

# Oregon Health Plan

## Section 1115 Quarterly Report



7/1/2014 – 9/30/2014

Demonstration Year (DY): 13 (7/1/2014 – 6/30/2015)

Demonstration Quarter (DQ): 1/2015

Federal Fiscal Quarter (FQ): 4/2014

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## I. Introduction

### A. Letter from the State Medicaid Director

On July 1, 2014, the Oregon Health Authority (OHA) proudly launched the Hospital Transformation Performance Program (HTPP) in collaboration with the Oregon Association of Hospitals and Health Systems (OAHHS). Under the HTPP, the state has established a financial pool to issue incentive payments to participating hospitals for implementing and reporting on initiatives to improve the quality of the Oregon health care system. This report includes a summary of activities to establish program rules, and outlines the new improvement measures.

OHA has also continued development of the core performance measures outlined in the Special Terms and Conditions: 2011 baseline data, calendar year 2013 data, and a rolling 12-month measurement period at the state level. These are included in this report along with available high and low scores.

The state is currently working on several evaluation activities, and findings from a number of research efforts are covered in this report, including:

- Researchers from Oregon Health & Sciences University (OHSU) presented a study looking at the early impacts of the CCOs using data through 2013;
- Results of Oregon's CAHPS survey were shared with the CCOs; and,
- Researchers from OHSU, OHA, and the State Health Access Data Assistance Center (SHADAC) released insurance coverage estimates for the state showing that between June 30, 2013, and June 30, 2014, the estimated number of uninsured Oregonians fell by 348,000, or 63%.

In addition, work has progressed on Mathematica's independent midpoint evaluation of the 1115 Demonstration, including initial construction of the analytic models to assess preliminary outcomes. Mathematica is finalizing the analysis and preparing the draft report for submission to CMS in December 2014.

Efforts to address the expansion of the Medicaid workforce in Oregon also continued this quarter, which saw more Traditional Health Workers (THW) trained than in any other quarter since we began reporting, bringing the state total to 145 THWs trained, 64 of whom have been certified. Out of the 145 individuals trained, 40 are of Hispanic origin, 38 are African American, 6 are Native American.

Finally, the Transformation Center continued support in this quarter of the CCOs, facilitating three sessions for the statewide CCO learning collaborative:

- A session in which the group reviewed year-end data from Oregon's Health System Transformation 2013 Performance Report and participated in a "clicker" voting process to determine topics for the next six months;
- A session focused on health equity, with a panel of community-based leaders; and
- A session on strategies to improve access to care and CAHPS data.



*Judy Mohr Peterson, PhD.*  
*State Medicaid Director*

**B. Demonstration description**

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

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

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

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

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

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

DY	Time Period	FFP Limit	DY	Time Period	FFP Limit
11	07/1/12-06/30/13	\$230 M	14	07/1/15-06/30/16	\$ 68 M
12	07/1/13-06/30/14	\$230 M	15	07/1/16-06/30/17	\$ 68 M
13	07/1/14-06/30/15	\$108 M			

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

The primary goals of the Oregon demonstration are:

- **Improving health for all Oregonians:** The State is committed to fostering innovative approaches to improving population health through a focus on linking community health and services with the clinical delivery system. Population health efforts and alignment with schools and the education system are integral to improving the health of all Oregonians by going beyond the walls of the clinics and hospitals.
- **Improving health care:** The State is working to coordinate physical, behavioral and oral health care and increase the focus on prevention and improved care. Individuals can get the care and services

they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language.

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

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

In June 2014, the Hospital Transformation Performance Program (HTPP) was approved, and OHA and CMS concluded final negotiations regarding the measures included in the program in September 2014. This two-year program will offer hospitals incentive payments to support quality improvement.

## C. State contacts

### Demonstration and Quarterly Reports

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## II. Title

Oregon Health Plan Section 1115 Quarterly Report  
 7/1/2014 – 9/30/2014  
 Demonstration Year (DY): 13 (7/1/2014 – 6/30/2015)  
 Demonstration Quarter (DQ): 1/2015  
 Federal Fiscal Quarter (FQ): 4/2014

## III. Events affecting health care delivery

### A. Overview of significant events across the state

Category of event	Impact? (Yes/No)			Interventions or actions taken? (Yes/No)
	Demonstration goals	Beneficiaries	Delivery system	
A. Enrollment progress	No	No	No	No
B. Benefits	No	No	No	No
C. CCO Complaints and Grievances	No	No	See notes	Yes, see notes
D. Quality of care – CCO / MCO / FFS	No	No	See notes	See notes
E. Access	No	No	No	No
F. Provider Workforce	No	No	No	No
G. CCO networks	No	No	No	No

#### Detail on impacts or interventions

- For details about interventions related to CCO complaints and grievances, please see [Section III.B](#) of this report (updated with outstanding plan information January 13, 2015).

### B. Complaints and grievances (updated January 13, 2015)

#### Table 2 – Complaints and grievances

This information is from quarterly submissions received from the contracted health plans and cross-referenced with complaint and grievance calls received internally by the Oregon Health Authority.

Complaint or grievance type	Number reported	Trend(s) identified? Yes/No	Number resolved	Actions to prevent recurrence? Yes/No	Range reported by CCOs
ELIGIBILITY AND ENROLLMENT	3042	n		y	28-698
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	123	Y	all	y	0-41
b) Plan unresponsive, not available or	33	Y	all	y	0-19

Complaint or grievance type	Number reported	Trend(s) identified? Yes/No	Number resolved	Actions to prevent recurrence? Yes/No	Range reported by CCOs
difficult to contact for appointment or information.					
c) Provider's office too far away, not convenient	18	N	all	n	0-8
d) Unable to schedule appointment in a timely manner.	96	Y	all	y	0-41
e) Provider's office closed to new patients.	34	N	all	n	0-13
f) Referral or 2nd opinion denied/refused by provider.	17	N	all	n	0-7
g) Unable to be seen in a timely manner for urgent/ emergent care	25	N	all	n	0-8
h) Provider not available to give necessary care	42	N	all	n	0-15
i) Eligibility issues	16		all	n	0-3
j) Client fired by provider	28	N	all	n	0-7
k) Availability of specialty provider	5	N	all	n	0-4
<b>INTERACTION WITH PROVIDER OR PLAN</b>					
a) Provider rude or inappropriate comments or behavior	179	Y	all	y	0-49
b) Plan rude or inappropriate comments or behavior	10	N	all	n	0-4
c) Provider explanation/instruction inadequate/incomplete	132	Y	all	y	0-59
d) Plan explanation/instruction inadequate/incomplete	83	Y	all	y	0-45
e) Wait too long in office before receiving care	27	N	all	n	0-11
f) Member dignity is not respected	14	N	all	n	0-6
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity.	6	N	all	n	0-4
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	1	N	all	n	0-1
i) Lack of coordination among providers	16	N	all	n	0-4
<b>CONSUMER RIGHTS</b>					
a) Provider's office has a physical barrier	0	N	all	N	0
b) Abuse, physical, mental, psychological	2	n	all	n	0-1
c) Concern over confidentiality	20	N	all	n	0-10
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.	99	Y	all	y	0-39
e) No choice of clinician	13	N	all	n	0-7
f) Fraud and abuse	11	N	all	n	0-5
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)	7	N	all	n	0-5
h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)	1	N	all	n	0-1
i) Differential treatment for Medicaid clients	14	N	all	N	0-5
j) Lack of adequate or understandable	1	N	all	N	0-1

Complaint or grievance type	Number reported	Trend(s) identified? Yes/No	Number resolved	Actions to prevent recurrence? Yes/No	Range reported by CCOs
NOA					
k) Not informed of consumer rights	1	N	all	N	0-1
l) Complaint and appeal process not explained	0	N	all	N	0
m) Denied member access to medical records	1	N	all	n	0-1
<b>CLINICAL CARE</b>					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.	131	N	all	N	0-51
b) Testing/assessment insufficient, inadequate or omitted	44	N	all	N	0-15
c) Medical record documentation issue	17	N	all	N	0-7
d) Concern about prescriber or medication or medication management issues	162	N	all	N	0-62
e) Unsanitary environment or equipment	7	N	all	N	0-2
f) Lack of appropriate individualized setting in treatment	4	N	all	N	0-5
<b>QUALITY OF SERVICE</b>					
a) Client feels unsafe/uncomfortable	21	N	all	N	0-9
b) Delay, quality of materials and supplies (DME) or dental	37	N	All	N	0-11
c) Lack of access to ENCC for intensive care coordination or case management services	2	N	all	N	0-1
d) Benefits not covered	432	Y	all	Y	0-197
<b>CLIENT BILLING ISSUES</b>					
a) Co-pays	3	N	all	N	0-1
b) Premiums	0	N	all	N	
c) Billing OHP clients without a signed Agreement to Pay	179	N	all	n	0-89

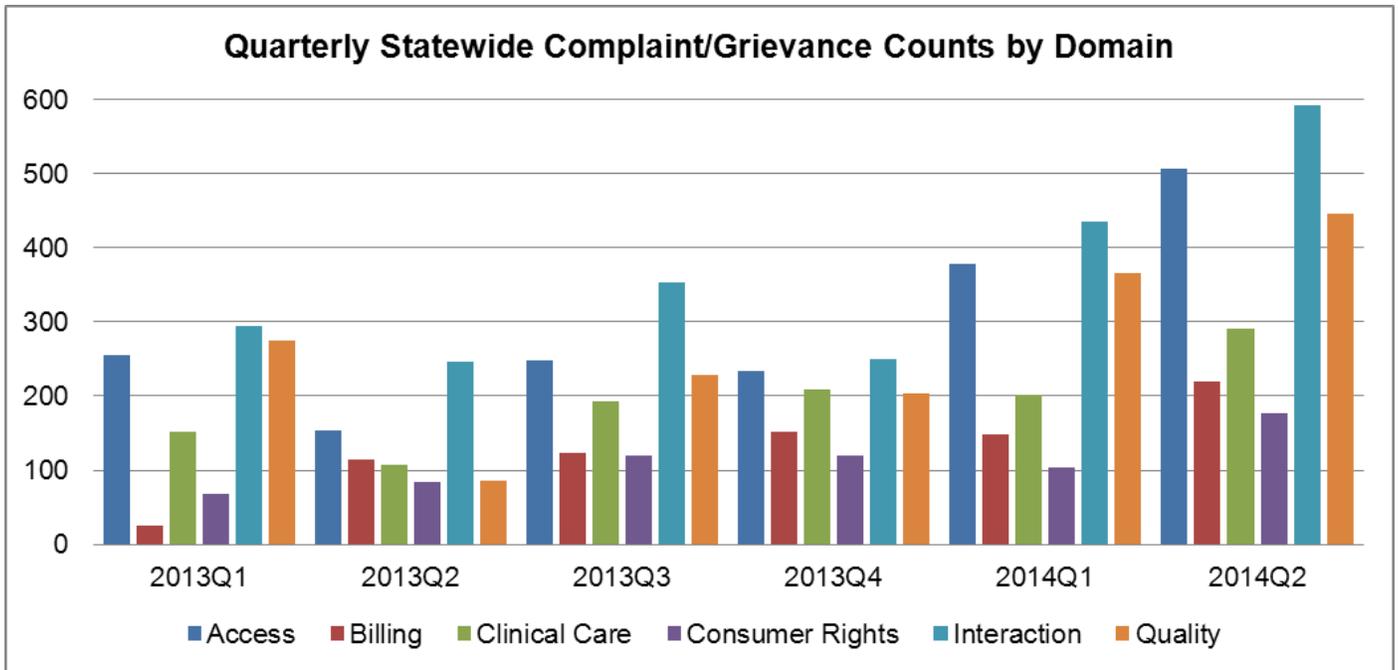
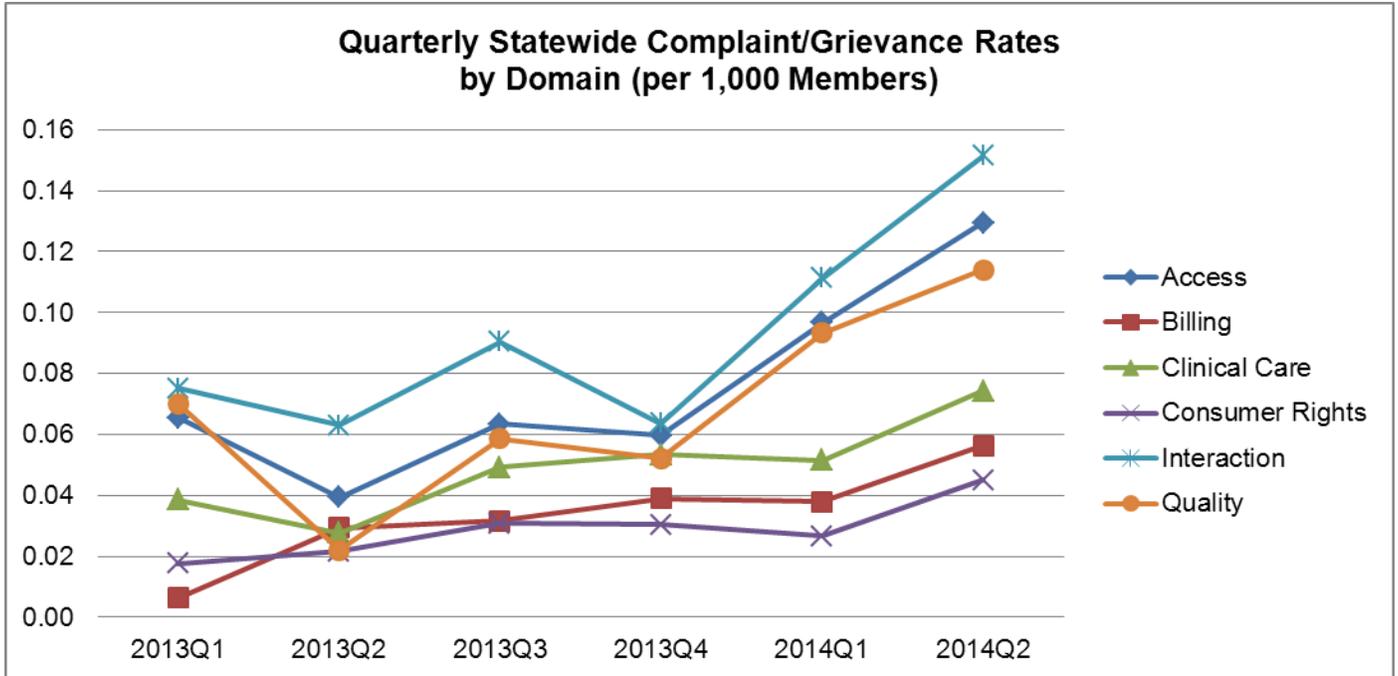
**Trends related to complaints and grievances**

Over the third quarter, OHP Client Services received over 3,000 calls directly related to concerns about OHP eligibility and enrollment into a managed care organization (MCO) or coordinated care organization (CCO). These calls fell into three general categories:

- Questions about letters received from OHA;
- Questions about their eligibility or enrollment status;
- Requests to change their MCO or CCO enrollment.

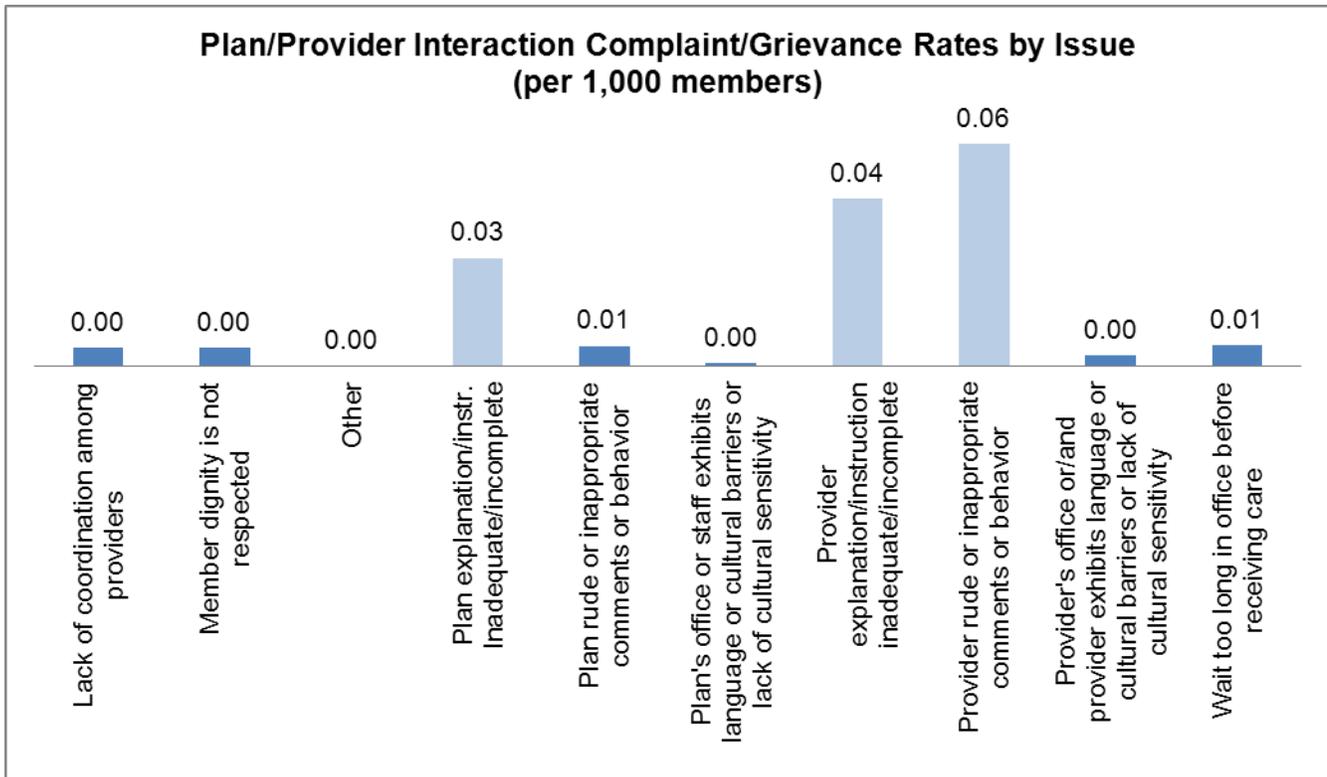
Trend rates for CCO grievance rates ranged from 0.51 to 5.39 per thousand members. As seen in the following chart, the categories showing the largest rise continue to rise this quarter:

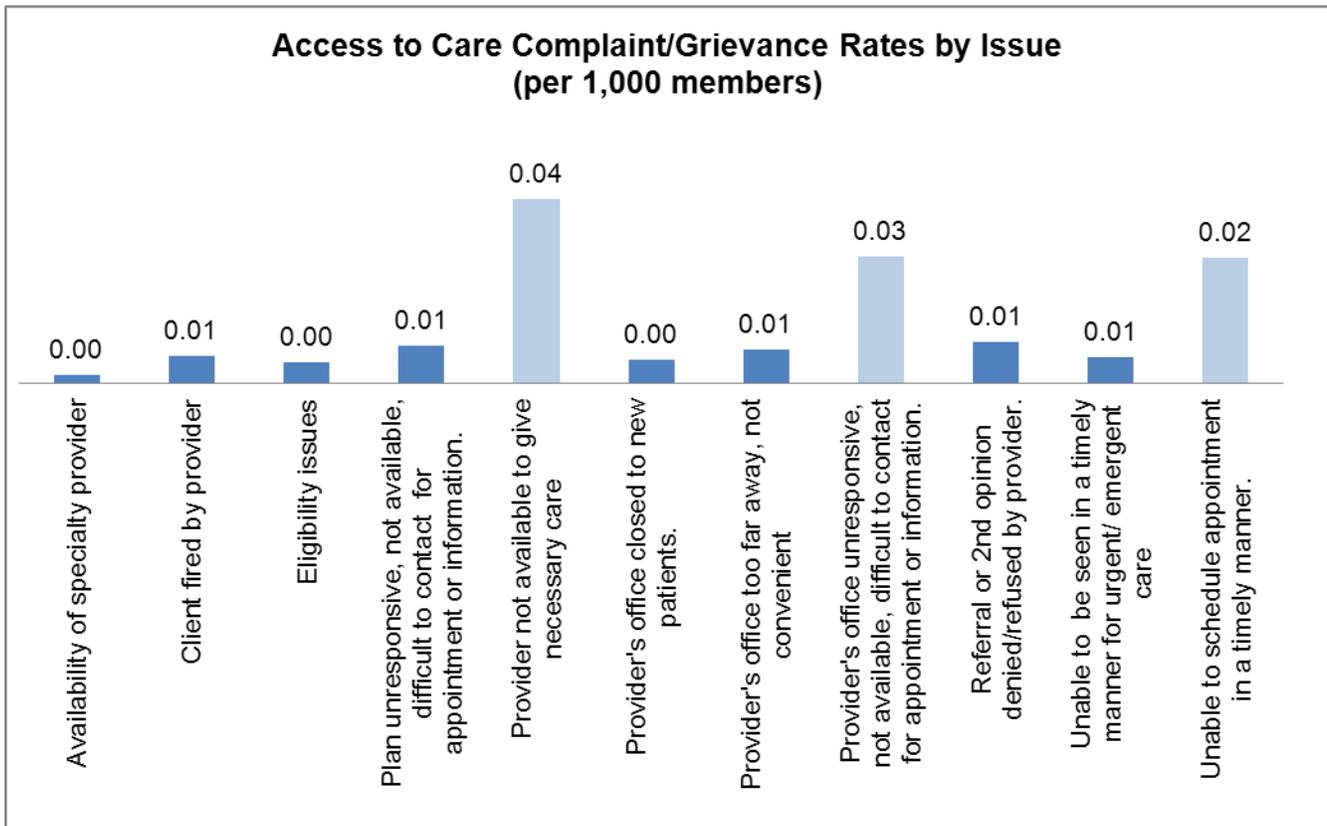
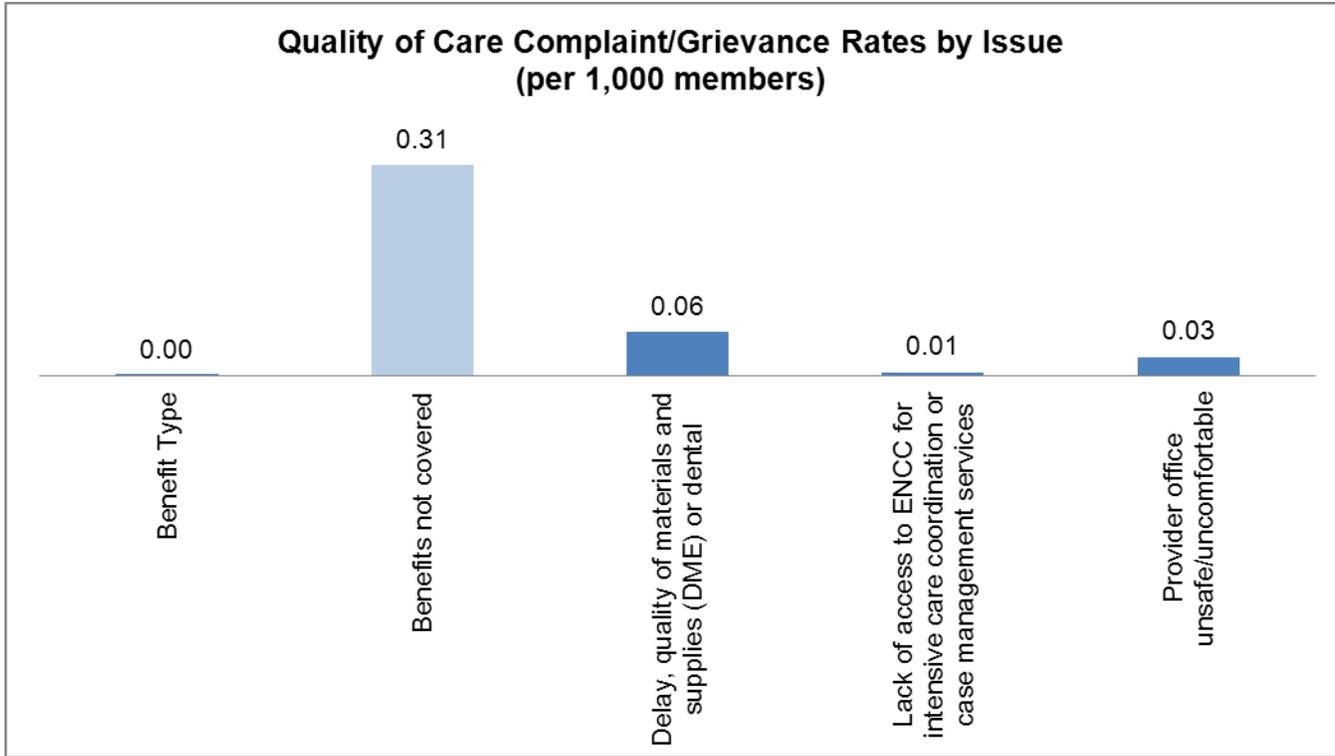
- **Interaction** with the plans and providers;
- **Access** to care;
- **Quality** of care.



OHA reviewed the individual issues reported under each of these domains to see if there were specific drivers for this rise. As seen in the following charts:

- The plan and provider interaction trends show that the client’s perceived experience with plan explanations, provider explanations and provider behavior trended upward with overall complaint totals.
- Quality complaints were driven by concerns over benefits not being covered. Upon review of hearing and appeals data, direct reviews of grievances, and quarterly review of Notices of Action, OHA observed that these concerns are largely related to pharmacy substitutions; treatments not covered by OHP, and seeking treatment from providers not enrolled with OHP or an MCO/CCO.
- Access concerns were related to timely and available appointments.





**Interventions**

MAP has worked with plans on their ongoing communications to clients about how to gain access to timely information, instruction navigating and advocating for their health services. Best practices in client and provider communications have been reviewed in several state-sponsored CCO meetings.

To address quality of care complaints, OHA continues to monitor for any issues related to pharmacy substitutions, non-covered services and out-of-network providers through our Medical Management Committees, Health Evidence Review Commission and metrics.

OHA also continues to closely monitor access concerns. Plans continue to use care coordinators to triage urgent and emergent requests and reach out to providers for appointment times. MAP and health plans have convened a Capacity Workgroup to develop a multi-tiered approach to evaluating access.

**C. Appeals and hearings**

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

Reporting according to the following categories is still in development. While we are able to provide totals for the status of appeal and hearings during the quarter, we are unable to provide these numbers by category.

**CCO appeals and hearings**

Category	CCO Appeals						Contested Case Hearings from CCO Appeals					
	Total		Overturned at plan level		Decisions Pending		Total		Overturned at hearing		Decisions Pending	
	#	Range	#	Range	#	Range	#	Range	#	Range	#	Range
a) Denial or limited authorization of a requested service	1553	0-223										
b) Single PHP service area, denial to obtain services outside the PHP panel	6	0-3										
c) Termination, suspension or reduction of previously authorized covered services	40	0-36										
d) Failure to act within the timeframes provided in §438.408(b)	0	0										
e) Failure to provide services in a timely manner, as defined by the State	0	0										
f) Denial of payment for a service rendered	366	0-124										
<b>TOTALS</b>	<b>1965</b>	<b>0-223</b>	<b>583/3-132</b>		<b>1</b>		<b>896/0-148</b>		<b>3</b>		<b>2</b>	

NOTE: Not all plans are currently using same reporting categories, which results in large range variations in the above categories. OHA is working with plans to align these categories.

**Contested case hearings information**

The following charts represent hearings information for cases that were initiated through the State's Fair Hearings process.

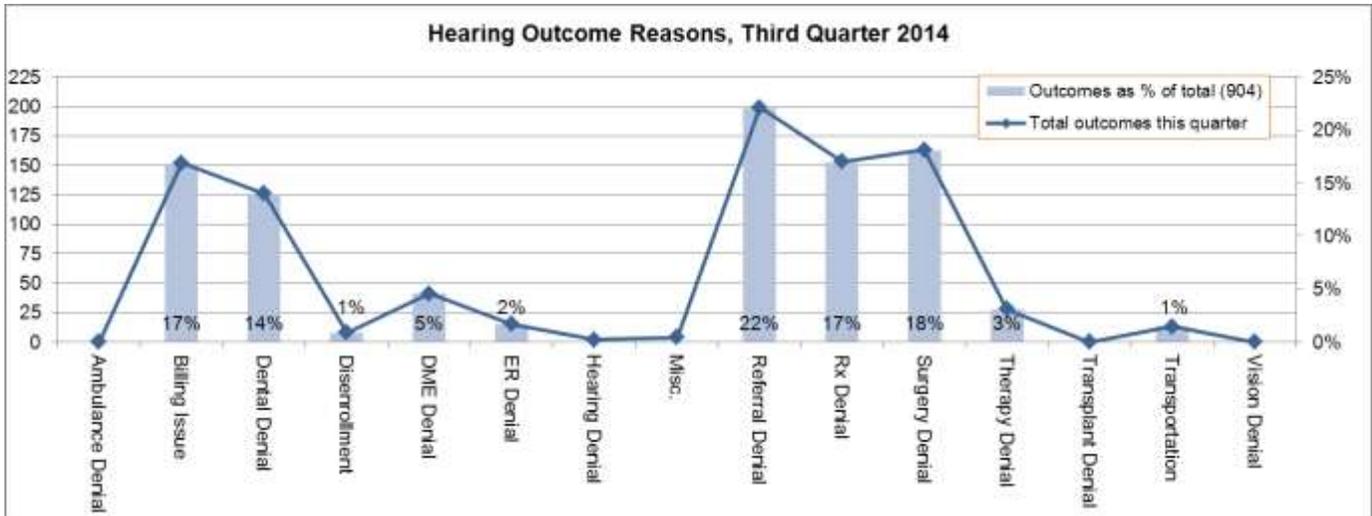
- They reflect hearing requests submitted to OHA by members of the following plans.
- They do not reflect appeal requests submitted to plans.

Plan Name	Total Received	Average Enrollment*	Per 1000 Members
<b>Coordinated Care Organization requests</b>			
AllCare Health Plan, Inc.	35	47,906	0.7306
Cascade Health Alliance	21	10,920	1.9231
Columbia Pacific CCO, LLC	19	25,587	0.7426
Eastern Oregon CCO, LCC	80	45,871	1.7440
FamilyCare CCO	110	109,809	1.0017
Health Share of Oregon	148	226,726	0.6528
Intercommunity Health Network	63	53,532	1.1769
Jackson Care Connect	5	28,222	0.1772
Kaiser Permanente OR Plus, LLC	7	2,040	3.4308
PacificSource Community Solutions	99	73,735	1.3427
PacificSource Community Solutions – Gorge		12,363	
PrimaryHealth of Josephine County CCO	5	10,657	0.4692
Trillium Community Health Plan	80	74,152	1.0789
Umpqua Health Alliance, DCIPA	49	25,868	1.8943
Western Oregon Advanced Health	22	20,072	1.0961
Willamette Valley Community Health	126	94,595	1.3320
Yamhill County Care Organization	5	21,529	0.2322
<b>Dental Care Organization requests</b>			
Access Dental Plan, LLC		1,803	0.0000
Advantage Dental	10	77,105	0.1297
Capitol Dental Care Inc.	1	22,846	0.0438
Care Oregon Dental		1,934	0.0000
Family Dental Care	1	1,790	0.5588
Managed Dental Care of Oregon	1	1,973	0.5069
ODS Community Health Inc.	9	12,055	0.7466
Willamette Dental Group PC		4,582	0.0000
<b>Fee-for-service (FFS) requests</b>			
	47	217,399	0.2162
<b>Total</b>	<b>943</b>	<b>1,225,071</b>	<b>0.7698</b>

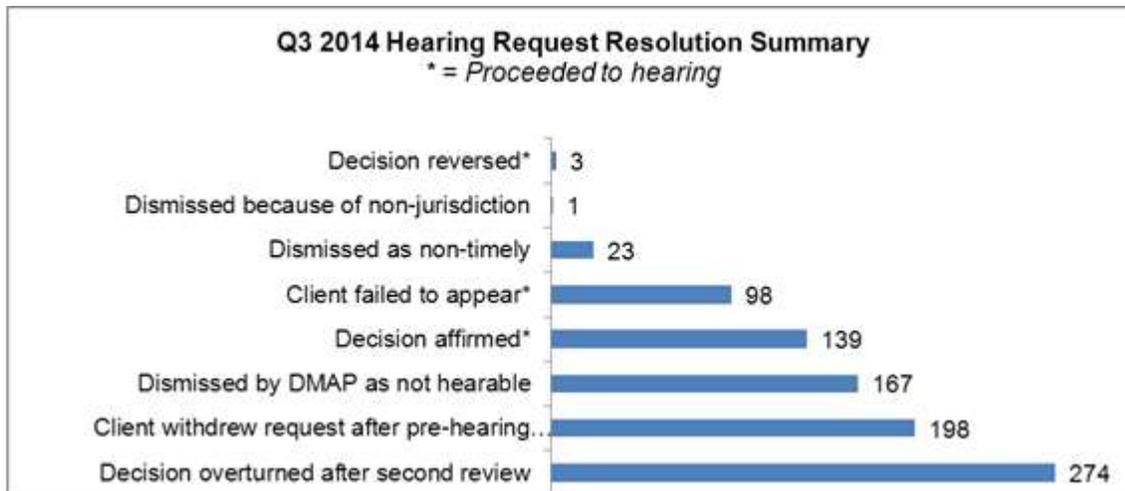
**Trends**

The following chart shows trends for contested case hearings for this quarter. As stated above, this information only reflects hearing requests submitted to OHA; it does not reflect requests submitted to plans.

Hearing categories have remained similar over the last 5 quarters. As shown below, referrals, surgery and billing have consistently remained high.



As shown in the following chart, plan coverage decisions that get overturned after a second review by OHA remain high. This happens when a plan denies coverage of the service, but OHA finds that this decision should be overturned upon a second review of information related to the denial.



### Interventions

OHA has increased its oversight of plan coverage denials and will be working with MCO/CCOs to look at overall denial rates. This work will support best practice reviews and hopefully lower the plan overturn rates.

### D. Implementation of 1% withhold

During this quarter, DMAP analyzed encounter data received for completeness and accuracy for the subject months of November 2013 through February 2014. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

Future reports will contain the following information:

**Table 3 – Summary**

Metric	Frequency	
	Quarterly	Annually
Actual amount paid of monthly PMPM capitation rate broken out by: <ul style="list-style-type: none"> <li>■ Average/mean PMPM</li> <li>■ Eligibility group</li> <li>■ Admin component</li> <li>■ Health services component</li> </ul> For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy)	X	X
Actual amount paid in incentives monthly broken out by: <ul style="list-style-type: none"> <li>■ Total by CCO</li> <li>■ Average/mean PMPM incentive</li> <li>■ The over/under 100% of capitation rate by CCO and by average enrollee PMPM</li> </ul>	X	X
Best accounting of the flexible services provided broken out by: <ul style="list-style-type: none"> <li>■ Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers)</li> <li>■ Services that are not reflected in encounter data (e.g., air-conditioners, sneakers)</li> </ul>	X	X
CCO sub-contractual payment arrangements – narrative <ul style="list-style-type: none"> <li>■ Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network</li> </ul>		X
Encounter data analysis <ul style="list-style-type: none"> <li>■ Spending in top 25 services by eligibility group and by CCO</li> <li>■ To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well</li> </ul>	X	X

### E. Statewide workforce development

#### Traditional Health Workers (THW)

THW Program	Total number certified statewide*		Number of approved training programs	
	Current Qtr.	Cumulative	Current Qtr.	Cumulative
<b>Community Health Workers</b>	11	53	0	6
<b>Personal Health Navigators</b>	2	5	0	1
<b>Peer wellness/support specialists</b>	30	190	0	16
<b>Other THW</b>	10	11	0	1 (Doula)
<b>Total Certified</b>	<b>64</b>	<b>259</b>	<b>0</b>	<b>24</b>

\*Statewide registry currently under reconstruction to add enhanced data collection features.

Training Program	Total number trained statewide		Cumulative trained by THW Type				
	Current quarter	To date	CHW	Personal Health Navigators	Peer Support	Peer Wellness	Other (doula)
IPCED	2	-		✓			
NAMI Lane County	37	-			✓		
Oregon Behavioral Health	15	-			✓		
Miracles Club Inc. (Each One Teach One)	25	-			✓		
Multnomah County Health Department	25	-	✓				
Oregon Family Support Network	9	-			✓		
Project Able	25	-			✓		
Addictions Counselor Certification Board of Oregon	7	-			✓		
<b>Total trained to date</b>	<b>145</b>	<b>469</b>	<b>222</b>	<b>2</b>	<b>214</b>	<b>17</b>	<b>14</b>

Approved Training Program Name	THW Type				
	CHW	PHN	Peer Wellness	Peer Support	Other (doula)
Addiction Certification Board of Oregon				✓	
Cascadia Behavioral Health			✓		
Central City Concern				✓	
Central Oregon Community College	✓				
Chemeketa Community College	✓				
Cultivating a New Life through Community Connections			✓		
Empowerment Initiatives				✓	
Eugene Relief Nursery				✓	
Institute for Professional Care Education	✓	✓			
Intentional Peer Support Program				✓	
International Center for Traditional Childbearing					✓
Lane/Clackamas Community College	✓				
Mental Health of America				✓	
Miracles Club Inc				✓	
Multnomah County Health Department	✓				
National Alliance on Mental Illness				✓	
Northeast Oregon Network	✓				
Oregon Behavioral Consultation and Training				✓	
Oregon Family Support				✓	

Approved Training Program Name	THW Type				
	CHW	PHN	Peer Wellness	Peer Support	Other (doula)
Network/Youth MOVE					
Portland Community College				✓	
Project ABLE				✓	
Recovery and Beyond				✓	
Rogue Community College	✓				
Willamette Family Treatment Services				✓	
<b>Total approved training programs</b>	<b>CHW 7</b>	<b>PHN 1</b>	<b>Peer Wellness 2</b>	<b>Peer Support 14</b>	<b>Other (doula) 1</b>

	THW presentations	Meetings with stakeholders
<b>July 2014</b>	<ul style="list-style-type: none"> <li>■ 16<sup>th</sup> OHA Member Engagement Outreach</li> <li>■ 21<sup>st</sup> Health Equity Policy Committee</li> </ul>	<ul style="list-style-type: none"> <li>■ 3 Addictions &amp; Mental Health Division-Peer Delivered Services</li> <li>■ 3<sup>rd</sup> Addictions' Counselor Certification Board of Oregon</li> <li>■ 8<sup>th</sup> OHA Transformation Center-THW Systems Integration (CCO Survey Development)</li> <li>■ 8<sup>th</sup> ORCHW-REC Research Team</li> <li>■ 14<sup>th</sup> THW Commission Executive Committee</li> <li>■ 14<sup>th</sup> Rogue Community College-THW System Coordination</li> <li>■ 18<sup>th</sup> Oregon Doula Association</li> <li>■ 25<sup>th</sup> Department of Medical Assistance Programs – THW Payment Model Discussion</li> <li>■ 25<sup>th</sup> Cascade Aids Project</li> <li>■ 28<sup>th</sup> THW Commission Meeting</li> </ul>
<b>August 2014</b>	<ul style="list-style-type: none"> <li>■ 12<sup>th</sup> Albina Ministerial Alliance –CHW Presentation</li> </ul>	<ul style="list-style-type: none"> <li>■ 1<sup>st</sup> Community Capacitation Center CHW Incumbent Workforce Assessment Development</li> <li>■ 4<sup>th</sup> Transformation Center-THW Survey Development</li> <li>■ 4<sup>th</sup> Volunteers of America-Story Bank Collection</li> <li>■ 7<sup>th</sup> Addictions &amp; Mental Health Division-Peer Delivered Services</li> <li>■ 7<sup>th</sup> Systems Integration Subcommittee</li> <li>■ 8<sup>th</sup> Department of Medical Assistance Programs – THW Payment Model Discussion</li> <li>■ 11<sup>th</sup> THW Commission Executive Committee</li> <li>■ 21<sup>st</sup> ORCHW-REC Research Team</li> <li>■ 25<sup>th</sup> THW Commission meeting</li> <li>■ 27<sup>th</sup> Coordinated Care Model Summit Planning for THWs</li> <li>■ 28<sup>th</sup> Volunteers of America-Peers</li> <li>■ 29<sup>th</sup> Community College Workforce Development</li> </ul>
<b>September 2014</b>	<ul style="list-style-type: none"> <li>■ 10<sup>th</sup> Health Reform in Oregon</li> <li>■ 12<sup>th</sup> Oregon Community Health Worker Annual Conference</li> <li>■ 15<sup>th</sup> Health</li> </ul>	<ul style="list-style-type: none"> <li>■ 3<sup>rd</sup> Health Related Workforce Committee</li> <li>■ 3<sup>rd</sup> Pacific and Southwest Regional Health Equity Council (Region IX)</li> <li>■ 3<sup>rd</sup> Story Bank for THWs w/Rene Ferran</li> <li>■ 4<sup>th</sup> Addictions &amp; Mental Health Division-Peer Delivered Services</li> <li>■ 4<sup>th</sup> Oregon Self-Management Network Quarterly Call</li> <li>■ 4<sup>th</sup> Transformation Center THW System Coordination</li> <li>■ 5<sup>th</sup> Department of Medical Assistance Programs – THW</li> </ul>

	THW presentations	Meetings with stakeholders
	Equity Policy Committee	Payment Model Discussion ■ 8 <sup>th</sup> THW Commission Executive Committee ■ 11 <sup>th</sup> Accumentra-THWs ■ 11 <sup>th</sup> Transformation Center THW Video Project ■ 18 <sup>th</sup> Health, Housing, and Community Health Workers for Mississippi ■ 19 <sup>th</sup> Oregon Community Health Worker Association ■ 19 <sup>th</sup> African American Community Health Workers ■ 19 <sup>th</sup> Oregon Doula Association ■ 22 <sup>nd</sup> THW Commission Meeting ■ 25 <sup>th</sup> Oregon Doula Association ■ 25 <sup>th</sup> CCO Flexible Services Workgroup ■ 26 <sup>th</sup> Oregon Community Health Worker Association meeting

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

**System integration**

During the third quarter, the Office of Equity and Inclusion (OEI) made efforts to coordinate THW system-level activities within OHA and with the Community College Workforce Development Agency (CCWD). Both OHA and CCWD share similar, complex, and legislatively required THW goals. OEI’s goal is to coordinate these agencies’ efforts to prevent duplication of the work. As a result, THW Commissioners helped to shape statewide THW surveys, focus groups and distribution planning conducted by the OHA Transformation Center. The survey was fielded among CCOs in all 15 regions. The results from this survey will be published in December 2014. Coming up in the fourth quarter, the Commission will work with Rogue Community College to develop and field their statewide THW needs assessment.

**Training, certification and hiring of THWs**

In the third quarter more THWs were trained than in any other quarter since we began reporting. There are a total of 145 THWs trained; of those numbers, 64 have been certified. Criminal background checks and limited staff capacity continues to slow the certification process. However, we hope to soon have a full-time staff person to support this program.

**Payment models**

In most delivery systems, THW services are funded using braided payment methods. For example, the behavioral health system uses a variety of federal, state, and local resources to fund Peer Support Specialists. Public Health has historically provided Community Health Workers in underserved communities to provide training, outreach, education and testing to stop the spread of communicable diseases and to eliminate infant mortality. These programs are grant-funded and their duration is often limited due to emerging national and global health priorities.

OEI is working with OHA Medical Assistance Programs and the Oregon Community Health Worker Association to develop payment concepts that CCOs can refer to when they are ready to use their global budgets to develop THW payment methods. We have created a preliminary guidance document to post on our website for the health care provider community. *Below are some examples of how Oregon THWs are funded within the health system.*

Coordinated Care Organization	Counties	# of THWs	Description
AllCare Health Plan	Jackson, Josephine, Douglas	6 CHWs	Funded with Medicaid admin dollars targeting with high utilizers
Pacific Source Community – Central Oregon	Deschutes	1 CHW	Funded with Transformation dollars; providers are capitated and invest as appropriate for their panel needs.
Health Share	Multnomah, Clackamas, Washington	2.5 FTE CHWs and PSS.	THWs employed through CBOs with the ORCHWA pilot.
Jackson Care Connect	Jackson	3	Two CHWs in FQHC and 1 in an ER.

**Other data collection:**

To ensure the training and certification of a diverse workforce and pathways to greater employment opportunities, OEI now collects relevant race/ethnicity, workforce, and educational attainment data from program trainers.

**Workforce Diversity n=87**

African American	Hispanic	Native American	Caucasian
11	31	4	41

Out of the 145 individuals trained, 40 are of Hispanic origin, 38 are African American, 6 are Native American.

**Employment n=42**

Employed at time of THW Training	Employed after THW Training Completion
38	4

Out of the 55 people who were employed 31 of those individuals are White and/or of non-Hispanic Origin.

**Education n=99**

Below Bachelor's Degree	Bachelor's Degree or Above
68%	32%

**Health professional graduates participating in Medicaid**

This quarter, OHA requested and received data files from Oregon Health and Sciences University (OHSU) representing 2013-14 graduates in the fields of medicine, nursing, dentistry, and physician assistant studies. Staff are currently attempting to match these graduates with Medicaid provider enrollment data and will report the results in the next quarterly report. Staff will also re-run 2012-13 dental, nursing, and physician assistant graduate data (results for these cohorts were described in a previous quarterly report) to ascertain whether graduates are more likely become enrolled Medicaid providers as time goes on.

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

Approval and contracting with new plans	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
None	-	-	-	-

Changes in CCO/MCO networks	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Willamette Dental DCO terminated 8/1/2014	None	Enrolled into dentally-integrated CCOs effective 7/1/2014	5	-

Rate certifications	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
July-December 2014 rates	-	-	16	-

Enrollment/disenrollment	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues				

CCO/MCO contract compliance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues				

Relevant financial performance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues				

**G. Transformation Center**

The Transformation Center continues to assist CCOs through Innovator Agent leadership and learning collaboratives.

**Key highlights from this quarter:**

***The Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee***

The Transformation Center facilitated three sessions for the statewide CCO learning collaborative in this period, where Innovator Agents served as small group discussion facilitators:

- A session in which the group reviewed year-end data from Oregon’s Health System Transformation 2013 Performance Report and participated in a “clicker” voting process to determine topics for the next six months;
- A session focused on health equity, with a panel of community-based leaders; and
- A session on strategies to improve access to care and CAHPS data.

More information is available at <http://transformationcenter.org/learning-collaborative/statewide-cco-learning-collaborative/>.

**The Community Advisory Council Learning Collaborative**

In response to feedback from the Community Advisory Council (CAC) Summit in May 2014, the CAC Steering Committee decided that the CAC learning collaborative should meet quarterly in person rather than continue monthly online meetings.

During the reporting period, the Transformation Center planned the first regional CAC meeting for October 27, 2014. This meeting will be held in conjunction with a provider training on health literacy and the culture of poverty, which is co-sponsored by Willamette Valley Community Health CCO and the Transformation Center.

As an outgrowth of conversations started at the CAC Summit, the Transformation Center also hosted online meetings for two new CAC leadership networks—one for the CAC chairs and co-chairs (who are CAC members) and one for the CCO CAC coordinators (who are staff of the CCOs)—to provide ongoing leadership development for CACs.

The Innovator Agents assisted in planning these events and recruiting new members to the CAC Steering Committee, which rotated membership in July. More information is available at <http://transformationcenter.org/learning-collaborative/cac/>.

**Health Equity Learning Collaborative:**

In response to requests from CCOs, the Transformation Center and Office of Equity and Inclusion are convening a new learning collaborative focused on promoting health equity for CCOs. The goals are to share promising practices on advancing health equity and to build a support network across CCOs.

A planning committee including CCO representatives met several times during the reporting period to prepare for the collaborative's first meeting in October 2014. Innovator Agents helped identify possible learning collaborative participants from each CCO.

**Quality Improvement Community of Practice:**

As follow-up from the IHI Improvement Science in Action training that happened in April 2014, the Transformation Center is conducting site visits to CCOs to review their measurement plans for Transformation Fund projects. This work is evolving into a quality improvement community of practice for the quality improvement (QI) and measurement leads within CCOs to learn from one another.

**Council of Clinical Innovators:**

The Transformation Center officially launched the year-long Council of Clinical Innovators learning experience at an opening meeting on July 25-26, 2014. Fourteen Clinical Innovator Fellows presented their innovation projects and participated in presentations by Dr. Chuck Kilo, Chief Medical Officer at Oregon Health and Sciences University; Dr. Doug Eby, Vice President of Medical Services for Southcentral Foundation; and Dr. Michelle Sanders, physician at Providence St. Vincent Medical Center and former CMMI Innovation Fellow.

The group gathered for online meetings in August and September; meeting topics included an introduction to CCOs and the coordinated care model and measurement for quality improvement. In addition, each Fellow met monthly with a faculty mentor, both individually and in small groups, to develop a project charter and receive support on project implementation. More information on the Council of Clinical Innovators is available at [www.transformationcenter.org/cci/](http://www.transformationcenter.org/cci/).

## *Oregon Health Authority*

### ***Transformation Center CCO Technical Assistance Bank:***

In September the Transformation Center launched a Technical Assistance Bank for CCOs. Each CCO may request up to 35 hours of technical assistance on topics such as alternative payment methods, behavioral health integration, primary care transformation, health equity, community health improvement plans and community advisory council development. The Transformation Center has developed contracts with 12 consultants and connected with various staff resources within OHA to help meet incoming requests. The Innovator Agents will play a key role in coordinating requests. The first technical assistance request was received at the end of September.

### ***Innovator Agent-led Tiger Teams:***

Innovator Agents continue to lead OHA internal transformation through Tiger Teams, which are teams formed to address key internal areas within the agency. Innovator Agents are the lead staff for teams working towards integrating adult mental health residential into the global budget, rate setting, rules promulgation, and contracts. The Director of OHA is the Executive Sponsor, the Transformation Center's Director is the Tiger Team Project Director, and OHA Sub-Cabinet approves completion of all chartered deliverables.

## **Plans for next quarter and beyond**

### ***CCM Summit***

The 2014 Annual Coordinated Care Model (CCM) Summit, "Oregon's Coordinated Care Model: Inspiring Health System Innovation," will take place on December 3-4, 2014, at the Oregon Convention Center.

- Featured keynote speakers include Don Berwick, M.D., Susan Johnson, Regional Director, HHS, Region X; Eric Coleman, M.D. and Governor John Kitzhaber, M.D.
- Innovator Agents are designing many of these sessions, reaching out to CCOs to identify best practices to share, and will facilitate some sessions.

This free conference will be open to anyone working on health system transformation nationwide. The goal of the two-day meeting is to celebrate successes, share lessons learned, and inspire future innovation based on Oregon's coordinated care model.

The Summit includes 16 breakout sessions on topics such as behavioral health integration, health information technology, oral health integration, patient engagement, alternative payment methods, and traditional health workers. The Summit will also feature in-person "triads" (comprised of a CCO CEO, provider, and consumer), each telling the story about how a particular element of the coordinated care model is playing out on the ground. Innovator Agents are working with their CCOs to identify the stories and work the CCOs want to highlight, as well as who might be the right people to tell those stories. In addition, Innovator Agents are working with their CCOs and CACs to identify who should attend the Summit and facilitate that attendance.

### ***The convening of the Public Health and CCOs:***

In conjunction with the 2014 Annual Coordinated Care Model Summit, the Transformation Center and the OHA Public Health Division are hosting a hands-on, facilitated discussion about opportunities for CCOs and local public health to work together to improve community health. Innovator Agents are members of the Steering Committee planning this meeting and will facilitate some of the small-group discussions. Participants will learn from CCO and local public health colleagues and engage in regional discussions focused on maternal and child health, early learning and chronic disease prevention.

### ***Traditional Health Worker (THW) Survey***

As recommended by the HB 2859 Task Force on Individual Responsibility and Health Engagement, the Transformation Center was tasked to:

- Conduct a formal assessment to identify barriers to the use of THWs, and
- Develop strategies to address barriers, foster engagement and support partnerships between THWs, community-based organizations and CCOs.

This fall the Transformation Center initiated the first phase of a formal assessment of CCOs to identify barriers to their use of THWs. A survey was developed in coordination with the Office of Equity and Inclusion and the THW Commission and distributed to all CCOs. The THW Commission will further distribute the survey to other health and community organizations and THWs. Preliminary results are pending.

**Table 6 - Innovator Agents – Summary of promising practices**

***Innovator agent learning experiences***

Summary of activities	The Office of Equity and Inclusion trained the group on health equity and how to interpret race and ethnicity OHP member data for each CCO.
Promising practices identified	Race and ethnicity data needs to be disaggregated as much as possible and collected in uniform methods for it to meaningfully inform health equity initiatives.
Participating CCOs	16
Participating IAs	8

***Learning Collaborative activities***

Summary of activities	A Strength Deployment Inventory (SDI) consultant helped identify Transformation Center staff member strengths and strategies to enhance teamwork; OHA teams from Child Health, Patient-Centered Primary Care Home Program, and OHP Outreach presented how they can collaborate with the Transformation Center.
Promising practices identified	Frequent communication and understanding of the strengths and changing roles of staff are important for building effective teamwork.
Participating CCOs	16
Participating IAs	8

***Assisting and supporting CCOs with Transformation Plans***

Summary of activities	IAs provided support for their CCOs in finalizing and getting OHA approval of their Community Health Improvement Plans. IAs also assisted their CCOs with Non-Emergent Medical Transportation integration for the July 1 deadline. IAs also participated in Transformation Center site visits with CCOs around the metrics they are using to measure progress on their Transformation Fund projects.
Promising practices identified	Since CCOs are in different stages of development, each IA’s role is different. Some IAs provide internal support for CCOs’ transformation, whereas others focus more on identifying solutions and addressing barriers within OHA.
Participating CCOs	16
Participating IAs	8

***Assist CCOs with target areas of local focus for improvement***

Summary of activities	IAs supported conversations with State Public Health, local public health, and Early Learning Hub staff to address upstream prevention alignment efforts between CCOs and these entities. IAs are also assisting with behavioral health integration, oral health, alternative payment methodology, Nonemergency medical transportation, cultural competency, and data collection.
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Promising practices identified	IAs are truly a key liaison between their CCOs and their communities, and the role is uniquely situated to provide value in this area.
Participating CCOs	-
Participating IAs	-

**Communications with OHA**

Summary of activities	Through their Tiger Team work, Innovator Agents began work on a number of system issues related to improved communications with OHA.
Promising practices identified	Tiger Teams have proved to be a very effective model of identifying system issues and creating solutions. Embedding Innovator Agents within OHA teams has served to strengthen IA relationships with other OHA staff, thus greatly improving communication.
Participating CCOs	16
Participating IAs	8

**Communications with other Innovator Agents**

Summary of activities	IAs have continued to work together on internal transformation, and sharing info on promising practices to promote spread through in person and electronic communication.
Promising practices identified	The IAs work as a team, sharing and benefitting from the expertise each IA brought to their job as well as their unique CCO experiences.
Participating CCOs	16
Participating IAs	8

**Community Advisory Committee activities**

Summary of activities	See CAC Learning Collaborative summary.
Promising practices identified	Monthly phone meetings are not as effective as bringing CAC members together in person, or convening the two CAC leader groups (Chairs/Co-Chairs, and CAC Coordinators).
Participating CCOs	-
Participating IAs	-

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

Summary of activities	The CCO Technical Assistance Bank provides customized resources to assist CCOs in adapting innovations. The first request received was for a CCO to support CAC development, which ultimately increases stakeholder and community engagement.
Promising practices identified	Each CCO has distinct priorities and efforts to support innovation in different areas of transformation. In addition to offering learning collaboratives that reach broad groups of participants, it's important for the Transformation Center to offer customized technical assistance to meet CCOs' diverse needs.
Participating CCOs	16
Participating IAs	8

**Data base implementation (tracking of CCO questions, issues and resolutions in order to identify systemic issues)**

Summary of activities	The Transformation Center has been training new staff in order to more appropriately and consistently capture data within the Issue Tracker. Innovator Agents have used the Issue Tracker to identify themes for forming Tiger Teams.
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Promising practices identified	Issues collected within the Issue Tracker have been important foundational information for the Tiger Teams.
Participating CCOs	16
Participating IAs	8

**Information sharing with public**

Summary of activities	Innovator Agents continue to present to a large variety of stakeholders and share information on enrollment, health equity data, leadership opportunities, and community partnership opportunities with their Community Advisory Councils and community partners.
Promising practices identified	Communicating with Community Advisory Councils is a good way to more broadly disseminate information to community members.
Participating CCOs	16
Participating IAs	8

**Table 7 - Innovator Agents – Measures of effectiveness****Measure 1: Surveys rating IA performance**

Data published for current quarter? Type?	N/A: Plans for qualitative interviews with CCO stakeholders are forthcoming in early 2015.
Web link to Innovator Agent quality data	-

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

Data published for current quarter? Type?	Innovator Agents submit quarterly reports that track their activities in three areas: (1) supporting transformation within their CCO; (2) partnership with OHA, and (3) other activities focused in the community.
Web link to Innovator Agent quality data	-

**Measure 3: Innovations adopted**

Data published for current quarter? Type?	See Good Ideas Bank, an online searchable database of innovative ideas in health system transformation.
Web link to Innovator Agent quality data	<a href="http://transformationcenter.org/good-ideas-bank/">http://transformationcenter.org/good-ideas-bank/</a>

**Measure 4: Progress in adopting innovations<sup>1</sup>**

Data published for current quarter? Type?	Progress in innovations surrounding behavioral health integration in primary care settings continues to be a top priority.
Web link to Innovator Agent quality data	-

<sup>1</sup> This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

**Measure 5: Progress in making improvement based on innovations<sup>2</sup>**

Data published for current quarter? Type?	CCOs are making solid progress based on progress reports and milestone reports submitted that report on 8 areas of transformation, including: oral and behavioral health integration; primary care home; alternative payment; health information; and community empowerment.
Web link to Innovator Agent quality data	-

**Measure 6: CCO Transformation Plan implementation**

Data published for current quarter? Type?	Transformation Plans are on track, as evidenced by milestone reports recently submitted. The Transformation Center recently launched a Technical Assistance Bank for CCOs, which will help CCOs move toward their Transformation Plan goals. The Transformation Center has created a menu of technical assistance topics for which CCOs may access a set number of hours of technical assistance. Each CCO will decide how to best utilize the TA resources by selecting the topics of most interest and need. Priority topics include: Community Health Improvement Plan (CHIP) implementation and evaluation; Community Advisory Council (CAC) development; health equity; oral health integration; metrics and measurement; and public health integration.
Web link to Innovator Agent quality data	-

**Measure 7: Learning Collaborative effectiveness**

Data published for current quarter? Type?	The Transformation Center’s Learning Collaboratives have been very well received, with the majority of the hundreds of participants indicating that their participation will result in the sharing and spread of innovative ideas. Evaluation data shows that an average of 78 participants attend each learning collaborative sessions. 89.2% of respondents found sessions valuable or very valuable to their work, 61.2% of attendees say will attend future sessions, 60.4% of attendees say will take action to change processes at organization as a result of the session, 50.9% of attendees say they will reach out to colleagues, experts or OHA for more information or ideas as a result of the session.
Web link to Innovator Agent quality data	-

**Measure 8: Performance on Metrics and Scoring Committee metrics**

Data published for current quarter? Type?	All Innovator Agents assist their CCOs in internal planning to align internal work with improvements on performance metrics. Their consultation and guidance include contract review and in some cases, clinical recommendations related to behavioral health integration.
Web link to Innovator Agent quality data	-

**Other evaluation results from Transformation Center learning collaborative can be found in Section V, Table 9.**

<sup>2</sup> This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

**H. Legislative activities**

Nothing to report this quarter.

**I. Litigation status**

Nothing to report this quarter.

**J. Two-percent trend data**

See [Appendix C](#).

**K. DSHP terms and status**

See [Appendix D](#).

**IV. Status of Corrective Action Plans (CAPs)**

**Table 8 – Status of CAPs**

There are no CAPs this quarter.

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

**V. Evaluation activities and interim findings**

In this quarter findings from a number of research efforts related to Oregon’s 1115 waiver were released:

- Researchers from Oregon Health & Sciences University (OHSU) presented a study looking at the early impacts of the CCOs using data through 2013;
- Results of Oregon’s CAHPS survey were shared with the CCOs; and,
- Researchers from OHSU, OHA, and the State Health Access Data Assistance Center (SHADAC) released insurance coverage estimates for the state.

Findings from these efforts are included in the table below.

In addition, work progressed on Mathematica’s independent midpoint evaluation of the waiver. Activities included processing of updated enrollment and claims data; and initial construction of the analytic models to assess preliminary outcomes. Mathematica is finalizing the analysis and preparing the draft report for submission to CMS in late December.

**Table 9 - Evaluation activities and interim findings**

In the tables below, relevant OHA and CCO activities to date are reported by the “levers” for transformation identified in our waiver agreement and Accountability Plan.

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

<p>Evaluation activities:</p>	<p>The last quarterly report included findings from the evaluation of Oregon’s PCPCH program. In this quarter, the program continued planning for future evaluation efforts.</p>
<p>Interim findings:</p>	<p>As of September 2014, there were 514 recognized clinics in the state (surpassing Oregon’s goal of 500 by 2015).</p> <p>With respect to PCPCH enrollment, the goal for CCOs is that 100% of members will be enrolled in a PCPCH. The statewide baseline (for 2012) for this measure is 51.8%.</p> <ul style="list-style-type: none"> <li>■ Progress report data indicate that for the second quarter of 2014, 76.9% of CCO members were enrolled in a PCPCH. This is a decrease from calendar year 2013 (when the rate was 78.6%); however, it is an increase from the 2012 baseline of 51.8%. The decrease is possibly due to increased enrollment in Medicaid and the time needed to enroll members in a PCPCH.</li> <li>■ Performance ranged from 97.9% - 45.3% across the CCOs. It is promising, however, that there was actually an <b>increase</b> in the PCPCH enrollment rate for the lowest performing CCO (from 41.8% in calendar year 2013 to 45.3% for the second quarter of 2014).</li> </ul> <p>Researchers from OHSU, OHA, and SHADAC found that between June 30, 2013, and June 30, 2014, the estimated number of uninsured Oregonians fell by 348,000, or 63%.</p> <p>The decline was driven in large part by the Medicaid expansion, which saw participation in the Oregon Health Plan increase by over 360,000 people, or 59%.</p>
<p>Improvement activities:</p>	<p>Oregon’s Patient-Centered Primary Care Institute provides technical support and transformation resources to practices statewide. This technical assistance includes learning collaborative opportunities for primary care practices throughout the state and additional technical assistance.</p> <p>In this quarter, the institute conducted three in-person sessions for its learning collaboratives. These sessions focused on patient experience of care.</p> <p>The Institute also held three webinars:</p> <ul style="list-style-type: none"> <li>■ Collaborating for Health – Motivational Interviewing for Primary Care;</li> <li>■ Strategies for Rural, Small Independent Practices; and,</li> <li>■ Enhancing Adolescent Well-visits.</li> </ul> <p>An average of 62 people attended each session. Webinar attendees were asked to rate the quality of the webinars on a scale ranging from 1 (poor) to 5 (excellent). Responses were 4 or above on all webinars.</p>

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

<p>Evaluation activities:</p>	<p>The Hospital Performance Metrics Advisory Committee met in July to finalize the list of metrics submitted to CMS for the Hospital Transformation Performance Program (HTPP). In August, OHA and CMS reached final agreement on the measures and payment allocation methodology for the program. This two year program creates an incentive pool for DRG hospitals similar to that for the CCOs and covers the period October 2013 – September 2015. Eleven incentive metrics were chosen. See <a href="http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx">http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx</a> and Appendix E for more detail.</p>
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	<p>In this quarter the CCO Metrics Technical Advisory Workgroup (TAG), the CCO Metrics Technical TAG Analyst Subgroup, the CCO Metrics and Scoring Committee also met, and metrics continued to be refined:</p> <ul style="list-style-type: none"> <li>■ Effective contraceptive use among women at risk of unintended pregnancy and tobacco use prevalence were added as incentive measures. A measure for dental sealants on permanent molars for children (previously recommended by the CCO Dental Quality Metrics Workgroup) was also formally adopted.</li> <li>■ Early elective delivery and follow-up care for children prescribed ADHD medications were dropped from the list of incentive measures.</li> <li>■ Revisions were also made to the specifications for the Screening, Brief Intervention, and Referral to Treatment (SBIRT), follow-up after hospitalization for mental illness, and mental and physical health assessments for children in DHS custody measures.</li> </ul>
<p>Interim findings:</p>	<p>Internal analysis of the Quarter Two (April-June 2014) CCO financial reports show an increase in the proportion of all plan payments that are non-fee-for-service (FFS) (from 52.5% in Q1 to 59.4% in Q2).</p> <p>The non-FFS payment arrangements include salary, capitation, and 'other' payment arrangements. Most of the growth in non-FFS reports was in the 'other' category.</p> <p>Note: These data should be treated as preliminary as OHA is working with the CCOs on reporting of APMs and flexible services.</p>
<p>Improvement activities:</p>	<p>CCOs were provided with a progress report on both the incentive and state performance measures in August 2014. This report covered the 12-month period from May 1, 2013, through April 30, 2014. It aids in tracking progress across the CCOs, and allows individual CCOs to identify the measures on which they might want to focus additional efforts.</p> <p>In addition, the July statewide learning collaborative for CCO Medical Directors and Quality Improvement Coordinators? focused on reviewing the final incentive measure data for calendar year 2013, and identifying opportunities for improvement.</p> <p>OHA has retained the services of a contractor (Bailit Health Purchasing) to be available to CCOs for assistance in setting up APMs.</p> <p>OHA contracted with the Center for Evidence-Based Policy at OHSU to prepare materials to assist CCOs with implementation of APMs. This work will result in tools and strategies for CCOs to use in their APM development. The draft report was shared with OHA in this quarter. The final report will be available in November 2015.</p>

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

<p>Evaluation activities:</p>	<p>OHA's Public Health Division contracted with Oregon Consensus to produce case studies highlighting collaboration between three CCOs and local public health authorities. The findings are below.</p> <p>The Transformation Center continued work on an environmental scan of behavioral health integration activities across the state. OHSU is conducting semi-structured qualitative interviews with primary care and behavioral health providers, as well as CCO leaders, in five areas of the state. Interviews have been completed in three CCO service areas. Two additional areas have been identified and will be completed by early 2015. Transformation Center staff are conducting supplemental interviews in other CCO service areas, as well as with Oregon Health Authority leaders engaged with</p>
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	<p>integration. OHSU meets regularly with Transformation Center staff to debrief after data collection and to discuss early findings.</p>
<p>Interim findings:</p>	<p>Findings from the case studies of CCO-local public health authority collaboration are below:</p> <ul style="list-style-type: none"> <li>■ Columbia Pacific CCO and Tillamook County Health and Human Services are focusing on integrating behavioral and physical health.</li> <li>■ Yamhill County CCO and Yamhill County Health and Human Services are collaborating on community-based programs for low-income populations.</li> <li>■ Trillium Community Health Plan (CCO) and Lane County Health and Human Services are focusing on prevention programs.</li> </ul> <p>The case studies can be found here:  <a href="http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Pages/Success-Stories.aspx">http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Pages/Success-Stories.aspx</a>.</p> <p>Five of the CCO incentive measures relate to integration. For four of the measures, preliminary progress report data<sup>3</sup> comparing the baseline from 2011 to the period June 2013–May 2014 are available. The data show progress on all four, though this varied across the CCOs:</p> <ul style="list-style-type: none"> <li>■ SBIRT increased from 0.0% to 4.4%, below the 13.0% benchmark<sup>4</sup> (ranging from 0.1%-15.7% across CCOs).</li> <li>■ Follow-up after hospitalization for mental illness increased from 65.2% to 68.3%, which is just under the benchmark of 68.8% (ranging from 40.0%-80.0% across CCOs).</li> <li>■ Follow-up care for children initially prescribed ADHD medications continued to exceed the benchmark (57.1% versus a 51.0% benchmark), though this varied by CCO (from 47.5% to 78.6%).</li> <li>■ Mental and physical health assessments for children in DHS custody improved from 53.6% to 66.1%, but was below the benchmark (90.0%). Rates across CCOs varied significantly, from 40.0% to 100.0%.</li> </ul> <p>Early findings from the behavioral health integration environmental scan show a great deal of variation across CCOs in the breadth and depth of integration. However, there are several reoccurring themes about what will be required to advance and sustain integration initiatives. These themes include work force, reimbursement and communication issues. Recommendations to address these issues will be included in the final report.</p>
<p>Improvement activities:</p>	<p>Work continues on Oregon’s Adult Medicaid Quality Grant, which is focused on two initiatives:</p> <ul style="list-style-type: none"> <li>■ A Performance Improvement Plan (PIP) supporting diabetes monitoring for those with severe, persistent mental illness (SPMI), and</li> <li>■ A learning collaborative on “reverse” integration (bringing primary care into behavioral health settings).</li> </ul> <p>Both initiatives progressed in this last quarter:</p> <p>In July, the CCOs submitted their quarterly reports related to the diabetes monitoring PIP to Acumentra Health. Acumentra scored responses to the Standard Eight Improvement Strategies criteria (not on individual CCO study indicators). Once</p>

3 Note these data are preliminary and subject to change.

4 Benchmarks noted are those for 2014.

	<p>reviewed, the CCOs received their scores for each of the Standard 8 criteria, as well as a brief summary of the strengths and opportunities for improvement. Initial scores ranged from 30 to 97, with a third of the plans scoring above 80%. The CCOs use the feedback provided and can resubmit their July reports to increase their scores. The CCOs continue to submit quarterly updates and share findings and best practices at the monthly CCO Quality and Health Outcomes meetings.</p> <p>Since its launch in May, the Behavioral Health Home Learning Collaborative has conducted two webinars and held two in-person Learning Sessions. The participating agencies have also been working intensively with practice coaches to design their improvement projects and conduct Plan, Do, Study, Act (PDSA) cycles.</p>
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**Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources**

Evaluation activities:	<p>In this quarter, activities related to Mathematica’s independent midpoint evaluation of the waiver continued to progress. Activities included processing updated enrollment and claims data and initial construction of the analytic models to assess preliminary outcomes. Mathematica is finalizing the analysis and preparing the report for submission to CMS in late December 2014 (OHA will review a draft in early December).</p> <p>Initial planning is also under way for the summative evaluation of the waiver (covering all five years of the waiver). OHA has the option of continuing the contract with Mathematica or selecting another vendor.</p>
Interim findings:	<p>Preliminary progress report data covering the period June – May 2014 were distributed to the CCOs in this quarter. When compared to the performance for calendar year 2013, there was improvement on many of the measures for which data are available (see Appendix E for more detail):</p> <ul style="list-style-type: none"> <li>■ The rate of Screening, Brief Intervention, and Referral to Treatment (SBIRT) increased from 2% to 4.4%.</li> <li>■ LDL Screening for those with diabetes increased from 70.1% to 72.7% while hemoglobin A1c testing for those with diabetes increased from 79.3% to 81.7%.</li> <li>■ Follow-up care for children prescribed ADHD medications increased from 53.3% to 57.1% (at initiation).</li> </ul> <p>OHA completed fielding the CAHPS Health Plan survey in spring 2014 and findings were released in August 2014.</p> <ul style="list-style-type: none"> <li>■ Overall, the CAHPS survey showed significant improvement in self-reported health status.</li> <li>■ While only four CCOs met the CAHPS benchmark for access to care, overall there was improvement on all aspects of the access composite measure. However, there were disparities in access for Hispanics and children with chronic conditions; children’s access to specialist care was the lowest for all of OHP.</li> </ul> <p>Researchers from OHSU presented preliminary findings from research into the characteristics of CCOs and their effects on spending and quality at a conference in September. They compared 2011 with 2013<sup>5</sup> and found:</p> <ul style="list-style-type: none"> <li>■ Spending increases in total acute care (non-RX); inpatient care; procedures; primary care; outpatient mental health; and DME.</li> </ul>

<sup>5</sup> Note their findings relate only those age 18-64 who were enrolled at least 9 months pre-CCO and at least 9 months post-CCO implementation. They exclude pregnant women, and Medicare/Medicaid dual eligibles.

	<ul style="list-style-type: none"> <li>■ Spending decreases in the emergency department; imaging; inpatient mental health; and prescription drugs.</li> <li>■ Increases on quality measures on SBIRT, adolescent well-child visits, and avoidance of non-recommended cervical cancer screening.</li> <li>■ Decreases in quality measures on lipid testing for people with CVD, monitoring of persistent medications, glucose and lipid testing for members with second generation antipsychotic medications, and appropriateness of asthma medications. Questions remain on whether these process measures will lead to desired clinical outcomes, and it is noted that patient outcomes may take longer to achieve.</li> <li>■ Diversity among the CCOs in terms of governance structures and performance related to both quality and expenditures.</li> </ul>
Improvement activities:	<p>Over the last several months staff from OHA’s Office of Health Information Technology conducted on-site meetings with each CCO to ensure that state IT initiatives align with and support CCO needs. OHIT will use information from the site visits to produce a summary document and profiles of health information technology at each of the CCOs. This will be part of a broader environmental scan on the status of health information technology and exchange across the state.</p> <p>The September statewide learning collaborative for CCO Medical Directors and Quality Improvement Coordinators focused on using the CAHPS Access to Care data to measure outcomes and drive improvement. The session included a discussion on identifying strategies, best practices, tools, and resources to improve member access to care.</p> <p>OHA has contracted with the Center for Outcomes Research and Education (CORE) at Providence to build automated metric reporting tools (“dashboards”) for CCOs. These new dashboards provide state- and CCO-level reporting on the incentive and state performance metrics in an interactive format with the ability to filter measures by population subgroups, including race/ethnicity, age, gender, ZIP code, and eligibility category. Future iterations of the dashboard will include filters for people with severe and persistent mental illness (SPMI), household language, and other subgroups of interest. The first iterations will be released to the CCOs in the next quarter.</p>

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

Evaluation activities:	Analysis of the Quarter One (January-March 2014) CCO financial reports, which are the first to include information on the provision of flexible services, showed a relatively low provision of flexible services. However, this may be due to lack of experience using the new format and form, and points to the need for technical assistance to ensure consistent reporting. This one-on-one technical assistance process will occur over the next few months in lieu of the Flexible Services Workgroup.
Interim findings:	None at this time.
Improvement activities:	OHA will review the CCO flexible services policies and provide technical assistance to the CCOs needed.

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

Evaluation activities:	The formative evaluation of the Transformation Center is underway, with the external evaluation team observing a range of Transformation Center meetings and events. The
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	<p>team is analyzing the data in real-time and debriefing with the Transformation Center routinely to share emerging findings and to refine the direction of the evaluation. Next quarter, they will turn their attention to conducting interviews with a purposively selected sample of CAC leaders and participants.</p> <p>In addition, findings from the Transformation Center’s process for rapidly evaluating the effectiveness of its learning collaboratives are below.</p>
<p>Interim findings/ Improvement activities:</p>	<p>The Transformation Center now hosts five external learning collaboratives (a sixth internal learning collaborative for the CCO Innovator Agents also exists):</p> <ol style="list-style-type: none"> <li>(1) Statewide CCO learning collaborative focused on incentive metrics;</li> <li>(2) Learning collaborative for CCO Community Advisory Council members;</li> <li>(3) Complex care collaborative;</li> <li>(4) Institute for Healthcare Improvement for CCO Transformation Fund Portfolio Managers collaborative; and</li> <li>(5) The Council of Clinical Innovators</li> </ol> <p>In addition, the Transformation Center is planning an additional learning collaborative focused on health equity; this collaborative will launch in the next quarter.</p> <p>The five external learning collaboratives held nine sessions in this quarter, attended by an average of 33 participants.</p> <ul style="list-style-type: none"> <li>■ The roles of attendees are as follows: 24% clinical; 15% administrative or operational lead; 14.0% QI/QA staff; the remainder hold other roles.</li> <li>■ As in previous quarters, these were a mix of in-person sessions and webinars. Topics ranged from ‘Measuring Health Equity in the CCO World’ to ‘Access to Care and CAHPS data’.</li> </ul> <p>Results from the Transformation Center’s internal evaluation of the effectiveness of the learning collaboratives is positive:</p> <ul style="list-style-type: none"> <li>■ 85.0% of respondents found the session valuable or very valuable to their work.</li> <li>■ 50.9% of respondents say they will attend future sessions.</li> <li>■ 52.7% of respondents say will take action to change processes at organization as a result of the session.</li> <li>■ 47.3% of respondents say they will reach out to colleagues, experts or OHA for more information or ideas as a result of today’s session.</li> </ul> <p>The evaluation forms also include free response questions asking attendees to note what they found most helpful from the session, as well as suggestions for improvement. Based upon this feedback, the Transformation Center has included future programming aimed at addressing those needs. For example:</p> <ul style="list-style-type: none"> <li>■ The Transformation Center has developed a curriculum plan and topics for Council of Clinical Innovator meetings based on feedback received.</li> <li>■ The format of the Community Advisory Council (CAC) Learning Collaborative monthly meetings has changed to a regional meeting format.</li> <li>■ The Transformation Center’s online learning communities continued to grow in this quarter. There are now 15 learning communities supporting internal and external transformation.</li> </ul> <p>The Transformation Center launched its Technical Assistance Bank for CCOs in September. This includes a menu of technical assistance topics for which CCOs may access a set number of hours of technical assistance. Each CCO will decide how to best utilize the technical assistance resources by selecting the topics of most interest and need. Sample topics include health equity, metrics/measurement, public health integration, and organizational development for CACs.</p>

## VI. Public Forums

### Public comments received

#### Future of Public Health Services Task Force

##### July 23, 2014

<p>Patricia Neal, Public Health Advisory Committee, Lincoln County</p>	<p>Currently all our services are local and should stay that way. Mental health isn't mentioned in the Task Force models but it is part of our department because we are trying to integrate behavioral health with primary care. If regionalization occurs, knowing that all counties are not organized the same, how will individual county needs be met?</p>
<p>Lesli Leone Uebel, Benton County Mental Health Planning Committee</p>	<p>Foundational or core components; the draft framework represents a base minimum and doesn't incorporate the unique role of public health in population health. We do not see a role for innovation or integration of the context of community health for health care systems and community resources. This is a critical time for health care transformation, and healthcare cannot transform in a vacuum. The draft framework is not innovative. Without additional funding, public health will lose ground</p> <p>Recommends meaningful, sustainable funding across the state; and incorporating innovation in the draft framework. A bare minimum of funding across the state will not spark innovation or support innovation; rather, it could risk lowering the services across the state to the lowest common denominator.</p>
<p>Morgan Cowling, Executive Director Coalition of Local Health Officials (CLHO)</p>	<p>CHLO held a recent webinar on the task force work and there were a number of large themes that emerged for recommendations. Participants overwhelmingly support shared services in local public health. Participants were very concerned about imposed consolidation of public health; would it be based on transformation?</p> <p>There is a belief that regional or shared services should be locally driven (based on community needs, transportation corridors, political relationships) and take into consideration local systems and challenges. There is widespread disregard for consolidating 34 health departments into 8 health departments. Substantial solutions to implement a conceptual framework like consolidation of health departments should use local funds for public health.</p> <p>During the webinar with CHLO, participants tried to answer the question, "How do we try to implement this?" Participants agreed that an assessment needs to take place to answer, "Where are we right now?" Morgan encouraged the task force to talk about funding in the workgroup developing the implementation plan.</p>

##### August 20, 2014

<p>Judy A. Sundquist, Benton County Public Health Planning and Advisory Committee</p>	<p>Judy appreciates the work of the task force to improve public health and suggests there be an ongoing dialogue with community members so they become well informed and can have input.</p>
<p>Morgan Cowling, Executive Director Coalition of Local</p>	<p>Morgan had 6 comments for the Task Force:</p> <ol style="list-style-type: none"> <li>1. Regarding governance: Ensure there is a connection between public health and health transformation. Morgan recommends a more formal</li> </ol>

<p>Health Officials (CLHO)</p>	<p>connection between the governance board, advisory board, and policy board.</p> <ol style="list-style-type: none"> <li>2. There should be a new and evolved role for CHLO in this new framework.</li> <li>3. When a county gives its public health authority back to the state, there could be a 4th pathway of establishing how to get it back.</li> <li>4. Regarding technical assistance: Counties may need technical assistance to help facilitate and mediate connections between local boards and county commissioners.</li> <li>5. Currently, local public health authorities have to deliver a set of required programs; they cannot pick and choose. This keeps public health services from becoming political.</li> <li>6. Timeline – the assessment to determine gaps in foundational capabilities could take a really long time.</li> </ol> <p>To do this right we will need to determine what the minimum amount of services are to implement the conceptual framework, what is needed to get there, and what technical assistance is necessary.</p>
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**September 10, 2014**

<p>Lila Wickham, President-Elect Oregon Public Health Association (OPHA)</p>	<p>OPHA is looking forward to legislation that addresses the changing health care system. OPHA believes we need to educate people on how to use health care (medical/dental/behavioral/pharmaceutical) while educating doctors on how to deal with patients in a different way.</p> <p>OPHA hopes there will be flexibility with the way public health is provided, and that the legislature becomes fully aware of the various ways that public health provides services.</p>
<p>Muriel DeLaVergne- Brown, Chair of Conference of Local Health Officials (CLHO)</p>	<p>The conceptual framework presented in this model will require additional resources. CLHO is ready to work with public health to improve the health of Oregonians. The implementation pathways are needed as we look toward the future and it is important that we all work together. Written public comment was provided and included in Task Force member packets.</p>
<p>Stacey Michaelson , Association of Oregon Counties</p>	<p>She would like the changes compiled in a final document to share with commissioners and community partners. The model should include a timeline, language about the legislature agreeing to foundational capabilities, and how long an agency has to come up with the process. If this turns out into a regional process, what does funding look like? The unfunded mandate causes some concern. She would like to see those areas addressed in the final report.</p>
<p>Kathleen Johnson, Program Manager, Coalition of Local Health Officials (CLHO):</p>	<ol style="list-style-type: none"> <li>1. CHLO would like to emphasize and encourage a shorter timeline for implementation; a longer timeline may result in a bifurcated system and a situation of “haves and have-nots.”</li> <li>2. We would like to see additional phases mentioned (not just Phase 1); include a statement that there is a plan to move beyond Phase 1.</li> <li>3. It is important to have a place for our Health Division partners and health departments to come together to work on public health issues as a partnership which includes innovation, bidirectional problem-solving and mutual respect; that opportunity and place should be explicitly stated in the report.</li> <li>4. This provides a wonderful opportunity to improve our public health system; keep in mind there are potential risks associated with opening the statutes.</li> </ol>

**Medicaid Advisory Committee**

- July 2014: No public comment.
- August 2014: MAC did not convene in August.
- September 2014: Committee received a presentation on the Oregon Oral Health Coalition’s Strategic Plan for Oral Health in Oregon. Public comment was received about dental care in Medicaid. Specifically, emergency rooms are not the place to provide dental care and too often hospitals are put in that position. The committee was encouraged to look at funding for school-based health centers or a school nurse to travel to schools to provide dental services.

**Oregon Health Policy Board**

**July 1, 2014:**

Kerry Gonzales, Executive Director, Oregon Academy of Family Physicians	Oregon Academy of Family Physicians is a statewide medical society for family practice doctors with 80% membership. Kerry wanted to reiterate that engaging all payers in supporting Alternative Payment Methodology is important to the success of Patient-Centered Primary Care Homes. The members aren’t seeing change in the way of payment. Kerry would like to encourage the board to look at the first recommendation to put “teeth” into the all payer agreement as there is no mechanism for starting or requiring the process.
Andy Smith, Association of Oregon Community Mental Health Programs	Andy commented on the PMPM pie chart and to look at data further than 2013 to see trend lines in behavioral health. In regard to new Medicaid expansion members, have separate pie charts for each to help understand the data better.

**August 5, 2014:**

Chris Alman, Physician	Chris commented on the pricing of pharmaceuticals. She passed out a draft commentary that will be in an upcoming issue of The Lund Report and referenced an equation that is used for the pricing of pharmaceuticals which is totally out of line with Sovaldi. Prices are being brought forward that have nothing to do with the reality of the cost of the medicine. She wants everyone to take a long hard look at what’s happening with profiteering.
Nancy Armand, licensed marriage and family therapist	<p>Nancy has been told she can only see patients that have an open card. Only 20% of the population have open card in Oregon. Some of those that were on open card have been changed back to managed care through the CCOs. She currently sees two individuals for free as they refuse to go to the CCO.</p> <p>Nancy has tried to talk to Umpqua Health Alliance and they referred her to the mental health provider in the area, Community Health Alliance, and they will not work with her. Leslie Clement and Nancy Armand will have further conversation to work through why there is a barrier between the CCO and the community providers.</p>

**September 9, 2014:**

Michelle Glass, Oregon Action	For the last several years, their focus has been on expanding access to quality affordable healthcare in Southern Oregon. They have done so by being involved with state and federal level conversations with the ACA and being involved with Cover Oregon. There is a continued need of commitment by the state for sustained funding for those individuals not housed in clinics that are in high need of coverage and struggle to gain the resources necessary to get it. Oregon Action’s role has been to help those individuals. Would like the Board to consider the role of “Assistors” to help with processes and providing resources to those in rural areas with difficulty to access
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Renee Balcham, Curry Community Public Health Board, Founder of Liberty Advocacy Group	Renee hopes to see the Board continue to sustain community health workers and thanked the Board for being present today.
Pat Crane Local judge (drug court)	Pat addressed a question that was asked during the meeting about how A&D providers establish required services for people released from correctional institutions. There is not enough alcohol and drug treatment available.
Ron Cypress, Family Advocate on the advisory committee of WellCare	Families need to be included in the recovery process, which was not discussed very much during the meeting. Early intervention – help is needed early on for those suffering from drug and alcohol abuse. Something needs to be done; let’s stop talking and do something about it.

## VII. Transition Plan, Related to Implementation of the Affordable Care Act

No updates to the Transition Plan this quarter.

## VIII. Appendices

### Appendix A. Quarterly enrollment reports

#### 1. SEDS reports

[Attached separately](#) (final report for April - June 2014 and preliminary report for current quarter).

#### 2. State reported enrollment tables

Enrollment	July 2014	August 2014	September 2014
<b>Title XIX funded State Plan</b> Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	593,737	593,877	594,267
<b>Title XXI funded State Plan</b>	71,694	72,079	73,084
<b>Title XIX funded Expansion</b> Populations 9, 10, 11, 17, 18	NA	NA	NA
<b>Title XXI funded Expansion</b> Populations 16, 20	NA	NA	NA
<b>DSH Funded Expansion</b>	NA	NA	NA
<b>Other Expansion</b>	NA	NA	NA
<b>Pharmacy Only</b>	NA	NA	NA
<b>Family Planning Only</b>	NA	NA	NA

<b>Enrollment current as of</b>	7/31/2014	8/31/2014	9/30/2014
*Numbers reflect final movement in enrollment reporting systems of CHIP children with incomes to 138% FPL to Medicaid			

#### 3. Actual and unduplicated enrollment

##### Ever-Enrolled Report

POPULATION	Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
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POPULATION			Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Expansion	Title 19	PLM Children FPL > 170%	1,837	5,282	-4.03%	-16.55%
		Pregnant Women FPL > 170%	968	2,725	0.93%	-22.00%
	Title 21	SCHIP FPL > 170	35,239	101,644	0.87%	35.47%
Optional	Title 19	PLM Women FPL 133-170%	14,196	40,003	4.13%	-11.83%
	Title 21	SCHIP FPL < 170%	48,434	134,372	4.35%	-41.16%
Mandatory	Title 19	Other OHP Plus	487,843	1,405,099	-0.90%	-3.50%
		MAGI Adults/Children	464,315	1,290,851	12.21%	0.00%
		MAGI Pregnant Women	7,762	19,276	34.97%	0.00%
<b>QUARTER TOTALS</b>			1,060,594			

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

**OHP eligibles and managed care enrollment**

OHP Eligibles*	Coordinated Care				Physical Health	Dental Care	Mental Health
	CCOA**	CCOB**	CCOE**	CCOG**	FCHP	DCO	MHO
April 982,590	834,692	9,351	2,120	47,521	3,179	60,723	4,460
May 998,218	850,131	1,782	1,582	49,335	3,140	60,362	4,427
June 1,008,953	866,303	2,089	1,805	52,865	3,091	58,744	4,624
Qtr Average 996,587	850,375	4,407	1,836	49,907	3,137	59,943	4,504
	85.33%	0.44%	0.18%	5.01%	0.31%	6.01%	0.45%

\*Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/ Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.

\*\*CCOA = CCO provides physical, dental and mental health services  
 CCOB = CCO provides physical and mental health services.  
 CCOE = CCO provides mental health services only.  
 CCOG = CCO provides dental and mental health services.

**Appendix B. Neutrality reports**

**1. Budget monitoring spreadsheet**

[Attached separately.](#)

**2. CHIP allotment neutrality monitoring spreadsheet**

[Attached separately.](#)

**Appendix C. Two-percent trend reduction tracking**

[Attached separately.](#)

**Appendix D. DSHP tracking**

[Attached separately.](#)

**Appendix E. Oregon Measures Matrix**

In this period, OHA began reporting on 2014 data, began the measure selection process for 2015, and continued development work on dashboards and measure specifications.

This quarterly report continues to include the final 2013 results for the 17 CCO incentive measures and 33 quality and access test measures, and provides data for a new rolling 12-month window (June 2013 – May 2014) for all claims-based measures.

During this reporting period, OHA also launched the Hospital Transformation Performance Program (HTPP) in collaboration with the Oregon Association of Hospitals and Health Systems (OAHHS). This report includes a summary of activities to establish program rules and measure specifications.

Now that CY 2013 data are finalized and OHA has begun progress reporting for 2014, the preliminary data previously reported for Jan – June 2013 and Jan – Sept 2014 have been removed from the measures matrix.

### CCO Incentive Metrics Updates

#### **CCO reporting and validation:**

- In August 2014, OHA provided CCOs with the first progress report to use a rolling 12-month window (May 1, 2013 through April 30, 2014). The rolling window provides a complete measurement period and results in a stable rate that is more directly comparable to the 2013 final rates. CCO incentive measures were produced using 2014 measure specifications, while state performance measures were produced using 2013 measure specifications. Two measures (colorectal cancer screening and timeliness of prenatal care) require medical record data to complete the numerator and were thus reported denominator-only.
- OHA has contracted with the Center for Outcomes Research and Education (CORE) at Providence to build automated metric reporting tools (“dashboards”) for CCOs. The first dashboard, scheduled for release in October, will use a rolling 12-month window (June 1, 2013 through May 31, 2014) and have the ability to filter key measures by population subgroups such as race/ethnicity, zip code, and eligibility, and allow CCOs to drill down to actionable member-level data. In addition, OHA will provide CCOs with 2014 calendar year data to date. While the October dashboard will contain only incentive and performance measures, OHA is developing future dashboards to include additional cost and utilization data.

#### **Statewide chart review and Year One proof of concept data**

OHA’s Office of Health Analytics has been working in collaboration with the Office of Health Information Technology (OHIT) to complete a comparative analysis of the 2013 statewide chart review data collected by OHA’s contacted EQRO, Acumentra Health, with the Year One proof of concept data extracted from electronic health records by CCOs. This comparison will address the three clinical measures and will be completed in November 2014.

#### **Hospital Metrics Updates**

Planning and implementation of HTPP, Oregon’s hospital incentive measure program, continued in this quarter. The two year program covers the period from September 2013 – October 2015 and creates an incentive pool for DRG hospitals similar to that for the CCOs. In this quarter the list of program metrics and the final version of the attachment to the waiver outlining the program were finalized with CMS. Eleven measures in total were selected, and are outlined in Addendum A. During this time period OHA also worked with its partner, OAHHS, on plans to launch the program and provide technical assistance to hospitals. In addition, OHA continued to refine the details of the measure specifications. Decisions made are outlined below (and included in Addendum A):

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT).** The benchmark for this measure is aligned with that used for the CCO SBIRT benchmark. The CCO benchmark will be

revised from 13% to 12% for 2015<sup>6</sup>; therefore, the HTPP benchmark was changed from 13% to 12%. In addition, hospitals are required to screen everyone ages 12+ (some previous communications with CMS noted screening was only required for those ages 18+).

- **Follow-up after Hospitalization for Mental Illness.** This measure is specifically for members enrolled in CCOs. It was decided that hospitals will receive credit for follow-up provided through *any* CCO, not just the CCO in which the member is enrolled. This is because members in rural areas may be treated and receive follow-up from hospitals and behavioral health providers in urban areas outside the members' CCO.
- **Readmissions.** The denominator has been updated to include **all ages**, not just those ages 18+. The baseline data provided to CMS during the attachment discussions was for all ages (not just those 18+), so there is no change to the benchmark (it remains the statewide 90<sup>th</sup> percentile).
- **Hypoglycemia with Insulin.** The benchmark has been changed from 5% to 7%. This is in line with the benchmark from the Hospital List Scoring Criteria and HEN-wide Performance Benchmarks prepared by HSAG and Mathematica for CMS's Partnership for Patients program.
- **CAUTI.** 'All tracked units' definition for CAUTI measure clarified to those defined or accepted by the National Healthcare Safety Network (NHSN).
- **Sharing ED Visit Information with Primary Care.** It was decided that the benchmark (TBD) will only be associated with notifications to primary care. Hospitals are required to report on the care guideline completion rate, but there will not be a benchmark which must be achieved for that part of the measure.

During the same period OHA worked with its partner, OAHHS, on plans to launch the program and provide technical assistance to hospitals. OHA also worked on the design of a website for the program; the website will house the detailed specifications for each metric, as well as additional documentation, including a guide to the improvement target methodology, the program timeline, and the payment protocol. The website will be launched in the next quarter.

### Committee and Workgroup Updates

The **CCO Metrics Technical Advisory Workgroup (CCO Metrics TAG)** continued to meet monthly throughout this reporting period to address details related to the incentive measures. Topics addressed this quarter included:

- Reviewing draft Year Two technology plans and data submission guidance;
- Recommend improvements to SBIRT documentation process;
- Reviewing draft 2015 measure specifications; and
- Receiving updates on USDOJ July 2014 report on community based services for those with severe and persistent mental illness.

During this reporting period, the CCO Metrics TAG data analyst subgroup met once. In their July meeting, the subgroup reviewed the draft year two data submission guidance for the three clinical measures, discussed 2014 CAHPS survey data, and addressed general questions about metrics reporting. Data analysts participated in the regular Metrics TAG meetings and a follow-up meeting to discuss constructing member month tables from eligibility files was scheduled for October.

The **CCO Metrics & Scoring Committee** met in July and August 2014. Meeting materials are available online at <http://www.oregon.gov/oha/Pages/metrix.aspx>.

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<sup>6</sup> This change was because CCOs (and hospitals) will be required to screen people age 12+ (previously CCOs were only responsible for screening those age 18+).

In July, the Committee reviewed final 2013 performance and quality pool payout. Based on stakeholder feedback collected through a survey fielded by OHA in May and June, the Committee also assessed the 17 current incentive metrics and reviewed proposed new measures for 2015.

In August, the Committee agreed to add two new incentive measures (effective contraceptive use among women at risk of unintended pregnancy and tobacco use prevalence), and drop two (early elective delivery and follow-up care for children prescribed ADHD medications).

In addition, the Committee formally adopted a measure that was previously recommended by the Dental Quality Metrics workgroup (dental sealants on permanent molars for children); and adopted modifications to three existing measures (SBIRT, follow-up after hospitalization for mental illness, and mental and physical health assessments for children in DHS custody).

The Committee also identified a list of “on deck” measures, to be considered first when selecting the 2016 incentive measures set in early 2015. There was a change in Committee membership beginning in August, with three new members replacing outgoing members.

The **Hospital Performance Metrics Advisory Committee** met in July to finalize the proposed performance measures that OHA submitted to CMS, and to discuss the hospital quality pool distribution methodology.

### Quality and Access Test Validation

OHA and its contractor, the Oregon Health Care Quality Corporation (Q Corp) have been conducting a multi-directional validation process on the CCO incentive measures and state performance measures. Throughout this reporting period, Q Corp has continued to work through technical challenges to validate claims-based measures and has also begun to focus on validation activities of the non-claims based measures. Progress this quarter includes:

- **Validation of measures computed with administrative claims:** There are twenty-two measures that are computed using administrative claims data. Validation had previously focused on the 2011 baseline period and the dry run (July 2012 – June 2013) period, but activities are shifting to CY 2013 and the first “test” period (July 2013 – June 2014). Q Corp will finalize the CY 2013 validation and produce the year one “test” in December 2014.
- **Non-claims based measures:** OHA and Q Corp reached agreement on validation approaches for non-claims based measures. Q Corp will complete the validation activities for these measures by December 2014.
- **Patient-Centered Primary Care Home Enrollment:** Q Corp has completed a validation of PCPCH enrollment data self-reported by CCOs compared against data collected by the PCPCH program. Q Corp is also developing a summary of findings that will be submitted to OHA in October.

### Measure Development Updates

#### ***Remaining State Performance (Test) Measure Status:***

**Provider Access Questions from the Physician Workforce Survey:** OHA will begin fielding the 2014 physician workforce survey in Q4 2014. Results will be available in Q1 2015.

#### ***Remaining Core Performance Measure Status***

OHA has continued development of Core Performance Measures, but several are still outstanding:

- **Low Birth Weight:** OHA is continuing to test specifications for running this measure out of claims-data, without including any birth record data. Preliminary results do not meet face validity and additional development is necessary.

- **Medication Reconciliation Post-Discharge:** OHA is considering utilizing CAHPS survey questions to produce this measure and will continue discussions with the CAHPS steering group. OHA will continue to explore options for collecting and reporting on this measure without requiring medical record review.
- **Obesity Prevalence:** OHA will have updated obesity prevalence data for the Medicaid population and by CCO in January 2015, when the Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) has completed fielding.
- **Effective Contraceptive Use:** As this measure was selected as a CCO incentive measure for 2015, OHA will transition reporting on this measure from the BRFSS-survey based annual approach, to a claims-based approach that can be reported at the CCO level. OHA will provide updated data and specifications for this measure in the next quarterly report.

**Core Performance Measure Matrix and PQI Matrix**

[Attached separately.](#) OHA has continued development work on the core performance measures outlined in the waiver; 2011 baseline data, calendar year 2013 data, and a rolling 12-month measurement period at the state level are included in the table below, as are high and low CCO performance on each measure where possible. Updates provided in red.

OHA anticipates having updated obesity prevalence and effective contraceptive use data in the next quarterly report.

**Core Performance Measures by Race/Ethnicity - June 2013 – May 2014**

As part of the dashboard reporting under development with OHA/CORE, additional measures and additional stratifications will be added in future quarterly reports.

CORE Performance Measures	White, non-Hispanic	African-American, non-Hispanic	American Indian / Alaska Native, non-Hispanic	Asian American, non-Hispanic	Hawaiian / Pacific Islander, non-Hispanic	Hispanic / Latino
Ambulatory care: ED utilization	54.3/1,000 mm	67.7/1,000 mm	63.3/1,000 mm	21.1/1,000 mm	41.4/1,000 mm	35.2/1,000 mm
Developmental screening	36.9%	36.1%	32.5%	34.3%	32.0%	31.2%
Follow up after hospitalization for mental illness	69.5%	52.1%	55.2%	62.9%	42.9%	73.2%

**Hospital Transformation Performance Program (HTPP) Measures**

[Attached separately.](#)

**Appendix E: Oregon Measures Matrix**

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

This quarterly report includes the final 2013 results for the 17 CCO incentive measures and 33 quality and access “test” measures, as well as a new rolling 12-month window (June 2013 – May 2014) for all claims-based measures and two non-claims based measures. Now that CY 2013 data are finalized and OHA has begun progress reporting into 2014, the preliminary data reported for Jan – June 2013 and Jan – Sept 2014 have been removed from this report.

Updates from last quarter’s report are indicated in track changes.

Focus Area	Measure Sets						Quality and Access ‘Test’		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access ‘Test’ Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
Improving behavioral and physical health coordination	*Alcohol or other substance misuse (SBIRT)	√	√			√	0.02%	13% Metrics & Scoring Committee consensus	MN method	13% Metrics & Scoring Committee consensus	State: 0.02% High CCO: 0.22% Low CCO: 0.0%	State: 2.0% High CCO: 8.7% Low CCO: 0.0%	State: <a href="#">4.4%</a> High CCO: <a href="#">15.7%</a> Low CCO: <a href="#">0.1%</a>
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	State: 65.2% High CCO: 88.9% Low CCO: 57.1%	State: 67.6% High CCO: 81.0% Low CCO: 51.2%	State: <a href="#">68.3%</a> High CCO: <a href="#">80.0%</a> Low CCO: <a href="#">40.0%</a>
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	0%	Reporting only in CY 2013.		Reporting only in CY 2013.	0%	<a href="#">N/A</a>	N/A

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
	*Mental and physical health assessment within 60 days for children in DHS custody	√	√				53.6%	90% Metrics & Scoring Committee consensus	MN method with 3% floor.	90%	State: 53.6% High CCO: 67.7% Low CCO: 35.7%	State: 63.5% High CCO: 100% Low CCO: 23.1%	State: <a href="#">66.1%</a> High CCO: <a href="#">100%</a> Low CCO: <a href="#">40.0%</a>
	*Follow-up care for children prescribed ADHD meds (NQF 0108)	√			√	√	Initiation: 52.3% C&M: 61.0%	Initiation: 51% C&M: 63.0% Medicaid 2012 NCQA National 90 <sup>th</sup> percentile	MN method	Initiation: 51% C&M: 63.0% Medicaid 2012 NCQA National 90 <sup>th</sup> percentile	Initiation: State: 52.3% High CCO: 88.9% Low CCO: 33.3% C&M: State: 61.0% High CCO: 100% Low CCO: 29.4%	Initiation: State: 53.3% High CCO: 70.8% Low CCO: 43.5% C&M: State: 61.6% This measure cannot be reported at the CCO level for 2013.	Initiation: State: <a href="#">57.1%</a> High CCO: <a href="#">78.6%</a> Low CCO: <a href="#">47.5%</a> C&M will be available in <a href="#">a future report.</a>
Improving perinatal and maternity	*Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	65.3% using admin data only.	69.4% 2012 National Medicaid 75 <sup>th</sup> percentile:	MN method with 3% floor.	69.4% 2012 National Medicaid 75 <sup>th</sup> percentile: (w/	State: 65.3% High CCO:	State: 67.3% High CCO:	OHA will report on this measure

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
care							(adjustment factor applied to account for difference between admin data and hybrid rates)		adjustment factor)	77.0% Low CCO: 47.7%	78.3% Low CCO: 56.0%	when hybrid data are available following the end of the CY - <a href="#">2014 measure period.</a>	
	*Prenatal and postpartum care: postpartum care rate (NQF 1517)			√		√	40.0% using admin data only	43.1%2012 National Medicaid 75 <sup>th</sup> percentile (adjustment factor applied)	n/a	n/a	State: 40.0% High CCO: 47.1% Low CCO: 22.6%	State: 33.4% This measure cannot be reported at the CCO level for 2013.	<a href="#">State: 33.4%</a> <a href="#">High CCO: 45.1%</a> <a href="#">Low CCO: 20.4%</a> <a href="#">Note admin data only – OHA will update with hybrid rates at the end of the CY 2014 measure period.</a>
	PC-01: Elective delivery	√		√		√	10.1%	5% or below.	MN method	5% or below.	State:	State:	N/A

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
	(NQF 0469) <i>Lower score is better.</i>										10.1% High CCO: 14.9% Low CCO: 7.2%	2.6% High CCO: 4.3% Low CCO: 0.2%	
Reducing preventable re-hospitalizations	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	State: 65.2% High CCO: 88.9% Low CCO: 57.1%	State: 67.6% High CCO: 81.0% Low CCO: 51.2%	<a href="#">State: 68.3%</a> <a href="#">High CCO: 80.0%</a> <a href="#">Low CCO: 40.0%</a>
	*Ambulatory Care: Outpatient (OP) and Emergency Department (ED) utilization. <i>Lower score is better for ED utilization.</i>	√	√		√	√	ED: 61.0/1,000mm OP: 364.2/1,000mm	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90 <sup>th</sup> percentile	<b>ED</b> State: 61.0/1,000mm High CCO: 86.2/1,000mm Low CCO: 55.4/1,000mm <b>OP</b> State: 364.2/1,000mm High CCO:	<b>ED</b> State: 50.5/1,000mm High CCO: 74.3/1,000mm Low CCO: 31.6/1,000mm <b>OP</b> State: 323.5/1,000mm	<a href="#">ED State: 48.8/1,000mm</a> <a href="#">High CCO: 69.4/1,000mm</a> <a href="#">Low CCO: 33.3/1,000mm</a> <a href="#">OP State: 310.9/1,000mm</a>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
										412.3/ 1,000mm  Low CCO: 296.6/ 1,000mm	High CCO: 345.7/1,000 mm  Low CCO: 267.4/1,000 mm	<a href="#">High CCO: 348.5/1,000 0mm</a>  <a href="#">Low CCO: 263.3/1,000 0mm</a>	
	*Plan all-cause readmission (NQF 1768)  <i>Lower score is better.</i>		√		√	√	12.3%	10.5%  Average of Commercial and Medicare 75 <sup>th</sup> percentiles	n/a	n/a	State: 12.3%  High CCO: 14.6%  Low CCO: 8.7%	State: 11.7%  High CCO: 13.6%  Low CCO: 6.6%	<a href="#">State: 11.5%</a>  <a href="#">High CCO: 13.7%</a>  <a href="#">Low CCO: 6.9%</a>
Ensuring appropriate care is delivered in appropriate settings	*Ambulatory Care: Outpatient and ED utilization  <i>Lower score is better for ED utilization.</i>	√	√		√	√	ED: 61.0/ 1,000mm  OP: 364.2/ 1,000mm	ED: 44.1 / 1,000mm  OP: 439/ 1,000mm  2011 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm  OP: 439/ 1,000mm  2011 National Medicaid 90 <sup>th</sup> percentile	<b>ED</b> State: 61.0/ 1,000mm  High CCO: 86.2/ 1,000mm  Low CCO: 55.4/ 1,000mm  <b>OP</b> State: 364.2/ 1,000mm  High CCO:	<b>ED</b> State: 50.5/1,000m m  High CCO: 74.3/1,000m m  Low CCO: 31.6/1,000m m  <b>OP</b> State: 323.5/1,000 mm	<a href="#">ED State: 48.8/1,000 mm</a>  <a href="#">High CCO: 69.4/1,000 mm</a>  <a href="#">Low CCO: 33.3/1,000 mm</a>  <a href="#">OP State: 310.9/1,000 0mm</a>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
										412.3/ 1,000mm  Low CCO: 296.6/ 1,000mm	High CCO: 345.7/1,000 mm  Low CCO: 267.4/1,000 mm	<a href="#">High CCO: 348.5/1,000 0mm</a>  <a href="#">Low CCO: 263.3/1,000 0mm</a>	
Improving primary care for all populations	Colorectal cancer screening <a href="#">2011 and 2013</a> measure specifications modified to identify unique members receiving colorectal cancer screening in 12 month period, reported per 1,000 member months (mm).  2014 measure will use HEDIS hybrid specifications	√				√	15.8/ 1,000mm using admin data only.		n/a  3% improvement only	n/a  3% improvement only	State: 15.8/ 1,000 mm admin data only.  High CCO: 21.3/ 1,000 mm  Low CCO: 5.1/ 1,000 mm	State: 11.4/1,000m m  High CCO: 15.7/1,000m m  Low CCO: 7.2/1,000m m	OHA will report on <a href="#">this measure when hybrid data are available following the end of the CY 2014 measure period.</a>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
Patient-Centered Primary Care Home Enrollment	√					√	51.8% (2012)	100% (Tier 3)	The % of dollars available to each CCO for this measure will be tied to the % of enrollees in PCPCH, based on formula.	The % of dollars available to each CCO for this measure will be tied to the % of enrollees in PCPCH, based on formula.	State: 51.8% (2012) High CCO: 94.4% (2012) Low CCO: 3.7% (2012)	State: 78.6% High CCO: 95.6% Low CCO: 41.8%	State: <a href="#">76.9%</a> High CCO: <a href="#">97.9%</a> Low CCO: 45.3%
*Developmental screening in the first 36 months of life (NQF 1448)	√	√			√	√	20.9% using admin data only.	50% Metrics & Scoring Committee consensus	MN method.	50% Metrics & Scoring Committee consensus	State: 20.9% High CCO: 67.1% Low CCO: 0.2%	State: 33.1% High CCO: 62.7% Low CCO: 16.8%	State: <a href="#">34.7%</a> High CCO: <a href="#">64.7%</a> Low CCO: <a href="#">19.5%</a>
*Well-child visits in the first 15 months of life (NQF 1392)					√	√	68.3%	77.3% 2012 National Medicaid 90 <sup>th</sup> percentile	n/a	n/a	State: 68.3% High CCO: 81.3% Low CCO: 45.0%	State: 60.9% High CCO: 75.3% Low CCO: 33.3%	State: <a href="#">60.1%</a> High CCO: <a href="#">67.4</a> Low CCO: 47.0%
*Adolescent well-care visits (NCQA)	√				√	√	27.1% (admin data only)	53.2% 2011 National Medicaid 75 <sup>th</sup>	MN method with 3% floor.	53.2% 2011 National Medicaid 75 <sup>th</sup>	State: 27.1% High CCO:	State: 29.2% High CCO:	State: <a href="#">29.5%</a> High CCO: <a href="#">High CCO:</a>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
							percentile (admin data only)		percentile (admin data only)	31.9% Low CCO: 20.7%	43.4% Low CCO: 20.5%	<a href="#">40.3%</a> Low CCO: 21.1%	
	Childhood immunization status (NQF 0038)				√	√	66.0% (Combo 2)	82.0% 2012 National Medicaid 75 <sup>th</sup> percentile (combo 2)	n/a	n/a	State: 66.0% High CCO: 73.1% Low CCO: 58.0%	State: 65.3% High CCO: 74.5% Low CCO: 49.0%	Data will be available in a future report.
	Immunization for adolescents (NQF 1407)				√	√	49.2% (Combo 1)	70.8% 2012 National Medicaid 75 <sup>th</sup> percentile (combo 1)	n/a	n/a	State: 49.2% High CCO: 57.2% Low CCO: 31.6%	State: 52.9% High CCO: 60.3% Low CCO: 29.6%	Data will be available in a future report.
	Appropriate testing for children with pharyngitis (NQF 0002)				√	√	73.7%	76.0% 2012 National Medicaid 75 <sup>th</sup> percentile	n/a	n/a	State: 73.7% High CCO: 90.7% Low CCO: 41.9%	State: 72.8% High CCO: 90.4% Low CCO: 36.7%	<a href="#">State: 73.7%</a> <a href="#">High CCO: 87.4%</a> <a href="#">Low CCO: 35.0%</a>
	Medical assistance with smoking and tobacco use cessation (CAHPS)			√		√	1: 50.0% of adult tobacco users on	2012 National Medicaid benchmark	n/a	n/a	State: 1: 50.0% 2: 24.0% 3: 22.0%	State: 1: 55.0% 2: 28.9%	N/A

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
	(NQF 0027)						Medicaid reported being advised to quit by their Dr; 2: 24.0% reported their Dr discussed or recommended medications with them; 3: 22.0% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)	90 <sup>th</sup> percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%		High CCO: 1: 61% 2: 34% 3: 27% Low CCO: 1: 45% 2: 19% 3: 16%	3: 23.6% High CCO: 1: 61.5% 2: 41.9% 3: 30.1% Low CCO: 1: 43.9% 2: 16.8% 3: 17.8%		
Deploying care teams to improve care and reduce preventable	*Ambulatory Care: Outpatient and ED utilization	√	√		√	√	ED: 61.0/1,000mm OP: 364.2/	ED: 44.1 / 1,000mm OP: 439/1,000mm 2011 National	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/1,000mm 2011 National	ED State: 61.0/1,000mm High CCO: 86.2/	ED State: 50.5/1,000mm High CCO: 74.3/1,000m	<a href="#">ED State: 48.8/1,000mm</a> <a href="#">High CCO: 69.4/1,000</a>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
of unnecessarily costly utilization by super users							1,000mm	Medicaid 90 <sup>th</sup> percentile		Medicaid 90 <sup>th</sup> percentile	1,000mm Low CCO: 55.4/1,000mm <b>OP</b> State: 364.2/1,000mm High CCO: 412.3/1,000mm Low CCO: 296.6/1,000mm	m Low CCO: 31.6/1,000mm <b>OP</b> State: 323.5/1,000mm High CCO: 345.7/1,000mm Low CCO: 267.4/1,000mm	<a href="#">mm</a> <a href="#">Low CCO: 33.3/1,000mm</a> <a href="#">OP State: 310.9/1,000mm</a> <a href="#">High CCO: 348.5/1,000mm</a> Low CCO: 263.3/1,000mm
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and	Controlling high blood pressure (NQF 0018)	√		√		√	0%	Reporting only in CY 2013.		Reporting only in CY 2013.	0%	N/A	N/A
	*Comprehensive diabetes care: LDL-C Screening (NQF 0063)			√		√	67.2%	80%	n/a	n/a	State: 67.2% High CCO: 73.1% Low CCO: 55.2%	State: 70.1% High CCO: 74.2% Low CCO: 61.5%	<a href="#">State: 72.7%</a> <a href="#">High CCO: 77.7%</a> Low CCO: 62.1%
	*Comprehensive diabetes care: Hemoglobin A1c			√		√	78.5%	86%	n/a	n/a	State: 78.5% High CCO:	State: 79.3% High CCO:	<a href="#">State: 81.7%</a> <a href="#">High CCO:</a>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013-May 2014
coordinating a broad set of resources, including CHW.	testing (NQF 0057)						percentile			86.4%	83.0%	<a href="#">85.7%</a>	
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	0%	Reporting only in CY 2013.	Reporting only in CY 2013.	0%	N/A	N/A	
	*PQI 01: Diabetes, short term complication admission rate (NQF 0272) <i>Lower is better</i>		√	√		√	192.9 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 192.9 Low CCO: 109.0 High CCO: 360.8	State: 211.5 Low CCO: 16.7 High CCO: 417.3	<a href="#">State: 183.6</a> <a href="#">Low CCO: 61.7</a> <a href="#">High CCO: 393.6</a>
	*PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275) <i>Lower is better</i>		√	√		√	454.6 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 454.6 Low CCO: 292.5 High CCO: 821.1	State: 308.1 Low CCO: 42.9 High CCO: 602.6	<a href="#">State: 253.3</a> <a href="#">Low CCO: 115.2</a> <a href="#">High CCO: 484.6</a>
	*PQI 08: Congestive heart failure admission rate (NQF 0277) <i>Lower is better</i>		√	√		√	336.9 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 336.9 Low CCO: 177.2 High CCO: 611.9	State: 247.0 Low CCO: 101.4 High CCO: 411.4	<a href="#">State: 231.5</a> <a href="#">Low CCO: 87.2</a> <a href="#">High CCO: 422.1</a>
	*PQI 15: Adult asthma		√	√		√	53.4 /	10% reduction	n/a	n/a	State:	State:	<a href="#">State:</a>

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	admission rate (NQF 0283) <i>Lower is better</i>						100,000 member years	from baseline			53.4 Low CCO: 16.1 High CCO: 180.3	43.6 Low CCO: 0.0 High CCO: 70.2	<a href="#">34.8</a> <a href="#">Low CCO: 15.7</a> <a href="#">High CCO: 58.9</a>
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	<b>Access to Care</b>  OR adult baseline: 79%  OR child baseline 87%  OR average: 83%	<b>Access to Care</b>  2012 National Medicaid adult 75 <sup>th</sup> percentile: 83.63%  2012 National Medicaid child 75 <sup>th</sup> percentile: 90.31%  National average: 86.97%	<b>Access to Care</b>  OR adult baseline: 79%  OR child baseline 88%  OR average: 83.5%	<b>Access to Care</b>  2012 National Medicaid adult 75 <sup>th</sup> percentile: 83.63%  2012 National Medicaid child 75 <sup>th</sup> percentile: 90.31%  National average: 86.97%	<b>Access to Care</b>  Adult: 79% Child: 87% Avg: 83%  High CCO: Adult: 85% Child: 94% Avg: 90%  Low CCO: Adult: 73% Child: 81% Avg: 81%  <i>Note: OHA cannot report on all CCOs for this measure – CAHPS 2011 was sampled for</i>	<b>Access to Care</b>  Adult: 80.1% Child: 87.1% Avg: 83.6%  High CCO: Avg: 88.3%  Low CCO: Avg: 80.4%	N/A

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										old managed care orgs – not current CCOs.			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	59.9%	63.0%	n/a	n/a	State: 59.9% High CCO: 65.8% Low CCO: 49.6%	State: 54.4% High CCO: 62.3% Low CCO: 41.5%	State: <a href="#">56.2%</a> High CCO: <a href="#">63.9%</a> Low CCO: <a href="#">41.6%</a>
	*Cervical cancer screening (NQF 0032)			√		√	56.1%	74.0%	n/a	n/a	State: 56.1% High CCO: 59.8% Low CCO: 47.5%	State: 53.3% High CCO: 58.9% Low CCO: 40.5%	State: <a href="#">55.0%</a> High CCO: <a href="#">61.4%</a> Low CCO: 42.3%
	*Child and adolescent access to primary care practitioners				√	√	12-24 mos 97.4% 25 mos – 6	12-24 mos 98.2% 25 mos –	n/a	n/a	<b>12-24 mos</b> State: 97.4% High CCO:	<b>12-24 mos</b> State: 96.4%	Data will be available in a future

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(NCQA)							years 86.2% 7-11 yrs 88.2% 12-19 yrs 88.9% All ages 88.5%	6 years 91.6% 7-11 yrs 93.0% 12-19 yrs 91.7% All ages n/a 2011 National Medicaid 75 <sup>th</sup> percentile			99.0% Low CCO: 96.2% <b>25 mos – 6 years</b> State: 84.3% <b>7-11 yrs</b> State: 87.2% <b>12-10 yrs</b> State: 87.6% <b>All ages</b> State: 87.0% CCO data not available for 2013. <b>12-19 yrs</b> State: 88.9% High CCO: 92.3% Low CCO: 86.9% <b>All ages</b> State: 88.5%	report	

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Provider Access Questions from the Physician Workforce Survey:					√	In 2012:	TBD	n/a	n/a	1) 85.0%	N/A. OHA is fielding a physician workforce survey in 2014 to be able to report on this measure.	N/A. OHA is fielding a physician workforce survey in 2014 to be able to report on this measure
1) To what extent is your primary practice accepting new Medicaid/OHP patients? (include: completely closed, open with limitations, and no limitations).						85.0% of Oregon's physicians accepted new Medicaid patients with no or some limitations				2) 81.7%		
2) Do you currently have Medicaid/OHP patients under your care?						81.7% of physicians have Medicaid patients.				3) TBD		
3) What is the current payer mix at your primary practice?						TBD				OHA cannot report this measure by CCO, but may be able to report regional variation in a subsequent report.		
Screening for depression and follow up plan (see above)												
*SBIRT (see above)												
*Mental and physical health assessment for												

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	children in DHS custody (see above)												
	*Follow-up care for children on ADHD medication (see above)												
	*Timeliness of prenatal care (see above)												
	Colorectal cancer screening (see above)												
	PCPCH enrollment (see above)												
	*Developmental screening by 36 months (see above)												
	*Adolescent well child visits (see above)												
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	<b>Satisfaction with Care</b>  OR adult baseline: 76%  OR child baseline: 80%  OR average: 78%	<b>Satisfaction with Care</b>  2012 National Medicaid adult 75 <sup>th</sup> percentile: 83.19%  2012 National Medicaid child 75 <sup>th</sup> percentile: 84.71%  National	<b>Satisfaction with Care</b>  OR adult baseline: 76%  OR child baseline: 80%  OR average: 78%	<b>Satisfaction with Care</b>  2012 National Medicaid adult 75 <sup>th</sup> percentile: 83.19%  2012 National Medicaid child 75 <sup>th</sup> percentile: 84.71%  National	Adult: 76% Child: 80% Avg: 87%  High CCO: Adult: 81% Child: 86% Avg: 83%  Low CCO: Adult: 65% Child: 72% Avg: 70%	Adult: 82.1% Child: 84.1% Avg: 83.1%  High CCO: Avg: 88.2%  Low CCO: Avg: 79.5%	N/A

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	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√		average: 83.95%		average: 83.95%			
Meaningful Use	EHR adoption See revised documentation online at <a href="http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx">www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx</a>	√				√	28.0%	49.2% <i>2014 Federal benchmark for Medicaid.</i>	Minnesota Method	49.2%	State: 28.0% High CCO: 35% Low CCO: 12%	State: 59.0% High CCO: 77.2% Low CCO: 46.0% <i>As of April 2014</i>	<a href="#">State: 63.5%</a> <a href="#">High CCO: 77.7%</a> <a href="#">Low CCO: 53.7%</a> <i>As of Sept 2014</i>

\*These measures are reported quarterly

\*\*The Minnesota Department of Health’s Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year’s results and the performance target goal to 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 [www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf](http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf).