified NQF 0754)	9.38%	9.38%	9.38%

Domains	Measures	Share of Available Funds by Year*		
		YR 1	YR 2	YR 3
Sharing ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	12.50%	12.50%	12.50%
Behavioral Health	10. Follow-up after hospitalization for mental illness (modified NQF 0576)	6.25%	6.25%	6.25%
	11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department	6.25%	6.25%	6.25%

*Note this is share of funds available after allocation of the floor

Table 3, below, is an example of how the hospital quality pool distribution for the Readmissions domain would work in a scenario where there are only three hospitals, with total available HTTP funds the maximum $150,000,000, and the assumption that two of the three hospitals achieved at least 75% (9 of 11) of the measures (meaning these hospitals are allocated the floor payment of $500,000). This example operates in the same manner for years one, two and three: In year one, 'achieving the measure' is defined as providing baseline data that is approved by OHA, and in year two 'achieving the measure' is defined as meeting either the benchmark or improvement target based on year one data. In year three, 'achieving the measure' is defined as meeting either the benchmark or improvement target based on year two data.

Table 3: Example of Hospital Quality Pool Distribution for Readmissions Domain

Total HTTP Funds Available (one year)	$150,000,000
Number of Hospitals Achieving at least 75% of measures (eligible for floor allocation)	2
Phase 1 Amount (floor allocation - 500,000*2)	$1,000,000
Funds Remaining for Phase 2 Allocation (total - floor)	$149,000,000
Readmissions	
Share of Available Funds	18.75%
Base Amount - total available to earn for measure (share of funds*funds for Phase 2 allocation)	$27,937,500

Phase 2 Allocation per Hospital Achieving Domain (Readmissions Example)

Hosp	Achieve Measure?	Discharges		Days		Adjustment Factor (% discharges*0.5) + (% days*0.5)		Amount Earned for Measure (Total Available for Measure * Adjustment Factor)	
		#	%	#	%				
A	Y	5,000	33.3%	2,000	20.0%	(33.3%*0.5) + (20.0%*0.5) =	0.27	$27,937,500 * 0.27 =	**$7,450,000**
B	Y	5,000	33.3%	1,000	10.0%	(33.3%*0.5) + (10.0%*0.5) =	0.22	$27,937,500 * 0.22 =	**$6,053,125**

C	Y	5,000	33.3%	7,000	70.0%	(33.3%*0.5) + (70.0%*0.5) =	0.52	$27,937,500 * 0.52 =	**$14,434,375**
Totals		**15,000**	**100.0%**	**10,000**	**100.0%**		**1.00**		**$27,937,500**

Data Collection

As detailed in Appendix B, OHA and its partner, the Oregon Association of Hospitals and Health Systems (OAHHS), share responsibility for collecting data on all measures selected. OHA and OAHHS will ensure the accuracy and validity of the data, with review by an independent third party.

Data Reporting

OHA is committed to transparency in health system transformation efforts. All measures will be reported on the OHA website on an at least annual basis, and will be available at the hospital level. This will allow OHA to work with hospital partners to track overall progress, and identify and address any areas needing additional attention.

Monitoring hospital performance ties in with the overall evaluation and ongoing quality improvement efforts for the waiver. Moreover, this work has a direct impact on OHA's overarching health system transformation goals of better health, better care, and lower costs for all Oregonians, not just the Medicaid population. Part of this work involves aligning and tracking metrics across different payers and populations. There may therefore be interest in continuing to monitor these metrics beyond the two years of the HTPP approved in the waiver.

Appendix B: Oregon Hospital Transformation Performance Program Measures Matrix

Note that in year one (October 1, 2013 – September 30, 2014), hospitals will receive payment for submitting baseline data that meets OHA approval. In year two (October 1, 2014 – September 30, 2015), hospitals will receive payment for submitting data to OHA and achieving the benchmark or improvement target. In year three (October 1, 2015 – September 30, 2016), hospitals will receive payment for submitting data to OHA and achieving the benchmark or improvement target. Specifications for the measures which overlap with the CCO state test for quality and access are aligned with those in Attachment H (see http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx for measure specification sheets). Here, however, all measures but follow-up after hospitalization for mental illness relate to patients from all payer-types; follow-up after hospitalization for mental illness relates only to Medicaid patients enrolled in a CCO. All benchmarks in year two will be evaluated against year one baseline data and amended as appropriate to ensure they foster continuous improvement. All benchmarks in year three will be evaluated against year two data and amended as appropriate to ensure they foster continuous improvement. OHA will update the benchmarks and improvement targets for years two and three with CMS approval by May 31, 2016.

Hospital Measures	**Waiver Measure Set**			**Target Calculations**		**Targets**		**Data Source**
	Aligned with CCO Incentive Set	**CCO State Quality**	**Hospital Specific (Not CCO)**	**Numerator**	**Denominator**	**Improvement from Baseline Target**	**Benchmark**	
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) in the ED	√			Measure set broken down as follows: **1. Alcohol and Other Drug Use Screening in the ED**- Patients in ED age 12+ screened for alcohol and other substance use using an age-appropriate,	Measure set broken down as follows: **1. Alcohol and Substance Use Screening** - ED patients age 12+.	1. MN method with a 3% floor	1. 13% (alignment with CCO benchmark) Note: Will change with any updates to CCO benchmark or if year one performance exceeds benchmark.	OAHHS will collect and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets		Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
				validated instrument. **2. Alcohol and Other Drug Use Brief Intervention Provided** – ED patients age 12+ who received a brief intervention.	**2. Alcohol and Other Drug Use Brief Intervention Provided** – ED patients age 12+ who screen positive for unhealthy alcohol or drug use.	2. N/A - reporting only (no target)	2. N/A – reporting only (no benchmark)	
Follow-up after hospitalization for mental illness (modified NQF 0576)	√			Discharges for Medicaid members enrolled in a CCO age 6 years of age and above at hospital of interest who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial	Discharges from acute inpatient settings (including acute care psychiatric facilities) for members age 6 years of age and above at hospital of interest who were hospitalized for treatment of selected mental health disorders.	MN method with 3% floor (alignment with CCO improvement target; will change with any updates to CCO target)	68.8% 2013 National Medicaid 90th percentile (alignment with CCO benchmark; will change with any updates to CCO benchmark or as needed to foster continuous improvement)	OHA MMIS – OHA will calculate rates for this measure through encounters/claims

Hospital Measures	Waiver Measure Set			Target Calculations		Targets		Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
				hospitalization within 7 days of discharges.				
Hospital-Wide All-Cause Readmissions		√		Number of readmissions, defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission.	Admissions to acute care facilities for patients aged 18 years or older	MN method with a 1% floor	State 90th percentile for all hospital types	OAHHS will calculate and report to OHA
Hypoglycemia in inpatients receiving insulin (American Society of Health Systems Pharmacist Safe Use of Insulin measure)			√	All patients with hypoglycemia (blood glucose of 50mg per dl or less)	All patients receiving insulin during the tracked time period	MN method with 1% floor	5% or below Note: Will change if year one performance exceeds benchmark	OAHHS will collect and report to OHA
Excessive anticoagulation with Warfarin (Institute for Safe Medication Practices measure)			√	Number of patients experiencing excessive anticoagulation (INR > 6)	All inpatients receiving warfarin anticoagulation therapy during tracked period	MN method with 1% floor	5% or below Note: Will change if year one performance exceeds benchmark	OAHHS will collect and report to OHA
Adverse Drug Events due to opioids (Institute for Safe			√	Number of patients treated with opioids who	Number of patients who received an opioid	MN method with 1% floor	5% or below Note: Will change if year	OAHHS will collect and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets		Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
Medication Practices measure)				also received naloxone	agent during tracked period		one performance exceeds benchmark	
HCAHPS, Staff always explained medicines (NQF 0166)			√	Number of clients reporting 'top box' responses for this measure domain.	Number of clients with number of valid responses >=2 for same domain	MN method with 2% floor	National 90th percentile	OAHHS will collect and report to OHA
HCAHPS, Staff gave patient discharge information (NQF 0166)			√	Clients answering 'Y' to Q19 and Q20	Number of clients with number of valid responses >=2 for same domain	MN method with 2% floor	National 90th percentile	OAHHS will collect and report to OHA
CLABSI in all tracked units (modified NQF 0139)			√	Total number of observed CLABSI in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	Total number of central line days in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	MN method	TBD	OAHHS will collect and report to OHA
CAUTI in all tracked units (modified NQF 0754)			√	Total number of observed healthcare-associated CAUTIs in all	Total number of catheter days for all patients that have an indwelling urinary	MN method	TBD	OAHHS will collect and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets		Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
				tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	catheter in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)			
Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits			√	1. Number of care guidelines completed for patients with 5+ ED visits in past 12 months 2. Number of outreach notifications to primary care providers for patients with 5+ ED visits in past 12 months	1. Number of patients with five+ ED visits in the past 12 months 2. Number of patients with five+ ED visits in the past 12 months	TBD	TBD	OAHHS will collect and report to OHA

Appendix C: Rationale for Incentive Measures

Domain and Measures	Brief Description	Rationale for Domain/Measure
Readmissions – Hospital-wide All-Cause Readmission	This measure estimates the hospital-level, risk-standardized rate of all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.	Reducing readmissions has value as an indicator of quality. Unnecessary readmissions may reflect poor coordination of services and transitions of care at discharge or in the immediate post-discharge period. Reducing readmissions is a function of both hospitals and primary care; the measure will therefore incentivize more integrated care across the hospital outpatient continuum.
Medication safety – (a) Hypoglycemia in inpatients receiving insulin (b) Excessive anticoagulation with Warfarin (c) Adverse Drug Events due to opioids	This measure focuses on preventing harm from high alert medication, which increases the risk of injury to patients if the dosage is not correct. The medications focused on are insulin, Warfarin, and opioids.	Adverse drug events (ADEs) are defined as any injuries resulting from medication use, including physical harm, mental harm, or loss of function. ADEs comprise the largest single category of adverse events experienced by hospitalized patients, accounting for about 19 percent of all injuries. The occurrence of ADEs is associated with increased morbidity and mortality, prolonged hospitalizations, and higher costs of care. The Institute of Medicine (IOM) estimates that 1.5 million preventable ADE occur each year[32]. The occurrence of ADEs in hospitalized patients varies between 2 and 52 ADEs per 100 admissions. An estimated 15% to 59% of these ADEs are considered preventable[33].
Patient experience – (a) HCAHPS, Staff always explained medicines (NQF 0166) (b) HCAHPS, Staff gave patient discharge information (NQF 0166)	This measure focuses on measuring patients' perspectives on hospital care. This is a composite measure that includes: 1. Communication about medicine 2. Discharge information The measure is the percent reporting positively in the above areas.	This is a national, standardized way of assessing patients' perspectives of hospital care. It is aligned with CMS public reporting, including the Hospital Value-based Purchasing Program. The measure creates an incentive for hospitals to improve quality of care and patient experience. It will support improvements in internal customer service and quality-related activities.

[32] "How-to Guide: Prevent Harm from High-alert Medications." Cambridge, MA: Institute for Healthcare Improvement, 2012.
Web February 2013.
http://www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventHarmfromHighAlertMedications.aspx

[33] Cano FG, Rozenfeld S: Adverse drug events in hospitals: a systematic review**.** *Cad Saude Publica* 2009, **25**(Suppl 3)**:**S360-S372.

Domain and Measures	Brief Description	Rationale for Domain/Measure
Healthcare Associated Infections (HAIs) – (a) CLABSI in all tracked units (modified NQF 0139) (b) CAUTI in all tracked units (modified NQF 0754)		CDC's HAI prevalence survey[34]1 shows: –On any given day, about 1 in 25 hospital patients has at least one healthcare-associated infection. –Estimated 722,000 HAIs in U.S acute care hospitals in 2011 –About 75,000 hospital patients with HAIs died during their hospitalizations. –More than half of all HAIs occurred outside of the intensive care unit.
Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	Hospitals who have implemented the EDIE program in Oregon or other Health Information Exchange technology that allows hospitals to share ED visit information with primary care providers and other hospitals. The EDIE program allows clinicians to identify patients who visit EDs throughout the state more than five times in a 12 month period.	Coordination of care between systems such as outpatient services and hospitals is important for better management and care of patients, particularly for patients who are 'high utilizers' of the health care system. By promoting the use of EDIE or other technologies, hospitals can better inform primary care of patient visits to the ED. Additionally, hospitals and primary care providers can begin to identify patients who are regularly accessing the health care system through the ED and work to better meet their needs. One of the seven CCO focus areas is to reduce over-use of care by 'super utilizers'. One focus of implementing the EDIE system is to reduce unnecessary use of the ED.
Behavioral health - Follow-up after hospitalization for mental illness (modified NQF 0576)	Percentage of Medicaid members age 6+ and mental health diagnosis with a follow-up visit within 7 days after hospitalization.	Oregon's 2013 baseline for follow-up after hospitalization for mental illness is 67.6%, which is just under the 90th percentile nationally (68.0%, 2012 Medicaid benchmark). Research has found patient access to follow-up care within 7 days of discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmissions.[35] In addition to potential cost savings from reducing readmissions, focusing on the integration between physical and behavioral health is a key component of Oregon's Health System Transformation.

[34] Magill SS, Edwards JR, Bamberg W, et al. Multistate Point-Prevalence Survey of Health Care–Associated Infections. *N Engl J Med* 2014;370:1198-208.

[35]Fortney J, Sullivan G, Williams K, Jackson C, Morton SC, Koegel P. Measuring Continuity of Care for Clients of Public Mental Health Systems. *Health Services Research*.2003; 38: 1157-1175.

Domain and Measures	Brief Description	Rationale for Domain/Measure
		This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Behavioral health – Screening for alcohol and drug misuse, brief intervention, and referral for treatment in the ED (SBIRT)	Percentage of patients age 18+ with an ED visit in the measurement year screened for substance abuse and referred as necessary.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health. Research shows that the ED can be an effective place to screen and refer patients for substance use services: One study found that 26% of patients screened in the ED exceeded the low-risk limits set by the National Institute of Alcohol Abuse and Alcoholism[36].

[36] Academic ED SBIRT Research Collaborative. The Impact of Screening, brief intervention and referral for treatment (SBIRT) on Emergency Department patients' alcohol use. Annals of Emergency Medicine. 2007;50:699–710. http://www.bu.edu/bniart/files/2011/02/SBIRT-emergency-alcohol.pdf