

Oregon Health Policy Board

AGENDA

November 13, 2012

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 a.m. to Noon

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll Action item: Consent agenda: 09/11/12 minutes 10/9/12 minutes	Chair	X
2	8:35	Director's Report	Bruce Goldberg	
3	8:45	Coordinated Care Organizations implementation overview: <ul style="list-style-type: none"> • Elements of Transformation Plans • Transformation Center and innovator agents • Metrics and measuring 	Tina Edlund: Overview, transformation center Leslie Clement: Innovator agents and transformation plans Carole Romm: Metrics and quality pool	
4	9:45	Early Learning Council and Oregon Health Policy Board Action item: Early Learning Council/Oregon Health Policy Board Joint Subcommittee	Jada Rupley, Early Learning Systems Director Dana Hargunani, Child Health Director, OHA	X
	10:20	Break		
5	10:30	Board Discussion: Community Health Initiative Refinement	Diana Bianco	
6	11:30	Plan for the December board meeting	Tina Edlund	
7	11:45	Public Testimony	Chair	
	12:00	Adjourn		

Next meeting:

December 11, 2012

1:00 to 5:00 p.m.

Public Forum on Health System Transformation

Multnomah County Board of Commissioners

501 Southeast Hawthorne Boulevard,

Portland, OR 97214

Oregon Health Policy Board
DRAFT Minutes
September 11, 2012
8:30am to 12 pm
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present.

Bruce Goldberg was present from the Oregon Health Authority (OHA).

Chair Eric Parsons noted that the Oct. 9 meeting will be held in Coos Bay, Oregon.

Consent Agenda:

The minutes from the August 14, 2012 meeting were unanimously approved.

Director's Report – Bruce Goldberg

Bruce Goldberg gave an update about CCO implementation. He said as of September 1st, there are 13 CCOs operational and three more have been provisionally certified. He spoke about CMS approvals, dental care and next steps for implementation. Goldberg said much has been accomplished but, "we're really just beginning the work."

Goldberg also spoke about the Center for Medicare and Medicaid's State Innovation Models grant opportunity and what the grant would mean for the OHA and the state.

Goldberg reported that the Patient Safety and Defensive Medicine Workgroup has developed some draft legislation that relates to early offer and resolution of serious medical events. He said the workgroup has engaged in great, collaborative work thus far.

The Director's Report can be viewed [here](#), starting on page 5.

Metrics and Scoring Committee Update – Bruce Goldberg

Bruce Goldberg gave an update about the recently formed Metrics and Scoring Committee. He said, as directed by statute, nine members were appointed to adopt the measures of cost, quality and access that will be reported by CCOs. Goldberg said, "It's not simply about dollars, it's about ensuring that we can improve health and improve quality of care."

Goldberg also said the committee's first charge is to make recommendations about the incentive program as the Quality Incentive Program design and specifications are due to CMS no later than November 5, per the state's 1115 Waiver.

He reported that one of the first recommendations from the committee was that OHA postpone its requirement that CCOs submit their Transformation Plans until January 1, 2013, so that CCOs can align their plans with the areas of emphasis identified in the Quality Incentive Program design. Goldberg said the state is in discussions with CMS about postponing those due dates.

The Metrics and Scoring Committee Update can be viewed [here](#), starting on page 15.

Public Testimony

The board heard testimony from three people:

- Tom McKee, Willamette Family Inc, spoke about CCOs providing detoxification services. He said these services should be accessible to all members of the Oregon Health Plan. He also thanked the Board because a member of his personal recovery programs who was diagnosed with cancer is now receiving life-saving benefits from the Oregon Health Plan.
- Laura Farr, Oregon Association of Naturopathic Physicians, gave an update on implementation from a provider's perspective. She said the most-asked question regarding transformation is: Can I go to my doctor? She said no CCOs have credentialed naturopathic physicians yet. Farr said this is a matter of access to care for many as Open Card patients are not able to see their naturopathic primary physician. She said CCOs need to come into compliance with non-discriminatory language.
- John Mullin, Oregon Law Center, said there are major players involved in transformation aside from the OHA, including DHS and the Health Insurance Exchange. He said discussions about important issues are also happening at other places outside of the Board. Mullin said he was hoping the state would pursue using waivers to select the Oregon Health Plan instead of the PacificSource Plan. Mullin also said he would like to see a discussion about the Basic Health Program that's contained in the ACA because he and the Oregon Law Center are very concerned about affordability.

Written testimony submitted to the Board can be found [here](#).

National Models for Community Health Integration: Introduction – Diana Bianco

Diana Bianco spoke about the Board's decision to make community health a focus moving forward. Bianco asked the Board what national models for community health are of interest for future presentations and then introduced Blue Zones by Healthways.

A summary of Community Health Initiatives can be viewed [here](#), starting on page 21.

Blue Zones by Healthways – Katie McClure, Michael Acker, Joel Spoonheim and Mary Lawyer

Katie McClure gave a presentation about Healthways' Blue Zones project. McClure said the strategy of Healthways is to lead the market in well-being improvement. She spoke about Healthways metrics, the Well-Being Index and operational measurements.

Joel Spoonheim spoke about the results from the initial pilot in Albert Lea, Minnesota. He said the most important result was "if you set clear goals with an aggressive timeline and have engaged leadership, on-the-board change will occur." Spoonheim also spoke about certification, pledges, engagement strategy and the nine principles of the Blue Zones project:

1. Move Naturally
2. Know Your Purpose
3. Down Shift
4. 80% Rule
5. Plant Slant
6. Wine at Five
7. Right Tribe
8. Community
9. Loved Ones First

Mary Lawyer spoke about Blue Zones as the cornerstone of Iowa's Healthiest State Initiative. Lawyer said Iowa wants to transform 10 communities into Blue Zones over the next five years. She said they select which communities will be transformed based on community factors, readiness and motivation.

Board Discussion – Diana Bianco

Diana Bianco led a conversation to discuss the Healthways presentation on Blue Zones.

Summary of Discussion:

- Outreach to different establishments: grocery stores, restaurants, employers, etc. / How do we involve local business?
- If you make it easy and shape the path, people are more likely to do something new. (i.e. recycling)
- Having a cultural buy-in is critical for sustainability.
- Beach cities are high-income with dense populations, etc. What happens in more rural communities or communities with high unemployment?
- We should run it like a political campaign
- If we committed to one community policy, which would it be? Where should we start?
- How do we articulate the benefits of these behavioral changes for members of the community?
- How do we put it all together in one package and align messaging/ marketing?
- Look at Public health initiatives that have been successful: seat belts, bike helmets
- A targeted strategy is needed around our top three priorities: tobacco use, obesity and suicide.
- How do we incorporate other communities into the CCO model?

Possible next steps:

- Environmental scan
- Three meeting approach:
 - What are the goals we are trying to achieve?
 - What are the elements of cultural change?
 - What strategies will tie together the goals we've identified and the elements of cultural change we've discussed?
- OHA should draft goals for discussion.

Adjourn

Next meeting:
October 9, 2012
1pm to 4pm
Bay Area Hospital
Coos Bay, Oregon

Oregon Health Policy Board
DRAFT Minutes
October 9, 2012
1pm to 4pm
Bay Area Hospital
Coos Bay, Oregon

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present.

Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).

Consent Agenda:

The minutes from the September 11, 2012 deferred to next meeting as Felisa Hagins requested a revision.

Director's Report – Bruce Goldberg

Bruce Goldberg gave an update on CCO Implementation. He said we now have 13 CCOs that are operational with two more soon to be up-and-running. Goldberg said that we're beginning a process and it's off to a good start.

Goldberg also spoke about the Metrics and Scoring Committee, which has been meeting regularly. He said the committee has narrowed its list to 17 candidate measures that include alcohol and drug-dependent screening, depression screening, prenatal care, follow-up for hospitalization for mental illness, potentially avoidable emergency department visits, assignment of members to patient-centered primary care homes, developmental screening for children, diabetes care and several others. He said the Committee has also been working with CoverOregon to align measures.

Goldberg said as a majority partner in CCO Implementation and Transformation, the federal government is not only interested in ensuring we start to become accountable towards metrics and outcomes but also they want to some financial incentive to ensure that there's alignment.

The Director's Report can be viewed [here](#), starting on page 7.

Local CCO Presentations – Gail Hedding and Phil Greenhill

Gail Hedding spoke about community involvement with AllCare Health Plan. She said AllCare began holding stakeholder meetings in January 2012. Hedding said 40 stakeholders helped to create the organization's name, logo and defined its structure. She spoke about AllCare's vision and described its members, primary care providers, community advisory panels and its clinical advisory panel.

Hedding also spoke about AllCare's integration efforts and focus on outcome metrics. She said the organization's successes have included:

- Synergies of relationships
- Trust and knowledge
- Innovator agent process
- PCPCH
- Framework

Hedding said the challenges that AllCare faces include:

- PCPCH issues
- Transitioning certain providers from FFS environment to Managed Care system
- Documentation requirements for Mental Health
- Alternate Payment Methodology Implementation
- Flexible Service Encounter processes
- Global Budget Programs Expansion

- Blending of organizational cultures

Phil Greenhill spoke about the history of Western Oregon Advanced Health. Greenhill said in the summer of 2011, they developed a planning committee with a growing number of stakeholders from the community. He said they also developed a care management team to develop a universal, one-page care plan. Greenhill said there were a lot of efforts happening in the community before CMS contracts were even signed. He said with the passage of SB 1580, they formed a 17-member board.

Greenhill said issues that need to be addressed going forward include incorporation of Public Health, Health Information Exchange, metrics and risk management. Greenhill said coordination of health information is especially important in order to control the quality of care and the cost of resources. He also acknowledged the importance of cooperation of the private sector to Western Oregon Advanced Health's success.

Gail Hedding's AllCare Health Plan presentation can be viewed [here](#).

Oregon 2010 Health Improvement Plan Review – Lila Wickham

Lila Wickham, Multnomah County, gave an overview of the Oregon 2010 Health Improvement Plan process. Wickham said the primary focus of the Plan was education is crucial to improvement for employment, improvement in health, community engagement and a critically thinking population.

She said we if focus our scarce resources on community assessment and the resulting health improvement plans, it will drive the improvement health outcomes by identifying thoughtful and cogent metrics.

Wickham said the strengths of the original plan was the extensive community engagement process, development on the return on investment analysis, identification of an owner for each of the health improvement strategies, and the recognition that mental health, addictions and oral health are all integrally related to overall health.

The Executive Summary of the Oregon 2010 Health Improvement Plan Review can be viewed [here](#), starting on page 13.

Oregon's Healthy Future 2012 State Health Improvement Plan – Jean O'Connor, Public Health

Jean O'Connor said Oregon's Healthy Future is built upon work from Oregon 2010 Health Improvement Plan Review. O'Connor said the 2012 plan is more specifically focused on the next five years and what policy changes that will help to create healthy environments. She said it was also important to align the 2012 plan with health assessments and Public Health's strategic plan.

O'Connor said during listening sessions that were held over the summer, five themes emerged:

- Advancing health equity
- Decreasing tobacco use
- Slowing increase in rate of obesity
- Oral health
- Substance abuse and mental health

O'Connor said the 2012 plan is still in process and another draft developed after the October public comment period will be released at the end of the year.

Oregon's Healthy Future Plan can be viewed [here](#).

What is already happening in Oregon around community health? – Noelle Dobson

Noelle Dobson, Oregon Public Health Institute, spoke about community health initiatives in Oregon. Dobson said most initiatives are related to healthy eating and active living. She said her work has grown from focusing on one community to broad policy changes that can affect multiple communities at one time.

Dobson said it takes a comprehensive approach to achieve the changes we want to see and no one initiative will be able to do it alone. The work on all of the comprehensive levels needs to be aligned.

Oregon Public Health Institute's Comprehensive Approach:

- Partnerships
- Programs
- Promotion
- Policy and systems change
- Physical improvements to the environment

Dobson said evidence-based and best practice strategies need to be tailored to each community to promote that community's overall health. Dobson described some of Oregon's integrated networks and collective action, which include geography, coalitions, sectors, worksites, active transportation, education, and access to care.

Noelle Dobson's Health Initiatives in Oregon presentation can be viewed [here](#). The draft of Community Health Initiatives in Oregon can be viewed [here](#), starting on page 17.

Board discussion – Diana Bianco

What is the Board's vision for community health in Oregon?

- The number of reports and healthy goals out there are overwhelming, how can we focus on what we're trying to achieve?
- We should narrow our goals and funnel the efforts to a measurable, quantifiable outcome. If we have razor-sharp focus, the private sector is more likely to become involved.
- Much like the 40-40-20 Education goal, all partners must buy into a goal in order to make it successful. All partners need to understand its benefits. The 40-40-20 Education goal is a great example because of the long-term buy-in from the business sector.
- If we improve education, we will have an impact on multiple outcomes.
- What are the elements of a healthy community?
- What if we strived to have the healthiest kids in the nation? We need to create environments where children will learn better and be healthier. There also needs to be a focus on the family and home environment, otherwise children will not be successful.

What are the opportunities?

- School can become a community resource. It can create value for the school and people can invest more in what happens there. A school can become a healthy, convening building where you can improve the health of the family and all members of the community.
- The focus on children ties into the work of the Early Learning council. Sectors that work with families can start thinking about health strategies and achieving these goals.
- How out of the box can we go? For example, Intel moved its soda machines into its health center to curb consumption. There is a lot of room for innovation.
- Children are the workforce of the future. Good health is in the business community's best interest. No one wants to hire chronically ill employees who will cost business more than the individuals will make.

Next steps:

- Draft proposal for next meeting
- Background about endeavors that have been successes and failures
- Advertising approach on how to message the concepts
- Discussion of the book "Switch"

Public Testimony

The board heard testimony from one person:

- Dick Leshley, Yellow Cab Taxi, spoke about non-emergency medical transportation and the current brokerage system. He said the brokerage system is very important to rural communities and has been a catalyst for higher standards.

Adjourn

Next meeting:

November 13, 2012

8:30am to 12pm

Market Square Building

Portland, Oregon

CCO TRANSFORMATION PLANS

PROJECT STATUS UPDATE
OREGON HEALTH POLICY BOARD
NOVEMBER 13, 2012



Transformation Plans

OHA has initiated a strategy to partner with CCOs that will identify dynamic Transformation Plan milestones, deliverables, and targets for becoming a fully integrated Coordinated Care Organization in the communities they serve.

Eight Minimum Standards

Integration, Primary Care, Payments

1. Implement a health care delivery model that integrates mental health and physical health care and addictions. (address the needs of individuals with severe and persistent mental illness).
2. Implement Patient-Centered Primary Care Home.
3. Implement consistent alternative payment methodologies that align payment with health outcomes.

Minimum Standards

Assessments, Improvement, & IT

4. Prepare a strategy for developing a Community Health Assessment and adopt an annual Community Health Improvement Plan.
5. Develop a plan for encouraging electronic health records; health information exchange; and meaningful use.

MINIMUM STANDARDS

Reflecting Diversity, Addressing Disparities

6. Assure communications, outreach, Member engagement, and services are tailored to cultural, health literacy and linguistic needs.
7. Assure that the culturally diverse needs of Members are met; provider and new health care workers reflect member diversity.
8. Develop a quality improvement plan focused on eliminating disparities in access, quality of care, experience of care, and outcomes.

Project Purpose

- To establish a mechanism that facilitates OHA's partnership with CCOs to achieve Oregon's health system goals.
- To provide clear, transparent guidance about CCO Transformation Plans.
- To collaborate with each CCO, providing individualized technical assistance that acknowledges each CCO is at a different starting point with different community resources and needs.
- To support CCOs with a knowledgeable team of experts.

Project Purpose

- To encourage continuous quality improvement, recognizing that transformation is an iterative process and that Transformation Plans will and should evolve overtime.
- To establish a process for OHA to review draft Plans, provide feedback, and finalize the OHA/CCO contract amendment.
- To identify a process for on-going review of CCO progress toward achieving the objectives and timelines identified in the Transformation Plan.

OHA Project Team

Project Manager:	Sandra Koelle
Operations Sponsor:	Leslie Clement
Communications Lead:	Melissa Hanks
Technical Assistance:	Subject Matter Experts
Executive Oversight:	OHA Cabinet members

Timeframe

Project Initiated

November 6, 2012

Work plan finalized

November 16, 2012

Webinar

November 27, 2012

- Expected deliverables, milestones, review process and technical assistance.
- General standards communicated.

Web Site established

November 27, 2012

- Established technical assistance web site will include materials on contract requirements,
- OHA guidelines, FAQs, best practices, and tools for developing Transformation Plans.

Technical Assistance

OHA TA teams contact CCOs

December 2012

- Individualized discussions with CCO-specific guidance
- OHA points of contact established for on-going dialogue

Plan Reviews

CCOs submit Draft Plans

January 15, 2013

- OHA Technical Assistance teams conduct initial review
- Cabinet members final review

Formalized feedback to CCO

January 28, 2013

- Written comments & guidance

Approval of Plans

CCOs submit Finalized Plans

February 15, 2013

Incorporate changes/additions

OHA approval of Plans

March 1, 2013

Contract Amendment incorporates Transformation Plan

Amendment Effective

July 1, 2013

Reflects Centers for Medicare & Medicaid approval

QUESTIONS?

Oregon Draft Incentive Measures with Specifications and Targets

Through a public process, the Metrics and Scoring Committee identified incentive measures and established improvement and performance targets that a CCO must meet to be eligible for receiving funds from the quality pool in year one. These proposed measures and targets are provisional, pending approval from CMS, and may change before Jan 1, 2013.

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
Total Emergency Department (ED) Utilization	Number of ED visits (multiple visits on one day are counted as one visit)	Per 1,000 member months	ED visits that result in hospital admission and CD/MH visits are excluded.	Admin Data	MN method ¹ with 3% floor	Medicaid 90 th percentile <i>2011 National Medicaid 90th percentile: 44.4</i>
Initiation and engagement of alcohol and other drug dependence treatment	Initiation: A CD enc/claim through inpatient admission or outpatient visit within 14 days of index date (see denominator).	Individual with an CD outpatient, detox, ED, or inpatient enc/claim. This defines the index date.	Individual must be continuously enrolled in plan for 60 days prior to index date and 45 days after. Individual must not have had an enc/claim for 60 days prior to index date.	Admin Data	MN method with 3% floor <i>Oregon Initiation baseline: 28%</i> <i>Oregon Engagement baseline: 13%</i>	Average of the 2011 National Medicaid 75 th percentiles for the two rates: <i>Initiation: 48.84%</i> <i>Engagement: 20.52%</i>

¹ The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to qualify for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: <http://www.health.state.mn.us/healthreform/measurement/QIPReport051012final.pdf>

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
	Engagement: Initiation of treatment and 2 or more CD enc/claims through inpatient admission or outpatient visit within 30 days of initiation enc/claim.				<i>Oregon Average: 20.5%</i>	<i>Average 75th percentile: 34.7%</i>
Follow-up after hospitalization for mental illness	MH outpatient or partial hospitalization enc/claim that occurs within 7 days of discharge.	Discharges from acute inpatient setting with principal mental health diagnosis and age 6+.	<p>Must be enrolled for 30 days after discharge.</p> <p>Readmissions or transfers to other inpatient facilities for non-mental health reasons are excluded.</p> <p>A note on provider type: HEDIS calls for a mental health practitioner to see the person within 7 days.</p> <p>HEDIS definition for MH practitioner includes practically all practitioners allowed to encounter a mental health service in Oregon.</p>	Admin Data	<p>MN method with 3% floor</p> <p><i>Oregon baseline: 51%</i></p>	<p>Medicaid 90th percentile</p> <p><i>2012 National Medicaid 90th percentile: 68%</i></p>

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
Adolescent Well Child Visits	Received at least one comprehensive well-care visit during the measurement year	Members 12-21 years of age continuously enrolled in a specific health plan, FFS, or primary care management for the measurement year with up to one 45 day gap in enrollment allowed.	The member may not have more than a 1-month gap in coverage.	Admin Data	MN method with 3% floor <i>Oregon baseline: 26.7%</i>	Medicaid 75 th percentile <i>2011 National Medicaid data 75th percentile: 56.93%</i>
Mental health and/or physical assessment for children in DHS custody	MH assessment (defined by agreed upon set of procedure codes) within 60 days of DHS custody date. Physical health service (to be defined) within 60 days of DHS custody date.	Children age 4+ taken into custody within a given timeframe (month, quarter or year) who remained in DHS custody for 60 days.	Children must be continuously enrolled for the 60 day follow up period. Note current agreed upon procedure codes may need to be updated with CCOs.	Admin Data and Child Welfare records	MN method with 3% floor <i>Oregon baseline for MH: 58%</i>	90%
Elective delivery before 39 weeks	Individuals with elective deliveries with ICD-9-CM principal procedure code or ICD-9-CM other procedure codes for one or	Individuals delivering newborns with >=37 and <39 weeks of gestation completed.	None noted.	Admin Data	MN method with 1% floor	5% or below

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
	more of the following: Medical induction of labor, Cesarean section while no in active labor or experiencing spontaneous rupture of membranes.					
Prenatal care	Number of live birth deliveries that received a prenatal care visit as a member of the CCO in the first trimester or within 42 days of enrollment.	All identified live births for individuals meeting enrollment criteria. (see relevant list of ICD 9 and CPT codes.)	Must be enrolled for 43 days prior to delivery with no gaps. From July 1, 2009, managed care plans receive bundled payments for prenatal, delivery and postpartum services in addition to capitation rates: a significant portion of ambulatory services may not generate a claim. Therefore, this measure could have unstable result.	Admin Data Or Hybrid	MN method with 3% floor <i>Oregon baseline: 30.4% using admin data only.</i>	Medicaid 75 th percentile <i>2012 National Medicaid benchmark data 75th percentile: 89%</i>

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
Developmental screening by 36 months	Children in denominator who had a claim with CPT code 96110 by their birthday in the measurement year. If hybrid: OHA may accept other forms of evidence. This would need to be defined and standardized across plans.	The children who turn 1, 2, or 3 years of age of the measurement year and were covered by Medicaid/CHIP program continuously for 12 months between last birthdate and this birthdate, regardless if they had a medical/clinic visit or not in the measurement year.	Cannot verify tools used. Note continuous enrollment specified in denominator. Hybrid method loses national comparison benchmark.	Admin Data Or Hybrid	5% over baseline <i>Oregon baseline: 19.6% using admin data only.</i>	50%
Screening for clinical depression and follow up plan	Individuals screened for clinical depression using an age appropriate standardized tool and follow-up plan is documented.	All individuals age 12+ screened during measurement year as indicated by appropriate CPT codes.	Measure to be further evaluated under CMS Adult Quality Measure Grant.	Hybrid: Admin Data and chart review	10% <i>Assume 0% baseline.</i>	10%
Substance abuse - SBIRT	Individuals screened using SBIRT as indicated by billing codes: H0049 or H0050.	All individuals age 12+ screened during measurement year as indicated by appropriate CPT codes.	Modeled after depression screening except for the chart review.	Admin Data	10% <i>Assume 0% baseline.</i>	10%

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
Colorectal cancer screening	<p>Individual who had an appropriate screening if a submitted enc/claim contains appropriate CPT code (see list in HEDIS manual)</p> <p>Hybrid approach: One or more screenings for colorectal cancer: FOBT during measurement year; Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year; or colonoscopy during the measurement year or the nine years prior to the measurement year.</p>	All eligible members meeting enrollment criteria and age 50-75 during measurement year.	Continuous enrollment for measurement year and prior year. No more than one gap of up to 45 days.	Admin Data Or Hybrid	<p>MN method with 3% floor</p> <p><i>Oregon baseline: 30.5% using admin data only.</i></p>	<p>2012 National commercial data, unadjusted 75th percentile: 65.76%</p> <p>Adjustment factor: 4.42</p> <p>Adjusted 75th percentile: 61.34%</p>
Patient-Centered Primary Care Homes	<p>The number of PCPCH enrolled members by tier:</p> <ul style="list-style-type: none"> # of enrollees in 	All enrolled members x 3.		Admin Data	No improvement target set for year one.	No performance target set for year one.

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
	tier 3 x3 <ul style="list-style-type: none"> # of enrollees in tier 2 x2 # of enrollees in tier 1 x1. 				The percentage of dollars available for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.	The percentage of dollars available for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.
Optimal diabetes use (D3)	Individuals ages 18 to 75 with diabetes who met all three D % goals. <ul style="list-style-type: none"> BP less than 140/90 LDL less than 100 mg/dl A1c is less than 8% 	Individuals ages 18 to 75 with diabetes who have at least 2 visits for this diagnosis in the last two years with one visit in the last 12 months.		Hybrid: Admin Data and chart review	No improvement target for year one set.	20%
Controlling high blood pressure	The number of members in the denominator who's most recent BP is adequately controlled during the measurement year. Controlled= both the systolic and diastolic BP must be <140/90.	Eligible population must be identified as hypertensive by having at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year.	Individual must be continuously enrolled during the measurement year with no more than one month gap in coverage.	Hybrid: Admin Data and chart review	No improvement target for year one set.	75 th percentile <i>2012 National Medicaid Benchmark 75th percentile: 60%</i>

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
		<p>Diagnosis must be confirmed in charts or in some other official form of documentation, for example a hospital discharge summary.</p> <p>Diagnosis can occur prior to measurement year.</p>				
<p>CAHPS Composite: Getting Care Quickly</p>	<p>This measure reports on the ease with which members can access care quickly. The composite score is the overall percentage of members who responded "Always" or "Usually" to the following questions:</p> <ul style="list-style-type: none"> • "In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?" (Adult) • "In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?" (Adult) • "In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed?" (Child) • "In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?" (Child) 			<p>CAHPS Surveys</p>	<p>MN method with 2% floor:</p> <p><i>Oregon adult baseline: 79%</i></p> <p><i>Oregon child baseline: 88%</i></p> <p><i>Oregon average: 83.5%</i></p> <p><i>Calculated as always + usually.</i></p>	<p>Average of the 2012 Medicaid 75th percentile for the two rates:</p> <p><i>2012 National Medicaid adult 75th percentile: 83.63%</i></p> <p><i>2012 National Medicaid child 75th percentile: 90.31%</i></p> <p><i>National average: 86.97%</i></p> <p><i>Calculated as always + usually.</i></p>

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
CAHPS Composite: Health plan information and customer service	<p>This measure reports members' customer service experience when contacting the plan. The composite score is the percentage of members who responded "Always" or "Usually" to the following questions:</p> <ul style="list-style-type: none"> "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" (Adult) "In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?" (Adult) "In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?" (Child) "In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?" (Child) 			CAHPS Surveys	<p>MN method with 2% floor:</p> <p><i>Oregon adult baseline: 76%</i></p> <p><i>Oregon child baseline: 80%</i></p> <p><i>Oregon average: 78%</i></p> <p><i>Calculated as always + usually.</i></p>	<p>Average of the Medicaid 75th percentile for the two rates:</p> <p><i>2012 National Medicaid adult 75th percentile: 83.19%</i></p> <p><i>2012 National Medicaid child 75th percentile: 84.71%</i></p> <p><i>National average: 83.95%</i></p> <p><i>Calculated as always + usually.</i></p>
EHR Composite	<p>This measure is a composite of three Meaningful Use Core Measures. Specifications can be found online at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EP-MU-TOC.pdf</p> <ol style="list-style-type: none"> Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.) Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions 				Set once baseline is available in late 2012.	Set once baseline is available in late 2012.

Draft incentive measures with specifications and targets

Measure	Numerator	Denominator	Exclusions/Notes	Data Source	Improvement Target	Performance Target
	<p>electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.)</p> <p>3. Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data</p>					

DRAFT

Oregon Measurement Strategy

This Measurement Strategy outlines how the Oregon Health Authority (OHA) will measure quality of and access to care for individuals enrolled in Coordinated Care Organizations (CCOs) and for the Oregon Health Plan population as a whole.

OHA Measurement Framework

Oregon has identified over 80 potential measures of cost, quality, access, patient experience, and health status that could be tracked over delivery settings and populations. These measures come from several measure sets, including the CMS Adult Medicaid Quality Measures, CHIPRA measures, Oregon's core performance measures, and the incentive measures for year one selected by the Metrics and Scoring Committee that will be tied to quality pool funding for CCOs. Potential measures by set are listed below.

Ensuring Continuous Quality Improvement

In coordination with the Metrics and Scoring Committee, the Oregon Health Authority will be revisiting selected measures annually to ensure that quality of and access to care are being tracked appropriately. OHA will be exploring National Quality Forum (NQF)-endorsed and other healthcare disparities and cultural competency measures for inclusion in the measurement framework. As new measures are identified, potentially through the CMS Adult Core Quality Measures Grant, or endorsed, through NQF or Meaningful Use Stage 2, OHA will add and retire measures from the overall measurement framework.

The Metrics and Scoring Committee will be reviewing CCO performance data, improvement over baseline, and distribution of the quality pool to determine if the initial incentive metrics selected were the right combination of measures to improve quality and access for the Oregon Health Plan population. Incentive measures may be added in subsequent years and it is likely that other measures will be retired from the list, either due to measurement concerns or progress.

Data Collection

The Oregon Health Authority will be responsible for collecting data on all measures selected. An external quality review organization (EQRO) will play a role in data collection and analysis where necessary, assisting with measures that require chart reviews and/or validation of information submitted by a CCO as specified by OHA. OHA is also contracting with the Oregon Health Care Quality Corporation (Quality Corp) for assistance in data cleaning and analysis, third party validation, and reporting.



Data Analysis

OHA is in the process of developing a more detailed timeline to establish the necessary steps and responsibilities for collecting and analyzing selected measures, while being as efficient with resources as possible. This reporting plan will be developed by December 2012.

OHA will also be responsible for conducting data analysis on these measures. Where possible, measures will be aggregated by CCO, and analyzed for trends, issues, areas of concern and areas of innovative improvement. Data will also be analyzed and reported by racial and ethnic groups, in addition to vulnerable populations such as people experiencing homelessness and people with specific diagnoses (disabling conditions, serious and persistent mental illness (SPMI), chronic conditions, addictions). OHA will be involving data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders in clearly defining selected subpopulations for analysis.

Data Reporting

The Oregon Health Authority is committed to transparency in health system transformation efforts: all selected measures will be reported publicly on the Oregon Health Authority website. With the exception of data that is collected annually (e.g., patient experience of care surveys), all metrics will be reported at least quarterly to track patterns of utilization and highlight potential issues with performance.

This data will be used to track program goals, address disparities, and drive quality improvement through financial incentives, performance reporting, and rapid cycle feedback processes. Data from selected measures will also be used to inform formative and impact evaluation questions.

For More Information

Metrics and Scoring Committee: <http://www.oregon.gov/oha/pages/metrix.aspx>

Contact:

Carole Romm, MPA, RN
carole.romm@state.or.us



Potential Measures by Set

Incentive Measures – Year One

- 1) Initiation and engagement of alcohol and other drug dependence treatment*
- 2) Pre-natal care
- 3) Follow-up after hospitalization for mental illness*
- 4) Total emergency department utilization (visits/1,000 members)*
- 5) Colorectal cancer screening
- 6) Patient-Centered Primary Care Home (PCPCH) enrollment
- 7) Developmental screening by 36 months*
- 8) Adolescent well-care visits
- 9) Screening for clinical depression and follow-up plan*
- 10) Controlling high blood pressure
- 11) Mental and physical health assessment for children in DHS custody*
- 12) Elective delivery before 39 weeks
- 13) Optimal diabetes care (D3): Percentage of patients with diabetes with:
 - a. BP less than 140/90
 - b. LDL less than 100 mg/dl
 - c. Hemoglobin A1c is less than 8%
- 14) Alcohol or other substance misuse screening, brief intervention and referral to treatment (SBIRT)*
- 15) Access to care (CAHPS¹ composite):
 - a. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?" (Adult)
 - b. "In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?" (Adult)
 - c. "In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed?" (Child)
 - d. "In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?" (Child)

¹ CAHPS – Consumer Assessment of Healthcare Providers and Systems survey

16) Satisfaction with health plan customer service (CAHPS composite):

- a. "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" (Adult)
- b. "In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?" (Adult)
- c. "In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?" (Child)
- d. "In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?" (Child)

17) EHR adoption (Meaningful Use composite – 3 questions)

Oregon Core Performance Measures

- 1) Member experience of care (CAHPS composite)
- 2) Member health status (CAHPS functional status)
- 3) Rate of tobacco use among CCO enrollees
- 4) Rate of obesity among CCO enrollees
- 5) Outpatient and emergency department utilization*
- 6) Potentially avoidable emergency department visits
- 7) Primary-care sensitive hospital admissions
- 8) Medication reconciliation post-discharge
- 9) All-cause readmissions
- 10) Alcohol or other substance misuse (SBIRT)*
- 11) Initiation and engagement in alcohol and drug treatment*
- 12) Mental health assessment for children in DHS custody*
- 13) Follow-up after hospitalization for mental illness*
- 14) Effective contraceptive use
- 15) Low birth weight
- 16) Developmental screening by 36 months*
- 17) Reduction of disparities
- 18) Planning for end-of-life care
- 19) Screening for clinical depression and follow-up plan*
- 20) Timely transmission of transition record
- 21) Care plan for members with long-term care benefits



CMS Adult Core Measures²

- 1) Flu shots for adults ages 50-64
- 2) Adult BMI assessment
- 3) Breast cancer screening
- 4) Cervical cancer screening
- 5) Medical assistance with smoking and tobacco use cessation
- 6) Screening for clinical depression and follow-up plan*
- 7) All-cause readmission
- 8) PQI 01: diabetes, short-term complications admission rate
- 9) PQI 05: chronic obstructive pulmonary disease (COPD) admission rate
- 10) PQI 08: congestive heart failure admission rate
- 11) PQI 15: adult asthma admission rate
- 12) Chlamydia screening in women age 21-24
- 13) Follow-up after hospitalization for mental illness*
- 14) PC-01: elective delivery
- 15) PC-03: antenatal steroids
- 16) Annual HIV/AIDS medical visit
- 17) Controlling high blood pressure
- 18) Comprehensive diabetes care: LCL-C screening
- 19) Comprehensive diabetes care: hemoglobin A1c testing*
- 20) Antidepressant medication management
- 21) Adherence to antipsychotics for individual with schizophrenia
- 22) Annual monitoring for patients on persistent medications
- 23) CAHPS health plan survey v4.0 – adult questionnaire with CAHPS health plan survey v4.0H – NCQA supplemental
- 24) Care transition – transition record transmitted to health care professional*
- 25) Initiation and engagement of alcohol and other drug dependence treatment*
- 26) Prenatal and postpartum care: postpartum care rate

CHIPRA Measures³

- 1) Prenatal and postpartum care: timeliness of prenatal care*
- 2) Frequency of ongoing prenatal care
- 3) Percentage of live births weighing less than 2,500 grams (e.g., low birth weight)

² These measures are subject to change by CMS.

³ These measures are subject to change by CMS

- 4) Cesarean rate for nulliparous singleton vertex
- 5) Childhood immunization status
- 6) Immunization for adolescents
- 7) Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents
- 8) Developmental screening in the first three years of life*
- 9) Chlamydia screening in women
- 10) Well-child visits in the first 15 months of life
- 11) Well-child visits in the 3rd, 4th, 5th, and 6th years of life
- 12) Adolescent well-care visit*
- 13) Total eligibles who received preventive dental services (ages 1-20)
- 14) Child and adolescent access to primary care practitioners
- 15) Appropriate testing for children with pharyngitis
- 16) Otitis media with effusion (OME) – avoidance of inappropriate use of systemic antimicrobials in children (ages 2-12)
- 17) Total eligibles who received dental treatment services (ages 1-20)
- 18) Ambulatory care: emergency department visits*
- 19) Pediatric central-line associated bloodstream infections – neonatal intensive care unit and pediatric intensive care unit
- 20) Annual percentage of asthma patients with one or more asthma-related emergency department visit (age 2-20)
- 21) Follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication
- 22) Annual pediatric hemoglobin A1c testing
- 23) Follow-up after hospitalization for mental illness
- 24) CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items)

* Measure (or similar measure) appears in more than one measurement set

Alignment and Opportunities: Health and Early Learning System Transformation

	Coordinated Care Model	Early Learning System	Shared Challenges	Policy Opportunities
Screening	<ul style="list-style-type: none"> • American Academy of Pediatrics (AAP)/Bright Futures Guidelines (ACA and OHP Prioritized List): <ul style="list-style-type: none"> ○ Developmental screening ○ Autism Screening ○ Psychosocial/Behavioral Assessment ○ Alcohol and Drug Use Assessment 	<ul style="list-style-type: none"> • Five Domains • Screening Tools Workgroup-recommendations accepted • Screening implementation 	<ul style="list-style-type: none"> • Workforce Training • Shared Data • Care Coordination/Referrals • Accountability • Billing/Payment 	
Quality Metrics	<ul style="list-style-type: none"> • CHIPRA: Initial Core Set of Children’s Health Care Quality Measures • <i>Draft</i> CCO Incentive Measures: <ul style="list-style-type: none"> ○ Developmental screening ○ Mental health and/or physical health assessment for children in DHS custody ○ Depression screening and follow-up plan ○ Substance abuse- SBIRT 	<ul style="list-style-type: none"> • ELC Charge <ul style="list-style-type: none"> ○ Readiness for kindergarten ○ Ready to read in 1st Grade ○ Reading at grade level by end of 1st grade • Outcome measures under development by the ELC “Hub Workgroup” 	Alignment	

Alignment and Opportunities: Health and Early Learning System Transformation

	Coordinated Care Model	Early Learning System	Shared Challenges	Policy Opportunities
Care Coordination	<ul style="list-style-type: none"> • Various levels of care coordination: <ul style="list-style-type: none"> ○ PCPCH ○ CCO- high needs 	<ul style="list-style-type: none"> • Family Resource Navigator • Individual program coordination services 	<i>Coordinated Care Coordination (within and across systems)</i>	
Data Source	<ul style="list-style-type: none"> • Billing Data: MMIS • All Payer All Claims (APAC) • Quality Corporation • EHR • Chart review (EQRO) • Surveys (e.g. CAHPS, NSCH) 	<ul style="list-style-type: none"> • Statewide Longitudinal Data System (SSID #) • MIECHV Data System work • Individual Program Data Systems e.g. EI/ECSE • Data System Workgroup recommendations <ul style="list-style-type: none"> ○ Early Childhood Data System 	Federal privacy regulations: FERPA and HIPAA Shared Data System-Governance and Development	
Accountability	<ul style="list-style-type: none"> • CCO: Core and incentive metrics • PCPCH: PCPCH Standards 	<ul style="list-style-type: none"> • Under development by the ELC “Hub Workgroup” 	How do we develop shared accountability? e.g. kindergarten readiness	

Alignment and Opportunities: Health and Early Learning System Transformation

	Coordinated Care Model	Early Learning System	Shared Challenges	Policy Opportunities
Governance	<ul style="list-style-type: none"> Local: CCO 	<ul style="list-style-type: none"> Early Learning Council Future Hubs: local community 	Alignment on cross-systems issues	
Social Determinants of Health (SDH) and Education	<ul style="list-style-type: none"> Shared determinants of population health/education success: <ul style="list-style-type: none"> Adverse Childhood Events/Trauma <ul style="list-style-type: none"> ACE Study Food Security Housing Security Energy Security 		Addressing social determinants in healthcare and education transformation	
Program-level Intersections: Examples	<ul style="list-style-type: none"> Early Intervention/Early Childhood Special Education (EI/ECSE): screening, referrals, tracking , Medicaid billing (ABCD 3 Project) Home visiting Head Start: lead/anemia screening, health exam requirements WIC: referrals, prescriptions, anemia screening, nutrition counseling Childcare 		Access Coordination Duplication Quality Childcare	

Charter: Early Learning Council/Oregon Health Policy Board Joint Subcommittee

Date Approved:

AUTHORITY

HB 2009 established the Oregon Health Policy Board (OHPB), a nine-member board appointed by the Governor and confirmed by the Senate. The Board serves as the policy-making and oversight body for the Oregon Health Authority (OHA) and is responsible for implementing the health policy reform provisions of HB 2009. Since the Board's establishment, the passage of HB 3650 (2011) and HB 1580 (2012) have provided the framework for transitioning to an integrated and coordinated health care delivery system through Coordinated Care Organizations (CCOs).

SB 909 (2011) established the Oregon Education Investment Board (OEIB) and the Early Learning Council (ELC), a nine-member Governor-appointed committee. The Council is responsible for assisting the OEIB in overseeing a unified system of early learning services for the purpose of ensuring that children enter school ready to learn by kindergarten. HB 4165 (2012) expanded the Early Learning Council to serve as the state advisory council for the purpose of the federal Head Start Act. To fulfill this role, the Council was expanded to nineteen members. By February 2013, the ELC is responsible for submitting a report to the Legislature on a regional system of early learning services including the functions and administration of community-based coordinators.

Subcommittee membership & Governance

Executive Sponsors:

Jada Rupley, Early Learning Director
Tina Edlund, Chief of Policy, Oregon Health Authority (OHA)

Staff:

Dana Hargunani
Jennifer Gilbert

Subcommittee Members:

Pam Curtis, ELC
Teri Thalsofer, ELC
Janet Dougherty-Smith, ELC
Mike Bonetto, OHPB
Carla McKelvey, OHPB

Scope

This subcommittee is responsible for developing strategies, a policy framework and a timeline to ensure alignment and/or integration between health care and early learning system transformation. The subcommittee will adopt guiding principles to direct their work (e.g. maximizing use of existing resources and decreasing duplication), with guidance from the founding principles of the OHPB and ELC.

Revision Date:

Key areas of focus for the subcommittee may include, but are not limited to: screening, care coordination, data, and metrics. The subcommittee will consider avenues for shared responsibility towards the outcome of kindergarten readiness for all Oregon children. The subcommittee will assess potential health and early learning policy impacts on the delivery system and outcomes for children and families.

Major Deliverables

- A set of guiding principles
- Assessment of key areas for potential alignment and/or integration across health and early learning, including review of existing evidence
- Strawperson proposal for alignment and/or integration of health and early learning policy and service delivery
- Proposal and timeline for establishing kindergarten readiness as a shared outcome

Exclusions or Boundaries

Policy implementation will not be carried out by this subcommittee. Recommendations will be brought forth to the Oregon Health Policy Board and Early Learning Council for decision-making. Prior legislative responsibilities and/or requirements placed on the Oregon Health Policy Board or Early Learning Council are excluded from this charter.

Dependencies

- Oregon Health Policy Board: health policy
- Oregon Education Investment Board: P-20 education policy
- Early Learning Council: early learning policy
- Metrics and Scoring Committee: CCO metrics
- Federal privacy policies: FERPA, HIPAA

Schedule

The joint subcommittee will meet bimonthly. The frequency of meetings may be altered to fit legislative timelines and/or other needs that arise. The subcommittee charter will end by December 2013 or when the ELC and OHPB accept their charter as completed.

Deliverable Timeline:

- 12/2012- Subcommittee convenes; guiding principles adopted
- 4/2013- Background work completed
- 8/2013- Strawperson proposal presented
- 10/2013- ELC, OHPB review completed
- 12/2013- Final proposal delivered

Revision Date:

Early Learning System



UPDATE TO OREGON HEALTH POLICY BOARD

NOVEMBER 13, 2012

Early Learning Council Members



- **Pam Curtis** Chair, Deputy Director, Center for Evidence-based Policy, Oregon Health & Sciences University
- **Bobbie Weber** Research Associate, Family Policy Program, College of Public Health and Human Sciences, Oregon State University
- **Janet Dougherty-Smith** Former Director, Early Childhood Services for Clackamas County Education Service District
- **Norm Smith** President, Ford Family Foundation
- **Marlene Yesquen** Attorney, Medford's Black Chapman Webber and Stevens, Medford School District Board Member
- **Teri Thallofer** RN, Director, North Central Public Health
- **Jim Tierney** Executive Director, Community Action Team
- **Harriet Adair** Regional Administrator, Portland Public Schools
- **Dana Hargunani** Child Health Director, Oregon Health Authority
- **Lynne Saxton** Executive Director, Christie Care-Youth Villages of Oregon
- **Kara Waddell** Administrator, Oregon Child Care Division
- **Eva Rippeteau** Political Coordinator, Oregon AFSCME
- **Vikki Bishop** Early Childhood Education Program Manager, Confederated Tribes of the Grande Ronde
- **Kim Williams** Director of North Central ESD Early Education
- **Charles McGee** Executive Director and Co-Founder of the Black Parent Initiative
- **Dick Withnell** Founder, Withnell Auto

The Charge



- 1. ENSURE ALL CHILDREN ARE:**
 - Ready for Kindergarten
 - Enters 1st Grade Ready to Read
 - Reading at 3rd Grade
- 2. INTEGRATE AND COORDINATE RESOURCES AND EFFORTS**

Our Youngest Oregonians



50% of children are born Medicaid eligible

4 in 10 children are not ready for Kindergarten



Children in Unlicensed Settings

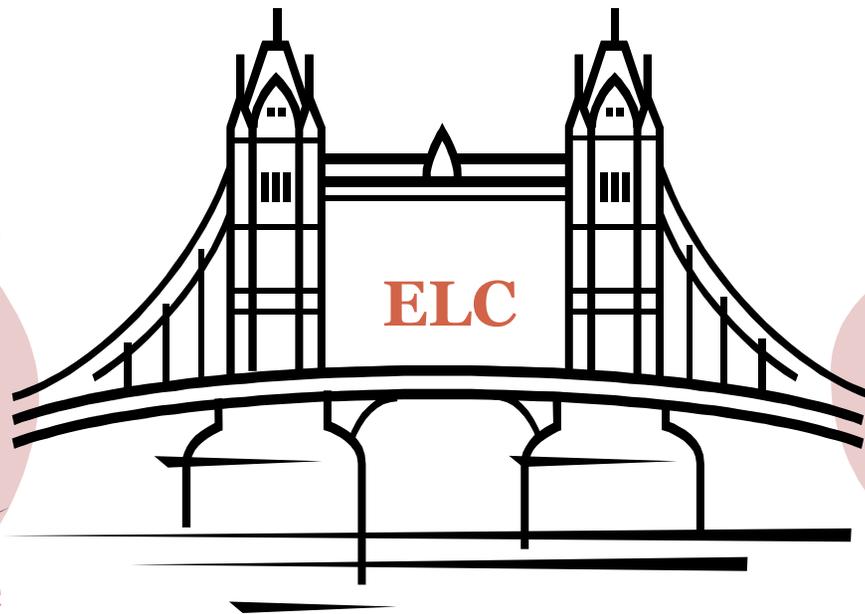


State	Percent of Children	State	Percent Of Children
Hawaii	69%	South Dakota	15%
Michigan	57%	Virginia	15%
Oregon	53%	Iowa	14%
Illinois	44%	Nebraska	13%
New York	40%	Vermont	12%
Connecticut	37%	Arizona	9%
Missouri	37%	Tennessee	9%
North Dakota	35%	Delaware	8%
Utah	34%	Florida	8%
Alabama	32%	New Jersey	7%
California	28%	Kentucky	6%
Indiana	28%	Maine	6%
Idaho	26%	Colorado	5%
Minnesota	26%	South Carolina	5%
Nevada	24%	West Virginia	5%
Pennsylvania	24%	Georgia	2%
Alaska	23%	Texas	2%
Mississippi	23%	District of Columbia	1%
New Mexico	23%	North Carolina	1%
Washington	20%	Rhode Island	1%
Louisiana	18%	Arkansas	0%
New Hampshire	18%	Massachusetts	0%
Wyoming	18%	Ohio	0%
Kansas	17%	Oklahoma	0%
Maryland	17%	Wisconsin	0%
Montana	17%		
		National Average*	19%

Source: FY2010 CCDF Data Tables,

http://www.acf.hhs.gov/programs/occ/data/ccdf_data/10acf800_preliminary/table4.htm

Bridging the Gap



In Oregon



- 45,000 CHILDREN BORN EACH YEAR
- 270,000 AGES 0-5
- 40% at risk
 - Low income
 - Children of color
 - Families accessing state assistance programs
- \$350+ MILLION PER YEAR

In Oregon



- **COMPLEX EDUCATION, HEALTH, AND SUPPORT SYSTEM**
 - More than 2 dozen state-sponsored programs
 - 28,000 non-profit organizations
 - Eight state-level coordinating bodies
 - Local governance structures
- **UNCOORDINATED AND DISCONNECTED**
- **DIFFICULT TO NAVIGATE**
- **LACK OF OUTCOME ACCOUNTABILITY**

The Future: Back to the Vision

Oregon's Early Learning System



1. **EARLY IDENTIFICATION & RISK ASSESSMENT**
2. **ALL CHILDREN HAVE EARLY LEARNING OPPORTUNITIES**
3. **COORDINATED & INTEGRATED SUPPORT (COMMUNITY HUBS)**
 - Use of Family Resource Management
 - Consistent regional approach
4. **OUTCOME FOCUS**
 - Service contracts
 - Kindergarten readiness assessment
 - Screening
5. **INTEGRATED DATA SYSTEM**

Oregon's Early Learning System



6. **CONSOLIDATE GOVERNANCE STRUCTURES**
7. **PARENTAL ACCESS AND TRANSPARENCY**
8. **TRAINED AND SUPPORTED WORKFORCE**

Community Based Coordinators of Early Learning Services (HB 4165)



- **COMMUNITIES WILL SUBMIT AN APPLICATION THAT DEMONSTRATES HOW THEY WILL ACHIEVE THE OUTCOMES**
- **MEET THE CHARGE—ENSURE ALL CHILDREN ARE READY FOR KINDERGARTEN, 1ST GRADE, AND 3RD GRADE**
- **MEETINGS: SEPTEMBER 20 – DECEMBER 19**

Governor's Vision is My Vision



- **IMPLEMENTATION PRIORITIES**
 - Strong Beginning
 - Joint Health Care Policy Board & ELC
- **ACCOUNTABILITY AND SERVICE FOR HUBS**
 - Professional Development
 - TQRIS/Kindergarten Assessment
 - Race to the Top
- **STRONG FINISH**
 - 100% READY FOR KINDERGARTEN

Laser-Like Focus



- **BLUR FUNDING LINE**
- **BRIGHTEN SERVICE TO FAMILIES LINE**
- **PROGRAMS & SERVICES**
- **DATA-DRIVEN**
- **ADDRESSING OREGON'S CHILDREN & FAMILIES**



**My Goal
and
Request**

Focus on getting 100% of
Oregon's children ready for
school.



JADA RUPLEY
EARLY
LEARNING
SYSTEM
DIRECTOR



OREGON EARLY
LEARNING COUNCIL



Oregon seeks public comment on Medicaid Benchmark Plan

Oregon Medicaid Benchmark Plan: preliminary recommendation

The federal Affordable Care Act (ACA) established new requirements beginning in January 2014 for benefits covering Medicaid expansion populations, such as those currently covered under Oregon Health Plan Standard. The Affordable Care Act requires states to offer a comprehensive package of items and services known as “essential health benefits.” From August through October 2012, the Oregon Medicaid Advisory Committee worked to select a benefit package that will meet all 10 federally required essential health benefits and meet the benchmark selection criteria. On October 24, the committee made a preliminary recommendation to designate the **Oregon Health Plan Plus** (*for non-pregnant adults) as the basis for the state’s Medicaid benchmark plan. This decision was based on a set of decision-making principles adopted by the committee and a desire to simplify, align, and streamline benefit coverage across the Oregon Health Plan (i.e., OHP Plus vs. OHP Standard). The preliminary recommendation seeks to minimize disruption for individuals who move among different benefit packages within OHP. Public comment is being requested.

Public comments will be accepted through 5 p.m. November 19, 2012

Please send comments to Mac.Info@state.or.us

Additional Information

Interested parties can view a comparison of the Oregon Health Plan and the commercial reference plan, and additional resources on the Medicaid Advisory Committee website at:

www.oregon.gov/OHA/OHPR/Pages/MAC/MACwelcomepage.aspx.

Background

The Affordable Care Act requires states to select a benchmark benefit plan that will be applied to any Medicaid expansion population of non-pregnant adults. Oregon will not be able to use the current OHP Standard benefits for the expansion population. If Oregon chooses to expand coverage to a new Medicaid eligibility group (non-pregnant adults aged 19-65 with incomes up to 138 percent of the federal poverty level (FPL) who become eligible for Medicaid starting in 2014 as described under §1937 of the Social Security Act), this new benchmark would be the covered benefit plan. Starting in January 2014, Medicaid benchmark or benchmark-equivalent plans must include all 10 categories of essential health benefits (EHBs). States, including Oregon, have the option to provide a benefit package that meets all 10 required EHBs from the following benchmark plans:

- Traditional Medicaid package (i.e. Oregon Health Plan)
- Largest federal employees health plan (Blue Cross Blue Shield)
- State employee health plan (in Oregon, Providence Statewide)
- Largest non-Medicaid HMO plan (in Oregon, Kaiser HMO)

States also can consider their commercial Essential Health Benefit reference plan as alternative option. In August 2012, the Essential Health Benefits Workgroup, established by Governor Kitzhaber for the purpose of recommending an Essential Health Benefit benchmark plan for Oregon’s individual and small group market, recommend the *PacificSource Preferred CoDeduct* small group plan. This plan will

be used as the “base” for all plans offered inside and outside of the Oregon Health Insurance Exchange in the *commercial individual and small group market*. For more information, please visit the EHB Workgroup [website](http://cms.oregon.egov.com/oha/OHPR/pages/ehb/index.aspx) at: <http://cms.oregon.egov.com/oha/OHPR/pages/ehb/index.aspx>

Next steps for the Medicaid Benchmark Plan selection process

The Oregon Medicaid Advisory Committee will develop a final recommendation for the Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) to consider. The committee is scheduled to meet November 28 to review public comment and adopt a final recommendation. After that meeting a final draft of the committee’s Medicaid benchmark plan recommendation will be posted for additional public comment through December 5. A summary of all public comment, committee discussion points and the recommendation will be presented to the Oregon Health Policy Board (OHPB) on December 11. Once the recommendation is finalized, OHPB will review the recommendation and forward it to OHA. OHA must then submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) for approval.
