

Appendix A: Supports for Health System Transformation

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Introduction

To meet the goals of the Triple Aim, Oregon’s coordinated care model and fee-for-service delivery system 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 through the supports described in this document, 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.

Supports include the Oregon Health Authority's Transformation Center, Innovator Agents, Patient-Centered Primary Care Home program, and programs and activities across the agency, including the Office of Equity and Inclusion, the Public Health Division, and the Office of Health Information Technology.

Transformation Center

Launched in 2013, the Oregon Health Authority's Transformation Center serves as the state's hub for innovation, improvement and learning for Oregon's health system in support of the triple aim: better health and better care at lower costs for all Oregonians. The Transformation Center (Center) helps good ideas travel faster through learning collaboratives, targeted technical assistance and other methods for sharing best practices and innovations. OHA intends for the Transformation Center to continue this role, with a priority of delivering more focused and targeted support to meet CCOs' evolving needs. The Center will focus on responding to identified and prioritized challenges with CCOs, PEBB and OEBC based on performance metrics and evaluation outcomes, as well as advancing the integration of population and behavioral health within the health system to improve health outcomes.

Activities to be performed by the Transformation Center

Examples of the types of activities that the Transformation Center will implement include:

- Technical assistance strategies to connect CCOs with resources for advancing work on a variety of topics, including behavioral health integration, value-based payment arrangements, health-related services, population health, Community Advisory Council development, health equity, and more.
- Technical assistance to support performance improvement on the CCO incentive measures.
- Technical assistance to support the development and implementation of value-based payments.
- Technical assistance to CCO Community Advisory Councils to improve the effectiveness of CACs, in areas such as member recruitment, engagement and retention.
- Support for implementation of Community Health Improvement Plan priorities.
- Coordination of the Clinical Innovation Fellows program to support local clinical leadership development and the spread of innovation across Oregon.
- Convening CCOs and other stakeholders to share and spread best practices to further advance health system transformation.
- Learning collaboratives, as described below.

For more information, see the Driver Diagram in the appendix below.

Learning Collaboratives

Building on its first few years of work, the Transformation Center intends to continue convening learning collaboratives. In alignment with the evolution of Oregon's health system transformation efforts in general, the focus of these learning collaboratives will become much more focused and targeted to meet CCOs' needs. Specifically, during the early stages of health system transformation, the Transformation Center's learning collaboratives were a vehicle for supporting relationship-building between CCOs and promote learning about a broad range of topics related to transformation. The future learning collaboratives will hone in on the CCOs' specific, technical needs related to, for example, reaching targets for specific incentive metrics; promoting health equity through enhanced language access or culturally competent workforce; and enhancing the effectiveness of CACs by supporting recruitment and retention of Oregon Health Plan membership. In addition, a number of emerging topics may result in future learning collaboratives, such as behavioral health integration; value-based payments for specific populations and/or settings; oral health integration; nurse home visiting; and

moving upstream to promote population health by expanding the use of health-related services (i.e., flexible services and community-benefit initiatives) such as housing.

Of particular note, the Transformation Center will develop a learning collaborative focused on nurse home visiting. The goal of the learning collaborative will be to increase coordination and partnership with other agencies including Early Learning Hubs and CCOs in an effort to foster collaboration on child and family well-being initiatives related to health. Additionally, the learning collaborative will focus on increasing CCO's understanding of the range of nurse home-visiting programs, the benefits of the programs and how to appropriately partner with home visitors in their regions. The desired outcome would be to create regional home-visiting partnerships (CCOs, Early Learning Hubs, Nurse home-visitors, social works, and DHS).

Finally, the Oregon Clinical Innovation Fellows Program—which strives to build the capacity of health system transformation leadership within Oregon—will continue over the coming years. Future goals of this program will include increased demographic and workforce diversity represented by the fellows.

Convening Stakeholders

The Transformation Center convenes a Statewide CCO learning collaborative as required by STC 25d, the purpose of which is to promote innovations and activities that contributes to the objectives of health system transformation and accountability for achievement of the Triple Aim. The Statewide CCO learning collaborative enables CCOs to share best and emerging practices on the CCO incentive measures and in areas such as value-based payments; opiates and pain management; leading change; health equity; and quality improvement. The purpose of the collaborative is to facilitate peer-to-peer learning and networking; identify and share information on evidence-based best practices and emerging best practices; and help advance innovative strategies in all areas of health care transformation.

Sessions take place within the OHA Quality and Health Outcomes Committee, a monthly public meeting. Most attendees participate in person and some attend by phone. Collaboratives convene monthly, and this frequency is 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.

Technical Assistance

The Transformation Center will continue to offer CCOs and their CACs the opportunity to receive technical assistance through external consultants. However, the technical assistance provided by the Center will evolve from being solely driven by CCO requests of Technical Assistance Bank consultants to the addition of specific technical assistance initiatives that are offered to the CCOs to help them achieve success in areas critical to health system transformation. For example, the Transformation Center will develop programs for delivering targeted technical assistance around incentive metrics that are particularly problematic for the CCOs, as well as any new metrics that are added over the coming years. In addition, the Center plans to offer technical assistance to the CCOs to help them achieve their Transformation Plan benchmarks. This process will entail individual needs assessment conversations with CCOs, followed by pairing the CCOs with consultants who can effectively support the CCOs' goals in

areas related to, for example, behavioral health integration or addressing health disparities.

Grants

Building on the Center's experience with managing the disbursement and oversight of the \$27 million Health System Transformation Fund, which the Oregon Legislature awarded to CCOs during the 2013 legislative session to support health system innovation, the Center plans to continue to award strategic grants to seed innovation within CCOs. Potential areas for grant funding include implementation of the CCOs' community health improvement plan (CHIPs) priorities or developing alternative payment methods to promote behavioral health or oral health integration.

Measures of Effectiveness

The Transformation Center's evaluation measures will vary according to the specific technical assistance activities provided. Examples of possible measures include:

- Percent of Transformation Center planning interviews or consultations that result in CCOs receiving technical assistance.
- Percent of CCOs that receive consultant support on a variety of topics, including behavioral health integration, population health integration, and health-related services, e.g., that report implementing some/all of what they learned.
- Percent of all technical assistance evaluations identifying the support provided as effective/very effective in meeting the technical assistance project goal(s).
- Number of CCOs that receive metrics-related technical assistance that meet the benchmark or improvement target, or make progress toward achieving those targets.
- Identification of distinguishing factors of CCOs that are able to move the metric and how TC support was involved.
- Number of CCOs receiving value-based payment technical assistance that implement a new value-based payment.
- Number of Clinical Innovation Fellows who rate the program as valuable or very valuable.
- Learning collaborative evaluation surveys to measure what actions participants took as a result of the collaborative.

The Transformation Center works closely with the Innovator Agents to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities.

Innovator Agents

Senate Bill 1580 (2012) required OHA to provide CCOs with Innovator Agents to provide a key point of contact between the CCO and OHA and to help champion and share innovation ideas, within the CCOs and the state agency. The Innovator Agents promote innovation and implementation of the coordinated care model within the CCOs, providers and community partners by:

- Providing an effective and immediate line of communication that allows streamlined reporting and reduced duplication of requests and information;
- Identifying and facilitating resolution on CCO questions and issues with OHA;
- Actively supporting the Community Advisory Councils; and
- Fostering vital connections with the CCOs and community partners to build partnership and support for innovation.

Innovator Agents, initially part of the Transformation Center were transitioned to the newly created Division of Health Systems in 2015. The transition helps to ensure that Innovator Agents provide a direct linkage between the CCO and Medicaid program staff and leadership. This linkage provides a direct avenue to identify key technical assistance needs and develop strategies to effectively increase the rate of transformation throughout the state. The Innovator Agents work closely with the Transformation Center to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities.

Each Innovator Agent is uniquely positioned within their assigned CCOs and communities to have first-hand, on-going observations and participation in CCO health system transformation success and challenges. While all CCOs share the common denominator of a commitment to the triple aim and implementation of the coordinated care model, each CCO has its own “personality” and those unique attributes are well understood by the Innovator Agents who are embedded in CCO structures and who work closely with CCO communities.

Key areas of involvement: Innovator Agents work closely with CCOs to innovate local health systems in numerous areas and are actively involved in areas such as; integration of behavioral health, oral health and physical health services, quality metrics, alternative payment methodologies, health information technology, Community Health Improvement Plans and Transformation Plans, testing ways to impact social determinants and reduce health disparities, integrate Non Emergent Medical Transportation, increase the use of Traditional Health Workers, development of CCO transformation initiatives, developing new partnerships and services to achieve greater population wellness, promote clinical innovation, develop approaches to trauma informed care, and assist development implementation of changing contract, policy, and benefit structures.

Innovator Agent Role

The role of the innovator agent will be to:

- Serve as a 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 regular meetings with OHA leadership.
- Assist the CCO in managing and using information to accelerate innovation, quality and health system 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 attend meetings and actively participate in the implementation of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing and disseminating strategies to accelerate movement toward the triple aim and the adoption of innovations in care.
- Build and participate in learning collaboratives with other Innovator agents, CCOs, Community Stakeholders, Transformation Center, divisions within OHA and other state agencies.
- Build partnerships with CCOs, community stakeholders, Transformation Center and other divisions within OHA to address the social determinates of health and health disparities.
- Gathering and disseminate state and national coordinated care model innovations.

Innovator Agent Tasks

- Attain and maintain knowledge about health system innovation in consultation with state and national leaders and models.
- Assist and support the CCOs in developing and implementing their transformation plans.
- Assist the CCO and OHA with gathering and using data and information to target areas of local and state 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. Coordinate improvements with CCO and state staff.
- Ongoing communication at least every week with all other innovator agents and meet in person at least once each month to discuss ideas, projects and creative innovation planned or undertaken by their assigned CCO.
- Attend and actively participate in Community Advisory Committee meetings and provide input into Community Health Assessment process and Community Health Improvement Plan.
- Participate in learning collaboratives; Participate and/or convene in other learning collaboratives as appropriate (CCOs, providers, etc.); and actively collaborate with the Transformation Center.
- 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. Communicate opportunities and obstacles with OHA leadership and staff on a regular basis and participate in improvement activities within OHA.
- Participate in information sharing through an interactive website, sharing documents, communicate, collaborate, and developing resources to share with the team.

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.
- Not less than once every month, 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.

Office of Equity and Inclusion

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 continue to 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 of 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.

Traditional Health Workers

Traditional Health 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. THWs 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.

Patient-Centered Primary Care Home (PCPCH) Program

The Patient-Centered Primary Care Home (PCPCH) Program was created by the Oregon Legislature through passage of House Bill 2009 as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon’s vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon’s version of the “medical home” which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

PCPCHs are an important part of healthcare transformation in Oregon, and are a foundational component of the Coordinated Care Model (CCM) Oregon has adopted as the basis for this transformation.

There are five core functions supported by OHA’s PCPCH Program: (1) practice recognition, (2) PCPCH Standards refinement, (3) technical assistance and resource development, (4) communication and provider engagement, and (5) aligning payment with quality.

The PCPCH Program has achieved a number of critical milestones since its inception and during our current 1115 Waiver. Oregon’s 16 Coordinated Care Organizations (CCOs) have embraced the program with the vast majority of OHP members enrolled in a provider site that’s recognized as a PCPCH in a CCO network. The adoption of patient-centered primary care homes has been integral to transforming the health system and is supported by Oregon’s statewide PCPCH standards and measures.

PCPCHs are an important part of health system transformation in Oregon, and are a foundational component of the coordinated care model. Following the legislative directive of HB 3650, as a component of the coordinated care model, coordinated care organizations are required to use PCPCHs for primary care delivery to the greatest extent possible in their networks and must report to OHA the number of members enrolled in a PCPCH. From 2012 – 2017, CCOs were eligible for financial incentives if at least 60 percent of their members were enrolled in a PCPCH. See Appendix C: Measurement Strategy for additional details about monitoring PCPCH enrollment.

Notable Achievements during 1115 Waiver Period

By the end of end of 2015 there were 604 recognized PCPCHs, representing over 50% of all eligible clinics in Oregon and serving approximately 2 million Oregonians (over half the state's population). More than 95 percent of clinics recognized as PCPCHs chose to reapply for recognition to maintain their PCPCH status.

The percentage of CCO members receiving health care from a recognized PCPCH has increased from 51.8 percent in 2012 to 80.4 percent in 2014. The increase in enrollment of CCO members in a PCPCH has been especially dramatic in Eastern Oregon where enrollment has increased from just 3.7 percent to 68.6 percent, over the same time period.¹ Through the ACA Section 2703, recognized clinics received an increase per-member per-month payment for OHP members.

Oregon implemented the PCPCH Program as part of the state's strategy to achieve the Triple Aim of improving the individual experience of care, improving population health management and decreasing the cost of care. A 2013 survey of PCPCH recognized clinics found that:

- 85 percent of practices feel that PCPCH model implementation is helping them improve the individual experience of care, and
- 82 percent report progress towards improving population health management.²

A recent study examined the change in health care service utilization and costs over time in PCPCHs compared to non-PCPCH clinics. The study found a significant increase in preventive procedures and a significant reduction in specialty office visit use and cost in the PCPCH group.³ Furthermore, PCPCH clinics demonstrated significantly higher mean scores than non-PCPCH clinics for diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years.⁴

Through our partnership with [Oregon Health Care Quality Corporation](#), the [Patient-Centered Primary Care Institute](#) (PCPCI) is advancing practice transformation state-wide through technical assistance opportunities and resources. In 2014 PCPCI hosted 15 webinars for over 600 participants, and worked with 24 clinics in a series of Learning Collaboratives focused on primary care home model implementation.

In 2012 PCPCH Program staff began conducting on-site visits to verify the clinic practice and patient experience in the practice accurately reflects the measures a clinic attested to on their PCPCH application. By the end of 2015 over 100 site visits had been completed in Oregon.

Accelerating the Spread of PCPCH

OHA is working with public and private payers across Oregon to pursue innovative payment methods that move us toward a health care system that rewards quality, patient-centered care. For example, OHA's Public Employee's Benefit Board (PEBB) provides an age-adjusted, per-member-per-month incentive payment to Tier 2 or Tier 3 recognized primary care homes in the PEBB Statewide plan, administered by

¹ Oregon Health Authority. (2015). Oregon's Health System Transformation: 2014 Mid-Year Report. Retrieved from <http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>

² Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012 – 2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

³ Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency. Portland State University. Submitted to the Oregon Health Authority.

⁴ Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://qcorp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

Providence Health & Services. A number of CCOs offer incentive payments for recognized primary care homes and have incorporated alternative payment methodologies (APMs). Oregon is one of seven states selected to participate in the federal Comprehensive Primary Care Initiative (CPCI). Nearly 70 Oregon primary care practices were selected to participate and each is required to be recognized as a PCPCH.

Looking Ahead to 2017 and Beyond

In 2015, the PCPCH Standards and Advisory Committee was convened to assist the OHA with revising model. Proposed changes to be implemented in 2017 and confirmed through administrative rulemaking in 2016 include clarifying and strengthening existing standards and measures, the addition of one new “must pass” measure, and a redistribution of total available points across five tiers. The proposed changes are designed to incrementally adapt the model to the changing health care needs of the state, align the model with the best evidence where it is available, and also to improve the effectiveness of the standards and measures overall, with a focus on fostering integration of physical and behavioral health care services.

Detailed information about the PCPCH Program is available at <http://www.oregon.gov/oha/pcpch/>

Other Supports

Community Advisory Councils

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 Plans

Community health assessments and the resulting community health improvement plan are required of each CCO. The CCOs are required to submit an annual community health improvement plan progress report. 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.

Coordination with Other State Agencies

Public Health Division

Many of the factors that lead to poor health outcomes 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 root causes of poor health outcomes as well as corresponding risk factors such as tobacco use, poor nutrition and physical inactivity. Oregon’s health system transformation initiative supports CCOs in addressing the root causes of poor health outcomes through the community health assessment and community health improvement plan process, which is overseen by the CCO Community Advisory Council and developed in collaboration with state and local public health agencies and community partners.

In collaboration with the OHA Transformation Center, the Public Health Division will provide opportunities for CCOs, Community Advisory Councils, local public health authorities and their partners to develop the skills necessary to complete robust community health assessments and community health improvement plans that utilize evidence-based practices to ensure maximum population health impact. The Public Health Division will provide access to county and CCO-level community health improvement plan goals. The Public Health Division provides annual updates to its State Health Profile indicators and manages the Oregon Public Health Assessment Tool, an online database that allows CCOs

and local public health authorities access to a variety of population data sets and lets users to create and save their own customizable queries.

The Public Health Division will also provide CCOs, Community Advisory Councils, local public health authorities and their partners with information about evidence-based population health interventions that can be included in community health improvement plans. Using Oregon's State Health Improvement Plan as a guide, the Public Health Division will provide leadership for statewide interventions that aim to reduce the prevalence of the leading causes of death and disability in Oregon. Together with the OHA Transformation Center, the Public Health Division will provide opportunities for local partners to convene and share strategies for improving population health by collaborating across health systems and public health.

Finally, the Public Health Division will provide resources and expertise to CCOs in pursuit of improvement on their incentive measures; specifically those that focus on a population health issue or leverage the public health system for best performance. Technical assistance will be provided individually, at regular meetings of CCO medical directors and quality improvement specialists, and through written guidance documents. The Public Health Division will equip local public health authorities to provide this type of support to their CCOs at the local level as well.

Oversight for Oregon's governmental public health system is provided by the Public Health Advisory Board, which is a subcommittee of the Oregon Health Policy Board. This relationship ensures that health system transformation and public health are consistently working towards the same goals and leveraging every opportunity to improve population health in Oregon.

[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 Health Information Technology

The Three Goals of Health IT-Optimized Health Care

The vision for Oregon is a transformed health system where health IT and health information exchange efforts ensure that the care all Oregonians receive is optimized by health IT. In a health IT-optimized health care system:

1. Providers have access to meaningful, timely, relevant, and actionable patient information at the point of care including information about the whole person, including information pertaining to relevant physical, behavioral, social and other needs.
2. Systems (health plans, CCOs, health systems, and providers) have the ability to effectively and efficiently use aggregated clinical data for quality improvement, population management and incentivizing value and outcomes. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.
3. Individuals, and their families, can access and engage with their clinical information and are able to use it as a tool to improve their health and engage with their providers.

Overview of CCO Health IT Efforts

In 2013, the Oregon Legislature approved \$30 million in Health System Transformation Funds. The OHA Transformation Center awarded \$27 million in Transformation Fund Grant Awards to help CCOs launch innovative projects aimed at improving integration and coordination of care for Medicaid patients. Specifically, the Legislature directed the funds to be used for projects that would create services targeting specific populations or disease conditions, enhance the CCO's primary care home capacity, and invest in information technology and electronic medical records. Almost all of the CCOs invested a portion of their grant funds in health IT initiatives, including electronic health records (EHRs), health information sharing and exchange, data aggregation tools for population health, metrics collection, and telemedicine.

In general, all 16 CCOs have made an investment in health IT (either through Transformation Funds or otherwise) in order to facilitate healthcare transformation in their community. Nearly all CCOs are pursuing and/or implementing both health information exchange/care coordination tools as well as population management/data analytics tool.

Even with those similarities, each of the 16 CCOs chose to invest in a different set of health IT tools. Through their implementation and use of health IT, CCOs reported early successes in achieving goals such as:

- Increased information exchange across providers to support care coordination
- Making new data available to assist providers with identifying patients most in need of support/services and to help providers target their care effectively
- Improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data.

In general, CCOs sought to understand which health IT and EHR resources were in place in their community and provider environments, identify which health IT capabilities were needed to support the CCO's efforts, and identify strategies to meet those needs including leveraging existing resources or bringing in new health IT tools to fill priority needs. Ultimately, the combination of different CCO community, organizational, geographic and provider contexts as well as the variation in EHR and existing health IT resources led to a number of differing approaches to health IT.

Changing Approaches and Next Phases for CCO's HIT Efforts

Many CCOs are in the process of building upon their progress to date and are pursuing additional and/or improved HIT tools to add to (or replace) what they initially implemented:

- Connecting providers to health IT through integration with their EHR workflows
- Moving from administrative/claims-based case management and analytics to incorporating and extracting clinical data from provider's EHRs
- Incorporating behavioral health information, long-term care and social services in order to increase care coordination across different provider types
- Working with providers and providing technical assistance to establish clinical data reporting
- Supporting providers in new ways with providing data and performance metrics/dashboards back to them
- Investing in new tools for patient engagement and telehealth

CCO accountability for health information technology (STC 23c (1))

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.

Adoption of Electronic Health Record Technology and Meaningful Use (STC 23c (2))

Through the Centers for Medicare & Medicaid Services EHR Incentive Programs, eligible Oregon providers and hospitals can receive federal incentive payments to adopt, implement or upgrade and meaningfully use certified EHR technology. Since the inception of the programs in 2011, 6,846 Oregon providers and 61 hospitals have received a total of \$394.2 million in federal incentive payments. (\$265.6 million under the Medicare EHR Incentive Program and \$128.6 million under the Medicaid EHR Incentive Program, as of October 31, 2015).

Minimum benchmarks based on federal targets for EHR adoption have been successfully surpassed by all CCOs. The incentives for EHR adoption has transformed beyond paying for adoption; CCOs must demonstrate the advanced use of EHRs by reporting and meeting thresholds for clinical quality metrics (CQMs) and other EHR-based measures. OHA in conjunction with the Metrics and Scoring committee will continue to monitor the CCOs' use of EHRs. If CCOs fall below the minimum threshold or standards, a plan will be implemented to move the CCO(s) to achieve at least the minimum threshold. This could be in the form of a corrective action plan, reinstating the EHR adoption metric and/or technical assistance. See Appendix C: measurement strategy for details on measures and benchmarks.

Oregon intends to leverage federal Medicaid HIT funding to support Oregon's providers, leveraging new federal funding to support Medicaid behavioral health, long-term care, and other social services providers to connect to HIT/HIE. Recently, CMS has issued guidance about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote HIE and encourage the adoption of EHR technology by certain Medicaid providers. Oregon intends to explore using these funds to build HIE infrastructure. To be eligible for onboarding funds, Oregon is considering requiring HIE entities (e.g., regional HIEs) to meet minimum criteria. Criteria could include: participating in provider directory, contribute to clinical quality metrics and/or public health reporting, provide base

HIE service (Direct Secure messaging), participating in a trust community that connects statewide, no data blocking, interoperability with disparate systems, and using certified technology/standards-based.

State Health IT Activities (STC 23c (3))

In 2013, all 16 CCOs agreed to support OHA's plan to use the remaining \$3 million of state Transformation Funds to leverage and secure significant federal matching funds for investing in statewide health IT infrastructure. These funds are being used to support OHA's vision of a statewide approach for achieving health IT-optimized health care. OHA-supported health IT infrastructure will connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

As we see the importance of supporting the CCO model and value-based care arrangements, OHA will continue to monitor and adapt to the environment. This includes exploring public/private partnerships and collaboratives with other organizations.

In 2015, Oregon passed legislation to align HIT efforts with health system transformation goals, formalize and support OHA's health IT efforts, improve OHA's ability to advance the necessary health IT to support CCOs and the spread of the coordinated care model. Oregon originally addressed health IT in HB2009 (2009) with the establishment of the Health IT Oversight Council (HITOC), setting forth a strategic, policy, and coordination role for OHA. HB2294 (2015) updates the health IT statute to account for changes since 2009 and has three major components:

1. Establishes the Oregon Health IT Program within OHA.
 - Grants OHA authority to provide optional health IT services to support health care statewide (e.g., beyond the Medicaid program)
 - Authorizes fees to cover the costs of operating OHA's health IT services. Fees would be charged to users of this program's service
2. Grants OHA flexibility in partnering with stakeholders and the ability to participate in partnerships or collaboratives that provide statewide health IT services. This is especially important where Oregon organizations are partnering to bring new statewide health IT services to Oregon, and allows OHA to participate and provide support, including:
 - Ability to vote on governance boards for such services, and
 - Ability to enter into agreements to support and provide funding for the appropriate Medicaid share of statewide HIT services.
3. Updates statute for Oregon's HIT Oversight Council (HITOC)
 - Aligns HITOC under the Oregon Health Policy Board and solidifies its role in providing strategic and policy recommendations and oversight on the progress of Oregon health IT efforts.

Since HB2294 has been in effect OHA has established the new HITOC formally under the Policy Board with a revised charter and new membership. In 2016 HITOC will focus on two priority policy topics: 1) behavioral health information sharing; and 2) achieving real-world interoperability. HITOC will participate in health IT strategic planning efforts over 2016-2017 to inform the next state health IT efforts. HITOC will continue in 2017-2022 as part of their oversight to monitor the environment and health IT efforts in the state.

In order to achieve the goals of a health IT-optimized health care system outlined above, the State will need to fill several roles:

The State will coordinate and support community and organizational health IT efforts.

- Recognizing that health IT efforts must be in place locally to achieve a vision of HIT-optimized health care, the State can support, facilitate, inform, convene and offer guidance to providers, communities and organizations engaged in health IT.

The State will align requirements and establish standards for participation in statewide health IT services.

- To ensure that health information can be seamlessly shared, aggregated, and used, the State is in a unique position to establish standards and align requirements around interoperability and privacy and security, relying on already established national standards where they exist.

The State will provide a set of health IT technology and services.

- New and existing state-level services connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

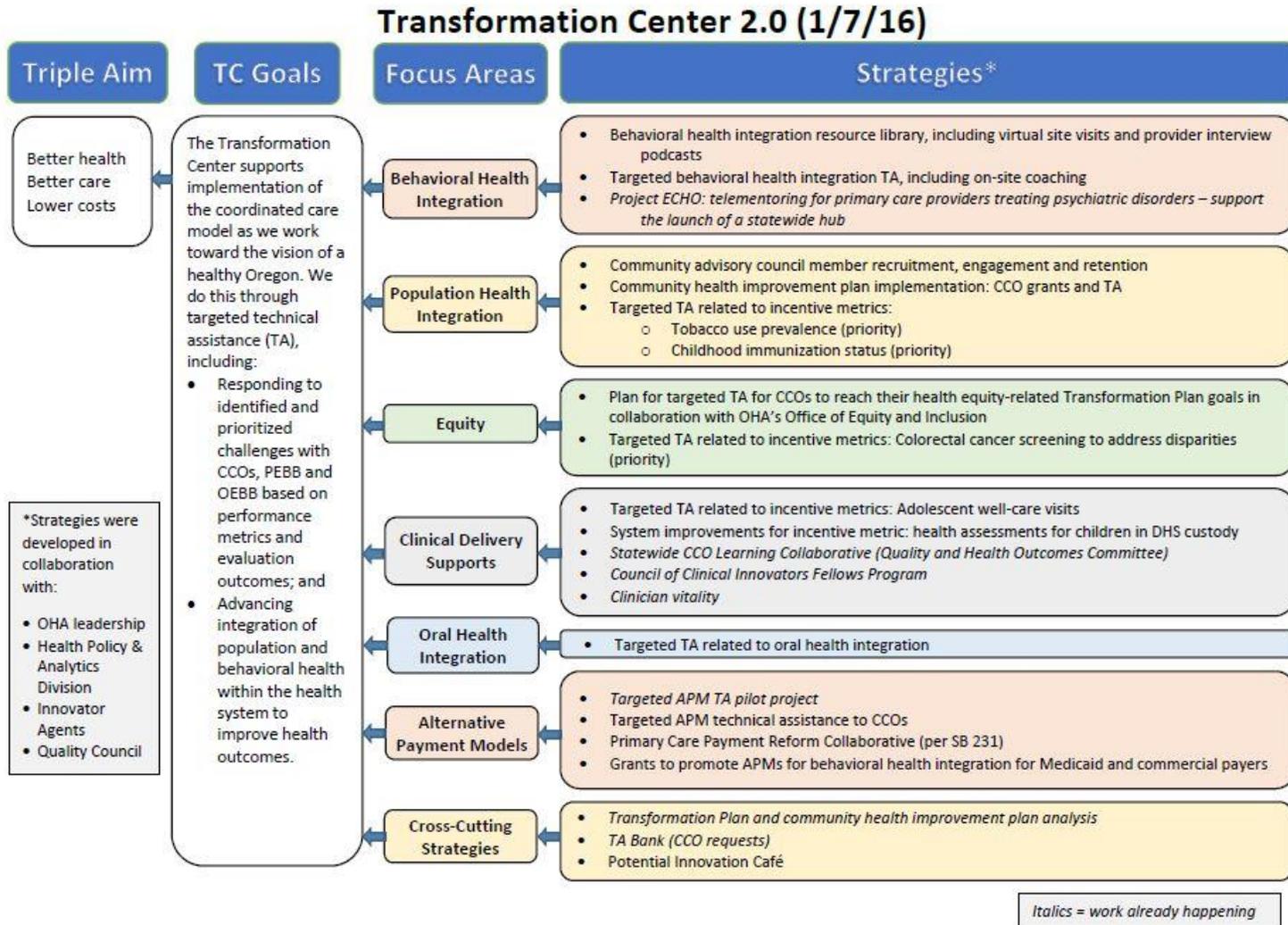
OHA's State-level Health IT Efforts

OHA's commitment to the CCOs in state-level health IT infrastructure includes the following:

- Statewide Direct secure messaging and CareAccord, offer a standards-based, HIPAA-compliant, common method of health information exchange, leveraging new requirements for certified EHRs and for hospital and providers seeking to meet meaningful use (funded, in part by CMS MMIS and CMMI SIM funds).
- Bringing real-time hospital event notifications to all 60 Oregon hospitals contributing admission, discharge and transfer (ADT) data (both emergency department and inpatient data) to the Emergency Department Information Exchange (EDIE). CCOs, health plans, and provider clinics can subscribe to PreManage to access the EDIE data and better manage their populations who are high utilizers of hospital services and support care coordination across the health care system around emergency and inpatient hospital events (funded, in part by CMS MMIS and CMMI SIM funds).
- Technical assistance to support Medicaid providers with the adoption and meaningful use of certified EHR technology as well as support providers in submitting their clinical quality metrics electronically from providers' EHRs to meet meaningful use and OHA's CCOs clinical quality metrics reporting requirements (funded, in part by CMS HITECH funds).
- Developing new HIT services to launch in 2017 to support efficient and effective care coordination, analytics, population management and health care operations, including:
 - A statewide Provider Directory, critical to supporting health information exchange, analytics and population management, accountability efforts, and operational efficiencies (funded, in part by CMS HITECH funds).
 - A Clinical Quality Metrics Registry to capture clinical quality metrics from electronic health records (see Part III for CCO reporting requirements) (funded, in part by CMS HITECH and MMIS funds).
 - A Common Credentialing program and database for the purpose of providing credentialing organizations access to information necessary to credential or re-credential all health care practitioners in the State.
- Grant-funded initiatives to support telehealth and patient access to full clinical notes, including:
 - Launching telehealth pilots in five communities (funded, in part by CMMI SIM funds).

- Supporting a telehealth resources and inventory website to link telehealth providers and purchasers (health plans, CCOs, etc.) to each other, through the Telehealth Alliance of Oregon (funded, in part by CMMI SIM funds).
 - Supporting an Oregon effort to promote OpenNotes to health care providers with EHRs not currently configured for OpenNotes, which allows full clinician notes to be available through an EHRs patient portal (funded, in part by CMMI SIM funds).
- Identifying and addressing barriers to behavioral health information sharing and care coordination. This work includes a 2016 behavioral health HIT environmental scan and survey to identify the HIT tools, opportunities and challenges faced by Oregon’s behavioral health providers; as well as support through a 2015-2017 \$1.6 million grant from the Office of the National Coordinator for Health Information Technology (ONC) to improve care coordination between behavioral and physical health care. Through the project, OHA’s subgrantee, Jefferson Health Information Exchange, is focusing on consent management to enable coordination between primary care, behavioral health and emergency providers, by developing a common consent model that will be supported within the JHIE technology (funded, in part by ONC Advance Interoperable Health IT Systems to Support Health Information Exchange Cooperative Agreement program).

Attachment A: Transformation Center Driver Diagram



Attachment B: Oregon Health Information Technology/Health Information Exchange Business Plan Framework

Goals, Aims, Strategies – 2016 Update

Overarching Aims & Objectives	Strategies
1. Improved culture of HIT-optimized health care where providers and other stakeholders value and expect electronic access to shared information	<ul style="list-style-type: none"> • Assess the changing environment and convene stakeholders • Educate stakeholders regarding HIT’s role in the changing healthcare environment • Share promising practices, positive outcomes and value • Promote policies that ensure HIT is incorporated into expectations for Oregon health care organizations
2. Increased alignment of standards to promote interoperability	<ul style="list-style-type: none"> • Promote alignment with federal and national standards where they exist and develop state standards or guidance where needed • Advocate for federal and national standards that are meaningful for Oregon stakeholders • Educate and provide guidance regarding specific standards in alignment with federal and national standards where possible • Encourage the collection, management, and use of discrete data
3. Improved distribution of financial burden for supporting HIT investments as payment models evolve	<ul style="list-style-type: none"> • Educate and promote value reimbursement for telehealth, including e-visits, telemedicine, and other resources • Promote HIT cost-consideration within payment models • Promote the use of alternative payment models that rely on, and support financial burden of, the use of associated HIT
4. Ensured protection of privacy and security of electronic health information	<ul style="list-style-type: none"> • Establish, promote and use policies and best practices that protect patient information • Provide resources to increase awareness, knowledge, and the means for ensuring privacy and security. • Support work to establish policies, processes, and documents to increase privacy and security of patient information • Support transparency in communicating to patients about providers’ policies and safeguards for information • Educate patients on security measures around the provision of their health data

Goal 1 of “HIT-Optimized Health Care”: Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care

- ❖ **Provider role in support of “HIT-Optimized Health Care”:** have the technology capabilities and workflows to participate in care coordination, including: (1) Pursue meaningful use of HIT (particularly for those eligible for EHR Incentive Programs); (2) Participate in care coordination and health information exchange that is inclusive of all members of the care team, including the patient

Aims & Objectives	Strategies
1. Increased adoption of standards-based technology for data capture, use, and exchange	<ul style="list-style-type: none"> • Promote⁵ participation in the EHR Incentive Program and standards that align with Meaningful Use and other quality incentive programs • Promote adoption of certified HIT and support those who may face challenges navigating the vendor arena • Promote and encourage streamlined processes to increase likelihood of adoption
2. Improved ability to capture, produce and use interoperable standards-based data in formats that are structured to be integrated and automated within EHRs and workflows	<ul style="list-style-type: none"> • Establish a “compatibility program” that sets baseline expectations for community, organizational and statewide HIT/HIE efforts to ensure interoperability, privacy and security and to facilitate the sharing of information • [See Overarching Aims above]
3. Improved access to and sharing of meaningful patient information across organizational and technological boundaries	<ul style="list-style-type: none"> • Connect and support entities with existing HIT infrastructure by providing foundational and enabling HIT services (e.g., Provider Directory, hospital notifications) • Ensure all members of a care team have a means to participate in the basic sharing of information needed to coordinate care (e.g., CareAccord) • Promote statewide Direct secure messaging as a common baseline for HIE and promote other standards that enable interoperability across all systems of care • Promote information sharing and care coordination with behavioral health, dental, long-term care providers • Promote the ingestion of relevant patient data into the EHRs to increase the likelihood of its use • Pilot innovation (e.g., telehealth, behavioral health sharing)

⁵ Activities that “Promote” can include educating, outreach, informing, advocating, convening, providing guidance, as well as applying state levers such as contract requirements, policies, aligning reporting requirements, etc.

Aims & Objectives	Strategies
4. Improved provider experience and workflows, reduced burden, and increased workforce capacity	<ul style="list-style-type: none"> • Provide guidance, information, and technical assistance • Identify and take action to remove barriers • Seek efforts that reduce administrative complexity and burden (e.g., Common Credentialing, align metrics) • Support efforts to increase workforce capacity

Goal 2 of “HIT-Optimized Health Care”: Systems effectively and efficiently collect and use aggregated clinical data for quality improvement, population management, and incentivizing health and prevention

❖ **Systems’ (e.g., CCOs, Health Plans) role/responsibility in support of “HIT-Optimized Health Care”:** (1) Implement HIT tools for data collection, processing, and reporting; (2) Align clinical metric reporting requirements with meaningful use clinical quality measures; (3) Encourage and support meaningful use and health information exchange among contracted providers

Aims & Objectives	Strategies
1. Improved use of HIT tools for data collection, analytics, and reporting	<ul style="list-style-type: none"> • Promote adoption of certified HIT and support providers who may face challenges navigating the vendor arena • Share promising practices, positive outcomes and value • Advocate for federal and national standards and oversight that are meaningful for Oregon stakeholders
2. Increased use of aggregated data, including clinical data for population management, quality improvement, and alternative payment methods	<ul style="list-style-type: none"> • Provide guidance, information, and technical assistance • Identify and take action to remove barriers • Support the appropriate collection and use of individual level clinical data where needed for more effective uses • Assess the changing environment and convene stakeholders • Support efforts to improve provider workflow to ensure accuracy and reliability of data • Support efforts to increase workforce capacity
3. Reduced reporting burden for data needed to support the coordinated care model across programs	<ul style="list-style-type: none"> • Align metrics and reporting across state programs with meaningful use specifications or other standards, ensuring metrics specifications are well-defined • Provide a clinical metrics data registry for Medicaid (CCO reporting and Medicaid EHR Incentive program) and, if valuable, expand registry to capture reporting for other programs

Goal 3 of “HIT-Optimized Health Care”: Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers

- ❖ **Individuals’ and families’ role/responsibility in support of “HIT-Optimized Health Care”:** (1) Expect providers to have electronic access to their relevant information; (2) Inform providers where they can access patient-generated information (e.g. personal health record); (3) Access their health records via available patient portals; (4) Communicate electronically with providers.

Aims & Objectives	Strategies
1. Increased patient access to/use of their complete health records	<ul style="list-style-type: none"> • Promote participation in Meaningful Use, which requires eligible providers to give patients secure, electronic access to their health information. • Support innovations (e.g., Open Notes) • Educate patients on the benefits of accessing their health information
2. Improved ability for individuals to provide relevant information into their health records	<ul style="list-style-type: none"> • Assess changing environments and convene both provider and patient stakeholders • Share promising practices, positive outcomes, and value • Provide information regarding the legal liabilities of patient-uploaded data
3. Increased use of HIT by patients to engage providers (e.g., patient portals, e-visits, messaging, remote monitoring, etc.)	<ul style="list-style-type: none"> • Promote participation in Meaningful Use, which requires eligible providers to support electronic patient engagement via messaging • Promote payment policies that support electronic interactions between providers and patients • Encourage and support providers to educate and promote patient engagement in HIT • Educate patients regarding the use of HIT as a tool for engaging providers

Appendix B: Quality Strategy

Monitoring the gains we've made

Introduction

To monitor how well Oregon's coordinated care model is achieving its goals of access, quality, and outcome 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 performance monitoring strategy and mechanisms to monitor and assess all Medicaid delivery systems (including Coordinated Care Organizations and Fee-For-Service).

As required by CFR 438.202(d), Oregon assesses how well the Coordinated Care Organizations (CCO) 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 Appendix C: Measurement Strategy. Oregon's evaluation plans, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries. Information on how Oregon will report to CMS on elements of the demonstration can be found in Appendix C: Measurement Strategy.

Oregon has developed a comprehensive program to assess all aspects of the delivery system, and CCO and MCO activities to determine quality improvement and contract compliance. This section describes the components of that program.

- Quality structure
The Oregon Health Authority is comprised of subject matter experts in evidence based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency wide committees who are responsible for oversight and planning. Underpinned across the quality and health transformation elements are health equity and social determinants of health with key contributions at the leadership committee level.

Current Oregon Health Authority structure to support quality and access monitoring:

- Oregon Health Authority
 - OHA Quality Council
 - Oregon Health Policy Board
- Health Systems Delivery
 - Quality and Health Outcomes Committee
 - Health Evidence Review Committee
 - Managed Care and CCO Collaborative
 - Quality Management / Contract Compliance

- Who is accountable for what

In an effort to drive innovation, improve health outcomes and maintain compliance with regulatory agencies the Oregon Health Authority is managing the substantial work through clear lines of responsibilities. Aligning programmatic expertise and skills with the appropriate quality activity supports the necessary detail needed to move healthcare forward. Specific delineation occurs for functions relating to quality and performance improvement; as well as quality assurance and compliance. Key attributes of accountability of quality structure (but not limited to):

- Oregon Health Authority
 - a. OHA Quality Council – monitor for the clinical quality performance, health transformation and quality improvement
 - b. Oregon Health Policy Board – develops strategic direction of health systems
- Health Systems Delivery (partnership committees with health delivery system and OHA)
 - a. Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation
 - b. Health Evidence Review Committee – review and development of evidence based practices for all managed care entities (including FFS)
 - c. Managed Care and CCO Collaborative – monitors the client experience, primarily through complaints and grievance, appeals, and utilization trending.
 - d. Quality Management / Contract Compliance - monitors managed care organizations and CCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud waste abuse)

- Methods and resources for monitoring

Across the Oregon Health Authority quality programs, the agency utilizes multiple quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and LEAN principles are examples of proven methods of improvement. Ongoing development with these methods across the agency supports the transformation in the health system delivery through train the trainer models with CCOs and contractual relationships with FFS. Additional resources for monitoring include robust data systems to drive a data decision culture. Key agency data systems include, but not limited to, all payer all claims database, performance monitoring through measures reporting, and CCO data dashboards from claims reporting. See Appendix III: Measurement Strategy for more detailed description of data sources.

- Framework for quality

To monitor quality, the Oregon Health Authority will build upon the implemented seven focus areas across the health systems of Oregon. Continuing the progress in the focus areas, the Oregon Health Authority will intensify key focus areas – such as adding oral health to the existing primary care and behavioral health integration. Collaboratively working across the system the Coordinated Care Organizations, Managed Care Organizations and the Oregon

Health Authority will support the framework through quality improvement in these focus areas. Focus areas are detailed in the following Improvement Strategies section.

- Alignment with managed care regulations
Continuing on the pathway to achieve the Triple Aim, the Oregon Health Authority recognizes the need for alignment across all health delivery systems for quality. Increased focus in alignment will include programs in Medicare, Medicaid CCO and FFS systems, and federal improvement programs (e.g. Value Based Payment). Working with regional Quality Improvement Organizations (QIOs), OHA's External Quality Review Organization and Health Delivery Systems (CCOs, MCOs), the Oregon Health Authority will look for opportunities to align state efforts with federal direction in quality and transformation activities. While maintaining the state's program integrity of the gains in health transformation, the Oregon Health Authority will develop strategic alignment for quality programs to increase organizations' efficiency, improve burden on the health systems for reporting and communicate common thread goals that will continue Oregon's work in better health, better care and decreasing costs.

Improvement Strategies

Performance Improvement Projects (PIPs)

As per STC 25b.i, OHA will contractually require each CCO to address four of the quality improvement focus areas 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 program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

Three of the focus areas will be conducted as performance improvement projects (PIPs) and one will be a focus study. One of the three required PIPs will focus on integrating primary care, oral 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. Integration of health: physical health, oral health and/or 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.

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 Assessment and Performance Improvement (QAPI) plans 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. The QAPI will be incorporated into the CCO's Quality Strategy and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. See Expectations of CCOs section below for further details.

Performance Monitoring

Oregon has developed a comprehensive program to assess all aspects of the delivery system. 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 (described below).

Monitoring

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 review

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.

Network Adequacy

In accordance with the applicable Code of Federal Regulations, Oregon's 1115 Demonstration Waiver, and Oregon's Medicaid Health Plan Contracts the Oregon Health Authority ensures an adequate network capacity is available for clients served under Medicaid. Monitoring access and service delivery is an integral part of CMS oversight of the State, as well as State monitoring of the contracted health plans. A contractually required Delivery System Network (DSN) report and analysis is received yearly on July 1st. Subsequently, managed care contractors are required to update these reports any time there has been a material change in their operations that would affect adequate capacity and services, and upon OHA request. Resources used to assist with the review of these reports include, but are not limited to: plan specific case mix reports, plan specific race, ethnicity and primary language reports, plan specific and OHA complaint/grievance/hearing reports, metric and utilization reports.

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. Additionally, all credentialed providers must verify regularly through the Office of Inspector General and SAMHSA for compliance with conflict of interest standards.

Policy requirements include standards credentialing, privileging, conflict of interest compliance including time and interval of credentialing functions. CCOs must also work with OHA to assure proper credentialing of Mental Health Programs, associated providers and non-traditional health care workers. See Appendix for a list of contractual elements and associated OARs.

Complaints and Grievances

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.

Equity

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 Health Systems Division, Transformation Center, and 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.

Compliance

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.

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.

Fraud and Abuse

The plan must submit, in a timely manner, to the OHA Office of Program Integrity, Provider Audit Unit, suspected cases and Complaints of Fraud, waste and Abuse made to or identified by the plan which necessitate a preliminary investigation. The plan must also submit the following information on an ongoing basis for each suspected or confirmed case of fraud, waste and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees, or any other source:

- The name, address, telephone number, provider and NPI number, of the individual or entity suspected of or confirmed to have committed the fraud or abuse;
- The source (name and contact information) that identified the fraud, waste or abuse, or noted as an anonymous source;
- The type of provider, entity, or organization that is suspected of or confirmed to have committed the fraud, waste or abuse;
- A description of the alleged or proven fraud, waste or abuse;
- Stage the research or investigation is in at the time of the report;
- The approximate dollar amount of the fraud, waste or abuse;
- Whether the complaint has been previously reported to OHA Office of Program Integrity Provider Audit Unit, Department of Justice Medicaid Fraud Control Unit, or other State agency or division;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the current 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.

External Quality Review Organization (EQRO) Activities

OHA has contracted with an External Quality Review Organization (EQRO) to support monitoring of quality in the CCO delivery system. An external quality review is conducted annually for all 16 CCOs and remaining contracted Mental Health Organization. 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.

Overview of External Quality Review Reports (2012-2015)

For the current 1115 Medicaid Demonstration Waiver by the Centers for Medicare & Medicaid Services (CMS), the EQR reports show the development of CCOs in the foundation and operations of CCOs to ensure quality, access and timeliness to care.

Areas of improvement since the launch of the CCOs have been in operational structure and systems to monitor and improve care. The following have been implemented over the last four years: development of community advisory councils, value-based payment arrangements, data systems to report gaps in care and utilization monitoring, population management programs, robust care management systems, use of community health workers, and strategies for integrating physical and behavioral health care.

While the gains by CCOs are remarkable, continued improvement is integral to a robust health system for ensuring quality for all Medicaid members. Specific areas of improvement will be in continued detailing for areas of network adequacy, integration of health systems to include oral health and mental health, and refinement of delegation oversight accountability and monitoring.

As Oregon continues to move towards achieving the Triple Aim – improving the lifelong health of all Oregonians; increasing the quality, reliability and availability of care for all Oregonians; and containing the cost of care so it is affordable for everyone – monitoring and continuous improvement of the quality of services, access, and timeliness of services will be supported through the annual external quality review. For detailed reports from 2012-2015, please visit:

<http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx>

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.

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.

List of conditions that may 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.

Expectations for CCOs

As Oregon's health transformation journey continues to meet the Triple Aim, how systems of care are delivered are becoming part of day-to-day functions. The ongoing performance management, while creating a culture of innovation, will be the foundation to move CCOs forward. Goals for coming years will be; maintaining the gains in health transformation while increasing alignment of quality activities at the federal and state level, decreasing the burden of reporting and ensuring compliance with federal regulations will be achieved through the CCO Quality Strategy. Rather than CCOs submitting Transformation Plans and QAPI, OHA will be requiring CCOs to submit, on an annual basis, a CCO Quality Strategy that will include elements of the QAPI, Transformation Plan and an annual Work plan.

The CCO Quality Strategy will reflect an analysis of quality and transformation activities of full prior calendar year. This analysis will provide CCOs the necessary picture to further determine gaps in health delivery, health improvement and cost containment. As gaps are defined, CCOs will determine interventions in alignment with CCO strategic plan to improve the quality of members care for their region. When developing interventions, CCOs will consider areas of transformation for the development of activities. CCOs will define in the annual work plan the interventions, measures of success and accountability of implementation of the determined interventions. The contract requirements (deliverables) will be updated annually for clear lines of understanding of format, due date, accountable review structure at Oregon Health Authority.

CCOs will be notified by October 2016 of the necessary elements of the CCO Quality Strategy that includes Health Transformation and QAP.

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 X 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.

Review of Quality Strategy

The OHA Quality Strategy shall be reviewed annually by OHA. The OHA Quality Strategy review and update will be completed by December of each year and submitted to CMS, upon significant changes, in the subsequent quarterly report update.

The OHA Quality Council 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:

- Addictions and Mental Health Planning and Advisory Council*
- Medicaid Advisory Committee*
- Health Systems Division Executive Team
- CCO Medical Directors
- FFS Contractors
- CCO Quality Management Coordinators
- Local Government Advisory Committee*
- DHS Internal Stakeholders
- OHA 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.

Appendix: Contract Compliance

This table itemizes where the federal requirements of CFR 438.204(g) are addressed in the Medicaid model contracts.

Required Component	Contract Provision
<p>438.206 - Availability of services</p> <ul style="list-style-type: none"> • 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. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • 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)
<p>438.207 - Assurances of adequate capacity and services</p> <ul style="list-style-type: none"> • 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. 	<p>Model Contract</p> <ul style="list-style-type: none"> • Exhibit B, Part 3.a.(1)
<p>438.208 - Coordination and continuity of care</p> <ul style="list-style-type: none"> • Each MCO must implement procedures to deliver primary care to and coordinate health care services to enrollees. • State must implement procedures to identify persons with special health care needs. Special health care needs are defined as: <ul style="list-style-type: none"> 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 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, Part 4, 2.i. • Exhibit B, Part 4, 2.e.

Required Component	Contract Provision
<p>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.</p> <ul style="list-style-type: none"> • 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). 	
<p>438.210 - Coverage and authorization of services</p> <ul style="list-style-type: none"> • Service authorization process. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit M, subsection 7
<p>438.214 - Provider selection</p> <ul style="list-style-type: none"> • 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. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, part 4, 3.b.
<p>438.218 - Enrollee information</p> <ul style="list-style-type: none"> • Plans must meet the requirements of 438.10 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit N
<p>438.224 - Confidentiality</p> <ul style="list-style-type: none"> • Plans must comply with state and federal confidentiality rules. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Ex. B, Part 4, Section 5.b.(3)
<p>438.226 - Enrollment and disenrollment</p> <ul style="list-style-type: none"> • Plans must comply with the enrollment and disenrollment standards in 438.56. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Ex. B, part 3, subsection 6
<p>438.228 - Grievance systems</p> <ul style="list-style-type: none"> • Plans must comply with grievance system requirements in the Federal regulations. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Ex. B, part 3, subsection 5

Required Component	Contract Provision
<p>438.230 - Subcontractual relationships and delegation</p> <ul style="list-style-type: none"> • 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. 	<p>Model Contract</p> <ul style="list-style-type: none"> • Exhibit D, section 18
<p>438.236 - Practice guidelines</p> <ul style="list-style-type: none"> • 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. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Ex. M, subsection 6
<p>438.240 - Quality assessment and performance improvement program</p> <ul style="list-style-type: none"> • 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 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 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Ex. B, Part 9

Required Component	Contract Provision
<p>increasing or sustaining improvement. Each plan must report to the state the results of each project.</p> <ul style="list-style-type: none"> The state must review at least annually, the impact and effectiveness of the each program. 	
<p>438.242 - Health information systems</p> <ul style="list-style-type: none"> 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. 	<p>Model Contract:</p> <ul style="list-style-type: none"> Exhibit B, Part 7

APPENDIX C: Measurement Strategy

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Introduction

Framework for Measurement

Since the July 2012 extension of the 1115 demonstration, Oregon has sought 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, access, and outcomes. Oregon utilizes community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of Medicaid beneficiaries in communities, as well as an active commitment to data and measurement.

As described in the narrative, Oregon intends to meet several key goals in the next five years, including:

- Build on Oregon’s Medicaid delivery system transformation with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve;
- Deepen focus on addressing the social determinants of health and improving health equity across all low-income, vulnerable Oregonians to improve population health outcomes;
- Commit to ongoing sustainability rate of growth that includes the 2% test, putting the federal investment at risk for not meeting that target and adopting a payment methodology and contracting protocol for CCOs that promotes increased investment in health-related services and advances the use of value-based payments; and
- Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

Oregon will accomplish these goals through a variety of strategies and quality improvement activities, described in the narrative and appendices, but also supported by a robust measurement strategy that will use financial incentives, multiple measure sets, and public transparency as mechanisms to drive improvement.

Improved Quality & Access

Oregon’s focus on measurement and transparency as key components of the coordinated care model has resulted in strong improvements across the seven quality improvement focus areas originally identified in the 2012 waiver. Oregon has also successfully demonstrated that quality and access to members has not been harmed despite transformation activities and the 2014 Medicaid expansion.

Under STC 52 and 54 of Oregon’s 1115 demonstration waiver (2012 – 2017), OHA must conduct a quality and access test in each program year that the state achieves its cost control goal to determine whether the state’s health system transformation efforts have caused the quality of care and access to care experienced by Medicaid beneficiaries to worsen. The test is passed if a composite score for the 33 quality and access metrics improves as compared to a historical baseline (2011).¹

Table 1: Quality & Access Test results by year

¹ Methodology is documented in Oregon’s 2012-2017 Accountability Plan, online at <http://www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf>

Demonstration Year	# of measures included (of 37) ²	Test Score ³
DY 12	25	114.3%
DY 13	28	58.4%

Through the coordinated care organization (CCO) incentive metrics program, Oregon has demonstrated improvements in a number of areas, including reductions in emergency department visits and increases in developmental screening, screening for alcohol and other substance use, and enrollment in patient-centered primary care homes.⁴

Through the Hospital Transformation Performance Program (HTPP), Oregon is demonstrating increased medication safety, and stronger hospital-CCO coordination, as evidenced by measures such as follow-up after hospitalizations for mental illness.⁵

Evaluation results to date have indicated that health system transformation is meaningfully affecting patterns of care without negatively impacting key outcomes. See Evaluation Plan for additional details.

Waiver Renewal

Measurement and evaluation are necessary to determine whether Oregon’s health system transformation efforts and goal of advancing the Triple Aim is met. This appendix describes Oregon’s robust measurement strategy, including the continued Quality and Access Test, the CCO and Hospital incentive metrics programs, data sources and validation, and commitments to transparent reporting. Most measurement activities are carried forward from the 2012-2017 waiver, reflecting updated focus areas and goals as part of the new waiver.

Oregon intends to measure quality of care, access to care, and health outcomes for individuals enrolled in CCOs and for the Oregon Health Plan population as a whole. The Oregon Health Authority intends to continue with a modified Quality and Access Test to ensure members are not being harmed as a result of Oregon’s continued health system transformation, and will use multiple other measure sets for various monitoring, quality improvement, and incentive purposes.

In addition to continuing to utilize measures from CMS’ adult and child measure sets, and CAHPS surveys, Oregon’s measures will likely reflect increased state and national focus on measure alignment, and enhanced focus on population health and health outcomes.

The measurement strategy will continue to evolve to support the following priority areas:

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

³ The claims-based measures included in the composite were independently calculated and validated by a third party, with remaining non-claims-based measures calculated by OHA.

⁴ Performance is publicly reported in semi-annual reports, online at <http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>

⁵ Performance is publicly reported in annual reports, online at <http://www.oregon.gov/oha/Metrics/Pages/Hospital-Reports.aspx>

- Behavioral health and oral health integration;
- Social determinants of health;
- Public health priorities;
- CCO collaboration and coordination with other systems, such as early learning hubs, hospitals, and the Department of Human Services (DHS);
- Specific populations, including members with severe and persistent mental illness (SPMI) and dual eligibles; and
- Populations experiencing disparities, including but not limited to inequities by race, ethnicity, language, gender, age, and geography.

OHA will continue its incentive programs, for both CCOs and hospitals, using the pay for performance lever to continue to drive focus and quality improvement efforts across the health system. Both CCO and hospital programs will continue to be guided by the legislatively-established public committees, although changes to the program structure and specific measures are anticipated over time. See sections below for details on the CCO and hospital incentive programs.

This measurement strategy will also better support CCO quality improvement efforts, with an overall goal to improve the health of members and improve administrative burdens on CCOs through the alignment of metrics, performance improvement projects, and transformation activities. See Appendix II for additional details on quality improvement efforts.

Committees

Oregon's robust measurement strategy includes several public committees, legislatively charged with selecting measures used in the CCO and hospital incentive programs, as well as providing oversight for measurement alignment. Committees include:

CCO Metrics and Scoring Committee

Established in 2012, the Metrics and Scoring Committee is charged with reviewing data and relevant literature to determine which measure will be included in the CCO incentive program each year, as well as establishing the benchmarks and improvement targets for that year.⁶

Beginning in 2017, the Metrics and Scoring Committee will become a subcommittee of the Health Plan Quality Metrics Committee (see below), and will select incentive metrics for CCOs from the master measure set selected by the HPQM Committee. However, the HPQM, when developing the master measure set, must take into account the recommendations of the Metrics & Scoring Committee.

Hospital Performance Metrics Advisory Committee

Established in 2013, the Hospital Performance Metrics Advisory Committee is charged with developing the hospital-specific metrics for incentive payments.⁷ This Committee is comprised of members from DRG hospitals, coordinated care organizations, and researchers, and recommends the measures for the hospital incentive program each year. The Committee also reviews data and relevant literature to establish benchmarks and improvement targets each year.

⁶ <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>

⁷ <http://www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx>

Health Plan Quality Metrics Committee

Legislatively established in 2017, the 15-member Health Plan Quality Metrics Committee (HPQM Committee) is charged with working collaboratively with the Oregon Educators Benefit Board (OEBB), the Public Employees' Benefit Board (PEBB), the Oregon Health Authority, and the Department of Consumer and Business Services (DCBS) to adopt health outcome and quality measures that are focused on specific goals and provide value to the state, employers, insurers, health care providers, and consumers.⁸

This Committee will convene in early 2017 and select an aligned set of health outcome and quality measures to be used for health benefit plans sold through the health insurance exchange, offered by PEBB and OEBB, and CCOs. State agencies are not required to adopt all of the measure selected by the Health Plan Quality Metrics Committee, but may not adopt any health outcome and quality measures that are different from the measures selected by the Committee.

The Committee is charged with prioritizing measures that:

- Utilize existing state and national health outcome and quality measures, including measures adopted by CMS, have been adopted or endorsed by other states or national organizations, and have a relevant state or national benchmark;
- Are not prone to random variations based on the size of the denominator;
- Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden;
- Can be meaningfully adopted for a minimum of three years;
- Use a common format in the collection of the data and facilitate the public reporting of the data; and
- Can be reported in a timely manner and without significant delay so that the most current and actionable data is available.

Technical Advisory Workgroups (TAG)

OHA also staffs monthly workgroup meetings for both CCO metrics and HTPP metrics.⁹ These technical advisory group (TAG) meetings are public meetings, where all CCOs and DRG hospitals are invited to send representatives to participate in the discussion. TAG meetings focus on operationalizing selected measures, developing measure specifications, making recommendations to the Metrics and Scoring, and Hospital Performance Metrics Advisory Committee, and quality improvement strategies.

Measure Sets

In addition to the specific measure sets (described below) for the quality and access test, the CCO incentive measures, and the hospital incentive measures, Oregon intends to explore developing, validating, and reporting on measures that support the following:

- Quality improvement focus areas described in Appendix II
- Quality

⁸ Oregon Senate Bill 440 (2015)

<http://www.oregon.gov/oha/analytics/APACDocs/Senate%20Bill%20440%20Enrolled.pdf>

⁹ <http://www.oregon.gov/oha/analytics/Pages/Hospital-Metrics-Technical-Advisory-Group.aspx> and <http://www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx>

- Access
- Population health and health outcomes
- Integration
- Behavioral health
- Oral health
- Social determinants of health
- Collaboration with other systems, particularly early learning and housing.

There are also several bodies of work that will inform Oregon’s overall measurement strategy, including the CMS adult and child measure sets, the Child & Family Well-being Measures Workgroup, behavioral health mapping, and in-state and national measure alignment activities.

Oregon will continue to publicly report measures at the state and CCO, or hospital, level where appropriate. See Transparency section below.

Performance Measures for Children and Adults in Medicaid/CHIP

Oregon intends to continue its commitment to reporting on the CMS Adult Medicaid Quality Measures and CHPIRA Measures where possible, and where appropriate, for the entire population.

As a participant in both the Adult Medicaid Quality Grant and the Children’s Health Insurance Program Reauthorization Act Quality Demonstration Program, Oregon has developed a deep understanding of these measures, and has developed capacity to report and analyze the data to identify opportunities to improve health care for Medicaid beneficiaries. One finding from this work is that the two measure sets artificially segment the population, which can limit a population health focus. Oregon intends to report these measures for the entire population where possible, unless it is clinically appropriate to use the age-segmentation.

Many of these measures may be included in other measure sets described below.

Child & Family Well-being Measures Workgroup

The Child & Family Well-being (CFWB) Measures Workgroup was created by the Joint Early Learning Council / Oregon Health Policy Board Joint Policy Subcommittee, which focused on identifying opportunities for coordination and integration between health and early learning system transformation efforts. The CFWB Workgroup was convened to provide recommendations for shared, cross-sector measures for child and family well-being in Oregon.¹⁰

The workgroup developed a 67-item child and family well-being measures library, as well as specific subsets of measures recommended for state level monitoring, and accountability measures that could be used as incentive or contract management measures with coordinated care organizations and early learning hubs. These measures, particularly the accountability measures, may be incorporated into future measure sets.

¹⁰ <http://www.oregon.gov/oha/analytics/Pages/Child-Family-Well-Being-Measures.aspx>

Behavioral Health Mapping

The Oregon Health Authority has convened a technical advisory committee to help develop a behavioral health system mapping tool that will assist OHA and partners to assess public resource and service needs, while tracking resource and service delivery.¹¹

The tool will enable the technical advisory committee to monitor and analyze system data to identify local areas with service gaps. Areas identified by the technical advisory committee may be appropriate for adoption into other monitoring or accountability measure sets.

Measure Alignment

There is growing interest in Oregon, and nationally, for measure alignment, and a developing understanding of measure fatigue. Both HB 2118 (2013) and SB 440 (2015, described above) created public committees charged with develop an aligned set of measures for public payers, and in 2016, CMS partnered with America's Health Insurance Plans to develop seven sets of clinical quality measures to support multi-payer alignment. Additional work from the Institute of Medicine and others provide important frameworks that Oregon will likely be incorporating into future measure development and selection.

Oregon is cognizant of the changing state and national landscape for quality measurement, and the need for parsimonious, aligned measure sets for Medicaid and other public payers (where possible). These conversations will affect measure selection in coming years, and measures proposed in this initial measurement strategy will likely change over time to address local and national movement. However, in the renewal period Oregon will have increased focus on selecting outcome measures and measures that reflect important aspects of health of Oregon Health Plan members.

Oregon is also particularly interested in ways in which the measure alignment conversation can overlap with CMS adult and child measures, and may be able to participate in future conversations determining which of the existing measures are essential to monitor state and national performance.

In addition, Oregon will monitor CMS and other national measure specifications to ensure implementation remains current and aligned. This includes updating measures to incorporate annual changes in HEDIS specifications, and potentially removing measures from measure sets described here if national measure stewards drop or significantly change measures.

Measure Development

Oregon is interested in a number of areas of measurement where national, standardized measures may not be available, or may need modification for Oregon's population or practice. Examples of this may include measures to address social determinants of health, such as developing a CCO-level measure for food insecurity screening, or housing, or transitioning existing claims-based measures to EHR-based measure, such as effective contraceptive use or alcohol and drug use screening (SBIRT).

As these measures are likely to be developmental and require testing before fully adopting them into the measurement framework, or incentive program(s), Oregon intends to instate a glide path for

¹¹ https://www.oregon.gov/oha/amh/Pages/bh_mapping.aspx

measure development and adoption, similar to California’s Medi-Cal 2020 Demonstration plan for testing innovative measures.¹²

Measures may be adopted as pay-for-reporting, or monitoring measures during the testing process, until they have been sufficiently vetted to be pay-for-performance metrics for CCOs or hospitals, or incorporated into the Quality & Access Test measure set. Developmental measures may be utilized in other processes, such as performance improvement project measures, where they can continue to be refined before being more formally adopted into pay-for-performance structures. The Metrics TAG workgroups described above will be critical partners in developing and testing innovative measures.

Quality & Access Test

This section lays out the details of the “quality and access test”, which will be applied in each year of the demonstration that Oregon achieves its cost control goal to determine whether health system transformation has caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen.

Original Test (2012-2017)

In the previous demonstration period, Oregon’s quality and access test consisted of two parts. In brief, part one 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 (2011). Part two is a more complex comparison of program period quality and access to a counterfactual level of quality and access that would exist had health system transformation not been undertaken. Part two of the test is only required if the state fails part one. Oregon fails the test for a given year if and only if it fails both part one and part two of the test. Failing the test would result in reductions in a portion of DSHP funding to the state, as described in the STCs.

Revised Test (2018-2022)

Oregon proposes continuing CMS and the state’s agreement to an annual test to assess whether unadjusted metrics for quality and access have demonstrated improvement. Oregon proposes continuing a two part test, with modifications made to the original methodology to better reflect the current state of health system transformation and the evolving measurement strategy (a summary of modifications is provided below).

Part One

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 differences between performance on this aggregate indicator in the current period (using the most recent full calendar year) and a baseline period (calendar year 2011). For component measures for which Oregon does not have a baseline period available, the earliest prior year available will be used as the comparative period instead.

Oregon will also explore a version of the quality and access test that compares performance on the aggregate indicator to performance in the prior year, rather than the historic baseline.

¹² CA 1115 Waiver – PRIME Attachment Q – PRIME Projects and Metrics Protocol
http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf

Oregon and CMS will agree on the initial component measures that will be used to construct the single quality and access aggregate indicator. Oregon will continue the original methodology for constructing the aggregate indicator developed under the 2012-2017 waiver which calculates a translated level of performance for each measure included in the aggregate indicator. Oregon's is proposing 29 measures for the initial aggregate indicator (listed below); these proposed measures build on the original quality and access test measures, as well as the current CCO incentive measures.

OHA will calculate the results for the quality and access test, in conjunction with third party contractor(s) who may calculate some of the measures, and/or validate OHA's calculation of the test measures. This is similar to OHA's current approach for the CCO incentive measures, and ensures iterative production and review of the measures for the most robust results.

Table: Initial Proposed Quality & Access Test Measures

Proposed Quality & Access Test Measures	Current (2016) CCO incentive measure	Former Q&A test measure	New test measure
Adolescent well care visits	x	x	
Alcohol or other substance misuse (SBIRT)	x	x	
All-cause readmissions		x	
Ambulatory care: emergency department utilization	x	x	
Ambulatory care: avoidable emergency department utilization (Medi-Cal method)			x
Assessments for children in DHS custody	x		x
CAHPS: access to care	x	x	
CAHPS: medical assistance with smoking cessation		x	
CAHPS: satisfaction with care	x	x	
Child and adolescent access to primary care practitioners		x	
Childhood immunization status	x	x	
Colorectal cancer screening	x	x	
Comprehensive diabetes care: HbA1c testing	x	x	
Comprehensive diabetes care: HbA1c poor control	x	x	
Controlling high blood pressure	x	x	
Dental sealants on permanent molars for children	x		x
Depression screening and follow up plan	x	x	
Developmental screening in the first 36 months of life	x	x	
Effective contraceptive use among women at risk of unintended pregnancy	x		x
Follow-up after hospitalization for mental illness	x	x	
Immunization for adolescents		x	
Patient-Centered Primary Care Home enrollment	x	x	
Timeliness of prenatal care: prenatal care	x	x	
Timeliness of prenatal care: postpartum care		x	
PQI 01: diabetes, short term complication admission rate		x	
PQI 05: COPD admission rate		x	
PQI 08: congestive heart failure admission rate		x	

Proposed Quality & Access Test Measures	Current (2016) CCO incentive measure	Former Q&A test measure	New test measure
PQI 15: adult asthma admission rate		x	
Well child visits in the first 15 months of life		x	

Measure Inclusion / Exclusion

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 encourage broad-based improvement and tends to increase the precision of the aggregate. CCO incentive measures are particularly attractive candidate measures, as the objectives of the CCOs should be aligned with those of the state as much as possible.

As measure sets are updated, new measures are developed, and measures are retired or adopted by the Health Plan Quality Metrics Committee and CCO Metrics and Scoring Committee, measures included in the aggregate indicator may shift. Oregon will keep the measure set the same to the extent possible, to ensure comparable results over time; however, allowing flexibility to remove measures if they are retired nationally, or to incorporate new measures that reflect care being provided in Oregon, will be important.

Measures in development that might also be included in the quality and access test by 2018 include a revised measure of electronic health record adoption across CCO provider networks, an opioid prescribing related measure, additional dental measures such as fluoride varnish or access to dental care, and behavioral health measures. Measures from the Hospital Transformation Performance Program may also be appropriate to include in the quality and access test.

In general, measures for which Oregon is already planning to collect data should be included in the aggregate indicator unless there is good reason to exclude the measure.

Good reasons to exclude a measure are:

- No data are available for that measure in the baseline, or prior year within the demonstration for comparison;
- Measure would contribute so much uncertainty to the aggregate that judgments about the aggregate would be affected;
- No benchmark is available;
- Lack of consensus at the state level about the value of the measure.

Measures may also be retired from the quality and access test if they are retired from other measure sets, such as HEDIS, or dropped by the national measure steward, or retired as a pay-for-performance metric by the public committees. This ensures that Oregon’s measures remained aligned and reduces measurement burden on health plans, hospitals, and providers who might otherwise be required to continue reporting on a measure for quality and access test purposes that has otherwise been retired.

Passing the Test

Part one of the test is passed if the aggregate score for quality and access metrics, rounded to the nearest tenth of a percentage, is greater than zero percent.

Part Two

If Oregon does not pass part one of the test in any year to which it is applied, Oregon will undertake and submit to CMS, a more detailed counterfactual analysis to determine whether quality and access have significantly diminished in a manner attributable to the state's efforts under the demonstration. Some or all of the counterfactual analysis may be addressed through Oregon's proposed evaluation activities, as described above.

If this analysis indicates a significant diminishment in quality and access under the demonstration in a given year, CMS will apply a reduction to the federal match claimed in the year immediately following the year for which the determination was made. Details of this reduction, as well as methodology and criteria for passing part two of the test are to be determined in conjunction with CMS.

Modifications to Original Q&A Test

- Change measurement period from state fiscal year to calendar year to better align with the CCO incentive measurement period (i.e., some measures are only available annually and on the calendar year).
- For new measures, allow baseline periods to be later than original CY 2011 baseline.
- Explore a version of the test that compares to a prior year, rather than historic baseline.
- Propose revisions to the measures included in the composite, as well as the flexibility to modify the measures further, depending on local measure development, strong performance, and prioritization / selection by public committees.

While not required in the 2012-2017 test period due to potential technical challenges and the increased risk of false-negative test results associated with a substantial increase in the number of comparisons, OHA will explore applying part one of the quality and access test to beneficiary subpopulations as one potential avenue for monitoring health equity and identifying potential disparities.

Regardless of the any potential results from part one of the test by subpopulation, Oregon will address subpopulation analysis through its proposed evaluation activities (described in the Evaluation Plan) and its metrics reporting (described below).

CCO Incentive Measure Program

Established in the 2012 waiver, and corresponding state legislation, the CCO incentive program is a mechanism for focusing CCO efforts and driving continuous quality improvement. Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. Oregon's strategy has been to annually increase the percentage of CCO payment at risk for performance, providing a meaningful incentive to achieve significant performance improvement and affect transformative change in care delivery.

To date, the CCO incentive metrics program has been a success. CCOs show improvements in a number of incentivized areas, including reductions in emergency department visits, and increases in developmental screening, screening for alcohol and other substance use, and enrollment in patient-centered primary care homes (PCPCHs). CCOs have made important strides in developing cross-sector relationships and systems to also improve care, such as coordination with the Department of Human Services to ensure children in foster care receive needed health assessments.

Oregon has learned that "what gets measured, gets managed." Measures selected as incentive measures have been incredibly powerful in driving quality improvement efforts, and have demonstrated broad reach, as CCOs work with providers to make improvements that affect their entire panel, not just Medicaid beneficiaries, as well as measure alignment happening across payers. Even measures potentially in development as *future* incentive measures have the ability to change the conversation, such as current work to develop a CCO-level measure of food insecurity screening.

Measure Selection

The CCO Metrics & Scoring Committee (described above), continues to select the annual incentive measures that will be tied to the quality pool, as required by STC 37b.ii. See Attachment A below for additional information on the CCO quality pool.

Many of the incentive measures that have been selected to date overlap with other, national measure sets, ensuring that the incentive program is aligned with existing state and national quality measures. Selected incentive measures also align with Oregon's quality improvement focus areas, and as health system transformation continues to deeper into the next phase, the incentive measures will evolve.

The Metrics & Scoring Committee will be selecting the 2017 incentive measures in the summer of 2016. The most current measure set is provided in the table below, as well as changes in the incentive measure set over time. Detailed measure specifications, technical documentation, and additional guidance are all published online.¹³

To ensure continuous quality improvement, the Committee has developed robust measure selection and retirement criteria to help guide measure selection each year, and continues to pursue measures that will help drive health system transformation.¹⁴ Each year, the Committee will consider additional measures as potential incentive measures as priorities evolve and new measures are developed.

¹³ <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

¹⁴ http://www.oregon.gov/oha/analytics/Documents/Measure_selection_criteria.pdf and http://www.oregon.gov/oha/analytics/Documents/MS_Committee_Measure_Retirement_Checklist.pdf

CCO Incentive Measures	2013	2014	2015	2016
Adolescent well-care visits	x	x	x	x
Alcohol or other substance misuse screening (SBIRT)	x	x	x	x
Ambulatory care: emergency department visits (per 1,000 mm)	x	x	x	x
CAHPS composite: access to care	x	x	x	x
CAHPS composite: satisfaction with care	x	x	x	x
Childhood immunization status				x
Cigarette smoking prevalence				x
Colorectal cancer screening	x	x	x	x
Controlling high blood pressure	x	x	x	x
Dental sealants			x	x
Depression screening and follow-up plan	x	x	x	x
Developmental screening (0-36 months)	x	x	x	x
Early elective delivery	x	x		
Diabetes: HbA1c poor control	x	x	x	x
Effective contraceptive use			x	x
Electronic health record adoption	x	x	x	
Follow-up after hospitalization for mental illness (FUH MI 7 day)	x	x	x	x
Follow-up for children prescribed ADHD medication	x	x		
Health assessments within 60 days for children in DHS custody	x	x	x	x
Patient-centered primary care home enrollment ¹⁶	x	x	x	x
Timeliness of prenatal care	x	x	x	x

Benchmark Selection

The Committee also establishes annual benchmarks and improvement targets for each of the incentive measures. CCOs must meet either the benchmark or improvement target to be eligible for receiving funds from the quality pool. The Committee will continue to review measures annually to ensure CCO performance is not stagnating. CCOs will not be allowed to coast on early successes, or demonstrate improvement in just one area of transformation.

Current (2016) benchmarks and improvement targets are available online.¹⁵

The Committee reviews CCO performance data, improvement over prior year's performance, distribution of the quality pool, and emerging areas of need to help determine the right combination of incentive measures and benchmarks to help improve quality, access, and outcomes for Medicaid beneficiaries. Incentive measures will be added in subsequent years, and it is likely that other measures will be retired from the set.

¹⁵ <http://www.oregon.gov/oha/analytics/CCOData/2016%20Benchmarks.pdf>

¹⁶ The current CCO incentive measure looks at the percent of CCO members who are assigned to a recognized patient-centered primary care home. As the PCPCH program standards are changing, the measure will need to be modified to reflect the new tiers.

Future Priorities

The Committee is also particularly interested in using the CCO incentive measure program structure to further health system transformation, by developing and adopting more transformational, and outcome-based measures, rather than traditional health care quality process measures, as well as exploring changes to the payment structure which would better support priority areas.

For example, the Committee is considering moving to a core and menu measure set, in which all CCOs would be incentivized for performance on the same core measures, but also have some flexibility to select additional incentive measures from a menu, based on local need and priority. The Committee will be developing this structure throughout 2016-17, for implementation as early as 2018 measurement.

The Committee is also interested in developing a measure, or mechanism, to more directly address health equity through the pay-for-performance program. This will also likely evolve throughout 2017 for implementation in a future measurement year.

Hospital Incentive Measure Program

Established 2014, Oregon operates the Hospital Transformation Performance Program (HTPP), which issues incentive payments to participating hospitals for quality improvement efforts as determined by the hospital incentive measures. The HTPP is an integral aspect of health system transformation in Oregon. Oregon's vision for achieving the triple aim of better health, better care, and lower costs means that all aspects of the delivery system must coordinate their transformation efforts.

Hospitals are an essential part of Oregon's delivery system. In recognition of this, the Oregon Legislature mandated the creation of a hospital incentive measure program covering the 2013-2015 biennium. CMS approved the initial two years, and an extension for a third year, under the 2012-2017 demonstration.

In 2015, the Oregon Legislature solidified the importance of hospitals in transforming the healthcare system by mandating the continuation of the HTPP for four additional years. In addition, the Legislature's extension recognized the vital and intertwined roles hospitals and CCOs play in transforming the delivery system and passed legislation that equally splits the incentive pool funding between hospitals and CCOs beginning in the third year (see Attachment A below for additional details on the hospital quality pool structure and distribution).

The implementation of the program has resulted in increased alignment and partnership work among hospitals, CCOs, primary care providers, and other community partners, particularly around three measures:

- *Screening, brief intervention, and referral to treatment (SBIRT) in the emergency department.* The inclusion of this measure in the HTPP has incentivized all of Oregon's DRG emergency departments to implement drug and alcohol screening, and compliments the CCO incentive measure (focused on SBIRT in primary care). This required a significant investment by hospitals to change their emergency department workflows and technology to screen patients and track outcomes. OHA estimates that the HTPP SBIRT measure alone has resulted in a net savings of over \$3.3 million (this is net of the \$8.5 million per year HTPP incentive payments made for this measure).¹⁷
- *Hospitals sharing emergency department (ED) visit information with primary care providers to reduce unnecessary ED visits by high utilizers.* For many hospitals, this was a completely new process implemented because of the HPP. Hospitals have made significant strides in increasing notifications to primary care providers since the first year of the program, and the HTPP has motivated partners like the Oregon Health Leadership Council to work with OHA to facilitate greater conversations among hospitals, CCOs, and primary care practices about the best processes to support this work.

¹⁷ Gentilello et al (2005). Alcohol interventions for trauma patients treated in emergency departments and hospitals: a cost-benefit analysis. *Annals of Surgery*, 241, 541-550. Study estimates net cost savings at \$89 per patient screened, or \$330 for each patient offered an intervention. OHA applied the SBIRT-related cost savings to the first two years of data for the HTPP.

- *Follow-up after hospitalization for mental illness.* This is both a CCO and hospital incentive measure and requires both systems to collaborate in order to be successful. Hospitals actively work with their local CCOs to ensure that they are successful on this measure and patients are able to attend their follow-up appointments after they are discharged from the hospital.

Additionally, the HTPP has resulted in collaboration between the Hospital and CCO Metrics Committees, hospital engagement in the Hospital Metrics Technical Advisory Group, coordination between CCOs and hospitals to achieve shared goals, and community partnerships to improve care. Hospitals and partners are engaged and invested in this work.

OHA is currently conducting an independent evaluation of the first two years of the HTPP, as required by CMS, to help demonstrate whether the HTPP is accelerating health system transformation among targeted providers, and whether the program is resulting in quality improvements. Results will be available in June 2016.

Because of the foundational role that hospital quality improvement plays in moving transformation forward, Oregon proposes continuing the HTPP through the 2017-2022 demonstration period, transitioning the program from the initial structure to a program which is fully integrated and aligned with overall health system transformation goals. This section provides a summary of years 1-3 and OHA's proposal for the fourth year of the program, as well as the broader vision, which will continue to evolve with the Hospital Metrics Advisory Committee (described above), and partners.

Years 1-3 Domains and Measures

The Hospital Metrics Advisory Committee recommended eleven outcome and quality measures across six domains for the initial years of the program. The measures can also be captured in two overarching focus areas: hospital-focused, and hospital-CCO coordination-focused (see table below).

The Committee also recommended annual benchmarks and improvement targets for each of the hospital incentive measures. CCOs must meet either the benchmark or improvement target to be eligible for receiving funds from the quality pool. Benchmarks and improvement targets are available online.¹⁸

To ensure continuous quality improvement, the Committee has adopted principles to help guide measure selection.¹⁹ For future years of the program, the Committee will consider additional measures as potential hospital incentive measures on an annual basis, as well as where to set the benchmark and improvement targets to ensure they provide stretch goals. Hospitals will not be allowed to coast on early successes from the first years of the program, or demonstration improvement in just one domain or area of transformation.

¹⁸ See Measures and Benchmarks Table document, <http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>

¹⁹ <http://www.oregon.gov/oha/analytics/HospitalMetricsDocs/Hosp%20Perf%20Metrics%20Guiding%20Principles.pdf>

Years 1-3 domains and measures

Focus Area	Domains	Measures
Hospital focus	1. Readmissions	1. Hospital-wide all-cause readmission ²⁰
	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. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Staff always explained medicines 6. HCAHPS: Staff gave patient discharge information
	4. Healthcare-Associated Infections	7. Central Line-Associated Bloodstream Infection (CLABSI) in all tracked units 8. Catheter Associated Urinary Tract Infection (CAUTI) in all tracked units
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 (two-part measure)
	6. Behavioral Health	10. Follow-up after hospitalization for mental illness 11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the emergency department (two-part measure)

Proposed Year 4

For the fourth year of the program that begins with the renewal demonstration, Oregon is proposing modifications to the domains to better reflect the focus of the program, and additional measures to further stretch hospital performance and improve quality.

Proposed Year 4 domains and measures

As shown in the table below, some of the initial measures have been realigned to make the aim for an overarching, community-focused program clearer. Two of the initial domains (medication safety and healthcare acquired infections) have been combined into a patient safety domain. While patient safety remains an important goal for all hospitals, this modification reduces the relative worth of these measures in terms of HTPP payment (see Attachment A for payment details) and shifts the emphasis to those measure which are more community-focused.

One of the healthcare acquired infections measures (CLABSI), and two of the medication safety measures (Excessive anticoagulation with Warfarin and Adverse Drug Events due to opioids) have been removed, due to strong hospital performance in the initial years of the program.

Three new measures have been added, including C-difficile, opioid prescribing in the Emergency Department, and reducing c-sections (combined with a balancing measure of unexpected newborn complications). The balancing measure will not be incentivized, but will be monitored to ensure that the new c-section measure does not result in unintended consequences.

²⁰ OHA has proposed changing the readmission measure from all-cause to potentially preventable (PPR) for the third measurement year. This change is pending CMS approval.

Domains	Measures
1. Fostering Effective Care Transitions	1. Potentially Preventable Readmissions 2. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Staff always explained medicines 3. HCAHPS: Staff gave patient discharge information
2. Improving Patient Safety	4. Catheter Associated Urinary Tract Infection (CAUTI) in all tracked units 5. C-Difficile 6. Hypoglycemia in inpatients receiving insulin
3. Reducing Avoidable ED visits	7. EDIE: reducing emergency department re-visits
4. Coordinating Behavioral Health and Substance Use Interventions	8. Follow-up after hospitalization for mental illness 9. SBIRT in the emergency department (two-part measure) 10. Safe opioid prescribing
5. Improving Maternal Health	11. Reducing c-sections / Unexpected newborn complications

The Hospital Performance Metrics Advisory Committee will be reviewing Year 2 performance data and Year 3 preliminary data where possible to determine benchmarks for the Year 4 measures.

[Proposed Year 4 Measurement Period](#)

OHA also proposes changing the measurement period from the federal fiscal year (FFY) to the calendar year to further align with the CCO incentive measure program and ease administrative burden. The performance period for the fourth year will begin January 1, 2017 and end December 31, 2017.

During the three month interim period between the end of the third year (September 30, 2016) and the beginning of the year four measurement period (January 1, 2017), hospitals are expected to continue quality improvement efforts related to the HTPP measures. While hospitals will not report these data to OHA for payment on performance, they will still be expected to track and report these metrics. This gap period may also be used to collect any baseline data for the new measures as needed.

OHA will also use this time to meet with the Hospital Metrics Technical Advisory Group (described above) to discuss the metrics and finalize any changes to the specifications and reporting processes for year 4.

While hospitals focus their efforts during year 4, OHA will work with partners and the Hospital Performance Metrics Advisory Committee to identify additional focus areas for future years of HTPP and ensure that the program aligns with the broader goals of the demonstration.

HTPP Vision for years 5 and beyond

Oregon's vision for the Hospital Transformation Performance Program is a program which is fully integrated with the 1115 Demonstration, which furthers collaboration between hospitals and CCOs and leads to achieving the triple aim.

Domains and Measures

Beginning in year 5 (January 1, 2018), the HTPP will include two measures sets: (1) the core measure set, and (2) the hospital-specific "menu" set. Similar to the CCO incentive measure program, these will be complimented by a challenge pool measure set, comprised of a subset of the most transformative domains and measures that are worth an additional incentive payment if benchmarks or improvement targets are achieved. See Attachment A below for additional details on the proposed payment structure.

- The core measure set will be comprised of domains and measures that are applicable to all hospitals. All hospitals would be expected to report on all domains and associated measures in this set. Payment would be contingent upon achieving either a benchmark or an improvement target.
- The hospital-specific menu set will include domains and measures from which hospitals would choose a specific number of measures, based on local priorities and need, and in accordance with parameters established by the Committee. Payment would be contingent upon achieving either a benchmark or an improvement target.
- The challenge pool will include the most transformative measures as selected by the Committee. Payment would be based on the dollars remaining after distribution of payments in the prior rounds, and contingent upon achieving either a benchmark or an improvement target.

This approach will hold hospitals accountable to a core set of domains and measures while allowing individual hospitals to identify locally relevant areas where they want to focus their quality improvement efforts. Hospitals would also be able to collaborate with their local CCOs on any hospital-specific measure that cut across the two systems. Additionally, this approach takes into account the differing service arrays offered at hospitals (e.g., a core metric focused on maternity care would be inappropriate as not all DRG hospitals in Oregon perform deliveries).

The core and menu set would be implemented incrementally, with additional measures added to both sets in each year, eventually including the maximal number of measures. As measures are removed due to high performance and new measures are introduced, hospitals would be paid for reporting in the first year (to establish a baseline), but must achieve benchmarks or improvement targets to qualify for payment in subsequent years.

Proposed measures for Year 5 and beyond are pending review with the Hospital Performance Metrics Advisory Committee.

Data Sources and Validation

The Oregon Health Authority will be responsible for collecting data on all measures selected, although CCOs and hospitals may be required to submit data according to specifications. Oregon will also work with contractors, including, but not limited to survey vendors and an external quality review organization to play a role in data collection and analysis where necessary. Oregon will also continue its robust measure validation process, both for the hospital and CCO incentive programs, but also for the quality and access test.

Data Sources

Oregon has developed many systems to collect data from plans and hospitals, and plans are required to have information systems capable of collecting, analyzing, and submitting required data and reports.

Data sources are described below. Data sources for specific measures are listed in the detailed specification sheets available online.²¹

Administrative Data – All CCOs 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.

Oregon follows all federal regulations regarding claims submission and processing.

Clinical Data / Chart Review – CCOs may be required to conduct annual chart review on defined samples of their member population to determine measure compliance. OHA provides guidance and collects the data for analysis.

Community Health Assessment – CCOs are contractually required to submit the community health needs assessment to OHA. See Appendix II for additional details.

Electronic Health Records - Oregon is building CCO and provider capacity to report on measures from their electronic health records. CCOs work with their provider network to develop and extract reports from their EHRs, where possible aligning with Meaningful Use requirements.

Member Satisfaction Surveys – Oregon, in conjunction with its external quality review organization, conducts statewide standardized surveys of patients' experience of care. These surveys allow for plan-to-plan comparisons. Plans are required to participate, as appropriate, in the performance of each survey. Survey results are shared with plans and reports are published on the OHA website, making them available to Medicaid beneficiaries to assist them in the process of selecting an appropriate plan.

Participating Provider Network Reports – Provider network reports are submitted by each plan and are used to monitor compliance with access standards, including travel time / distance requirements, network capacity, panel size, and provider turnover.

²¹ <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx> and <http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>

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.

Race/Ethnicity Data

In MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Ethnicity is currently defined as Hispanic / non-Hispanic. Oregon does not have data on multiple races. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

Oregon historically has only collected data on preferred household language, but is in the process of moving to collecting individual preferred language.

The Oregon Health Authority and the Department of Human Services have adopted rules establishing uniform standards and practices for the collection of data on race, ethnicity, preferred spoken or signed and preferred written language, and disability status.²²

Validation

The Oregon Health Authority will contract with an independent third party for assistance in measure validation as part of the quality and access test. To date, OHA has contacted with the Oregon Health Care Quality Corporation (Quality Corp) for assistance in this area. 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.

OHA currently engages in rigorous, multi-directional, and ongoing validation activities with two contractors, as well as with the 16 CCOs and 28 DRG hospitals as part of the incentive programs. OHA and contractors independently produce measures and compare results, leading to identification of discrepancies and code.

CCOs and hospitals review data provided by OHA and compare to their own internal analysis, resulting in questions and corrections made if necessary. Both the hospital and the CCO incentive metrics program have established periods for final review and validation of data, prior to closing out the measurement year and paying for performance, to ensure quality and accuracy of results.

Validation also occurs as part of the external quality review organization activities, including the ISCA. See Appendix II for additional details. Oregon intends to continue robust validation activities to ensure accurate measurement throughout the 2017-2022 period.

²² ORS 413.161 collection of data on race, ethnicity, language and disability status
<http://www.oregonlaws.org/ors/413.161>

Data Analysis

OHA is responsible for conducting data analysis for the measurement strategy. Where possible measures will be aggregated by CCO and by hospital, 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 specific populations of interest (see below).

Where possible, measures will be analyzed and reported for the fee-for-service (FFS) population. Oregon is developing a dashboard to monitor performance measures for the FFS population, and additional monitoring and analysis is being explored as part of an FFS Access Project.

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 Appendix I. Data from selected measures will also be used to inform the evaluation questions described below.

Subpopulation Analysis

Where possible and appropriate, measures will be reported by race, ethnicity, language, disability, and where there is a diagnosis of serious and persistent mental illness (SPMI). Other subpopulations of interest include beneficiary language, individuals eligible for Medicare and Medicaid, and rural versus non-rural locations, as well as gender, and people with specific diagnoses (e.g., chronic conditions, substance use, experiencing homelessness, etc).

Evaluation questions will also be explored for populations of focus. See the Evaluation Plan above for additional details.

OHA will involve data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders as appropriate in defining additional subpopulations, and reviewing and interpreting any subpopulation analysis.

Reporting and Transparency

The Oregon Health Authority has committed to transparency in health system transformation efforts. Throughout the demonstration, Oregon has been improving its documentation and availability of public facing reports, as well as the user-friendliness of the reports. OHA intends to continue this emphasis throughout the renewal period.

Public Reporting

Since 2013, Oregon has been providing regular public reports on statewide and CCO performance on a suite of metrics. In the interest of advancing transparency, and providing Oregon Health Plan member with information about quality and access of care to help them make informed choices, OHA will continue publishing these reports.

Oregon will also publish an annual report on statewide and hospital performance on the hospital incentive metrics, as well as enhance its hospital reporting through price transparency projects.

At minimum, data will be reported publicly on an annual basis, however a subset of information or measures may be reported more frequently to track patterns of utilization and highlight potential issues with performance. Measures will be reported by CCO, and by hospital, and in aggregate. Oregon will only publish data at aggregate levels that do not disclose information otherwise protected by law.

CCO Reporting

In addition to the semi-annual public reporting, Oregon has also developed a monthly metrics dashboard for reporting interim results to CCOs. This dashboard allows OHAs and CCOs to have an ongoing conversation about metrics, including understanding specifications, identifying potential issues with performance and areas for improvement, and allow CCOs to make course corrects as needed to meet benchmarks or improvement targets.

These dashboards will continue throughout the renewal period.

Hospital Reporting

Unlike the CCO incentive measure program, the majority of hospital measures are reported by the hospitals directly. The information is collected by the Oregon Association of Hospitals and Health Systems (OAHHS) for initial validation, prior to its submission to OHA. As the data come directly from the hospitals, a monthly report on their performance is not provided. OHA provides quarterly reports for metrics that are produced by the state.

As part of its Hospital Reporting Program, Oregon produces quarterly reports on its acute care hospitals. These reports track key measures of hospital finances and utilization, including profitability, charity care, bad debt, and inpatient, outpatient, and emergency department utilization.²³

Under SB 900 (2015), OHA is also charged with posting median health care price data for the most common inpatient and outpatient hospital services. These reports are currently in development, but will increase price transparency, and potentially help Oregonians make better informed choices about health care.

²³ http://www.oregon.gov/oha/OHPR/RSCH/pages/hospital_reporting.aspx

Attachment A: Quality Pool

Financial incentives are a key strategy for stimulating quality and for moving the health system from a capitated payment structure to value-based purchasing. It is expected that over time, savings accruing from the restructuring of the 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.

This attachment to Appendix III describes the CCO incentive program and hospital incentive program quality pool structures and distribution methodologies for the 2017-2022 demonstration period.

CCO Quality Pool Structure and Distribution

The Oregon Health Authority intends to continue its' CCO incentive metrics program and quality pool, as established in 2012 (STC 37.b.ii). Originally, Oregon's strategy was to annually increase the percentage of CCO payment at risk for performance, from 2 percent of the global budget in 2013 to 5 percent in 2017.²⁴

When the quality pool was established, OHA believed that unless CCOs had a meaningful percentage of their payment at risk for performance, they would be unlikely to take the steps necessary to achieve significant performance improvement and affect the transformative changes in the delivery system.

Quality Pool Size

Looking forward through 2022, OHA intends to cap the CCO quality pool size at 5 percent of the global budget (or, 5 percent of the actual paid amounts to the CCO for a given calendar year). This will ensure that the annual at-risk amount is not so large as to threaten the financial viability of a CCO should it not perform well relative to the established benchmarks and improvement targets, while also being sufficiently large enough to prompt transformative changes and drive performance improvements.

Quality Pool Distribution

Disbursement of the CCO quality pool funds is contingent on CCO performance relative to both the absolute benchmark, and improvement targets for the selected measures (described above). Funds from the quality pool will be distributed on an annual basis, with the calendar year payment made by June 30th of the following year.

Quality pool award amounts will be determined through a two-stage process. In stage one, the maximum amount of dollars that a CCO is eligible for will be allocated based on performance on the incentive measures relative to the benchmarks and improvement targets established by the Metrics & Scoring Committee.

In stage two, any remaining quality pool funds that were not disbursed in stage one based on performance on the incentive measures (i.e., funds remaining if a CCO does not meet all benchmarks or

²⁴ The quality pool is financed at a set percent of the aggregate value of the per member per month (PMPM) CCO budget, not including several specific payments (the prior year's quality pool payments, the federal Health Insurers Fee, Targeted Case Management, and Hospital Reimbursement Adjustment payments). Additional details about the annual quality pool composition is available in the "reference instructions" online at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

improvement targets) will be distributed to CCOs that meet “challenge pool” criteria, as determined by the Metrics & Scoring Committee.

The Metrics & Scoring Committee will continue to examine the quality pool operation over time and annually re-evaluate the incentive measures, benchmarks and improvement targets, and challenge pool criteria.

The current stage one and two distribution mechanisms are described below; however these are under review with the Metrics & Scoring Committee and may be modified for future years, to better accommodate the core / menu measure set concept, and other priority areas, such as “must pass” measures related to health equity. The quality pool distribution methodology is documented online and updated annually²⁵.

Stage One Distribution

Distribution based on performance on all incentive measures

For most of the current CCO incentive measures, the portion of available quality pool funds that a CCO receives is based on the number of measures on which it achieve either an absolute benchmark or demonstrates improvement over its own prior year’s performance (improvement target). The benchmarks are the same for all CCOs, regardless of geographic region and patient mix.

CCO performance on these measures is treated on a pass / fail basis, and all measures are independent from one another. If the benchmark is met or the improvement target reached for a specific measure, the CCO receives all of the credit available for that measure, regardless of performance on other measures.

For the patient-centered primary care home (PCPCH) enrollment measure, as long as it remains an incentive measure, performance is measured according to a tiered formula. The original formula:

$$\frac{(\# \text{ of members in Tier 1} * 1) + (\# \text{ of members in Tier 2} * 2) + (\# \text{ of members in Tier 3}) * 3}{\text{total number of members enrolled in the CCO} * 3}$$

The revised formula, updated to reflect new certification standards:

$$\frac{(\# \text{ of members in Tier 1} * 1) + (\# \text{ of members in Tier 2} * 3) + (\# \text{ of members in Tier 3} + 4 + 5 * 3)}{\text{total number of members enrolled in the CCO} * 3}$$

The results of the tiered formula are added to the number of measures on which a CCO meets the benchmark or the improvement target, for the CCO’s total score.

Since 2013, CCOs were required to meet three criteria to earn 100 percent of the quality pool funds for which they were eligible:

- Meet or exceed the benchmark or the improvement target on at least 75 percent of the incentive measures (i.e., 12 of 16); and
- Meet or exceed the benchmark or improvement target for the Electronic Health Record (ERH) adoption measure as one of the required 75 percent measures above; and

²⁵ Quality Pool Reference Instructions, available online at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

- Score at least 0.60 on the PCPCH enrollment measure using the tiered formula.

If CCOs did not meet the EHR adoption measure, or the PCPCH measure, the maximum payment they were eligible to receive was 90 percent.

Table: current quality pool distribution

Number of benchmarks or improvement targets met	Percent of the quality pool payment for which the CCO is eligible
At least 12 (including EHR adoption) and (at least 60% PCPCH enrollment)	100%
At least 12 (not including EHR adoption) or (less than 60% PCPCH enrollment)	90%
At least 11.6	80%
At least 10.6	70%
At least 8.6	60%
At least 4.6	50%
At least 3.6	40%
At least 2.6	30%
At least 1.6	20%
At least 0.6	10%
Fewer than 0.6	No quality pool payment

In future years of the CCO incentive metric program (potentially beginning with CY 2018 measurement, and payments made in 2019), the Metrics & Scoring Committee is interested in moving to a core and menu set of measures, in which all CCOs would be held accountable for meeting benchmarks and improvement targets on the same measures (core set), but would also be able to select a specific number of measures from an approved list (menu set) based on their local priorities and need. As this will result in a consistent total number of incentive measures for all CCOs, the quality pool distribution during 2017 – 2022 will likely remain very similar to the tiered table above, but depending on the total number of measures across the core and menu sets, the specific number of measures in the tiers may shift.

The Committee may also choose to recommend that CCOs meet a higher percentage of all the measures to earn 100% of the quality pool funds for which they are eligible. For example, when the tiered distribution was originally established, there were 17 incentive measures (12 of 17 measures, plus PCPCH enrollment was roughly equivalent to meeting 75 percent of the measures to earn 100 percent of the funds). The Committee may choose to recommend CCOs must meet 90 or 100 percent of the measures to earn 100 percent of the funds.

These changes will be reflected in the annually updated Quality Pool Methodology documentation posted online.

Stage Two Distribution

Challenge Pool

In the second stage, remaining quality pool funds that have not been allocated to CCOs in stage one will become the ‘challenge pool’ – these funds will be distributed to CCOs that qualify based on the challenge pool criteria.

Historically, the challenge pool has been a subset of the incentive measures, those measures that the Committee believed were ‘most transformational’. CCOs that performed well on those measures received both the phase one distribution, and any challenge pool dollars.²⁶

Looking forward, the Committee is considering alternate ways to utilize the challenge pool, potentially selecting different measures, rather than a subset, to better incentivize areas of particular interest. For example, the Committee is considering a measure of health equity for future use in the challenge pool. These changes will be documented in the annually updated Quality Pool Methodology posted online.

Through the second stage, all quality pool funds will be distributed; no quality pool funds will roll over into a subsequent year.

Hospital Quality Pool Structure and Distribution

The Oregon Health Authority intends to continue its’ hospital incentive metrics program and quality pool. This section describes the Hospital Transformation Performance Program (HTPP) funding and distribution methodology.

HTPP Funding

Unlike Delivery System Reform Incentive Payment (DSRIP) Programs, the HTPP is part of Oregon’s 1115 Demonstration. Rather than leveraging new funding mechanisms, the HTPP uses the existing Hospital Assessment Program that has been authorized in Oregon since 2004. HTPP spending is subjected to the total computable expenditures in the two percentage point reduction in the per capita growth rate of spending requirements (Oregon’s 2% test) under the 2012-2017, and 2017-2022 demonstration.

In the first two years of the HTPP, funding is equivalent to the federal match rate of the state dollars generated by one percent of the Assessment. In the third year, and all subsequent years, funding is equivalent to the federal match rate of the state dollars generated by half of one percent of the Assessment. The other half of the funding has been legislative re-directed to contribute directly to funding the CCOs to further align the roles that hospitals and CCOs must play collaboratively in transforming the delivery system in Oregon.

HTPP funds have been capped by CMS at no more than \$150 million per year and are therefore a small, but important proportion of those generated by Oregon’s historical Hospital Assessment Program. Oregon’s hospitals have historically qualified for increased Assessment related reimbursements prior to the HTPP. HTPP provides an important mechanism for OHA to hold hospitals accountable for transforming and improving quality in order to qualify for a portion of these dollars. It is one of OHA’s

²⁶ Additional details about the challenge pool calculation and distribution to date are available in the “reference instructions” online at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

most important levers in engaging hospitals in quality improvement, and long-term funding is assured by the pre-existing Hospital Assessment Program.

Quality Pool Distribution

Quality pool payment is based on hospital performance on metrics recommended by the Hospital Performance Metrics Advisory Committee. Each hospital must meet benchmarks or improvement targets to earn funds associated with each measure. The size of payments to individual hospitals will vary based on the amount of funds available from the Hospital Assessment Program, the measures achieved by an individual hospital, and hospital size.

All funds are distributed each year; there will be no carryover.

Years 1-3 Quality Pool Distribution

In the initial years of the program, quality pool distribution occurred in two phases. Phase 1 involves determining whether a hospital is eligible for a \$500,000 floor payment, by achieving at least 75 percent of the measures for areas in which it operates. For example, if a hospital does not have an emergency department, measures related to emergency departments will not be included in the calculation of whether the hospital has met 75 percent of the measures.²⁷ Phase 2 involves allocating the remaining funds to hospitals based upon performance on individual measures.

Phase 1 Distribution

The first step in distributing the hospital quality pool funds involves determining the number of instances in which a hospital has achieved a measure. Hospitals achieving at least 75 percent of the measures will be allocated a \$500,000 floor. Phase 1 allocation is pass/fail; hospitals cannot receive partial credit. Hospitals must achieve at least 75 percent of the measures to receive the floor payment. This impacts the amount remaining in the pool for Phase 2 allocation.

Example of Phase 1 floor allocation	
Total HTPP available funds	\$133.0 million
Available funds – floor for 28 hospitals (assuming all achieve at least 75% of the measures) (\$500,000 * 28)	\$14.0 million
Remaining to earn in Phase 2 allocation (payment per measure achieved) (Total – floor)	\$119.0 million

Phase 2 Distribution

The portion of Phase 2 quality pool funds that a hospital receives is based on the number of measures for which it submits data meeting OHA standards and for which it achieves an absolute benchmark or demonstrates improvement over its prior year performance. The benchmarks are the same for all hospitals, regardless of geographic region and patient mix.

²⁷ With the exception of the follow-up after hospitalization for mental illness measure, for which all hospitals are eligible regardless of whether they operate in this area. In instances where a hospital does not have an acute psychiatric ward, OHA uses an attribution methodology in which Coordinated Care Organization performance is attributed to the hospital to further hospital-CCO collaboration.

Hospital performance on these measures is treated on a pass/fail basis and all measures are independent from one another. If a hospital meets the benchmark or improvement target for a specific measure, it 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 benchmarks and targets, it will calculate the amount of funds each hospital will receive. The number of measures achieved by hospitals affects the ‘base amount’ that each measure is worth after the Phase 1 allocation.

The proportions in the table below will be applied to hospital quality pool funds remaining after Phase 1. 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 on the proportion of total Medicaid discharges and total Medicaid inpatient days at each hospital that achieved the target: 50 percent based on Medicaid discharges and 50 percent based on Medicaid inpatient days.

Domains	Measures	Share of Available Funds for Phase 2 Distribution (Years 1-3)
Readmissions	1. Hospital-wide all-cause readmission	18.75%
Medicaid Safety	2. Hypoglycemia in inpatients receiving insulin 3. Excessive anticoagulation with Warfarin 4. Adverse Drug Events due to opioids	6.25% 6.25% 6.25%
Patient Experience	5. HCAHPS: staff always explained medicines 6. HCAHPS: staff gave patient discharge info	9.38% 9.38%
Healthcare-Associated Infections	7. CLABSI in all tracked units 8. CAUTI in all tracked units	9.38% 9.38%
Sharing ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	12.50%
Behavioral Health	10. Follow-up after hospitalization for mental illness 11. Screening for alcohol and drug use, brief intervention, and referral to treatment (SBIRT) in the emergency department	6.25% 6.25%

Phase 2 Distribution Example for the Readmissions Measure

The table below provides an example of how the hospital quality pool distribution for the Readmissions measure worked in the initial years of the program in the following scenario:

- There are only three hospitals;
- The total available HTPP funding is \$150,000,000; and
- Two of the three hospitals achieved at least 75 percent of the measures (meaning these two hospitals are allocated the floor payment of \$500,000 each).

Example Total HTPP Funds available	\$150,000,000
Number of hospitals achieving 75 percent of measures (eligible for floor allocation)	2
Phase 1 amount (floor allocation: \$500,000*2)	\$1,00,000
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 Measure (Readmission example)									
Hosp	Achieved Measure?	Discharges		Days		Adjustment Factor (% discharges*0.5)+ (% days*0.5)		Amount earned for Measure (Total available for Measure * Adjustment Factor)	
		#	%	#	%				
A	Y	2,500	20%	8,000	21.05%	(20.0%*0.5)+ (21.05*0.5)=	0.21	\$27,937,500 *0.21=	\$5,866,875
B	Y	5,000	40%	10,000	26.23%	(40.0%*0.5)+ (26.32*0.5)=	0.33	\$27,937,500 *0.33=	\$9,219,375
C	Y	5,000	40%	20,000	52.63%	(40.0%*0.5)+ (52.63*0.5)=	0.46	\$27,937,500 *0.46=	\$12,851,250
Totals		12,500	100%	38,000	100%		1.00		\$27,937,500

Proposed Future Quality Pool Distribution

Beginning in the fourth year, OHA proposes modifying the HTPP payment method to a three-phased structure that includes a challenge pool (similar to the CCO quality pool methodology). This will further incentivize quality improvement efforts focused on a subset of the most transformative HTPP measures and domains.

Phase 1: Floor Payment

OHA would retain the floor payment from the initial years of the program. A hospital is eligible for a floor payment of \$500,000 by achieving at least 75 percent of the measures for which it is eligible. If a hospital does not achieve at least 75 percent of the measures, then its floor payment will be reallocated to the challenge pool.

Phase 2: Payment per Measure Achieved

Again, similar to the initial distribution, after the floor payments are allocated, the remaining funds will be allocated based on whether hospitals meet the benchmark or improvement targets on the measures. However, beginning in year four, funds not achieved by hospitals in Phase 2 will not be reallocated to the other hospitals or domains (as was done initially); instead, they will also be reallocated to the challenge pool.

The distribution formula will continue to be based on Medicaid discharges and Medicaid days, however, this will be rebased for CY 2015 or CY 2016, rather than the initial 12 months ending Sept 2012, which was used for the first three years of the program.

Phase 3: Challenge Pool

Any unclaimed funds from Phases 1 and 2 will be used for the challenge pool. The Committee will recommend a set (1-4) of the most transformative measures as the challenge pool measures. Additional measures outside of the core or menu set may also be considered for the challenge pool measures.

Hospitals achieving any of these measure will receive an additional incentive payment from the challenge pool funds.

Appendix D: Concept Paper on Increasing Use of Health-Related Services and Value-Based Payments

In 2012, under an amendment to its 1115 waiver, Oregon began the process of transforming its Medicaid delivery system by establishing Coordinated Care Organizations (CCOs), charging them with integrating and coordinating care and requiring them to meet key quality metrics, with financial incentives for achieving performance benchmarks. As contemplated by the waiver, CCOs receive a capitated or global payment for each member, which provides CCOs with the flexibility to offer health-related services, in addition to health services, to improve care delivery and member health. The waiver also established an annual sustainable growth rate target of 3.4% for aggregate health care costs. To date, Oregon has succeeded in meeting this growth rate target and efforts to “bend the cost curve” remain a top priority for the State.

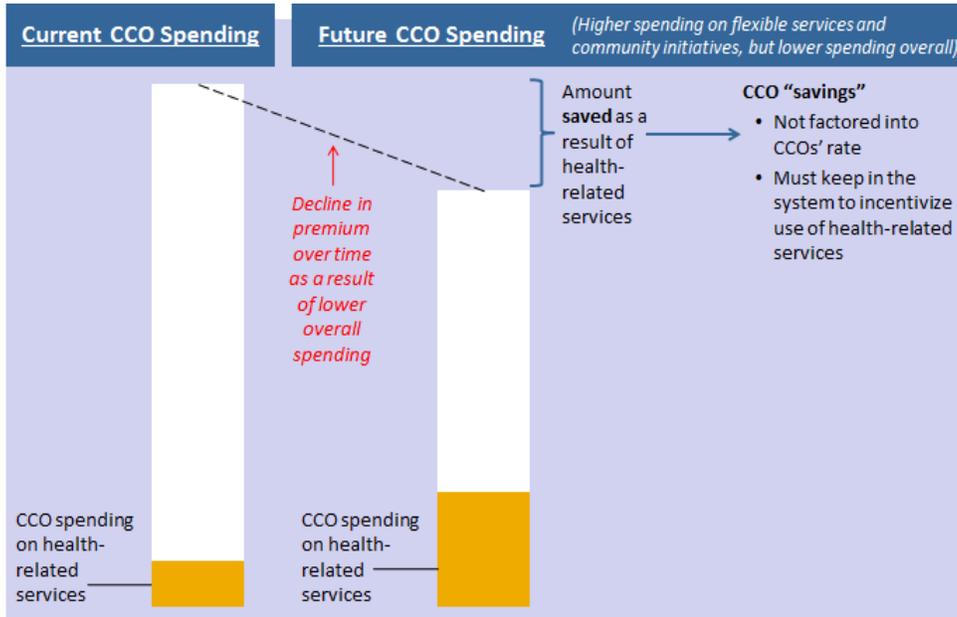
To continue meeting this growth rate target, Oregon has determined that additional actions are necessary to ensure that CCOs and the providers and community organizations with which they partner are positioned to drive the delivery of cost-effective, quality care and advance population health. Today, 16 CCOs provide services to more than one million Medicaid beneficiaries throughout the State. Some CCOs are using **flexible services** and **community benefit initiatives (CBIs)** to address member and community needs. Flexible services, specifically authorized through the waiver, are cost-effective services offered instead of or as an adjunct to covered benefits (e.g., home modifications and healthy cooking classes). CBIs are community-level—as opposed to member-specific—interventions, such as investments in provider capacity and care management capabilities. Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. Flexible services have generally been funded through Medicaid capitation dollars while CBIs have generally been grant-funded. For the purposes of this paper, flexible services and CBIs are collectively referred to as “**health-related services.**” Oregon seeks to increase the use of health-related services, which are essential to achieving the triple aim of better health, better care and lower costs—the core of the State’s transformation goals.

Oregon has identified several barriers to achieving greater use of health-related services. Under the waiver, the costs of these services¹ must be counted as administrative (not medical) expenses in building the premium rate paid to CCOs, thereby inflating the CCOs’ administrative expenses. In addition, when CCOs reimburse providers on a fee-for-service basis, there is no incentive—and no resources—to invest in health-related services. Moreover, as investment in cost-effective health-related services reduces utilization of state plan services (on which the capitated rate is based), CCO rates may decline over time. (This paper refers to this decline as “premium slide.” See Figure 1 on the following page.) As premium slide occurs, there is neither funding nor incentive for CCOs and providers to continue investing in these cost-effective health-related services. While the waiver contemplates the flow of incentives outside the premium rates, CMS restricts the amount of payments that can be made outside of the capitated rate to no more than five percent.² Oregon’s quality incentive program will reach this limit by the end of its current waiver period.

¹ CBIs are not referenced in the Waiver or the State’s contracts with CCOs.

² CMS requires that incentive payments and withhold amounts not exceed 5% of the certified rates to managed care plans; see 2016 Medicaid Managed Care Rate Development Guide, September 2015.

Figure 1. Depicting Premium Slide



As discussed below, Oregon seeks approval from CMS to amend its waiver and adjust its rate setting methodology to better support and incentivize the use of health-related services consistent with the intent of the waiver, the interest of CMS to promote value-based purchasing within managed care, and the need to assess the program’s risk through the lens of actuarial soundness. The State also seeks CMS approval to amend its contracts with CCOs to require investment in health-related services through, among other things, use of value-based payment arrangements that support *provider* use of these services. The following proposals, when implemented together, should enable the State to continue meeting its growth rate targets. Accordingly, the State requests CMS approval to do the following:

- 1) **Include the costs of health-related services in the base of CCOs’ capitated rate.** The waiver currently requires the State to include the costs of flexible services in the administrative expense portion of the capitated rate. Oregon seeks to amend its waiver and modify its rate setting methodology to categorize health-related services as “activities that improve health care quality” and include their costs in the base of the CCO capitation rate (*i.e.*, treat them like medical expenses for rate setting purposes). Treating these costs as medical expenses would align with how flexible services are captured in the State’s current medical loss ratio (MLR) calculation and would help prevent premium slide by capturing these costs as part of the base rate. Further, by categorizing health-related services as “activities that improve health care quality” while treating them as medical expenses, the State will be able to separately track the costs and effectiveness of these services.

It is the State’s understanding that, in order to include the costs of health-related services in the base of the rate, CMS and OACT will require evidence that these interventions are cost-effective.³

³ This understanding is based on conversations among Oregon Health Authority, its actuaries (Optumas), CMS and OACT.

Oregon also wants to ensure these are cost-effective investments. Accordingly, Oregon will amend its contracts with CCOs to require them to collect and report additional data on health-related services. For example, the State will require CCOs to: identify and report unmet needs or problems in their region as well as the health-related services utilized to address these needs or problems; assess the cost-effectiveness of these services; and report their data, methodology and findings to the State. Oregon will then conduct its own assessments to substantiate the CCOs' findings and submit the details of both assessments to CMS as part of its annual rate certification.⁴ The State will work with CCOs and other stakeholders to develop a process for determining cost-effectiveness of health-related services.

2) Implement a reinvestment requirement. Oregon will further amend its contracts to require CCOs to reinvest savings achieved through investment in health-related services. Such a reinvestment requirement may include:

- a) **A hard MLR standard** of 85%, where the State will recoup and share with CMS the difference between a CCO's MLR and 85% whenever the CCO's MLR falls below 85%; and
- b) **A target MLR standard** that is set and used for developing CCOs' capitation rates and is higher than the hard MLR standard. CCOs with MLRs *above* the hard MLR standard and *below* the target MLR standard may be eligible (depending on their performance on quality and cost measures) to retain some or all of the difference between their actual MLR and the target MLR, so long as the amount of the difference is reinvested in health-related services. For example, if the target MLR is set to 88% and a CCO's medical expenses (which include the costs of health-related services) totaled 86%, the CCO may be allowed to keep the 2% difference provided that it meets certain quality and cost outcomes *and* reinvests the amount of the difference in health-related services the following year.

Such a reinvestment requirement assures that a portion of the savings generated by health-related services to remain in the system (instead of being returned to the State) and be reinvested in members' care. Oregon will work with CMS, CCOs and other stakeholders to develop this reinvestment requirement.

3) Require CCOs to enter into value-based payment (VBP) arrangements with network providers. Oregon's waiver calls for CCOs to adopt alternative payment methodologies to "align CCOs and their providers with health system transformation objectives." However, the State's CCO contracts do not require CCOs to enter into a minimum percentage of VBP arrangements and at present, many CCO payments to providers are made through fee-for-services arrangements, which do not support provider investment in health-related services. Accordingly, Oregon will submit to CMS a VBP plan that describes how the State and CCOs will achieve a specific percentage of VBP payments by the end of the demonstration period. The plan will provide a definition of VBP that involves the sharing of risk (not just savings) and quality measures, describe how CCO contracts will be amended, and propose a schedule for phased-in implementation. The State will work with CCOs and providers to develop this VBP plan.

In addition, Oregon may also require CCOs to have policies in place that instruct VBP-contracted providers to report their medical spending and revenue and invest a portion of any surplus on health-related services. Currently, a number of CCOs have subcapitation arrangements with network providers (e.g., primary care provider groups or hospitals) in which the CCOs pass a

⁴ The State's goal would be to obtain information on the cost-effectiveness of health-related services in advance of including their costs in the rates.

percent of their premium payments from the State directly onto the providers and the providers become the risk-accepting entities for the CCOs' members. While these arrangements may constitute value-based purchasing, many of these risk-accepting entities perform a mix of medical and administrative services and the breakdown of their spending has historically not been reported to the State. Requiring this breakdown to be reported would help ensure that CCOs and their provider partners are both investing in health-related services to ensure efficient use of resources and address the social determinants of health.

4) Implement a CCO performance incentive program. To further incentivize CCOs to utilize health-related services, Oregon will enhance the rate setting methodology to prevent premium slide and compensate CCOs identified as high performing (e.g., CCOs showing quality improvement and cost reduction). Three approaches to such an incentive program are described below. These approaches would require the State to develop a mechanism for measuring CCO performance. None of the approaches would replace the existing risk factor adjustments. Oregon will leverage, to the maximum extent possible, the existing cost and quality metrics included in the waiver.

a) Margin augmentation: The State could develop rates with a profit margin range, such as 1% to 3%, as opposed to a fixed percentage of premium, which is used today. The margin percentage built into the rate would vary based on CCO-specific scoring within each rating region, where higher performing CCOs would receive higher percentages than lower performing CCOs for the following 12-month period.

b) Base a portion of CCOs' capitated rate on quality and cost measures: The State could set aside a portion of the capitated rate and allocate it to CCOs based on performance. For example, the State could assign scores to CCOs based on their performance in cost reduction and quality improvement; CCOs with high scores in *both* areas of measurement would be allocated more dollars than CCOs with lower scores.

c) Tiered Risk Corridor along with the hard MLR: The State could incorporate a tiered risk corridor along with the hard MLR requirement, resulting in higher performing CCOs being allowed to keep a higher percentage of surplus as opposed to lower performing CCOs that would be required to reinvest more of their surplus.

While the details of measuring CCO performance still need to be developed, the overall goal is to incorporate an approach, like the three described above, in the State's rate setting methodology in a manner consistent with all Actuarial Standards of Practice and CMS and OACT guidance.

Actions Needed to Implement These Concepts

To implement the proposals described above, Oregon plans to take the following actions:

- 1) **Amend the 1115 Waiver.** The State proposes to amend its waiver so that costs of health-related services are categorized as "activities that improve health care quality" and are included in the base of the CCO capitation rate. The State may also make technical and other adjustments to ensure that the policy programs contemplated in this paper are accurately reflected in the waiver.
- 2) **Amend its CCO contracts.** Oregon intends to amend its contracts with the CCOs to include the following:
 - a) Requirements related to the collection and reporting of information on the cost-effectiveness of health-related services;

- b) Information on the reinvestment requirement and MLR standard(s);
 - c) The requirement that a certain percentage of CCO payments to providers be made through VBPs (this will include a definition for VBP and a timeline for phasing in the requirement);
 - d) The potential requirement that CCOs have policies in place that instruct VBP-contracted providers to report their medical spending and revenue and invest a portion of any surplus on health-related services; and
 - e) Information on a CCO performance incentive program (i.e., a program involving margin augmentation or a CCO-specific set-aside or tiered risk corridor).
- 3) **Amend State rules to treat costs related to flexible services and community benefit initiatives as medical expenditures and to define community benefit initiatives.** Oregon intends to amend recently adopted State rules that define flexible services and prohibit them from being counted in the medical expenses portion of the capitated rate; the State will also include a definition for community benefit initiatives.
- 4) **Enhance the rate setting methodology.** Working with CMS and OACT, the Oregon Health Authority (OHA) and its actuaries will enhance the CY 2016 rate setting methodology to incorporate the features of the approach described above in the CY 2017 methodology. OHA will continue to evaluate the risk of the program through the lens of actuarial soundness, ensuring that the rate setting methodology is consistent with all applicable CMS and OACT guidelines and Actuarial Standards of Practice.

Public Notice and Engagement

In January, the State met with the CCOs and State legislators to discuss and obtain feedback on the concepts described in this paper. In addition, interviews were conducted over a two and a half-month period with representatives from nine CCOs across the State. In March, the State met with CMS and OACT to discuss the first draft of the concept paper. This version of the concept paper reflects the feedback received from the CCOs, CMS, OACT and other stakeholders during these various discussions.

Appendix E: Integrating Health Care Delivery for Individuals Eligible for Both Medicare and Medicaid

Background

Focus on reform - OHA made a difficult decision not to participate in the national financial alignment demonstration in 2012 due to concerns that it would not have suited Oregon's unique marketplace. An in-depth analysis indicated that the demonstration was not likely to be financially viable for Oregon's CCOs and their affiliated Medicare Advantage plans. Oregon chose instead to focus on delivery system reforms underway in CCOs paired with Medicare/Medicaid administrative alignments without the proposed financial component of the financial alignment demonstration.

CCO CMS Alignment Workgroup - OHA developed a CCO CMS Alignment Workgroup that reports to the CCO Advisory Workgroup. The alignment workgroup focuses on opportunities to pursue administrative alignments and problem-solve care coordination issues. This group has been meeting regularly since 2013. The workgroup is a forum for OHA and DHS to work with CCOs, and their affiliated Medicare plans, serving individuals dually eligible for Medicaid and Medicare to get input on policies and to resolve issues that arise related to providing services to dually eligible members. The workgroup is also a forum for carriers to work together to share information and resources related to operating health plans that serve dually eligible individuals. The workgroup focuses on topics that have a Medicaid link, or are specific to dually eligible individuals, and not on general Medicare issues. The meetings have focused on communication strategies, mechanisms to address care coordination and care transitions, building linkages with LTSS and Oregon's system of Aging and People with Disabilities programs, targeting outreach to minority and at-risk dual eligible populations, use of new Medicare billing codes to enhance preventive care for dual eligible beneficiaries, potential alignment for grievances and appeals, the integrated denial notice, and more.

The types of issues that are within the scope of this workgroup include:

- Issues relevant to serving dually eligible individuals, including the integration of Medicare and Medicaid benefits, and the coordination with external services such as DHS long term care services for aged and physically disabled individuals; services for individuals with intellectual or developmental disabilities; and mental health services not included in the CCO.
- Issues relevant to Medicare/Medicaid plans, including issues specific to Special Needs Plans (SNPs) and other areas of Medicare/Medicaid regulatory alignment and oversight.

OHA and DMAP held bi-weekly meetings from 2013-2015 to address issues related to dual eligibles and to problem solve challenges from the field for beneficiaries. In addition, they also developed a plan to address the identified issues using targeted approaches for systemic vs. onetime concerns. Additional meetings were held to bring in expertise with SHIBA and MMA Staff working on Part D and LIS issues, and joint presentations were provided around enhanced understanding of dual eligible systems and statewide issues.

Technical assistance - Recent implementation of our new ONE system in OHA included training for DHS staff on the new system and ability for use to enhance ability to provide supports to dual eligibles. OHA has made technical assistance available to CCOs for duals issues and developed the Duals Technical

Assistance Tool to support a review of communication, population health management, health equity, care coordination, care transitions and administrative policies and supports.

Oregon held a complex care collaborative event in September 2015 (“Engaging Beneficiaries with Medicaid and Medicare and Long-Term Services and Supports: Strategic Approaches and Partnerships”) and is planning another event (“Care Coordination to Improve Health for High Need Members Across the Lifespan: Aging and Disability”) for September 2016. These events serve as an opportunity to focus on improving health outcomes for OHP members with dual eligibility and complex care needs, support the spread of innovative complex care models and successes throughout Oregon, and promote information sharing and networking.

CCO progress to date - As reported by CCOs regarding their affiliated plans in November 2015, the majority of Oregon’s affiliated MA plans are aligning the following with their CCO for dual eligible members: care coordination planning across plans, care transitions planning across plans, sharing health risk assessment/client risk identification across plans. Plans that are the same parent company as the CCO are also integrating claims processing, provider network information to members, and in some cases providing one single ID card. Oregon has two CCOs that have no specific MA affiliation in place and do not report work toward coordinating care for duals members with MA plans.

Oregon added new care coordination elements and reporting requirements to DSNP MIPPA contracts for 2016 and 2017. OHA has been working closely with Oregon’s current DSNP plans on which metrics will be reported by each plan and used to develop an Oregon statewide DSNP report beginning in 2017.

Evaluation - Oregon began a project in 2015 to bring APAC data and Medicaid data together to inform a statewide evaluation of duals in coordinated care. We have engaged the OHSU Center for Healthcare Effectiveness with us in that work. Oregon joined the CMS BCN IAP to assist us with the project and recently added a super-utilizer analysis to the project. We anticipate having better data integration to allow us to take a deeper dive into duals work and help inform legislative and policy initiatives going forward.

Pre-Implementation Outreach - Proposed Dual Eligibles Outreach Project: May through September 2016 - The Oregon Health Authority (OHA) is interested in increasing the amount of Dual Eligible Medicare/Medicaid beneficiaries enrolled in Coordinated Care Organizations (CCOs) rather than Fee for Service (FFS). Working with contracted community assistors, OHA will conduct targeted outreach to FFS Duals Eligible Beneficiaries, approximately 26-27k. OHA will develop letters, flyers and talking points using information gathered from previously conducted dual eligible focus groups as well communication messages from other states working to enhance dual communications on coordinated / integrated care. Messages will inform members about coordinated care and the added benefit for the member.

Letters will go to members in their identified primary language and a selection form and postage-paid return address envelop will be included in each letter. Mailings will be staggered over the project period of May – September so that outreach can be staggered.

Follow-up calls will be conducted to answer questions and provide enrollment assistance. If members aren’t reached on the first attempt, outreach will be scheduled for a different day or another time in which the member can be reached.

Processes for ensuring smooth and efficient enrollment for those choosing to enroll in a CCO will be developed. Where possible, community connections will be used to help identify or locate any members for whose mail is returned or invalid phone numbers, i.e. such as outreach to community organizations serving vulnerable seniors or homeless populations.

Appendix F: Federal authority to continue and enhance Oregon’s Health Care Transformation

July 2017-June 2022

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	Potential State Plan action
Requested new Waiver and Expenditure (CNOM) authorities or changes to existing authorities					
Value based payment methodologies	Ability to: <ul style="list-style-type: none"> Require a specific percentage of CCO payments to network providers to be made through value-based payment (VBP) arrangements. Implement a CCO performance incentive program 	42 CFR § 438.6	Value-based payment authority in place, but lack authority to require CCOs to meet a standard.	Waiver authority, as follows: <i>Waiver of 42 CFR § 438.6, to the extent necessary, to allow the state to require a specific percentage of CCO payments to network providers to be made through value-based payment (VBP) arrangements.</i>	NA
Global budget <ul style="list-style-type: none"> Flexible, health-related services and Risk arrangements 	<ul style="list-style-type: none"> CCOs are expected to have comprehensive risk contracts. State is considering potential options for risk-sharing arrangements. 	42 CFR § 434.20 and 21–basic HMO and PHP rules and contract requirements SSA § 1902(a)(30): Payments must be consistent with efficiency, economy, and quality of care. 42 CFR § 438.6(b)–comprehensive risk contracts	<ul style="list-style-type: none"> CCOs are expected to have comprehensive risk contracts. Flexible services are included as administrative costs to CCOs. 	Waiver authority, as follows: <i>Waiver of federal statute and regulation under SSA § 1902(a)(30); 42 CFR § 434.20, 42 CFR § 438.6(c) and 42 CFR § 438.6(b) to the extent necessary, in order to include flexible, in-lieu of, services as reimbursable at the medical services payment rate rather than as administrative costs.</i>	NA
Global budget <ul style="list-style-type: none"> Financial solvency, including reinvestments 	<ul style="list-style-type: none"> Financial solvency requirements– State is considering brokering re-insurance or stop-loss insurance. 	42 C.F.R. § 434.50–protection against insolvency 42 CFR § 438.116–solvency standards	<ul style="list-style-type: none"> CCOs are expected to meet state financial solvency requirements Reinvestment of savings not required 	Waiver authority, as follows: <i>Waiver of federal statute and regulation under 42 C.F.R. § 434.50 and 42 CFR § 438.116, to the extent necessary, to allow the state to require CCOs to reinvest a portion of savings achieved through investment in health-related services.</i>	NA

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	Potential State Plan action
Hospital Transformation Performance Program (HTPP)	Extension of CNOM authority through June 2020	SSA § 1115(a) - Costs not otherwise matchable	HTPP is approved and in place, but due to expire prior to the end of this waiver renewal. If maintained, we seek authority to continue through June 2022 at the same level of expenditure	Amendment to current CNOM authority, as follows: <i>Expenditures - Hospital Transformation Performance Program (HTPP): Beginning July 1, 2017, through June 30, 2022, 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.</i>	NA
Tribal Uncompensated Care Program	Authority to: Extend the Tribal Uncompensated Care Program (UCCP) to extend payments to Tribal providers for certain services previously not funded under the OHP. The Uncompensated Care Program was established to broaden the numbers of services that can be reimbursed by Medicaid funds, thereby allowing other health care funding streams to be used toward the goal of eliminating health disparities in this population.	SSA § 1115(a) - Costs not otherwise matchable	HTPP is approved and in place. The state wishes to continue the program in the renewal	Amendment to current CNOM authority, as follows: <i>To extend the uncompensated care program through the 2017-2022 renewal period</i>	NA
Care Coordination for individuals residing in institutions for mental diseases (IMDs)	Authority to: <ul style="list-style-type: none"> Provide or ensure provision of case management/care coordination services to residents of IMDs to ensure a smooth medical care transition to housing in the 	42 CFR §438.3(e), 42 CFR § 435.1009 and 42 CFR § 435.1010 - Regulations pertaining to providing Medicaid benefits to incarcerated individuals and	NA	Waiver and CNOM authority, as follows: <i>Waiver of federal regulation to the extent necessary, and to authorize federal financial</i>	NA

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	Potential State Plan action
	<p>community.</p> <ul style="list-style-type: none"> Apply the program to those with IMD stays that do not qualify as short-term 	<p>prohibiting FFP</p> <p>42 CFR §438.3(e) – new managed care regulations at 42 CFR §438.3(e) rule provides that states may make a capitation payment for enrollees with a short-term stay in an Institution for Mental Disease to address access concerns for inpatient psychiatric and substance use disorder services.</p>		<p><i>participation for the state to serve individuals residing in institutions for mental diseases (IMDs) with case management/ care coordination services during the final 30 days prior to discharge from the institution.</i></p> <p>Expenditures for costs of measures necessary to ensure case management/care coordination to the population.</p>	
<p>Care Coordination for pre-adjudicated incarcerated individuals in local or regional correctional facilities (not state penitentiaries) for up to 30 days of the initial incarceration period</p>	<p>Authority to:</p> <ul style="list-style-type: none"> Provide or ensure provision of case management/care coordination services to pre-adjudicated inmates of local or regional correctional facilities in order to ensure continuity of care while the individual is incarcerated. Medical services outside case management/care coordination would not be provided. 	<p>42 CFR § 435.1009 and 42 CFR § 435.1010</p> <p>Regulations pertaining to providing Medicaid benefits to incarcerated individuals</p> <p>SSA § 1115(a) - Costs not otherwise matchable</p>	<p>NA</p>	<p>Waiver and CNOM authority, as follows:</p> <p><i>Waiver of federal regulation to the extent necessary, and to authorize federal financial participation for the state to serve pre-adjudicated incarcerated individuals with case management/care coordination services for up to 30 days of the initial incarceration.</i></p> <p>Expenditures for costs of measures necessary to ensure case management/care coordination to the population.</p>	<p>NA</p>
<p>Social Determinants of Health - Supportive Housing Grants for Coordinated Health Partnerships</p>	<p>Authority to:</p> <ul style="list-style-type: none"> Allow the state to pay for rent for transitional housing for up to 30 days for patients leaving an acute care setting who require health care services. 	<p>SSA - § 1905(a)</p>	<p>NA</p>	<p>Waiver and CNOM authority, as follows:</p> <p><i>Waiver to allow limited rental assistance</i></p>	<p>NA</p>

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	Potential State Plan action
	<ul style="list-style-type: none"> • Provide one-time grants to local entities to: <ul style="list-style-type: none"> ○ Engage in homelessness prevention for a targeted population of Medicaid-eligible and enrolled high-risk individuals ○ Support care coordination and other services not available through other authorities to eligible individuals ○ Support transitional services from inappropriate non-institutional settings to more appropriate community setting ○ Expand Health Information Technology (HIT) opportunities to new providers 	SSA § 1115(a) - Costs not otherwise matchable		<p><i>Expenditures for costs of grants to foster collaboration and coordination among CCOs, hospitals, community-based organizations, Tribes, Indian health entities, housing authorities, county and city agencies and public health agencies to assist eligible individuals with specific supportive housing services for which federal financial participation is not otherwise provided.</i></p> <p><i>Such investments serve to ensure housing security and avoid negative health impacts of homelessness or inappropriate housing for identified at-risk Medicaid and CHIP-eligible populations.</i></p>	
Psychiatric telephonic consultation line pilot for adults and older adults	Federal financial participation (FFP) for Psychiatric telephonic consultation line pilot for adults and older adults to address Oregon’s limited access to prescribing psychiatric clinicians.	SSA § 1905(a)	OPAL-K in place for kids with state GF. State wishes to expand to adults with federal participation.	<p>CNOM authority, as follows:</p> <p><i>Expenditures for a real time, psychiatric, telephonic consultation program to help address the significant shortage of prescribing psychiatric physicians in Oregon.</i></p>	State Plan amendments as appropriate
Allow Doulas to provide services within the doula’s scope of practice without supervision of an existing licensed medical provider	Ability to provide payments to doulas as certified, but unlicensed, providers under the OHP	1905(a)(6); 42 CFR 440.60	Doulas are among certified traditional health workers, who must be under the supervision of a licensed practitioner to be eligible for payment.	<p>Waiver authority as follows:</p> <p><i>Waiver of federal regulation to the extent necessary to ensure doulas are able to practice and be reimbursed independent of supervisory regulations.</i></p>	NA

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	Potential State Plan action
Eligibility/enrollment <ul style="list-style-type: none"> • Mandatory • Auto • Choice of plan • Lock-in 	Change to allow dually eligible individuals to disenroll from CCOs without cause at any time	42 CFR § 431.51–freedom of choice 42 § 438.52–choice of plan 42 CFR § 438.50(f)(2)–equitable distribution of enrollees 42 CFR §438.6–contract requirements 42 CFR §438.10–required information, including available providers	State has a <i>waiver in place (of 42 CFR 431.51)</i> to allow mandatory managed care enrollment, auto-enrollment without choice of plan, and lock-in for Medicaid-eligible populations, including for those dually eligible for Medicaid and Medicare. State will continue to provide choice among providers in plan.	Amendment to description of current Waiver authority, as follows: <i>Add to the current waiver under 42 CFR 438.56(c) the authority to allow Dual Eligible individuals to disenroll from CCOs without cause at any time</i>	NA
Selected state designated health programs (DSHP)	Ability to receive federal financial participation (FFP) for certain state-funded health care programs	SSA § 1115(a)	Approved and in place with a sunset of June 30, 2017.	CNOM authority, as follows: <i>Expenditures for 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.</i>	NA
Facilitate Care Coordination and Care Coordination resources and access for American Indians and Alaska Natives (AI/AN), including primary care case management PCCM.	Ability to work with tribes, urban Indian populations and tribal health entities to ensure efficient and effective care coordination services for AI/AN individuals in Oregon Ability to require CCOs to contract with Indian Health Service (HIS), tribal and urban Indian health entities (I/T/Us)	SSA § 1905(a) § 1902(a)(1) 42 CFR 431.50	NA	STC s only – requiring state collaboration with AI/AN population and health entities, and delivery system changes, as necessary, including re-establishment of PCCM program for Tribes, and requirement for CCOs to contract with AI/AN entities	Add PCCM to current Delivery System

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	Potential State Plan action
Expand Nurse Home Visiting services	Ability to improve access to early intervention services that can improve health outcomes and social-emotional well-being for at-risk families and children, ranging from prenatal support to age five.	SSA § 1905(a)	NA	NA	<p><i>Using a State Plan Amendment, expand the use of Targeted Case Management codes that allow for nurse home-visiting programs (including those focused on social services, care coordination, and wraparound services) to directly bill Medicaid for a defined set of services.</i></p> <p><i>This change would allow CCOs to help categorize family supportive services as “health-related” services and be eligible for reimbursement. Billable codes would also allow for gathering of sufficient data and metrics that can be used to track process measures related to nurse home-visiting services across CCOs.</i></p>
Increase access to Targeted Case Management services	Ability to extend Targeted Case Management services to CCO members	SSA § 1905(a)			<p><i>Retain existing Targeted Case Management (TCM) programs as State Plan benefits, offered through county public health programs and available to CCO members upon referral.</i></p>

Citations from the Code of Federal Regulations (CFR) and the Social Security Act

References to 42 CFR § 438	Other CFR references	Social Security Act references
<ul style="list-style-type: none"> • 42 CFR § 438.2–Definitions • 42 CFR § 438.6– Contract requirements; actuarial soundness; entities eligible for comprehensive risk contracts; certification of MCO data for rate setting; services not covered under state plan • 42 CFR §438.10–Required information, including available providers • 42 CFR § 438.12 Provider discrimination prohibited • 42 CFR § 438.50(f)(2)–Equitable distribution of enrollees • 42 § 438.104–Marketing activities • 42 CFR § 438.116–Solvency standards • 42 CFR §§ 438.204–Elements of state quality strategies • 42 CFR § 438.206 – Availability of services and credentialed providers; responsibilities of health care professionals • 42 CFR § 438.207–Assurances of adequate capacity • 42 CFR § 438.208–Coordination/ continuity of care • 42 CFR § 438.209–Direct access to specialists • 42 CFR § 438.210–Coverage and authorization; communications with clients; EQRO requirements • 42 CFR § 438.240 (a)(2)–PIP topics • 42 CFR §§ 438.608 and 610–program integrity • 42 CFR § 438.228–Grievance systems • 42 CFR § 438.240–Quality assessment and program performance improvement • 42 CFR § 438.416–Managed care reporting requirements • 42 CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708–Member communications 	<ul style="list-style-type: none"> • 42 C.F.R. § 430– Grants to states for Medical Assistance programs • 42 CFR § 431.51–Freedom of choice; funds from units of government • 42 CFR § 434.20 and 21–Basic HMO and PHP rules and contract requirements • 42 C.F.R. § 434.50–Protection against insolvency • 42 CFR § 417.479(i)–Physician incentive requirements (422.208-Medicare) • 42 CFR §422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230–Communications • 42 CFR § 431.53 	<ul style="list-style-type: none"> • SSA § 1902(a)(10)(A)–Services required • SSA § 1902(a)(10)(B)–Amount, duration and scope • SSA § 1902(bb)–Payments to FQHCs/RHCs • SSA § 1905(a)–Services eligible for reimbursement • SSA § 1115(a)–costs not otherwise matchable (CNOM) authorities • SSA § 1915(b)

Budget Neutrality Summary
OHP Section 1115 Demonstration
Summary In Total Funds

<u>Calendar Year</u>	<u>Neutrality Ceiling</u>	<u>Actual/Projected Expenditures</u>	<u>Surplus/Deficit</u>
Original Waiver Period			
1994 Actual	\$ 390,951,750	\$ 346,190,634	\$ 44,761,116
1995 Actual	\$ 818,988,036	\$ 827,254,935	\$ (8,266,899)
1996 Actual	\$ 892,465,451	\$ 885,011,152	\$ 7,454,299
1997 Actual	\$ 1,040,624,108	\$ 895,762,310	\$ 144,861,798
1998 Actual	\$ 1,224,165,720	\$ 1,051,592,807	\$ 172,572,913
Jan-99	\$ 112,450,962	\$ 95,260,442	\$ 17,190,520
Total Original Waiver	\$ 4,479,646,027	\$ 4,101,072,280	\$ 378,573,747
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)	\$ 1,236,961,227	\$ 1,071,151,312	\$ 165,809,915
2000 Actual	\$ 1,448,108,685	\$ 1,275,376,104	\$ 172,732,581
2001 Projection (1)	\$ 1,602,109,256	\$ 1,398,528,881	\$ 203,580,375
Jan-02	\$ 152,138,992	\$ 132,715,597	\$ 19,423,395
Total First Waiver Extension	\$ 4,439,318,160	\$ 3,877,771,894	\$ 561,546,266
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)	\$ 1,253,756,577	\$ 1,051,310,479	\$ 202,446,098
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)	\$ 1,987,913,110	\$ 1,542,201,604	\$ 445,711,506
DY 2 (FFY 04 Actual)	\$ 2,093,044,450	\$ 1,494,082,316	\$ 598,962,134
DY 3 (FFY 05 Actual)	\$ 2,278,562,238	\$ 1,733,929,530	\$ 544,632,708
DY 4 (FFY 06 Actual)	\$ 2,454,368,136	\$ 1,558,038,076	\$ 896,330,060
DY 5 (FFY 07 Actual)	\$ 2,588,680,697	\$ 1,488,456,119	\$ 1,100,224,578
Total Second Waiver	\$ 11,402,568,631	\$ 7,816,707,645	\$ 3,585,860,986
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)	\$ 3,047,303,332	\$ 1,980,350,291	\$ 1,066,953,041
DY 7 (FFY 09 Actual)	\$ 3,210,937,225	\$ 1,857,765,840	\$ 1,353,171,385
DY 8 (FFY 10 Actual)	\$ 3,882,351,591	\$ 2,275,008,353	\$ 1,607,343,238
DY 9 (FFY 11 Actual)	\$ 4,521,446,161	\$ 2,847,833,594	\$ 1,673,612,567
DY 10 (FFY 12 Actual)	\$ 3,717,258,708	\$ 2,034,387,873	\$ 1,682,870,835
Total OHP2 Waiver Extension	\$ 18,379,297,017	\$ 10,995,345,951	\$ 7,383,951,066
OHP2 Waiver Extension			
DY 11 (SFY 13 Actual)	\$ 5,489,605,375	\$ 3,035,739,903	\$ 2,453,865,472
DY 12 (SFY 14 Actual)	\$ 6,169,664,585	\$ 4,572,687,190	\$ 1,596,977,395
DY 13 (SFY 15 Actual)	\$ 10,258,848,642	\$ 6,024,979,658	\$ 4,233,868,984
DY 14 (SFY 16 Actual/Projection)	\$ 11,134,048,316	\$ 6,578,825,705	\$ 4,555,222,611
DY 15 (SFY 17 Projection)	\$ 11,324,289,719	\$ 6,563,632,982	\$ 4,760,656,737
Total Waiver Extension	\$ 44,376,456,637	\$ 26,775,865,438	\$ 17,600,591,199
OHP Waiver Renewal			
DY 16 (SFY 18 Projection)	\$ 11,805,785,434	\$ 6,827,114,449	\$ 4,978,670,985
DY 17 (SFY 19 Projection)	\$ 12,441,523,499	\$ 7,038,290,715	\$ 5,403,232,784
DY 18 (SFY 20 Projection)	\$ 13,233,748,982	\$ 7,342,548,481	\$ 5,891,200,501
DY 19 (SFY 21 Projection)	\$ 14,078,410,420	\$ 7,660,930,957	\$ 6,417,479,463
DY 20 (SFY 22 Projection)	\$ 14,979,145,600	\$ 7,994,022,481	\$ 6,985,123,119
Total Waiver Renewal Request	\$ 66,538,613,935	\$ 36,862,907,083	\$ 29,675,706,852
Cumulative Total	\$ 150,869,656,984	\$ 91,480,980,770	\$ 59,388,676,214

Budget Neutrality

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
EXPENDITURE LIMIT (CEILING)										
MEMBER MONTHS										
Base Member Mos										
AFDC (Parent, Caretaker, Relative)	2,253,369	2,253,883	775,343	736,838	652,414	738,719	721,748	730,409	739,174	748,044
PWO	157,919	182,746	258,696	207,435	167,382	160,916	162,728	164,681	166,657	168,657
CMO (Children's Medicaid Program)	1,803,966	1,984,180	4,167,270	4,196,755	4,116,925	4,077,516	4,077,516	4,126,446	4,175,963	4,226,075
Old Age Assistance	422,934	438,634	466,345	492,289	515,502	535,687	556,843	563,525	570,287	577,130
Aid to Blind/Disabled	982,751	1,009,099	991,201	975,434	981,879	999,290	1,010,421	1,022,546	1,034,817	1,047,235
Foster Care & SAC	227,611	224,620	228,623	238,472	236,863	235,089	236,150	238,984	241,852	244,754
New ACA Adults	-	1,748,385	4,810,790	5,353,971	4,769,101	4,512,264	4,484,962	4,538,782	4,593,247	4,648,366
BCCP	9,968	10,886	7,707	4,673	3,285	3,144	2,685	2,717	2,750	2,783
Total Base	5,858,518	7,852,433	11,705,975	12,205,867	11,443,351	11,262,625	11,253,053	11,388,090	11,524,747	11,663,044
Expansion Member Mos										
General Assistance										
Parents	256,428	126,456								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	7,618	2,955								
FHIAP - Non-Medicaid										
Total Expansion	264,046	129,411								
Total Member Months	6,122,564	7,981,844	11,705,975	12,205,867	11,443,351	11,262,625	11,253,053	11,388,090	11,524,747	11,663,044
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)										
Base Populations PMPM										
AFDC (Parent, Caretaker, Relative)	\$ 504.08	\$ 529.80	\$ 553.83	\$ 578.95	\$ 605.22	\$ 632.45	\$ 660.91	\$ 690.65	\$ 721.73	\$ 754.21
PWO	\$ 1,917.16	\$ 2,018.86	\$ 2,117.88	\$ 2,221.76	\$ 2,330.74	\$ 2,444.95	\$ 2,564.75	\$ 2,690.42	\$ 2,822.25	\$ 2,960.54
CMO (Children's Medicaid Program)	\$ 734.70	\$ 768.80	\$ 798.32	\$ 828.98	\$ 860.81	\$ 893.52	\$ 927.47	\$ 962.71	\$ 999.29	\$ 1,037.26
Old Age Assistance	\$ 658.53	\$ 721.39	\$ 786.23	\$ 855.19	\$ 928.47	\$ 966.54	\$ 1,006.17	\$ 1,047.42	\$ 1,090.36	\$ 1,135.06
Aid to Blind/Disabled	\$ 2,179.61	\$ 2,419.85	\$ 2,673.57	\$ 2,946.88	\$ 3,241.11	\$ 3,406.41	\$ 3,580.14	\$ 3,762.73	\$ 3,954.63	\$ 4,156.32
Foster Care & SAC	\$ 887.03	\$ 934.56	\$ 977.06	\$ 1,021.43	\$ 1,067.77	\$ 1,108.35	\$ 1,150.47	\$ 1,194.19	\$ 1,239.57	\$ 1,286.67
New ACA Adults	\$	\$ 522.00	\$ 559.88	\$ 600.50	\$ 644.07	\$ 689.15	\$ 737.39	\$ 789.01	\$ 844.24	\$ 903.34
BCCP	\$	\$ 2,631.69	\$ 2,750.12	\$ 2,873.87	\$ 3,003.20	\$ 3,138.34	\$ 3,279.57	\$ 3,427.15	\$ 3,581.37	\$ 3,742.53
Expansion Population PMPM										
General Assistance										
Parents	\$ 391.86	\$ 658.53								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	\$ 352.72	\$ 352.72								
FHIAP - Non-Medicaid										

Oregon
population
growth estimate
inflation rate for
SFY20-SFY22
1.2%

Current allowable
PMPM trend rates
4.5%
4.9%
3.8%
4.1%
5.1%
3.8%
7.0%
4.5%

Budget Neutrality

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
TOTAL EXPENDITURES LIMIT										
Base Populations Expenditures										
AFDC (Parent, Caretaker, Relative)	\$ 1,135,878,246	\$ 1,194,107,213	\$ 429,408,215	\$ 426,592,360	\$ 394,854,001	\$ 467,202,832	\$ 477,010,471	\$ 504,456,976	\$ 533,484,051	\$ 564,182,265
PWO	\$ 302,755,989	\$ 368,938,590	\$ 547,887,084	\$ 460,870,786	\$ 390,123,923	\$ 393,431,574	\$ 417,356,638	\$ 443,061,056	\$ 470,347,718	\$ 499,315,795
CMO (Children's Medicaid Program)	\$ 1,325,373,822	\$ 1,525,437,584	\$ 3,326,814,986	\$ 3,479,025,960	\$ 3,543,890,209	\$ 3,643,342,096	\$ 3,781,773,765	\$ 3,972,570,829	\$ 4,172,998,066	\$ 4,383,538,555
Old Age Assistance	\$ 278,514,726	\$ 316,426,181	\$ 366,654,430	\$ 421,000,630	\$ 478,628,142	\$ 517,762,913	\$ 560,278,721	\$ 590,247,356	\$ 621,818,133	\$ 655,077,178
Aid to Blind/Disabled	\$ 2,142,013,908	\$ 2,441,868,215	\$ 2,650,045,257	\$ 2,874,486,946	\$ 3,182,377,846	\$ 3,403,991,449	\$ 3,617,448,639	\$ 3,847,564,511	\$ 4,092,318,353	\$ 4,352,643,775
Foster Care & SAC	\$ 201,897,787	\$ 209,920,867	\$ 223,378,389	\$ 243,582,455	\$ 252,915,206	\$ 260,560,893	\$ 271,683,491	\$ 285,392,303	\$ 299,792,484	\$ 314,917,629
New ACA Adults			\$ 2,693,465,107	\$ 3,215,059,586	\$ 3,071,634,881	\$ 3,109,626,736	\$ 3,307,166,129	\$ 3,581,144,386	\$ 3,877,802,847	\$ 4,199,054,942
BCCP		\$ 28,648,577	\$ 21,195,174	\$ 13,429,595	\$ 9,865,512	\$ 9,866,941	\$ 8,805,645	\$ 9,311,567	\$ 9,848,768	\$ 10,415,461
Total Base	\$ 5,386,434,478	\$ 6,085,347,228	\$ 10,258,848,642	\$ 11,134,048,316	\$ 11,324,289,719	\$ 11,805,785,434	\$ 12,441,523,499	\$ 13,233,748,982	\$ 14,078,410,420	\$ 14,979,145,600
Expansion Population Expenditures										
General Assistance										
Parents	\$ 100,483,876	\$ 83,275,070								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	\$ 2,687,021	\$ 1,042,288								
FHIAP - Non-Medicaid										
Total Expansion	\$ 103,170,897	\$ 84,317,357	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Non-Allowable Expansion Population Expenditures										
General Assistance										
Adults/Couples										
FHIAP - Existing										
FHIAP - Non-Medicaid										
Total Non-Allowable Expansion	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Annual Expenditure Limit	\$ 5,489,605,375	\$ 6,169,664,585	\$ 10,258,848,642	\$ 11,134,048,316	\$ 11,324,289,719	\$ 11,805,785,434	\$ 12,441,523,499	\$ 13,233,748,982	\$ 14,078,410,420	\$ 14,979,145,600
Cumulative Expenditure Limit	\$ 45,444,191,787	\$ 51,613,856,371	\$ 61,872,705,013	\$ 73,006,753,329	\$ 84,331,043,048	\$ 96,136,828,482	\$ 108,578,351,981	\$ 121,812,100,963	\$ 135,890,511,383	\$ 150,869,656,983

Budget Neutrality

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
ACTUAL & PROJECTED EXPENDITURES (WITH WAIVER)										
MEMBER MONTHS										
Base Populations Member Months										
AFDC (Parent, Caretaker, Relative)	2,253,369	2,253,883	775,343	736,838	652,414	738,719	721,748	730,409	739,174	748,044
PWO	157,919	182,746	258,696	207,435	167,382	160,916	162,728	164,681	166,657	168,657
CMO (Children's Medicaid Program)	1,803,966	1,984,180	4,167,270	4,196,755	4,116,925	4,077,516	4,077,516	4,126,446	4,175,963	4,226,075
Old Age Assistance	422,934	438,634	466,345	492,289	515,502	535,687	556,843	563,525	570,287	577,130
Aid to Blind/Disabled	982,751	1,009,099	991,201	975,434	981,879	999,290	1,010,421	1,022,546	1,034,817	1,047,235
Foster Care & SAC	227,611	224,620	228,623	238,472	236,863	235,089	236,150	238,984	241,852	244,754
New ACA Adults	-	1,748,385	4,810,790	5,353,971	4,769,101	4,512,264	4,484,962	4,538,782	4,593,247	4,648,366
BCCP	9,968	10,886	7,707	4,673	3,285	3,144	2,685	2,717	2,750	2,783
Total Base	5,858,518	7,852,433	11,705,975	12,205,867	11,443,351	11,262,625	11,253,053	11,388,090	11,524,747	11,663,044
Expansion Member Months										
General Assistance										
Parents	256,428	126,456								
Adults/Couples										
FHIAP - Existing										
FHIAP - Medicaid	7,618	2,955								
FHIAP - Non-Medicaid										
Total Expansion	264,046	129,411	-	-	-	-	-	-	-	-
Non-Allowable Expansion Population Member Months										
General Assistance										
Adults/Couples	532,651	244,489								
FHIAP - Existing	2,477	972								
FHIAP - Non-Medicaid	44,588	17,134								
Total Non-Allowable Expansion	579,716	262,595	-	-	-	-	-	-	-	-
Total Member Months	6,702,280	8,244,439	11,705,975	12,205,867	11,443,351	11,262,625	11,253,053	11,388,090	11,524,747	11,663,044
PER MEMBER PER MONTH COSTS (PMPM)										
Base Population PMPM										
AFDC (Parent, Caretaker, Relative)	\$ 295.27	\$ 316.81	\$ 520.15	\$ 535.31	\$ 582.81	\$ 602.63	\$ 623.12	\$ 644.31	\$ 666.22	\$ 688.87
PWO	\$ 1,174.82	\$ 1,056.49	\$ 977.26	\$ 1,203.37	\$ 1,399.13	\$ 1,446.70	\$ 1,495.89	\$ 1,546.75	\$ 1,599.34	\$ 1,653.72
CMO (Children's Medicaid Program)	\$ 204.21	\$ 223.51	\$ 214.42	\$ 233.81	\$ 239.38	\$ 247.52	\$ 255.94	\$ 264.64	\$ 273.64	\$ 282.94
Old Age Assistance	\$ 232.31	\$ 305.23	\$ 316.04	\$ 358.88	\$ 350.76	\$ 362.69	\$ 375.02	\$ 387.77	\$ 400.95	\$ 414.58
Aid to Blind/Disabled	\$ 984.34	\$ 1,099.88	\$ 1,049.16	\$ 1,174.02	\$ 1,215.36	\$ 1,256.68	\$ 1,299.41	\$ 1,343.59	\$ 1,389.27	\$ 1,436.51
Foster Care & SAC	\$ 491.68	\$ 605.19	\$ 634.80	\$ 644.52	\$ 676.76	\$ 699.77	\$ 723.56	\$ 748.16	\$ 773.60	\$ 799.90
New ACA Adults	\$ -	\$ 580.69	\$ 569.47	\$ 580.82	\$ 647.48	\$ 669.49	\$ 692.25	\$ 715.79	\$ 740.13	\$ 765.29
BCCP	\$ 3,066.43	\$ 2,958.74	\$ 2,655.02	\$ 1,360.52	\$ 2,327.37	\$ 2,406.50	\$ 2,488.32	\$ 2,572.92	\$ 2,660.40	\$ 2,750.85
Expansion Population PMPM										
General Assistance										
Parents	\$ 382.35	\$ 327.81	\$ 353.38							
Adults/Couples	\$ -	\$ -	\$ -							
FHIAP - All Title XIX	\$ -	\$ -	\$ -							
FHIAP - Existing	\$ -	\$ -	\$ -							
FHIAP - Medicaid	\$ 171.94	\$ 147.41	\$ 158.91							
FHIAP - Non-Medicaid	\$ -	\$ -	\$ -							
Non-Allowable Expansion Population PMPM										
General Assistance										
Adults/Couples	\$ 818.76	\$ 701.96	\$ 756.71							
FHIAP - Existing	\$ 366.41	\$ 314.14	\$ 338.65							
FHIAP - Non-Medicaid	\$ 407.37	\$ 349.26	\$ 376.50							

**Projected annual
inflation rate
3.4%**

Budget Neutrality

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
TOTAL EXPENDITURES (Member Months x PMPM)										
Base Population Expenditures										
AFDC (Parent, Caretaker, Relative)	\$ 665,357,818	\$ 714,049,690	\$ 403,296,504	\$ 394,433,856	\$ 380,235,735	\$ 445,174,231	\$ 449,735,614	\$ 470,609,823	\$ 492,452,502	\$ 515,305,070
PWO	\$ 185,527,167	\$ 193,070,042	\$ 252,814,222	\$ 249,620,744	\$ 234,189,258	\$ 232,797,177	\$ 243,423,188	\$ 254,720,337	\$ 266,541,206	\$ 278,911,454
CMO (Children's Medicaid Program)	\$ 368,391,830	\$ 443,484,857	\$ 893,534,287	\$ 981,223,087	\$ 985,499,603	\$ 1,009,266,760	\$ 1,043,599,445	\$ 1,092,022,669	\$ 1,142,710,515	\$ 1,195,725,661
Old Age Assistance	\$ 98,252,220	\$ 133,886,140	\$ 147,384,288	\$ 176,673,743	\$ 180,818,921	\$ 194,288,318	\$ 208,827,262	\$ 218,518,089	\$ 228,656,573	\$ 239,266,555
Aid to Blind/Disabled	\$ 967,359,925	\$ 1,109,887,765	\$ 1,039,930,976	\$ 1,145,182,423	\$ 1,193,339,308	\$ 1,255,787,757	\$ 1,312,951,152	\$ 1,373,882,580	\$ 1,437,640,214	\$ 1,504,363,550
Foster Care & SAC	\$ 111,912,157	\$ 135,937,770	\$ 145,129,519	\$ 153,700,910	\$ 160,298,718	\$ 164,508,230	\$ 170,868,694	\$ 178,798,269	\$ 187,096,707	\$ 195,778,725
New ACA Adults	\$ -	\$ 1,015,277,287	\$ 2,739,593,547	\$ 3,109,687,128	\$ 3,087,883,870	\$ 3,020,915,625	\$ 3,104,714,945	\$ 3,248,814,768	\$ 3,399,599,902	\$ 3,557,348,016
BCCP	\$ 30,566,217	\$ 32,208,805	\$ 20,462,260	\$ 6,357,688	\$ 7,645,415	\$ 7,566,036	\$ 6,681,139	\$ 6,990,624	\$ 7,316,100	\$ 7,655,616
Total Leverages	\$ 186,166,774	\$ 230,730,998	\$ 17,058,017	\$ 98,072,388	\$ 55,609,340	\$ 76,840,864	\$ 76,840,864	\$ 76,840,864	\$ 76,840,864	\$ 76,840,864
Total Base	\$ 2,613,534,108	\$ 4,008,533,354	\$ 5,659,203,620	\$ 6,314,951,967	\$ 6,285,520,167	\$ 6,407,144,998	\$ 6,617,642,303	\$ 6,921,198,023	\$ 7,238,854,583	\$ 7,571,195,511
Expansion Population Expenditures										
General Assistance										
Parents	\$ 89,271,730	\$ 45,140,938								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	\$ 1,521,803	\$ 529,677								
FHIAP - Non-Medicaid										
Total Expansion	\$ 90,793,533	\$ 45,670,615	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Non-Allowable Expansion Population Expenditures										
General Assistance										
Adults/Couples	\$ 313,969,297	\$ 148,120,151								
FHIAP - Existing	\$ 933,153	\$ 326,655								
FHIAP - Non-Medicaid	\$ 16,509,812	\$ 5,738,428								
Total Non-Allowable Expansion	\$ 331,412,262	\$ 154,185,234	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Hospital Transformation Performance Program										
Hospital Transformation Performance Program	\$ -	\$ -	\$ 149,999,999	\$ 150,000,000	\$ 150,000,000	\$ 150,000,000	\$ 150,000,000	\$ 150,000,000	\$ 150,000,000	\$ 150,000,000
Tribal Uncompensated Care Program										
Tribal Uncompensated Care Program	\$ -	\$ -	\$ -	\$ 9,451,160	\$ 19,312,815	\$ 19,969,451	\$ 20,648,412	\$ 21,350,458	\$ 22,076,374	\$ 22,826,970
DSHP FFP (STC 55)	\$ -	\$ 230,000,000	\$ 122,654,457	\$ 68,092,578	\$ 68,000,000	\$ -	\$ -	\$ -	\$ -	\$ -
DSHP State Share	\$ -	\$ 134,297,987	\$ 93,121,582	\$ 36,330,000	\$ 40,800,000	\$ -	\$ -	\$ -	\$ -	\$ -
DSHP Total Computable	\$ -	\$ 364,297,987	\$ 215,776,039	\$ 104,422,578	\$ 108,800,000	\$ -	\$ -	\$ -	\$ -	\$ -
Continued Federal Investment to further advance Healthcare System Transformation						\$ 250,000,000	\$ 250,000,000	\$ 250,000,000	\$ 250,000,000	\$ 250,000,000
Annual Actuals/Projected Expenditures	\$ 3,035,739,903	\$ 4,572,687,190	\$ 6,024,979,658	\$ 6,578,825,705	\$ 6,563,632,982	\$ 6,827,114,449	\$ 7,038,290,715	\$ 7,342,548,481	\$ 7,660,930,957	\$ 7,994,022,481
Cumulative Actuals/Projected Expenditures	\$ 30,691,781,378	\$ 35,264,468,568	\$ 41,289,448,226	\$ 47,868,273,931	\$ 54,431,906,913	\$ 61,259,021,361	\$ 68,297,312,076	\$ 75,639,860,557	\$ 83,300,791,514	\$ 91,294,813,995
Annual Budget Neutrality Margin	\$ 2,453,865,472	\$ 1,596,977,395	\$ 4,233,868,984	\$ 4,555,222,611	\$ 4,760,656,738	\$ 4,978,670,985	\$ 5,403,232,784	\$ 5,891,200,501	\$ 6,417,479,463	\$ 6,985,123,119
Cumulative BN Margin	\$ 14,566,243,635	\$ 16,163,221,030	\$ 20,397,090,014	\$ 24,952,312,625	\$ 29,712,969,363	\$ 34,691,640,348	\$ 40,094,873,131	\$ 45,986,073,632	\$ 52,403,553,096	\$ 59,388,676,214

Title XXI Allotment

	Actual	Actual	Actual	Actual/Projection	Projection	Projection	Projection	Projection	Projection	Projection	Projection
Template for States Using CHIP Funds	Actual DY 11 (SFY 2013)	Actual DY 12 (SFY 2014)	Actual DY 13 (SFY 2015)	Actual/Projection DY 14 (SFY 2016)	Projection DY 15 (SFY 2017)	Projection DY 16 (SFY 2018)	Projection DY 17 (SFY 2019)	Projection DY 18 (SFY 2020)	Projection DY 19 (SFY 2021)	Projection DY 20 (SFY 2022)	Projection
State's Allotment	\$ 143,895,447	\$ 152,919,671	\$ 193,533,316	\$ 211,330,598	\$ 222,120,237	\$ 233,460,749	\$ 245,380,258	\$ 257,908,328	\$ 271,076,027	\$ 284,916,012	
Funds Carried Over From Prior Period(s)	\$ 82,821,577	\$ 77,230,788	\$ 61,338,237	\$ 105,180,173	\$ 143,062,824	\$ 180,869,041	\$ 233,460,748	\$ 245,380,257	\$ 257,908,327	\$ 271,076,026	
SUBTOTAL (Allotment + Funds Carried Over)	\$ 226,717,024	\$ 230,150,459	\$ 254,871,553	\$ 316,510,771	\$ 365,183,061	\$ 414,329,790	\$ 478,841,006	\$ 503,288,585	\$ 528,984,354	\$ 555,992,038	
Reallocated Funds (Redistributed or Retained that are Currently Available)											
TOTAL (Subtotal + Reallocated funds)	\$ 226,717,024	\$ 230,150,459	\$ 254,871,553	\$ 316,510,771	\$ 365,183,061	\$ 414,329,790	\$ 478,841,006	\$ 503,288,585	\$ 528,984,354	\$ 555,992,038	
State's Enhanced FMAP Rate	73.71%	74.08%	74.68%	92.26%	98.12%	97.87%	97.11%	79.63%	73.88%	73.88%	
COST ACTUALS/PROJECTIONS OF APPROVED CHIP PLAN - (CHIP 0-300%)											
Benefit Costs											
Insurance payments											
Managed care	\$ 126,678,193	\$ 153,873,286	\$ 148,292,397	\$ 118,508,563	\$ 121,561,770	\$ 114,083,389	\$ 116,272,134	\$ 121,668,091	\$ 127,314,464	\$ 133,222,874	
Member Months	\$ 907,493	\$ 1,080,484	\$ 890,388	\$ 795,961	\$ 758,468	\$ 688,402	\$ 678,539	\$ 686,681	\$ 694,922	\$ 703,261	
per member/per month rate	\$ 175.44	\$ 187.46	\$ 220.62	\$ 219.97	\$ 236.79	\$ 244.84	\$ 253.17	\$ 261.78	\$ 270.68	\$ 279.88	
Fee for Service	\$ 32,528,290	\$ 48,671,833	\$ 48,148,418	\$ 56,580,080	\$ 58,037,786	\$ 54,467,349	\$ 55,512,332	\$ 58,088,548	\$ 60,784,321	\$ 63,605,200	
Total Benefit Costs	\$ 159,206,483	\$ 202,545,119	\$ 196,440,815	\$ 175,088,643	\$ 179,599,556	\$ 168,550,738	\$ 171,784,466	\$ 179,756,639	\$ 188,098,785	\$ 196,828,074	
Benefit Costs											
Insurance payments	\$ 24,131,320	\$ 12,279,473									
Managed care											
Member Months	\$ 89,989	\$ 47,347									
per member/per month rate	\$ 268.16	\$ 259.35									
Fee for Service											
Total Benefit Costs for Kids Connect	\$ 24,131,320	\$ 12,279,473									
Administration Costs											
Personnel	\$ 1,365,490	\$ 790,477	\$ 323,135	\$ 454,314	\$ 293,106	\$ 463,177	\$ 472,064	\$ 493,971	\$ 516,896	\$ 540,884	
General administration	\$ 5,689,544	\$ 3,293,654	\$ 1,346,393	\$ 1,892,978	\$ 1,221,277	\$ 1,929,906	\$ 1,966,932	\$ 2,058,214	\$ 2,153,731	\$ 2,253,681	
Contractors/Brokers (e.g., enrollment contractors)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Claims Processing	\$ 4,324,051	\$ 2,503,177	\$ 1,023,258	\$ 1,438,662	\$ 928,171	\$ 1,466,728	\$ 1,494,869	\$ 1,564,242	\$ 1,636,836	\$ 1,712,798	
Outreach/marketing costs	\$ 36,272	\$ 1,567,650	\$ 1,075,904	\$ 538,790	\$ 1,075,904	\$ 1,034,000	\$ 1,069,156	\$ 1,105,507	\$ 1,143,095	\$ 1,181,960	
Other	\$ 1,397,680	\$ 7,035,504	\$ 10,035,008	\$ 6,741,101	\$ 4,812,978	\$ 4,976,619	\$ 5,145,824	\$ 5,320,782	\$ 5,501,689	\$ 5,688,746	
Total Administration Costs	\$ 12,813,037	\$ 15,190,462	\$ 13,803,698	\$ 11,065,845	\$ 8,255,532	\$ 9,870,431	\$ 10,148,845	\$ 10,542,717	\$ 10,952,246	\$ 11,378,069	
10% Administrative Cap	\$ 20,370,867	\$ 23,869,399	\$ 21,444,153	\$ 19,454,294	\$ 19,955,506	\$ 18,727,860	\$ 19,087,163	\$ 19,972,960	\$ 20,899,865	\$ 21,869,786	
Federal Title XXI Share	\$ 144,582,785	\$ 170,388,516	\$ 154,441,084	\$ 172,447,594	\$ 184,314,020	\$ 174,616,338	\$ 176,666,342	\$ 151,535,377	\$ 147,058,902	\$ 153,822,698	
State Share	\$ 51,568,055	\$ 59,626,536	\$ 52,359,989	\$ 13,706,894	\$ 3,541,068	\$ 3,804,831	\$ 5,266,969	\$ 38,763,979	\$ 51,992,129	\$ 54,383,445	
TOTAL COSTS OF APPROVED CHIP PLAN	\$ 196,150,840	\$ 230,015,054	\$ 210,244,513	\$ 186,154,488	\$ 187,855,088	\$ 178,421,169	\$ 181,933,311	\$ 190,299,356	\$ 199,051,031	\$ 208,206,143	
Benefit Costs for Demonstration Population #16 (FHIAP Children - Group 0-200% FPL)											
Insurance payments	\$ 817,583	\$ 462,334									
Managed care											
Member Months	\$ 7,099	\$ 2,720									
per member/per month rate	\$ 115.17	\$ 169.96									
Fee for Service											
Total Benefit Costs for Waiver Population #16	\$ 817,583	\$ 462,334									
Benefit Costs for Demonstration Population #16 (FHIAP Children - Individual 0-200% FPL)											
Insurance payments	\$ 781,778	\$ 449,899									
Managed care											
Member Months	\$ 3,583	\$ 1,374									
per member/per month rate	\$ 218.19	\$ 327.44									
Fee for Service											
Total Benefit Costs for Waiver Population #16	\$ 781,778	\$ 449,899									
Benefit Costs for Demonstration Population #20 - FHIAP Children ESI (200%-300% FPL)											
Insurance payments	\$ 33,498	\$ 15,508									
Managed care											
Member Months	\$ 233	\$ 117									
per member/per month rate	\$ 143.77	\$ 132.55									
Fee for Service											
Total Benefit Costs for Demonstration Population #20 - FHIAP ESI	\$ 33,498	\$ 15,508									

FY 2016 Allotment Increase Factor 105.11%

Enhanced 23% FMAP increase started 10/2015 thru 9/2019.

Projected annual inflation rate	3.4%	Oregon population growth estimate inflation rate for SFY20-SFY22	1.2%
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Title XXI Allotment

Template for States Using CHIP Funds	Actual	Actual	Actual	Actual/Projection	Projection	Projection	Projection	Projection	Projection	Projection
	Actual DY 11 (SFY 2013)	Actual DY 12 (SFY 2014)	Actual DY 13 (SFY 2015)	Actual/Projection DY 14 (SFY 2016)	Projection DY 15 (SFY 2017)	Projection DY 16 (SFY 2018)	Projection DY 17 (SFY 2019)	Projection DY 18 (SFY 2020)	Projection DY 19 (SFY 2021)	Projection DY 20 (SFY 2022)
Total Demonstration Benefit Costs (Waiver Pop. #16 & #20)	\$ 1,632,859	\$ 927,741								
Administration Costs										
Personnel	\$ 288,167	\$ 87,818								
General administration	\$ 1,200,696	\$ 365,907								
Contractors/Brokers (e.g., enrollment contractors)	\$ -	\$ -								
Claims Processing	\$ 912,528	\$ 278,089								
Outreach/marketing costs	\$ -	\$ -								
Other (specify)	\$ -	\$ -								
Total Administration Costs	\$ 2,401,391	\$ 731,814								
10% Administrative Cap	\$ 181,429	\$ 103,082								
Federal Title XXI Share	\$ 2,973,645	\$ 1,229,357								
State Share	\$ 1,060,604	\$ 430,198								
TOTAL COSTS FOR HIFA DEMONSTRATION	\$ 4,034,249	\$ 1,659,555								
Total Combined Administration Cost of SCHIP State Plan										
Administration Costs										
Personnel	\$ 1,653,657	\$ 878,295	\$ 323,135	\$ 454,314	\$ 293,106	\$ 463,177	\$ 472,064	\$ 493,971	\$ 516,896	\$ 540,884
General administration	\$ 6,890,240	\$ 3,659,561	\$ 1,346,393	\$ 1,892,978	\$ 1,221,277	\$ 1,929,906	\$ 1,966,932	\$ 2,058,214	\$ 2,153,731	\$ 2,253,681
Contractors/Brokers (e.g., enrollment contractors)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Claims Processing	\$ 5,236,579	\$ 2,781,266	\$ 1,023,258	\$ 1,438,662	\$ 928,171	\$ 1,466,728	\$ 1,494,869	\$ 1,564,242	\$ 1,636,836	\$ 1,712,798
Outreach/marketing costs	\$ 36,272	\$ 1,567,650	\$ 1,075,904	\$ 538,790	\$ 1,000,000	\$ 1,034,000	\$ 1,069,156	\$ 1,105,507	\$ 1,143,095	\$ 1,181,960
Other (specify)	\$ 1,397,680	\$ 7,035,504	\$ 10,035,008	\$ 6,741,101	\$ 4,812,978	\$ 4,976,619	\$ 5,145,824	\$ 5,320,782	\$ 5,501,689	\$ 5,688,746
Total Administration Costs	\$ 15,214,428	\$ 15,922,276	\$ 13,803,698	\$ 11,065,845	\$ 8,255,532	\$ 9,870,431	\$ 10,148,845	\$ 10,542,717	\$ 10,952,246	\$ 11,378,069
Confirm										
10% Administrative Cap	\$ 20,552,296	\$ 23,972,481	\$ 21,826,757	\$ 19,454,294	\$ 19,955,506	\$ 18,727,860	\$ 19,087,163	\$ 19,972,960	\$ 20,899,865	\$ 21,869,786
HIFA Demonstration Waiver Budget Allotment Expenditure Analysis										
	State Fiscal Year 11 (SFY 2013)	State Fiscal Year 12 (SFY 2014)	State Fiscal Year 13 (SFY 2015)	Actual/Projection DY 14 (SFY 2016)	Projection DY 15 (SFY 2017)	State Fiscal Year 16 (SFY 2018)	State Fiscal Year 17 (SFY 2019)	State Fiscal Year 18 (SFY 2020)	State Fiscal Year 19 (SFY 2021)	State Fiscal Year 20 (SFY 2022)
Prior Period Adj - Program Costs	\$ 1,488,772	\$ (1,916,802)	\$ (9,856,394)	\$ (574,459)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Prior Period Adj - Admin. Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Prior Period Adj - Fed Title XXI Share Collections	\$ 1,101,713	\$ (1,412,373)	\$ (7,320,576)	\$ (1,610,778)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other Adjustments/Client-Related										
TOTAL CURRENT PROGRAM COSTS (State Plan + Demonstration)	\$ 201,673,861	\$ 229,757,807	\$ 200,388,119	\$ 185,580,025	\$ 187,855,088	\$ 178,421,169	\$ 181,933,311	\$ 190,299,356	\$ 199,051,031	\$ 208,206,143
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$ 226,717,024	\$ 230,150,459	\$ 254,871,553	\$ 316,510,771	\$ 365,183,061	\$ 414,329,790	\$ 478,841,006	\$ 503,288,585	\$ 528,984,354	\$ 555,992,038
Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$ 148,658,140	\$ 170,202,483	\$ 149,690,027	\$ 170,836,812	\$ 184,314,020	\$ 174,616,338	\$ 176,666,342	\$ 151,535,377	\$ 147,058,902	\$ 153,822,698
Reporting period difference due to timing between CMS 21 Reporting and FHIAP Reporting	\$ 828,096	\$ (1,390,261)	\$ 1,353	\$ 2,611,135	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Unused Title XXI Funds Expiring (Allotment or Reallocated)						\$ 6,252,704	\$ 56,794,407	\$ 93,844,881	\$ 110,849,426	\$ 117,253,328
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$ 77,230,788	\$ 61,338,237	\$ 105,180,173	\$ 143,062,824	\$ 180,869,041	\$ 233,460,748	\$ 245,380,257	\$ 257,908,327	\$ 271,076,026	\$ 284,916,011

Appendix J: Populations Affected by or Eligible under the Demonstration from July 2017-June 2022

I. Medicaid Populations-1115 Demonstration							
Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
1	Pregnant Women	Title XIX	Title XIX state plan and section 1115	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 0 through 18	Title XXI	Title XXI state plan and section 1115	134% up to 300% FPL	None	OHP Plus	Base 1
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 converted to MAGI-equivalent amounts	\$2,000	OHP Plus	Base 2

6	Medicaid mandatory section 1931 low income families. (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	\$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 Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	SSI Level	\$2,000 for a single individual, \$3,000 for a couple	OHP Plus	Base 2
8	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	\$2,000 single individual; \$3,000 for a couple	OHP Plus	Base 2
9	Former Foster Care Youth to age 26	Title XIX	Title XIX state plan and Section 1115	No FPL limit if in Oregon Foster Care at age 18	None	OHP Plus	Base 1
21	Uninsured or underinsured women under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program (BCCTP)	Title XIX	Title XIX state plan and Section 1115	0% up to 250% FPL	None	Limited – case-by-case basis	Base 1
23	Low-Income Expansion Adults	Title XIX	Title XIX state plan and Section 1115	0% up to 133% FPL	None	ABP (OHP Plus)	Base 2