Oregon Health Plan

Section 1115 Annual Report

Demonstration Year: 14

July 1, 2015 – June 30, 2016

Table of Contents

I. Introduction

A. Letter from the State Medicaid Director

I am pleased to let you know about the Oregon Health Authority's progress in meeting the goals of the Oregon Health Plan (OHP) demonstration for the past demonstration year.

Lever 1 - Improving care coordination

In this demonstration year, the number of recognized PCPCH clinics in the state increased from 589 in quarter 2, 2015, to 629 in quarter 2, 2016. This surpasses Oregon's goal of 500 clinics by 2015, and represents 60% of the estimated number of primary care clinics in Oregon.

Lever 2 – Implementing alternate payment methodologies (APMs)

In this demonstration year, the Federally Qualified Rural Health Center (FQHC) APM program found that engagement touches among the cohorts steadily increased. It is estimated that, as the program becomes more efficient and technical assistance for health centers will continue to improve.

- Clinical quality measures continue to maintain a consistent level, or improve significantly, demonstrating that detaching FQHC revenue from the office visit does not reduce quality.
- The actuarial consulting firm Optumas authored two reports showing significant reductions in emergency department and inpatient utilization for Phase 1 FQHC's patient populations.

Lever 3 – Integrating physical, behavioral and oral health care

Behavioral Health - Five of the CCO incentive measures relate to physical and behavioral health care integration. Measure specifications for three measures (Screening, Brief Intervention and Referral to Treatment (SBIRT), Follow-Up After Hospitalization for Mental Illness, and Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody) changed in 2015. Generally, performance on all measures increased over the demonstration year, with most exceeding their target benchmark. Please go to www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx for a full report on 2015 Health Systems Transformation metrics.

Oral Health - Since becoming OHA's Dental Director in February 2015, Dr. Bruce Austin has been working closely with CCOs to integrate oral health services and align school based sealant programs with the CCOs. In 2015, the state added a dental sealant measure for kids to CCO metrics. Data from that year show that all 16 CCOs improved in the percentage of students receiving a sealant during the measurement year, and that the statewide change increased by 65% over 2014. At the same time, oral health has become more fully integrated into coordinated care benefits. As of July 1, 2016, all 16 CCOs have integrated oral health providers and dental care organizations (DCOs) to provide care to their members.

Lever 4 – Increased efficiency in providing care

Key measures of efficient and effective care - such as Adolescent Well-Care Visits (+17%), Developmental Screening in the first 36 months of life (+28%), Substance Abuse Screening and Treatment (SBIRT) (+98%) and effective contraceptive use (+9%) - continued to improve. Please go to: www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx for a full report on 2015 Health Systems Transformation metrics.

The Oregon Health Authority's Public Health Division's Sustainable Relationships for Community Health program awarded five grants to local consortia for Local Public Health Authorities (LPHA) to partner with

their regional Coordinated Care Organizations (CCO) and local Community Self-Management Program (CSMP) organizations to align roles and responsibilities to improve health outcomes in prevention, early detection and self-management of chronic disease. All grantees developed plans and identified quality improvement initiatives focusing on tobacco cessation referrals.

Lever 5 – Implementation of health-related flexible services

OHA's evaluation contractor will include findings about the effectiveness of flexible services in its final report, which will be delivered by the end of 2017. In addition, the contractor will provide recommendations for evaluating flexible services following the end of the demonstration period. Indications of the usage and success of Flexible Services were surveyed and reviewed by the Transformation Center in 2015, and a survey summary reported the most commonly used Flexible Services as well as those that presented challenges. A Learning Collaborative of Flexible Services was subsequently held in October 2015. Please see Attachment XXXX for summaries of these processes, including reports from specific CCOs.

Lever 6 – Innovation through the Transformation Center:

The Transformation Center continued to assess the implementation of the Community Advisory Councils' (CAC's) Community Health Improvement Plans (CHIPs) in order to help guide the Transformation Center's support of the CACs, which are key in developing the CHIPS.

Lori Coyner
State Medicaid Director

B. Demonstration description

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

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

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

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

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

- **Coordinated care organizations (CCOs):** The state established CCOs as the delivery system for Medicaid and CHIP services.
- **Flexibility in use of federal funds:** The state can use Medicaid dollars for flexible services (*e.g.*, traditional health care workers), to be used for health-related care that is authorized under managed care rules and regulations. CCOs will have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health.

- **Federal investment:** The federal government agreed to provide federal financial participation (FFP) for several health care programs that previously had been supported entirely by state funds. These are called designated state health programs (DSHPs). DSHP spending is limited to $704 million FFP over the demonstration period July 5, 2012 through June 30, 2017. It is allocated by demonstration year (DY) as follows:

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

DY	Time Period	FFP Limit
14	07/1/15-06/30/16	$ 68 M
15	07/1/16-06/30/17	$ 68 M

- **Workforce:** To support the new CCO model of care, Oregon agreed to establish a loan repayment program for primary care providers who agree to work in rural or underserved communities in Oregon, and training for 300 community health workers by 2015. As mandated by House Bill 3396 (2015 Regular Session), Oregon will do further evaluation and research to determine how to best recruit and retain health care providers to practice in rural and medically underserved areas of the state.

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, Public Health Modernization 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 Quarterly Reports

Janna Starr, Operations and Policy Analyst
503-947-1193 phone
503-373-7689 fax

State Plan

Jesse Anderson, State Plan Manager
503-945-6958 phone

503-947-1119 fax

Coordinated Care Organizations

Rhonda Busek, Provider Services Director
503-945-6552 phone
503-373-7689 fax

Quality Assurance and Improvement

Chris Norman, Compliance and Regulations Director
503-945-7818 phone
503-945-6548 fax

For mail delivery, use the following address

Oregon Health Authority
Health Policy and Analytics
500 Summer Street NE, E54
Salem, OR 97301-1077

II. Title

Oregon Health Plan Section 1115 Annual Report
Demonstration Year (DY): 14 (July 1, 2015 – June 30, 2016)

III. Overview

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	
B. Benefits	No	No	No	
C. CCO Complaints and Grievances	-	-	-	
D. Quality of care – CCO / MCO / FFS	-	-	-	
E. Access	No	No	No	
F. Provider Workforce	No	No	No	
G. CCO networks	No	No	No	

Details on impacts or interventions

Nothing to report.

B. Complaints and grievances

The information provided is a compilation of data from the 16 coordinated care organizations. The reporting period covers the quarters beginning 07/01/2015 and ending 06/30/2016. The chart shows the individual line items that are required under each main category. The chart includes:

- The total of all complaints reported statewide by the 16 coordinated care organizations (CCOs) for the quarter.
- Total number of statewide complaints that were pended at the end of the quarter,
- Average rate of enrollment during the quarter as reported by the CCOs,
- Rate per enrollee, which is based on the average total enrollment and calculated per 1000 members.

Looking at the trends over the four quarters for all CCOs, shows the rate per 1000 members fluctuated from the lowest amount of 3.67 in the third quarter to 4.178 in the fourth quarter.

The data shows the rate was higher in the last quarter of the reporting period. This is due to a change in the Non-Emergency Transportation contracts during the reporting period. As reported in the last two quarterly reports, the CCOs are taking steps to reduce the rate of grievances received. Areas where the trend and rate is higher are seen in Access to Care and Interaction with Providers, or Plans.

Interventions

While there has been an increased focus on tracking and reporting complaints, additional work internally with OHA staff and processes as well as with the Plans is needed to improve reporting and trending analysis going forward.

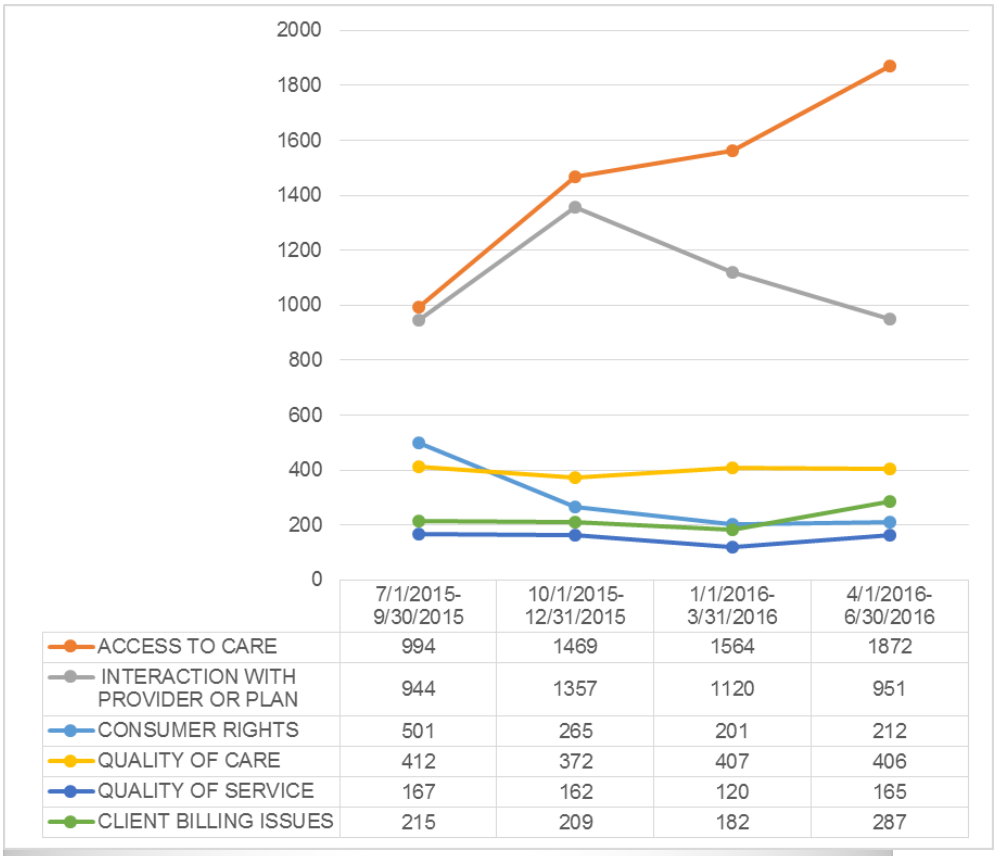
All categories of CCO complaints and grievances per quarter

Complaint or grievance type	7/1/2015-9/30/2015	10/1/2015-12/31/2015	1/1/2016-3/31/2016	4/1/2016-6/30/2016	2015-2016 Total
ACCESS TO CARE					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	152	100	508	114	**874**
b) Plan unresponsive, not available, difficult to contact for appointment or information.	16	25	76	40	**157**
c) Provider's office too far away, not convenient	41	14	14	45	**114**
d) Unable to schedule appointment in a timely manner.	165	136	112	152	**565**
e) Unable to be seen in a timely manner for urgent/emergent care	43	31	13	30	**117**
f) Provider's office closed to new patients.	25	41	26	92	**184**
g) Referral or 2nd opinion denied/refused by provider.	24	50	39	57	**170**
h) Referral or 2nd opinion denied/refused by plan.	7	19	36	17	**79**
i) Provider not available to give necessary care	74	62	106	39	**281**
j) Eligibility issues	47	30	38	56	**171**
k) Female or male provider preferred, but not available	11	13	7	12	**43**
l) NEMT not provided, late pick up w/missed appointments, no coordination of services	389	941	582	1213	**3125**
m) Dismissed by provider as a result of past due billing issues		4	5	0	**9**
n) Dismissed by clinic as a result of past due billing issues		3	2	5	**10**
ACCESS TO CARE TOTAL:	**994**	**1469**	**1564**	**1872**	**5899**

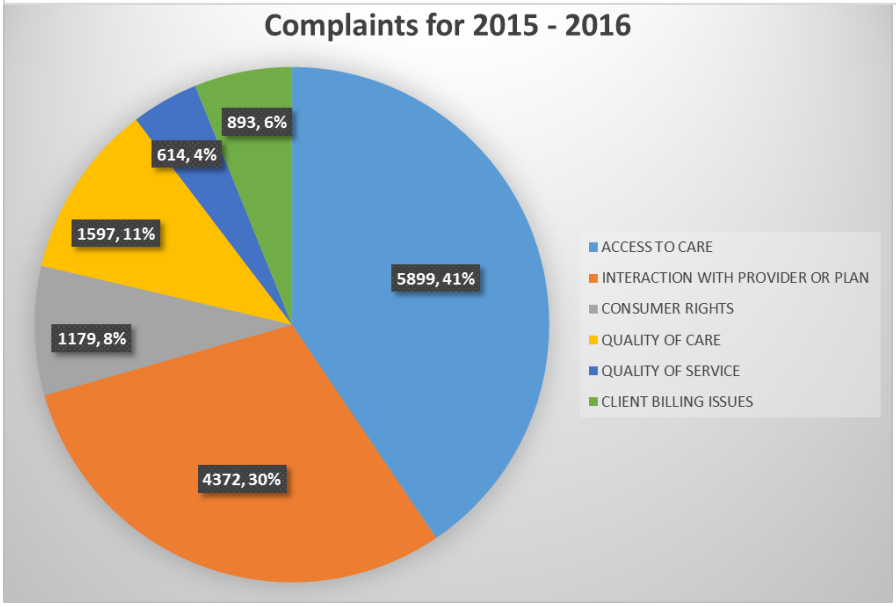
Complaint or grievance type	7/1/2015-9/30/2015	10/1/2015-12/31/2015	1/1/2016-3/31/2016	4/1/2016-6/30/2016	2015-2016 Total
INTERACTION WITH PROVIDER OR PLAN					
a) Wants to change providers; provider not a good fit.	136	207	1	151	**495**
b) Provider rude or inappropriate comments or behavior	267	368	191	261	**1087**
c) Plan rude or inappropriate comments or behavior	48	32	304	34	**418**
d) Provider explanation/instr. inadequate/incomplete	194	411	44	161	**810**
e) Plan explanation/instr. inadequate/incomplete	97	115	193	125	**530**
f) Wait too long in office before receiving care	63	34	221	43	**361**
g) Member not treated with respect and due consideration for his/her dignity and privacy	45	50	46	25	**166**
h) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.	9	2	38	5	**54**
i) Plan's office or staff exhibits language or cultural barriers of lack of cultural sensitivity.	3	32	5	34	**74**
j) Member has difficulty understanding provider due to language or cultural barriers.		1	32	7	**40**
k) Lack of communication and coordination among providers.	49	42	7	34	**132**
l) Dismissed by provider (member misbehavior, missed appts. etc.)	33	55	31	57	**176**
m) Dismissed by clinic (member misbehavior, missed appts. etc.)		8	7	14	**29**
INTERACTION WITH PROVIDER OR PLAN TOTAL:	**944**	**1357**	**1120**	**951**	**4372**
CONSUMER RIGHTS					
a) Provider's office has a physical barrier	24	7	19	3	**53**
b) Concern over confidentiality.	38	30	19	32	**119**
c) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.	94	98	98	97	**387**
d) No choice of clinician	25	20	17	23	**85**
e) Fraud and financial abuse	12	15	13	16	**56**
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)	21	17	16	17	**71**
g) Complaint/appeal process not explained, lack of adequate or understandable NOA		2	5	11	**18**
h) Not informed of consumer (Member) rights	263	66	1	4	**334**
i) Denied member access to medical records	8	0	5	3	**16**
j) Did not respond to members request to amend inaccurate or incomplete information in the middle record (includes right to submit a statement of disagreement)	2	6	7	5	**20**
k) Advanced or Mental Health Directive not discussed, offered or followed.	3	4	0	1	**8**
l) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Restraint or seclusion used other than to assure members immediate safety.	2	0	1	0	**3**

Complaint or grievance type	7/1/2015-9/30/2015	10/1/2015-12/31/2015	1/1/2016-3/31/2016	4/1/2016-6/30/2016	2015-2016 Total
Differential treatment form Medicaid clients	9				**9**
CONSUMER RIGHTS TOTAL:	**501**	**265**	**201**	**212**	**1179**
QUALITY OF CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.	134	114	105	153	**506**
b) Testing/assessment insufficient, inadequate or omitted	51	57	57	57	**222**
Medical record documentation issue	7	0			**7**
c) Concern about prescriber or medication or medication management issues	139	130	148	152	**569**
d) Member neglect or physical, mental or psychological abuse	12	19	12	14	**57**
e) Unsanitary environment or equipment	37	28	68	16	**149**
f) Lack of appropriate individualized setting in treatment	32	24	17	14	**87**
QUALITY OF CARE TOTAL:	**412**	**372**	**407**	**406**	**1597**
QUALITY OF SERVICE					
a) Delay, quality of materials and supplies (DME) or dental	113	106	64	76	**359**
Lack of access to ENCC for intensive care coordination or case management services	0	0			**0**
b) Lack of access to medical records or unable to make changes	2	3	8	14	**27**
d) Benefits not covered	52	53	48	75	**228**
TOTAL:	**167**	**162**	**120**	**165**	**614**
CLIENT BILLING ISSUES					
a) Co-pays	13	7	7	14	**41**
b) Premiums	5	2	3	2	**12**
c) Billing OHP clients without a waiver	197	185	172	256	**810**
Miscellaneous		15		15	
CLIENT BILLING ISSUES TOTAL:	**215**	**209**	**182**	**287**	**893**
Total complaints received	3233	3834	3594	3893	**14,554**
Total average CCO enrollment	850,258	979,331	980,042	931,586	
Rate per 1000 members	3.8	3.91	3.67	4.178	

Complaints and grievances by category, SFY 2016



	7/1/2015-9/30/2015	10/1/2015-12/31/2015	1/1/2016-3/31/2016	4/1/2016-6/30/2016
ACCESS TO CARE	994	1469	1564	1872
INTERACTION WITH PROVIDER OR PLAN	944	1357	1120	951
CONSUMER RIGHTS	501	265	201	212
QUALITY OF CARE	412	372	407	406
QUALITY OF SERVICE	167	162	120	165
CLIENT BILLING ISSUES	215	209	182	287



C. Appeals and hearings

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

D. 1 percent withhold and incentives

OHA analyzed encounter data received for completeness and accuracy for the subject months of July 2015 through June 2016. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

For incentives discussion, please refer to the 2015 Quality Pool.

E. Statewide workforce development

Traditional Health Workers

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

Health professional graduates participating in Medicaid

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

F. Significant CCO/MCO network changes

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

G. Accomplishments:

Transformation Center

The Transformation Center assists CCOs through Innovator Agents and CCO leadership, learning collaboratives and technical assistance. Key highlights from this year:

Transformation Center Strategic Plan

Halfway through this year, the Transformation Center completed a strategic plan for initiatives to be implemented during the remainder of the State Innovation Model grant (January through September 2016) and beyond. The plan includes the following focus areas: behavioral health integration, population health integration, value-based payment methods, CCO incentive metrics, health equity, clinical delivery supports, oral health integration and cross-cutting strategies. The plan reflects a shift toward providing targeted technical assistance, with the goals of responding to needs within CCOs, the Public Employees' Benefit Board and the Oregon Educators Benefit Board; and advancing integration of population and behavioral health. To inform this plan development, the Transformation Center reviewed a variety of data sources, consulted with multiple stakeholders and interviewed all 16 CCOs in December.

Behavioral Health Integration

This year, the Transformation Center made progress on new initiatives to support behavioral health integration:

- The Patient-Centered Primary Care Institute created an online **behavioral health integration resource library**, which is live at www.pcpci.org under "Resources." The library includes five virtual site visits filmed at four integrated primary care practices and one behavioral health home. The website will also include videos of expert interviews focusing on topics such as behavioral health funding, psychiatry, substance use screening and treatment, and telehealth. This project was initiated based on a request from CCO and partner participants at last year's Innovation Café.
- **Behavioral health integration technical assistance consultation –** The Transformation Center is supporting CCOs and their provider networks to implement their 2015-2017 Transformation Plans

and achieve the integration standards established by the Patient-Centered Primary Care Home Standards Advisory Committee. Each CCO can access up to 30 hours of behavioral and physical health integration technical assistance. Staff met with 15 CCOs to discuss integration needs, and so far 11 CCOs have been matched with appropriate consultants. Topic areas include trauma-informed care; behavioral health homes; workflow; metrics; value-based payment models; screening, brief intervention and referral to treatment (SBIRT); and team development.

- **Project ECHO (Extension for Community Healthcare Outcomes)** – Project ECHO is an evidence-based tele-mentoring program that uses videoconferencing to connect primary care providers with specialty providers. In September 2014, Health Share of Oregon and Oregon Health and Science University (OHSU) launched Project ECHO in the Portland Metro region with Transformation Fund grant dollars from the Oregon Legislature. During that time, Transformation Center staff participated in a multi-state training about tele-mentoring implementation and the Project ECHO in Medicaid Learning Collaborative organized by the Center for Health Care Strategies. In February, OHA released a solicitation ($300,000 maximum) to establish a statewide Project ECHO tele-mentoring infrastructure with initial focus on psychiatric medication management. One proposal was received and accepted from OHSU focused on behavioral and mental health issues affecting children. The ECHO clinic has space for 20 practices, and 40 practices requested to participate. OHSU is selecting practices and exploring ways to include more.

Population Health

Community Advisory Council Support

In alignment with the Transformation Center's new strategic focus on providing targeted technical assistance, the Transformation Center is moving away from convening CCO community advisory councils (CACs) for monthly meetings on general topics and toward providing targeted support for CAC member recruitment and engagement.

During this year, the Transformation Center convened multiple CAC subgroups and committees. The center hosted several monthly conference calls for the two CAC leadership networks one for the CAC chairs and co-chairs (who are CAC members) and one for the CCO CAC coordinators (who are primary CCO staff) to provide ongoing leadership development. The CAC steering committee was also convened several times to advise the Transformation Center on how best to support community advisory councils statewide; discuss how CACs could get their community health improvement plan (CHP) topics incorporated into contractual agreements with their CCOs; and to make recommendations for the 2015 Coordinated Care Model Summit. CAC members were invited to the summit, and 114 CAC members attended. Several CAC members also participated in an OHA Accessibility Advisory Committee, which was convened to offer recommendations for ensuring accessibility at OHA events.

With the guidance of a CAC recruitment and engagement committee, the Transformation Center led a recruitment and engagement-focused event for CAC leaders on May 24, 2016, in Eugene, Oregon. Objectives of this event included:

- Compiling a list of CAC member engagement strategies used by CCOs across the state
- Sharing and discussing materials used for outreach and recruitment
- Identifying CAC-specific recruitment goals

The event brought together 63 participants from across the state, representing all 16 CCOs and 21 of the 36 CACs. Event evaluation feedback was very positive overall and approximately 90 percent of respondents reported the event was valuable in supporting their work.

In addition, the Transformation Center contracted with Intersect Video to produce a 30-second public service announcement to support CCOs in recruiting and engaging Oregon Health Plan members in their local CACs. A separate English and Spanish version was created for each CAC to use in their communities.

Community Health Improvement Plan Implementation Grants

The Transformation Center's Community Health Improvement Plan (CHP) Implementation Grants were announced in January and all 16 CCOs submitted applications. The grants include up to $30,000 per CCO to support the implementation of strategies identified in their CHPs. Applications included activities such as chronic disease self-management, diabetes prevention, tobacco treatment specialist training, trauma-informed care training, motivational interviewing training, community engagement and needs assessment initiatives, and health and early learning program expansions. An overview of all 16 grant projects is available on the Transformation Center website. The CCOs have until December 31, 2016, to complete their grant-funded activities, and the funds are meant to spark longer-term population health transformation at the community level.

By June 30, all 16 applicants moved toward grant execution, and the 13 that were executed by May 2016 submitted progress reports. Progress reports showed that all thirteen CCOs had begun grant activities and three CCOs (23%) had completed at least one grant outcome.

Value-based Payment Method Support

- **Value-based Payment Method Technical Assistance –** The Transformation Center is providing support for three CCOs to work with consultants to develop value-based payments (VBPs). One CCO is creating a VBP development process to apply across all provider types and expand current VBP models from primary care to hospitals and specialist providers. Another CCO is developing a fair value of behavioral health services for sub-capitated community mental health program providers and develop a VBP for providers outside of the sub-capitated arrangement. The third CCO is developing VBP options for an integrated maternal health and substance use disorder project.
- **Primary Care Payment Reform Collaborative –** As required through Senate Bill 231, the Transformation Center is convening a Primary Care Payment Reform Collaborative. This collaborative is convening payers and providers to share best practices on primary care value-based payment methods and initiative alignment. The group has met three times with diverse, multi-stakeholder participation to learn about models and outcomes of multi-payer collaboratives from around the country. The collaborative considered the opportunity presented by Comprehensive Primary Care Plus (CPC+) and is providing input on the key components of a primary care transformation initiative in Oregon. Forty-six participants have joined the collaborative, including payers, providers, purchasers and consumers. The collaborative is ongoing at this time.
- **Behavioral Health Integration Value-Based Payment Method Grants –** The Transformation Center awarded two grants totaling $300,000 to two health care payers to advance value-based payment methods for integrated care. Work outlined in these grants will be complete by the end of December 2016.

Incentive Metrics Targeted Technical Assistance

The Transformation Center is offering targeted technical assistance for four CCO incentive metrics based on interviews and needs assessment conference calls with CCO representatives, input from the OHA Public Health Division and consultants, and resources available:

Childhood immunization rates

- A pilot root-cause analysis was completed with one CCO, and the opportunity is opening up to all 16 CCOs in July. This includes a facilitated root-cause analysis, prioritization of root causes, and technical assistance in creating an implementation plan to address prioritized root causes.
- Community convenings on immunization challenges and opportunities for improvement will be offered to all CCOs in July.

Smoking cessation

The Transformation Center contracted with Carol Gelfer to address CCOs' needs for provider-level trainings on tobacco cessation counseling and CCO-level quality improvement. The following activities will be completed by the end of 2016:

- Assess the current environment by connecting with CCOs to identify current practices and TA needs related to this metric
- Create a best-practices resource document for use by CCOs
- Develop a training plan to promote evidence-based approaches to tobacco cessation in clinical practices
- Identify culturally responsive materials and support networks relevant to specific populations

Adolescent well-care visits

- The Oregon Pediatric Improvement Partnership (OPIP) has provided four of ten webinars on improving adolescent well-care visits for CCO staff and their teams. OPIP is also offering follow-up consultation calls. Thirteen CCOs have participated in at least one webinar.
- The Oregon School-Based Health Alliance and Statewide Youth Action Committee will hold three in-person, youth-led Eye-to-Eye trainings in August, September and November. The trainings will focus on youth-centered care in the context of adolescent well-care visits.

Colorectal cancer screening

- The Oregon Rural Practice-based Research Network (ORPRN) has provided four of five webinars for CCO staff and their teams, with 15 CCOs having participated in at least one.
- Ten CCOs participated in follow-up individual consultation calls with ORPRN. During these meetings, consultants gathered information on the CCOs' colorectal cancer screening plans, brainstormed areas for support and provided direct consultation.
- ORPRN has developed a proposal for providing additional assistance based on information gathered during the consultation calls.

Health Equity Consultations

The Transformation Center, in collaboration with the Office of Equity and Inclusion, conducted pilot health equity consultations with Willamette Valley Community Health and Yamhill CCO in May. Consultant Ignatius Bau provided each CCO with a comprehensive health equity analysis of their Transformation Plan, community health improvement plan and CCO incentive metric data to identify health equity opportunities. Each consultation was well attended with participation from CCO executive leadership. A majority of evaluation respondents reported that the consultation was valuable for supporting their work. Based on this positive feedback, the Transformation Center is offering all CCOs health equity data analysis and consultations. Each CCO participating in the consultation may also request up to ten hours of technical assistance to focus on the health equity opportunities identified.

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The statewide CCO learning collaborative includes CCO medical, behavioral and oral health directors and quality improvement coordinators. The collaborative focuses on CCO incentive measures and other relevant topics. The Transformation Center facilitated seven sessions this year, with topics selected with input from participants. While the first year of the collaborative focused on operational and measure specifications of the incentive measures, the second and third years have concentrated on emerging best practices from around the state and peer learning. Sessions this year covered two of the 18 incentive measures (colorectal cancer screening and childhood immunization), leading change, behavioral health homes, traditional health workers, transgender health and low back pain management. Presenters included CCOs, clinicians, county health departments, dental care organizations, community-based leaders and national experts. An average of 71 participants attended each session. Participants consistently reported that the most valuable aspects of the learning collaborative were hearing specific details of how others are doing the work, learning from experienced presenters, and discussing implementation barriers and program issues. A majority of respondents rated each session as very valuable or valuable in supporting their work.

More information about the CCO learning collaborative is available at transformationcenter.org/cco.

Quality Improvement Community of Practice

The Quality Improvement Community of Practice includes the CCO Transformation Fund project portfolio managers and builds upon the previous Improvement Science in Action Learning Collaborative and last year's three-month training, "Leading Quality Improvement: Essentials for Managers." This year the Transformation Center completed a six-month customized quality improvement coaching program tailored specifically to the needs in Oregon. This monthly webinar program led by the Institute of Healthcare Improvement began in July and focused on peer-to-peer learning, with a cohort of about 20 CCO quality improvement leads and OHA colleagues. The sessions covered topics including developing teams, identifying change styles and managing improvement. At each session, a participant presented a case study for the group to discuss and share lessons learned. The program further developed relationships among CCOs that will facilitate the sharing of lessons learned and the spread of innovation.

Flexible Services Learning Collaborative

Flexible services are health-related services not covered by the Medicaid state plan. These are provided in lieu of traditional benefits and intended to improve care delivery, improve member health and lower costs. The Transformation Center hosted a Flexible Services Learning Collaborative for CCOs to share lessons learned about how to operationalize flexible services. Forty-eight participants attended, representing 15 CCOs, OHA staff and a facilitator. The collaborative included a presentation on the use of flexible spending in a health resiliency program and a CCO panel discussion about the innovations, successes and challenges of implementing and institutionalizing flexible services and communicating with members about flexible services. Participants engaged in two rounds of rotating small-group discussions on the following topics: 1) how flexible services have been used in CCOs – successes and challenges; 2) member communication; 3) work flow, policies and procedures; and 4) evaluating the impact of flexible services on health outcomes. Of those who completed an evaluation, 95% rated the session as valuable or very valuable in supporting their work.

Clinician Vitality

In 2015, in collaboration with The Foundation for Medical Excellence, the Transformation Center commissioned a study to identify:

1. Challenges to the well-being and work satisfaction of Oregon health care clinicians;

2. Programs developed by health care organizations in Oregon to promote clinician well-being;
3. Gaps that remain to be filled to strengthen the vitality of all health care professionals in Oregon.

Findings indicate that Oregon health professionals are stressed to keep up with the clinical demands of increased enrollment of patients with more complex and chronic diseases, as well as the ancillary non-clinical work demanded by documentation in the electronic health record, meeting the regulatory requirements of Medicare and Medicaid, and increased complexity of coding diagnoses and procedures.

This study outlines several recommendations, including to provide Oregon health care organizations with a set of well-validated instruments to measure the well-being of their clinicians; develop and disseminate a toolkit of well-being program practices for health care organizations; and develop a statewide network of "well-being champions" to promote programs for health professionals in their organizations.

Findings and recommendations were presented to a group of statewide stakeholders including legislators, health system leaders, professional society leadership, Board of Medical Examiner leaders and key providers in December 2015.

The executive summary of the report is available at www.oregon.gov/oha/Transformation-Center/Documents/Clinician-Vitality-Executive-Summary.pdf

Clinical Innovation Fellows

This year, the Transformation Center continued the Clinical Innovation Fellows program to build the capacity of health system transformation leadership in Oregon and support the success of the coordinated care model. The second cohort of 15 fellows participated from July 2015–June 2016 and included physical, behavioral and oral health providers, as well as public health, social work and quality improvement professionals. This year's fellows represented 12 of the 16 CCOs across the state.

Through developing innovation projects, participating in a year-long learning experience and mentorship, the fellows developed and refined skills in leadership, quality improvement and methods for spreading innovation across the delivery system. The full cohort met monthly by webinar or in person. All 15 fellows presented project posters at the Coordinated Care Model Summit, and three fellows presented in breakout sessions. Each fellow also met monthly with their faculty mentor, both individually and in small groups. The Transformation Center offered each fellow a $15,000 grant, travel stipend and continuing medical education credits for participating. To provide further support for the fellows' projects and professional development, each fellow was offered 10 hours of technical assistance through the Technical Assistance Bank. Fellows are working with consultants on topics like payment models, return on investment analysis and evaluation plans for their innovation projects.

In their final reports, every fellow indicated the program was very valuable in supporting their work and they would recommend the program to their colleagues. Fellows reported they learned the most about leadership, project management and communications. Every fellow implemented a project during the fellowship year, either as proposed (10 fellows) or with considerable changes (5 fellows). All 15 projects are expected to be sustained after the fellowship ends. As one fellow said, "I was able to turn an idea into something real – a viable, transformational delivery model that made a real difference." Another fellow said, "I've been involved at a leadership level over the course of my career, but I never had the occasion to develop and implement a project within an institution. This fellowship has given me that opportunity."

In June, the cohort graduated from the program. To learn more, see the graduates' bios and project abstracts: www.oregon.gov/oha/Transformation-Center/Pages/Council-Clinical-Innovators-Fellows-2015-2016-Bios.aspx

The council has recruited applicants and selected 12 fellows for the third cohort, which begins in August 2016. To make the program more sustainable past the State Innovation Model grant period, this third cohort will not receive grant awards. One of the successes of this unique program was to continue building a network of next generation change leaders across the state. The program is considering ways to connect previous and future cohorts to further strengthen clinical innovation leadership in Oregon.

More information about the Clinical Innovation Fellows program is available at transformationcenter.org/cci.

Coordinated Care Model Summit

The Transformation Center held its third Coordinated Care Model Summit, "Oregon's Coordinated Care Model: Highlighting Outcomes and Promoting Excellence," in November 2015. The event drew 826 CCO staff, other public and private health care purchasers, providers and clinicians, CAC members, community stakeholders, health leaders, lawmakers, policymakers and funders to share outcomes and lessons learned from innovative strategies for implementing health system transformation. A call for proposals elicited high-quality, results-oriented presentations. Materials from the summit are available at transformationcenter.org/ccmsummit.

Highlights included:

- **Keynote presentation by Soma Stout, M.D.**, who emphasized partnering with entities beyond the health care system – such as schools, social services and public health – to improve health, well-being and equity. Dr. Stout reflected that changing our culture to value health is as important as changing our payment models;
- **Thirty-seven project posters** from clinical innovation fellows and CCO, nonprofit, public and academic partners; and
- **Twelve breakout sessions** on behavioral health integration, community engagement, patient experience, health information technology, patient empowerment, traditional health workers, complex care, oral health integration, county leader reflections, trauma-informed care, opioids and social determinants of health.

With an evaluation response rate of 32%, 80% of respondents said the overall summit was valuable in supporting their work, close to 70% of respondents planned to follow up with new connections made at the summit, and close to 60% of respondents planned to implement at least one innovative practice learned at the summit.

Health Equity and Health & Early Learning Conferences

The day prior to the 2015 Coordinated Care Model Summit, half-day conferences focused on health equity and health and early learning were held. Materials for both events are available at transformationcenter.org/ccmsummit.

The OHA Office of Equity and Inclusion hosted a conference that focused exclusively on the implementation of health equity, diversity and inclusion policies and strategic equity initiatives throughout Oregon's health system. The conference brought together OHA leadership, CCOs and health systems; providers and health care stakeholders; community-based organizations; community stakeholders; and other organizations that address social determinants of health to focus on:

- Upstream approaches to achieving health equity;
- Community-led decision-making for organizational change and policy;
- Social determinants of health and opportunities for collaboration throughout the state; and

- Developing equity leadership skills among executives, administrators, providers and clinicians in Oregon's health system.

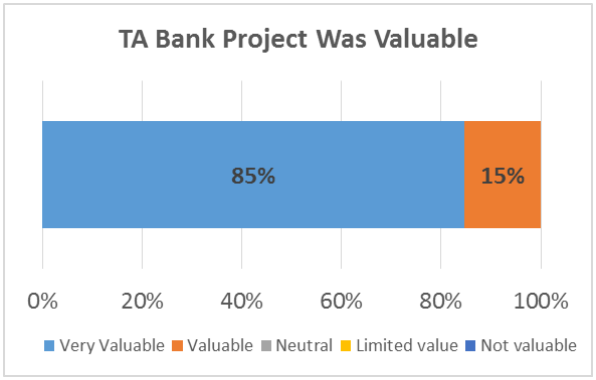
The OHA Child Well-being Team and the Oregon Department of Education Early Learning Division invited CCO and Early Learning Hub representatives to a Health and Early Forum to:

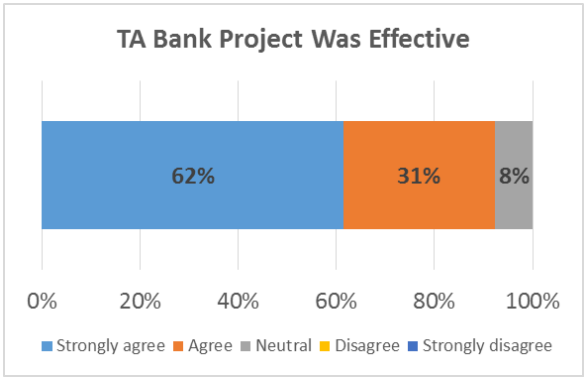
- Identify collaborative opportunities to support early learning and children's health;
- Inspire and strengthen cross-sector connections; and
- Learn about existing CCO/Hub initiatives, projects and policies that can be replicated in other regions of Oregon.

Transformation Center CCO Technical Assistance Bank

As a result of requests from CCOs and their CACs, in October 2014 the Transformation Center began offering the opportunity to receive technical assistance (TA) in key areas to help foster health system transformation. This includes SIM-funded consultation from outside consultants on contract with the Transformation Center, in addition to support and technical assistance provided by other parts of OHA. Starting October 2015, a new allocation of 35 hours per CCO was made available for year two. The Transformation Center continues to recommend that 10 of those hours be used to support community advisory councils (CACs) and other community-based work.

As of June 2016, the Transformation Center had received 56 TA Bank requests from CCOs, for a total of 756 anticipated TA hours upon completion of those requests. Twenty-two of the 56 requests came during year two of the TA Bank for 402 of the 756 anticipated TA hours. Close to 20% of these requests focused on organizational development, often focusing on CACs. Close to 15% focused on community health assessments and community health improvement plans or health equity. Other requests focused on CAC member engagement, program evaluation, value-based payments, behavioral health integration, health information technology, tobacco cessation and other topics. Evaluation results for 13 of 28 completed projects show that 100% of CCOs rated the assistance as very valuable (85%) or valuable (15%), and 93% of CCOs rated the assistance as very effective (62%) or effective (31%) in meeting the project goals.



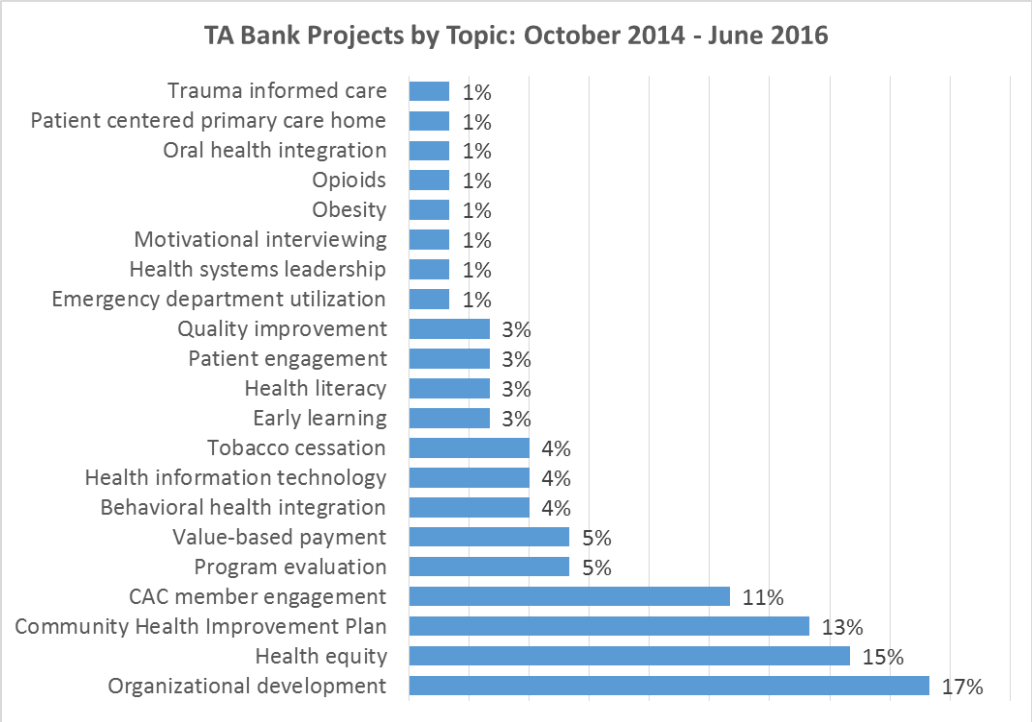


In May 2015, the Transformation Center released a request for applications (RFA) for consultants to contract as technical assistance providers. The RFA has resulted in over 60 contractors being available to provide technical assistance on a variety of topics. The Transformation Center continues to partner with the Office of Equity and Inclusion, Office of Health Information Technology, Public Health Division, Office of Health Policy and Research, and the Child Well-being Team to ensure coordination of OHA technical assistance for the topics listed below.

TA Bank technical assistance topics:

1. Value-based payment methods	10. Oral health integration
2. Behavioral health integration	11. Organizational development for CCOs and/or CCO community advisory councils
3. Community health improvement plan (CHIP) review, implementation and evaluation	12. Primary care transformation, including patient-centered primary care homes
4. Early learning systems and strategies	13. Program Evaluation
5. Engagement strategies for person and family-centered health care systems	14. Project management
6. Health information technology	15. Public health integration
7. Health systems leadership	16. Quality improvement science
8. Improving childhood immunization	17. Tobacco cessation
9. Improving health equity	18. Other topics upon request

TA Bank projects by topic*:



*Each TA Bank project may have up to three identified focus areas.

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

Legislative activities

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

H. Litigation status

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

I. Quantitative and case study findings

Statewide Performance Improvement Project (PIP) on Opioid Safety.
This report, which can be found on OHA's Quality and Health Outcomes Committee website, summarizes improvement strategy updates, barriers and next steps by CCOs in addressing opioid use and safety for Oregonians statewide who are Medicaid beneficiaries.

Innovator agents – Summary of promising practices statewide

Innovator agent learning experiences

Summary of activities	The innovator agents convene a monthly in-person meeting to share information and learn from others in OHA as well as outside experts. Over the past year, the innovator agents have received updates and training in: ■ behavioral health integration and mapping ■ public health modernization ■ health equity ■ early learning ■ dental health ■ contracts ■ childhood obesity ■ trauma informed care ■ community advisory council recruitment and retention ■ social determinants of health One innovator agent completed OHA's Developing Equity Leadership through Training and Action (DELTA) program in the past year and another innovator agent began with this year's cohort.
Promising practices identified	The monthly meetings allow innovator agents to build and sustain relationships with leadership across OHA and other state divisions, which in turn facilitates the relationships with CCOs. The knowledge and training the innovator agents have received has helped them further health care transformation within the CCOs they serve. Often these learnings occur in partnership with CCOs, which spurs further creativity.
Participating CCOs	16
Participating IAs	8

Learning collaborative activities

Summary of activities	See list of learning collaborative activities.
Promising practices identified	The learning collaboratives have provided guidance and impetus for CCOs to learn from each other about the latest practices. Participation and interest in learning collaboratives continues to grow. Innovator agents regularly participate in them either in person or by phone whenever possible.
Participating CCOs	16
Participating IAs	8

Assisting and supporting CCOs with Transformation Plans

Summary of activities	Innovator agents provided support to their CCOs in writing their 2015-17 Transformation Plans. In addition, they helped the CCOs develop their Transformation Plan benchmark reports and initial progress reports. Innovator agents also provided support and guidance to their CACs in the annual community health improvement plan (CHP) update. Innovator agents helped CCOs and CACs analyze their need for technical assistance that would enhance the transformation plans and the CHPs and request appropriate support through the Technical Assistance Bank.
Promising practices identified	CCOs are embracing the concept of transformation and viewing the plans as blueprints to better health care for the members they serve. The result has been increased behavioral and dental health integration, promoted value-based payment methods, focus on health equity, and refined use of electronic health records. Innovator agents have provided ongoing support and consultation for CCOs as they update and implement their Transformation Plans.
Participating CCOs	16
Participating IAs	8

Assist CCOs with target areas of local focus for improvement

Summary of activities	Technical assistance was available through the Transformation Center for CCOs. Innovator agents helped CCOs identify areas where they could best use the hours they were allotted and worked collaboratively with the CCOs and the Transformation Center to choose providers and arrange training.
Promising practices identified	CCOs received technical assistance in the areas of member engagement, CAC support, value-based payment methods and health equity. Innovator agents have also assisted CCOs with community engagement with their local DHS offices, their Long-Term Support Services Innovator Agents, behavioral health agencies and housing authorities.
Participating CCOs	16
Participating IAs	8

Communications with OHA

Summary of activities	Innovator agents have monthly in-person meetings with the Transformation Center, Public Health Division, Health Analytics, Office of Equity and Inclusion, and other OHA divisions. They have weekly phone meetings that include outside speakers to inform them about the most current health practices. Innovator agents frequently serve as the connection between the CCOs and the State when questions arise or policy needs to be clarified.
Promising practices identified	Frequent communication with OHA and the Transformation Center has enhanced the ability of the innovator agents to identify and act upon specific strategies to improve state communications to CCOs.
Participating CCOs	16
Participating IAs	8

Communications among Innovator Agents

Summary of activities	Innovator agents meet monthly and have twice-weekly huddles. They also communicate frequently through email.
Promising practices identified	Through frequent communication, innovator agents are able to quickly identify issues and trends across the state and strategize to appropriately address them.
Participating CCOs	16
Participating IAs	8

Community advisory council activities

Summary of activities	All innovator agents regularly attend CAC meetings and provide support and guidance. They have assisted with the development and implementation of the community health improvement plans and updates. Innovator agents are able to continue to clarify the CAC's role within health transformation. The innovator agents have assisted CACs in obtaining technical support through the Transformation Center and connecting them with training, community support and activities.
Promising practices identified	The CACs continue to accomplish varying degrees of growth across the state. Many CACs, with the support of their innovator agents, are working on member engagement with the CAC and looking at how to have more diverse boards that better represent their community. This is being accomplished through technical assistance from the Transformation Center, including some grant monies and public service announcements developed by the Transformation Center.
Participating CCOs	16
Participating IAs	8

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

Summary of activities	Innovator agents are the feet on the ground for OHA and have developed strong relationships and trust with CCO executive staff, OHA leadership and stakeholders. These relationships and the expertise they have gained through transformation have enabled them to provide feedback to the CCOs and OHA about where barriers lie. Because the innovator agents provide support for more than one CCO, they are able to cross-pollinate good ideas and support and promote sharing.
Promising practices identified	As the key point of contact, innovator agents represent the needs of the community and the CCO to OHA. In addition, the communities they serve look to the innovator agents as leadership representatives of the state. That relationship enables innovator agents to present information in a way that can remove barriers and improve health transformation and better collaboration between the state and local communities.
Participating CCOs	16
Participating IAs	8

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

Summary of activities	The Issue Tracker is being revised to capture additional information about innovator agent presentations.
Promising practices identified	The Issue Tracker continues to be helpful for documenting issues and steps toward resolution.
Participating CCOs	16
Participating IAs	8

Information sharing with public

Summary of activities	Innovator agents provide community outreach in a variety of formats that include but are not limited to: serving on community boards; participating in community planning; providing training for volunteer groups, medical providers, behavioral health providers and other stakeholders at conferences and summits; and actively participating in the Early Learning Hubs.
Promising practices identified	Innovator agents' presence and participation within the communities they serve promotes and makes the public more aware of health transformation.
Participating CCOs	16
Participating IAs	8

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

None reported.

Comments and issues raised by the public at public forums

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

Status of corrective action plans

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

IV. Utilization data

See interim evaluation findings for discussion of access to health care services.

V. Evaluation activities and interim findings (Demonstration Year July 2015 – June 2016)

In this demonstration year, independent evaluators delivered a report that assessed the implementation and impact of Oregon's Coordinated Care Model (CCM), Coordinated Care Organizations (CCOs), and Hospitals:

- The Hospital Transformation Performance Program (HTPP) Evaluation report, from evaluators at Oregon Health & Science University (OHSU) Center for Health Systems Effectiveness (CHSE), assessed the first two years of the HTPP program to better understand how hospitals have performed on HTPP measures over the first two years of the program, how that performance compares to CCOs, and how performance on these measures reflected coordination of care between hospitals and CCOs.

Also in this demonstration year OHA staff:

- Published Oregon's Health System Transformation CCO Metrics for 2015, which is the first report to provide comprehensive demographic information about Oregon Health Plan members at the CCO level, and an overall summary of performance across multiple measures using an "at-a-glance" display.
- Published a process evaluation report on the Sustainable Relationships for Community Health (SRCH) initiative, which is a technical assistance grant to develop sustainable community-based models that address hypertension, pre-diabetes and diabetes prevention, and early detection and self-management.
- Contracted with Providence's Center for Outcomes Research and Education (CORE) and OHSU CHSE to assess the adoption, Spread, and "Spillover" of the Medicaid's Coordinated Care Model in Oregon.
- Started contract negotiations for the summative evaluation of the waiver with OHSU CHSE, which will improve on the waiver midpoint evaluation published last year, as well as other preliminary efforts, to assess the implementation and impacts of Oregon's Medicaid waiver.

In the tables below, relevant OHA and CCO activities for the demonstration year are reported by the "levers" for transformation identified in our waiver agreement and accountability plan.

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 the 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)

Evaluation activities:

In this demonstration year, the PCPCH program conducted an in-depth evaluation of 20 recognized clinics, who are considered to have exemplary practice and to be top performers. On-site interviews were conducted with key staff to better understand which aspects of the PCPCH model are most important to successful practice transformation. The final report will be published by the end of the 2016 calendar year.

Interim findings:

In this demonstration year, the number of recognized PCPCH clinics in the state increased from 589 in quarter 2, 2015, to 629 in quarter 2, 2016. This surpasses Oregon's goal of 500 clinics by 2015, and represents 60% of the estimated number of primary care clinics in Oregon.

PCPCH enrollment is also a CCO incentive metric, and data shows that since 2012 enrollment has increased 69% (see Appendix E). This shows that coordinated care organizations (CCOs) continue to increase the proportion of members enrolled in recognized PCPCHs. It is notable that CCOs have sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

Improvement activities:

Oregon's Patient-Centered Primary Care Institute (PCPCI) provides technical support and transformation resources to practices statewide, including learning collaborative opportunities. In this demonstration year, PCPCI closed out the 2015 contract, and executed a new contract for 2016, designed and piloted a regional

primary care extension program, aligned resources, facilitated communication and coordinated collaboration among related initiatives, developed partnerships, and expanded its role as a resource hub.

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

Evaluation activities:

Oregon's Coordinated Care Organizations

In this demonstration year, OHA published Oregon's Health System Transformation Coordinated Care Organizations (CCOs) Metrics 2015 final report, and made its third annual quality pool payments to CCOs in June 2016.

Hospital Transformation Performance Program

In this demonstration year, the hospital transformation performance program (HTPP) established a technical advisory group, finalized approval of an extension of HTPP for the third year (October 2015-September 2016), with CMS, including final benchmarks for year 3, made its second quality pool payments to hospitals, and contracted with Oregon Health & Science University (OHSU) Center for Health Systems Effectiveness (CHSE) to evaluate HTPP. See a high level overview of the findings and the link to the report under "interim findings" below.

Federally Qualified Health Center Alternative Payment Methodology Program

Eight Federally Qualified Health Center (FQHC) participate in the FQCH APM program, which provides an Advanced Payment and Care Model by payer per-member-per month (PMPM) payments for each health center's attributed patient population, rather than the traditional fee-for-service encounter rates. This allows practitioners to engage their communities in more patient-centered health engagement strategies.

OHA tracks several metrics on a quarterly basis, including the Uniform Data System (UDS) measures, and a subset of CCO inventive measures to hold clinics accountable for the quality of care offered. Additionally, each FQHC submits a quarterly Touches report, which tallies the total number of engagement touches (ETs), or non-billable alternative/enabling services occurring for their OHP patient populations. See the results below in interim findings.

Certified Community Behavioral Health Clinics

In this demonstration year, Oregon completed the first half of the one-year federally Certified Behavioral Health Clinics (CCBHC) Planning Grant, which helps to establish standards for CCBHs. Additionally, Oregon added two requirements to align with the Oregon Behavioral Health Home standards. Twenty-two clinics have applied to become CCBHCs, and site reviews of these clinics are underway. OHA is working with the clinics to develop processes to collect and report metrics required by the federal government. Programs will need to meet the requirements by the end of 2016. In October Oregon will apply to become one of eight states to be included in the two-year demonstration starting January, 2017.

Interim findings:

Medicaid Transformation

In June, 2016 OHA published two key reports on Medicaid Transformation:

- Oregon's Health System Transformation CCO Metrics 2015 final report. This is the first report to provide comprehensive demographic information about Oregon Health Plan members at the CCO level, and an overall summary of performance across multiple measures using an "at-a-glance"

display. The findings from the report demonstrated there have been continued improvements in a number of areas, including but not limited to, hospital readmissions, access to primary care for children and adolescents, rates of dental sealants, use of effective contraceptives, blood sugar testing for adults with diabetes, PCPCH enrollment, and increased member satisfaction (see Appendix E). The full report can be found here.

- Oregon Hospital Transformation Performance Program (HTPP) Year 2 Performance Report. This report details how hospitals are performing on 11 outcome metrics and compared the second year of the program to the baseline year. The findings from the report demonstrate that hospitals are doing very well in the area of medication safety and hospital/CCO coordination. The report also includes areas for improvement, which include, but are not limited to, readmissions, central-line bloodstream infection rates, and patient experiences reported through the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey (See Appendix E). The full report can be found here.

CCO Financial Reports

During this demonstration year, an internal analysis showed that 35.1% of all plan payments were non-fee-for-service (FFS). This is an decrease of 17.7% from the previous reports, in which 52.8% of plan payments were non-FFS. However, in 2015, OHA held a Financial Reporting Workgroup meeting with CCOs to better standardize reporting and definitions. Therefore, this decrease is a result of more accurate reporting by CCOs.

Federally Qualified Health Center Alternative Payment Methodology Program

In this demonstration year, the FQHC APM program found that engagment touches among the cohorts steadily increased. It is estimated that, as the program becomes more efficient and technical assistance for health centers will continue to improve.
Other evaluations occurring for the FQHC APM program in this demonstration year included monitoring clinical quality measures, estimating the value of engagement touches, measuring the total cost of care, and monitoring utilization trends. Clinical quality measures continue to maintain a consistent level, or improve significantly, demonstrating that detaching FQHC revenue from the office visit does not reduce quality.

In this demonstration year, Oregon contracted with actuarial consulting firm Optumas, who has authored two reports showing significant reductions in emergency department and inpatient utilization for Phase 1 FQHC's patient populations. These reports are under review by OHA leadership.

Improvement activities:

Federally Qualified Health Center Alternative Payment Methodology Program

During this demonstration year, the Oregon Primary Care Association (OPCA) hosted a quarterly Advanced Payment & Care Model (APCM) Learning Collaborative. These events focused on assisting health centers in aspects such as implementing clinical care teams, studying and understanding their patient populations, segmentation of the patient population, social determinants of health, as well as other technical components of the program. Additionally, OHA commissioned Optumas, an actuarial consulting firm, to produce another report on Phase 1, 2, and 3 FQHCs on the program, and include a Total Cost of Care measurement. This report will be completed by the end of 2017.

Transformation Center

During this demonstration year, the Transformation Center awarded grants to two health care payers to advance an alternative payment method for integrated care.

Additionally over this demonstration year, APM CCO Technical Assistance work shifted to include four consults:

- OHA continued to contract with Oregon Health & Science University's Center for Evidence-based Policy (CEbP) to provide CCOs with technical assistance for developing and implementing APMs.
- OHA has contracted with Bailit Health Purchasing to provide technical assistance for developing APMs for Health Share.
- OHA has contracted with the National Council on Behavioral Health and Dale Jarvis and Associates for developing APMs for PacificSource Community Solutions – Columbia Gorge.

Health Share of Oregon is developing APM options for Project Nurture (an integrated maternal care and substance use disorder program) payers and providers including: operational considerations, pros/cons for each of the models, and opportunities and challenges with implementing the options from the plan and provider perspective.

As required through Senate Bill 231 (2015) the Transformation Center convened a new Primary Care Payment Reform Collaborative (PCPRC). The PCPRC has met once a month with diverse, multi-stakeholder participation to learn about models and outcomes of multi-payer collaboratives from around the country, consider the opportunity presented by CPC+, and provide input on the key components of a primary care transformation initiative in Oregon.

Finally, CareOregon is evaluating pilot integration alternative payment efforts to develop a sustainable alternative payment methodology for behavioral and physical health integration that is capable of cross-regional and bi-directional implementation.

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

Evaluation activities:

The Behavioral Health Home Learning Collaborative (BHHLC) is supported by Oregon's Adult Medicaid Quality Grant and assists organizations with integrating primary care into behavioral health settings. Under a no-cost extension, the BHHLC will continue through December 2016.

In this demonstration year OHSU's Oregon Rural Practice-based Research Network (ORPRN) conducted an evaluation of the first two years of the learning collaborative and submitted a draft report, which is currently undergoing OHA internal review, and will be published by the end of 2016. Additionally, ORPRN developed instruments to assist the sites in developing their capacity to collect and use data to improve population health management, worked with OHA to develop a template for the sites to create registries of their Medicaid clients receiving integrated care. Finally, ORPRN and OHA staff presented posters at OHAs Coordinated Care Model Summit and CMS's QualityNet Conferences and gave presentations across the state, including OHSUs Grand Rounds.

Interim findings:

Five of the CCO incentive measures relate to physical and behavioral health care integration. Measure specifications for three measures (Screening, Brief Intervention and Referral to Treatment (SBIRT), Follow-Up After Hospitalization for Mental Illness, and Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody) changed in 2015. As a result, performance on these measures in CY 2014 and subsequent reporting periods is not comparable to performance in prior reporting periods. Generally, performance on all measures increased over the demonstration year, with most exceeding their target benchmark.

- Alcohol or Other Substance Misuse (SBIRT) increased from 6.4% in CY 2014 to 12.7% in CY 2015. The measure was above the 2015 benchmark target of 12%.
- Follow-Up After Hospitalization for Mental Illness increased from the 71.8% in CY 2014 to 75.3% in CY 2015. The measure exceeded the CY 2015 benchmark target of 70.0%.
- Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody has increased from 27.9% in CY 2014 to 58.4% in CY 2015. The measure was below the 2015 benchmark target of of 90%.
- Screening for Clinical Depression and Follow-Up Plan increased from 27.9% in CY 2014 to 37.4% in CY 2015, and was above the target of 25.0% for CY2015.
- Follow-Up Care for Children Initially Prescribed ADHD Medications increased from 52.3% in 2011 to 57.7% in CY 2014 and 61.1% in CY 2015 for initiation phase. The measure increased from 61.0% in 2011 to 68.9% in CY 2015 for continuation and maintenance phase, which exceeds the CY 2015 benchmark target of 64.0. Please note that this measure has been removed from the incentive measure set for 2015 given strong CCO performance (above the 90th percentile nationally), but OHA continues to monitor and report on the measure as part of the quality and access test.

Improvement activities:

Nine of the ten organization participating in the BHHLC collaborative provided integrated physical health services within the behavioral health facility, and more than 2,500 clients had received primary care services.

In this demonstration year:

- BHHLC received a no-cost extension to continue to assists organizations with integrating primary care into behavioral health settings.
- ORPRN continued to provide ongoing practice coaching to participating sites, focusing on helping them develop the capacity to collect and use data to improve population health management.
- ORPRN worked with OHA staff to clarify measure specifications, develop detailed instructions on how sites track three Adult Core Measures (BMI, hypertension, diabetes), and create a RedCap Survey for the sites to enter their data.
- OHA provided presentations on data collection, tools for closed loop referrals, and a panel on strategies to decrease no show rates that are appropriate for the challenging sub-populations of those with severe mental illness and substance use disorders served by behavioral health homes.
- OHA continued to provide practice coaching, generally meeting twice per month, and providing individualized technical assistance for each site.
- OHA hosted webinars on the rules governing confidentiality and information exchange between behavioral and medical practitioners.

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:

Evaluating Oregon's Medicaid Waiver

In this demonstration year, OHA started contract negotiation for the summative evaluation of the waiver with OHSU CHSE. The summative evaluation will improve on the waiver midpoint evaluation and other preliminary efforts to assess the implementation and impacts of Oregon's Medicaid waiver. Specifically, the evaluation will include data from all five years of the demonstration (with allowances for lag associated

with some types of data). In addition, OHA expects the contractor will use Medicaid members from another state and "weighted" Oregon commercial plan members as comparison groups, enabling the contractor to rigorously estimate the effect of the waiver on health care spending, quality, access, and other key outcomes. The contractor will also synthesize findings about OHA's and CCOs' transformation activities from existing evaluations, and provide actionable recommendations for advancing Medicaid transformation beyond the current waiver period. The contractor will deliver evaluation findings to CMS and OHA by the end of 2017.

Assessing the Spread and tracking "Spillover" of Medicaid's Coordinated Care Model in Oregon

In this demonstration year, Providence's Center for Outcomes Research and Education (CORE) re-administered a second round of survey's to 103 organizations, including 12 CCOs, to assess the spread of the Coordinated Care Model (CCM) among CCOs, commercial health plans, hospitals, and other provider organizations. In addition to surveying payer and provider organizations, CORE conducted in-depth interviews with representatives at a small number of organizations that responded to the survey. The interviews provided context for survey results and enable CORE to answer questions about the organizations' motivation and mechanisms for transformation.

OHSU CHSE completed its analysis of health care claims and encounters data to determine whether the effects of Medicaid transformation may have "spilled over" to non-CCO patients. Spillover may occur in clinics that are working to improve care management and coordination for Medicaid patients also adopt these improvements for other patients.

Findings from the spread and spillover analysis will be included in the SIM Grant evaluation report from CHSE and CORE to be delivered October 2016.

Sustainable Relationships for Community Health Program

The Sustainable Relationships for Community Health (SRCH) program is made possible through a Centers for Disease Control and Prevention (CDC) grant, and is a technical assistance initiative designed to develop sustainable community-based models that address hypertension, pre-diabetes and diabetes prevention, and early detection and self-management.

In this demonstration year SRCH developed and implemented a formal evaluation. See "Interim Findings" below for results. Additionally, the SRCH program 2015 continued work on implementing sustainable self-management program referral and payment systems. below).

Interim findings:

Sustainable Relationships for Community Health Program

Final evaluation results from the first SRCH cohort are still being compiled, but an interim evaluation of the first six months of the funding cycle identified a number of findings and recommendations. Some of the findings included that dedicated time and space to co-create approaches to address chronic conditions was the most valuable part of the SRCH process, and that OHA program staff were critical to progressing the grantees' CDSMP and DPP work. Some of the recommendations included to continue to provide dedicated time and space for teams to work collaboratively away from daily distractions, and to make sure to tailor process and quality improvement tools to be more user-friendly to people with public health and health care backgrounds, who may be less familiar with business terminology and strategies, and improvement science. The full report can be found here.

Measures of Efficient and Effective Care Collected by OHA

The following measures of efficient and effective care improved in CY 2015 (see Appendix E for details):

- Emergency department visits per 1,000 member months decreased by 4.2% (from 47.3 per 1,000 member months in CY 2014 to 43.1 per 1,000 member months in CY 2015).
- Potentially avoidable hospital admissions per 100,000 member years decreased for the following conditions: chronic obstructive pulmonary disease or adult asthma (24.7%), diabetes short-term complications (3.4%), and asthma in youger adults (5.8%).
- Developmental Screening in the First 36 Months of Life increased from 42.6% in CY 2014 to 54.7% in CY 2015, exceeding the CY 2015 benchmark of 50.0%. In addition, Adolescent Well-Care Visits increased from 32.0% in CY 2014 to to 37.5% in CY 2015.
- Potentially Avoidable hopsital admissions per 100,000 member years for congestive heart failure increased by 29.2%; however, is the rate remains below the CY 2011 and CY 2013 rates.

Improvement activities:

Sustainable Relationships for Community Health Program

In this demonstration year, the SRCH program awarded five grants to local consortia. All grantees developed plans and identified quality improvement initiatives focusing on tobacco cessation referrals.

Future initiatives will focus on referrals for patients with prediabetes or at high risk to the Diabetes Prevention Program, patients with diabetes and/or hypertension, and patients aged 50+ to colorectal cancer screening. Grantees will create joint agreements and coordinate key performance indicators to implement the work moving forward. These efforts are funded by the CDC and Tobacco Master Settlement Agreement funds and align with Oregon's CCO incentive measures and statewide performance improvement project.

Summary of Health Information Technology Initiatives

In this demonstration year, OHA's office of Health Information Technology (OHIT) continued to make progress on health information technology (HIT) initiatives, which included:

- Bringing real-time hospital event notifications to CCOs and care teams. OHA increased adoption of PreManage, a tool that brings real-time hospital notifications to CCOs and care coordinators.
- Engaging CCOs in the development of technical assistance for Medicare practices related to their EHRs and meaningful use.
- Implementing telehealth pilots in five communities.
- Passing critical legislation that improves OHAs ability to advance HIT in Oregon.

Also in this demonstration year:

- OHA executed a contract with OCHIN to provide technical assistance to CCO priority practices to meaningfully use their Electronic Health Records (EHRs).
- The Office of the National Coordinator (ONC) for Health Information Technology awarded OHA and our program collaborator, Jefferson Health Information Exchange, a $1.6 million grant to advance the adoption and expansion of health information technology infrastructure and interoperability
- OHIT continued to coordinate the Health Information Exchange Onboarding Program (HOP) to strategize around opportunities to assist with onboarding providers onto Health Information Exchanges through the 90/10 funding recently identified in the State Medicaid Directors' letter.

CCO Metrics "Dashboards"

The CCO Metrics Dashboard includes all claims-based CCO inventive measures, and five additional quality and access measures. In this demonstration year, OHA continued to release quality metric progress reports for CCOs using the automated metric reporting tool ("dashboard") developed by CORE. CCOs and OHA utilized the dashboard extensively during the calendar year 2015 metrics validation process, which took place during May 2016. Also during this demonstration year, measures were updated to include ICD10 codes. The dashboard will continue to be expanded to include additional measures, filters, and capabilities.

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

Evaluation activities:

Transformation Center

During this demonstration year, the Transformation Center finalized a summary report about flexible services, which was based on interviews with 10 CCOs, and facilitated a state wide learning collaborative based on the findings. See themes from the summary report and state wide learning collaborative below under "Interim Findings".

Evaluating Oregon's Medicaid Waiver

During this demonstration year, the evaluation plan with the OHA's prospective contractor for the waiver summative evaluation (see Lever 4, above) was revised to include a proposal to evaluate the impact of flexible services on health care spending and other key outcomes. The contractor will formulate a more detailed proposal for evaluating flexible services, which may include but is not limited to, qualitative analysis of member experience with flexible services, quantitative analysis of data from select CCOs as available, and other methods.

Interim findings:

Transformation Center

Among the 10 CCOs interviewed, the Transformation Center found that flexible services usually addressed chronic conditions. Successes reported by CCOs included gym memberships and pool passes to support physical activity and wellness, rental assistance to stabilize mental health, early childhood programs to address trauma, incentives to increase adolescent well child visits, and health resilience specialists to identify member needs. CCOs expressed interested in learning about flexible services definitions and design, member communication, relationship of flexible services to rate setting, and examples of flexible services that worked at other CCOs.

The following themes emerged from the flexible services state wide learning collaborative:

- CCOs provide very different flexible services and capture information about them differently.
- Providers need help to understand and use flexible services.
- CCOs are concerned about potential demand and costs of flexible services if availability of the services is advertised.
- CCOs want to evaluate and demonstrate the effectiveness of flexible services, but clearly identifying their effects is challenging.

Improvement Activities:

Evaluating Oregon's Medicaid Waiver

In this demonstration year, as mentioned above and under Lever 4, OHA's evaluation contractor will include findings about the effectiveness of flexible services in its final evaluation report, which will be delivered to CMS and OHA by the end of 2017. In addition, the contractor will provide recommendations for evaluating flexible services following the end of the 2012 – 2017 demonstration period.

Transformation Center

In this demonstration year, the Transformation Center:

- Convened a meeting of internal stakeholder to discuss OHAs recent posting of revised Oregon Administrative Rules (OARs) for flexible services. It was decided that the OARs will need to be revisited as a result of Oregon's CMS 1115 waiver renewal. In the meantime, OHA will address any questions about the OAR on a case-by-case basis.
- As mentioned above the Transformation Center hosted a Flexible Services Learning Collaborative in Salem, Oregon. This collaborative brought together 48 participants (30 in person and 18 by webinar) from CCOs around the state, including 15 of the 16 CCOs.
- The evaluation feedback for the learning collaborative was very positive overall. Almost all of the 20 evaluation respondents (95%) found the collaborative to be very valuable or valuable in supporting their work. Participants indicated that the most helpful aspect of the event was hearing from other CCOs about their flexible services programs.

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:

In this demonstration year, the Transformation Center:

- Continued the fromative evaluation to assess the implementation of the Community Advisory Councils' (CAC's) Community Health Improvement Plans (CHIPs) in order to help guide the Transformation Centers support of the CACs, which are key in developing the CHIPS (see findings below in "Interim Findings/Improvement Activities).

Interim findings/ Improvement activities:

In this demonstration year, the Transformation Center:

- Continued its work on seven external learning collaboratives. Over 20 session were held and included teleconferences, webinars, and in-person session and spanned topics. These session were well attended, and most respondents found the session valuable or very valuable to their work.
- Held a Coordinated Care Model Summit, which was attended by 830 people. The summit provided the opportunity for CCOs to hear about innovative approaches to transformation around the state.
- Clinical Innovation Fellows (2015-2016) submitted final reports describing the outcomes of their projects and providing feedback on their fellowship experience. Every fellow indicated the program was very valuable in supporting their work and they would recommend the program to their colleagues. All 15 projects are expected to be sustained after the fellowship ends.
- Provided targeted technical assistance to CCOs on colorectal cancer screening, adolescent well-care visits, and childhood immunizations.
- Provided support to the CCOs through the Technical Assistance (TA) Bank.

VI. Metrics progress

Throughout the demonstration year, OHA continued its standardized reporting to coordinated care organizations, hospitals and the public, as well as ongoing measure development. During this year of the transformation demonstration, OHA distributed the third quality pool payment to CCOs and the second quality pool payments to hospitals. CCO and hospital data are provided in the measures matrices in Appendix A.

A. CCO measure development and reporting

Throughout the demonstration year, OHA produced regular reports as well as final calendar year 2015 data at the state and CCO level. OHA continued to work with stakeholders to refine measure specifications, such as improving exclusions for the effective contraceptive use measure, and to develop new measures, including food insecurity screening. OHA has maintained updated measure specifications and guidance online.

Clinical quality measures

All 16 CCOs successfully submitted their year three EHR-based data for the three clinical quality measures (diabetes, hypertension, and depression screening). Year three data was used to calculate statewide and CCO level rates, which were published in the 2015 final report (see below).

Progress reporting

OHA continued to provide CCOs with monthly metrics dashboards, an interactive tool to analyze performance on CCO incentive and quality and access test measures. Measure results are reflected for a rolling 12-month period and member-level detail is included for claims-based measures to facilitate measure validation and quality improvement activities. OHA continued to work with its vendor to refine dashboard filters, including gender, race/ethnicity, disability status, and geography.

Final 2015 Performance Report

OHA published two reports on the CCO incentive, state performance, and core performance measures to the Oregon Health Policy Board and the general public. A mid-year report was published in January 2016 and the final CY 2015 report was published in June 2016. All reports are available online at http://www.oregon.gov/oha/Metrics/

The coordinated care model continues to demonstrate improvement in a number of areas, such as reductions in emergency department visits and increases in depression screening and enrollment in patient-centered primary care homes. Specific improvements include:

- Hospital readmissions have decreased: the percent of adults who had a hospital stay and were readmitted for any reason within 30 days has improved by 33 percent since 2011. Fifteen of 16 CCOs have met or exceeded the benchmark. This measure is also shared with the Hospital Transformation Performance Program (see below).
- Decreased hospital admissions for short-term complications from diabetes: decreased 29 percent since 2011. Admissions for chronic obstructive pulmonary disease (COPD), congestive heart failure, and asthma have all also decreased from 2011 baseline. Lower is better for these measures.
- Increased access to primary care for children and adolescents: the percent of children and adolescents who had a visit with their primary care provider in the past year has increased from 2014. Adolescent well-care visits have also increased 38 percent since 2011.
- Increased rates of dental sealants: the percent of children ages 6-14 who received a dental sealant on a permanent molar in the past year increased 65 percent since 2014.

- Increased use of effective contraceptives: the percent of women ages 15-50 who are using an effective contraceptive increased almost 9 percent since 2014, even with the addition of thousands of new Oregon Health Plan members in 2014.
- Patient-centered primary care home enrollment continues to increase: CCOs have increased the percent of their members enrolled in PCPCHs 69 percent since 2012.
- Increased member satisfaction: the percent of CCO members who report they received needed information or help and thought they were treated with courtesy and respect by customer service staff has increased almost 10 percent since 2011 baseline.

After several years of reporting declines in chlamydia screening and cervical cancer screening, both rates have improved slightly compared to 2014, although there is still much room for improvement. Other measures in this report that highlight room for improvement include continued engagement in treatment for alcohol or drug dependence, and tobacco users receiving advice and supports to quit from their doctor.

2015 quality pool

OHA made the third annual quality pool payments to CCOs in June 2016. This year, OHA held back four percent of the monthly payments to CCOs, which were put in the common quality pool and distributed to CCOs that met the benchmark or improvement target on at least 12 of the 17 incentive measures (including Electronic Health Record adoption) and that had at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from the quality pool formed the challenge pool, which was distributed to CCOs that met the benchmark or improvement target on a subset of four measures: depression screening and follow up plan, diabetes HbA1c poor control, alcohol and substance use screening (SBIRT), and PCPCH enrollment.

In summary: 15 of the 16 CCOs earned 100 percent of their quality pool, and one CCO earned 60%.

Table: 2015 Quality Pool Distribution by CCO

Coordinated Care Organization	Number of measures met (of 17)	Percent of quality pool funds earned (without challenge pool)	Percent of quality pool funds + challenge pool funds earned	Total dollar amount earned
AllCare Health Plan	15.8	100%	100.8%	$8,859,678
Cascade Health Alliance	9.8	60%	60.4%	$1,893,533
Columbia Pacific	12.8	100%	100.5%	$5,668,725
Eastern Oregon	12.7	100%	100.7%	$10,226,498
FamilyCare	13.9	100%	100.9%	$19,225,001
Health Share	13.9	100%	100.8%	$42,715,283
Intercommunity Health Network	12.9	100%	100.7%	$11,015,172
Jackson Care Connect	14.8	100%	100.8%	$5,264,395
PacificSource – Central	14.9	100%	100.7%	$10,192,492
PacificSource – Gorge	16.9	100%	100.7%	$2,491,148
PrimaryHealth	15.0	100%	100.8%	$2,088,454
Trillium	12.8	100%	100.7%	$17,594,952
Umpqua Health Alliance	13.9	100%	100.8%	$4,870,778
Western Oregon Advanced Health	14.9	100%	100.6%	$4,368,463
Willamette Valley Community Health	12.9	100%	100.8%	$17,441,992
Yamhill CCO	13.7	100%	100.8%	$4,070,174
			Total 2015 Quality Pool	**$167,986,738**

B. Hospital measure development and reporting

This demonstration year covered the second year of the Hospital Transformation Performance Program (HTPP). Year two data were finalized and published, and hospitals received their second payments from the quality pool. This was the first year hospitals were paid for performance, compared to pay for reporting in the prior year.

Year 2 Performance Report

The second Hospital Transformation Performance Program report details how hospitals are doing on 11 key quality and outcome metrics focused on improving the quality of care and improving patient safety. The report covers the second year of the program (October 2014 through September 2015). Results were compiled and published in June 2016.

The report showed:

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

- Adverse drug events due to opioids: all hospitals achieved the benchmark
- Excessive anticoagulation with Warfarin: all hospitals achieved the benchmark
- Hypoglycemia in inpatients receiving insulin: 26 of 28 hospitals achieved the benchmark

Hospitals also did well in the area of hospital / CCO coordination

- Follow-up after hospitalization for mental illness: 23 of 28 hospitals met the benchmark
- Emergency Department Information Exchange (EDIE): 24 of 28 hospitals met the benchmark or improvement target.
- Screening, brief intervention, and referral to treatment (SBIRT) in the emergency department: 22 of 28 hospitals met the benchmark or improvement target.

Key areas needing improvement include readmissions, central-line associated bloodstream infection rates, and patient experience measures reported through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Year 2 Quality Pool

OHA made the second quality pool payments to hospitals in June 2016. In this second year, a total of $150 million in funds were awarded based on hospitals attaining benchmarks or improvement targets on the 11 measures.

A two-phase distribution method determined amounts awarded. In the first phase, all participating hospitals were eligible for a $500,000 “floor” payment if they achieved at least 75 percent of the measures for which they were eligible (achieved meant meeting benchmarks or improvement targets). Only three hospitals achieved this floor, resulting in $1.5 million in payments. In the second phase, the remaining $148.5 million was distributed on a measure-by-measure basis.

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

Measure	Measure weight	Total amount available for measure	Number of hospitals qualifying for baseline payment
CAUTI in all tracked units	9.38%	$13,921,875	22
CLABSI in all tracked units	9.38%	$13,921,875	9
Adverse drug events due to opioids	6.25%	$9,281,250	28
Excessive anticoagulation with Warfarin	6.25%	$9,281,250	28

Measure	Measure weight	Total amount available for measure	Number of hospitals qualifying for baseline payment
Hypoglycemia in inpatients receiving insulin	6.25%	$9,281,250	26
HCAHPS: staff always explained medicines	9.38%	$13,921,875	6
HCAHPS: Staff gave patient discharge information	9.38%	$13,921,875	11
Hospital-wide all-cause readmissions	18.75%	$27,843,750	6
Follow-up after hospitalization for mental illness	6.25%	$9,281,250	23
SBIRT: screening for alcohol and other substance misuse in the emergency department	6.25%	$9,281,250	22
EDIE: hospitals share emergency department visit information with primary care providers and other hospitals to reduce unnecessary ED visits.	12.5%	$18,562,500	24
TOTAL	**100%**	**$148,500,000**	

C. Committees and workgroups

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

CCO Metrics & Scoring Committee

This legislatively-appointed Committee met nine times during the demonstration year to select measures and benchmarks and refine overall methodology for the CCO incentive program. All meeting materials are available online.

CCO Metrics Technical Advisory Workgroup

This workgroup met monthly during the demonstration year to address details related to the incentive measures and overall analytic activities. All 16 CCOs and a variety of stakeholders participated. Meeting materials are available online.

Hospital Performance Metrics Advisory Committee

This legislatively-appointed Committee met ten times during the demonstration year to develop measures and domains, establish benchmarks, and refine specifications and methodology for the hospital incentive program. All meeting materials are available online.

Hospital Metrics Technical Advisory Workgroup

This workgroup was convened by OHA in July 2015 to address details related to the incentive measures and overall analytic activities. All DRG hospitals and a variety of stakeholders participated. Meeting materials are available online.

D. Quality and access test

During the demonstration year, OHA has been working with its contractor, the Oregon Health Care Quality Corporation (Q Corp) to conduct the quality and access test. Q Corp has been independently producing the quality and access "test" measures to verify OHA's reporting.

OHA and Q Corp have been conducting a multi-directional validation process on the CCO incentive measures and quality and access "test" measures that includes code review and process checks on multiple measurement periods. Validation is an ongoing process for both the DY and the CY measurement periods, to reflect annual updates to specifications. OHA and Q Corp have worked to reconcile differences found in the data to ensure the quality and accuracy of the quality and access test.

Results from the first and second quality and access tests have been previously reported to CMS and are available online. Results from the third quality and access test will be reported to CMS in early 2017.

VII. Appendices

A. Enrollment reports

SEDS reports

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

State reported enrollment tables

See quarterly reports for the first, second, third and fourth quarters of the demonstration year.

Actual and unduplicated enrollment

Ever enrolled report

		Population	Total Number of Clients	Member Months
	Title 19; OHP Plus	PLM Children FPL > 170%	302	1,518
		Pregnant Women FPL > 170%	386	1,396
	Title 21; Plus	SCHIP FPL > 170	42,516	264,219
Optional	**Title 19; Plus**	PLM Women FPL 133-170%	7,936	28,875
	Title 21; Plus	SCHIP FPL < 170%	102,335	767,736
Mandatory	**Title 19; Plus**	Other OHP Plus	222,724	2,059,436
	Title 19; Plus	MAGI Adults/Children	1,004,594	9,768,087
	Title 19; Plus	MAGI Pregnant Women	31,577	204,731
		TOTALS	1,412,370	

OHP eligibles and managed care enrollment

	OHP Eligibles*	FCHP	CCOA[1]	CCOB[2]	DCO	MHO	CCOE	CCOG
July	1,030,594	1	891,714	1,047	51,370	3,902	983	37,042
August	1,054,453	0	905,631	1,204	52,943	3,878	1,028	36,364
September	1,051,620	0	909,784	1,180	54,138	3,999	1,067	37,696
October	1,056,014	0	908,923	1,105	53,847	3,930	1,073	36,780
November	1,019,385	0	869,950	1,103	52,164	3,805	933	35,611
December	1,033,484	0	905,462	1,122	53,858	3,819	966	35,581
January	1,045,836	0	911,396	1,081	54,090	3,781	928	35,299
February	1,066,977	0	927,738	1,542	55,494	3,839	1,044	35,437
March	1,076,833	0	941,854	1,190	56,771	3,825	975	36,011
April	1,059,042	0	906,030	1,176	55,579	4,155	3,013	35,590
May	1,045,896	0	899,119	1,128	52,872	4,072	1,139	36,416
June	1,034,640	0	892,255	1,132	52,219	4,111	1,013	37,174
Average	**1,047,898**	**0** **0.00%**	**905,821** **86.44%**	**1,168** **0.11%**	**53,779** **5.13%**	**3,926** **0.37%**	**1,180** **0.11%**	**36,250** **3.46%**

*Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, CX Families, Adults & Couples, OAA, ABAD, CHIP, FC and SAC.
[1] =CCOA Physical, Dental and Mental Health
[2]= CCOB Physical and Mental Health
[3] = CCOE Mental Health only

[4]= CCOG Mental and Dental

B. Neutrality reports

Attached separately.

C. Two-percent trend reduction tracking

The state reports quarterly on its progress of reducing the per capita expenditure growth trend. For state fiscal year (SFY) 2016, the state limits the per-member-per-month (PMPM) growth to 3.4 percent—two percentage points below the 5.4 percent trend assumed without health system transformation. Oregon's quarterly reports demonstrate that the state's PMPM growth, which included $150 million in bonus payments for the CMS-approved Hospital Transformation Performance Program, remained within the parameters of the test for SFY 2016. Preliminary estimates for SFY 2017 also indicate the state will remain within the parameters of the test.

D. DSHP tracking

For SFY 2016, the overall DSHP limitation was reduced per waiver requirements to $68 million in expenditure authority. This was due to the Waiver requirement to only use the "Other" (Traditional) category for DSHP draws. The draws by quarter were:

State Fiscal Year 2016 Demonstration Year 14	FF Draw/ DSHP limitation	New FF Drawn as Result of DSHP
SFY 16 Quarter 1	$92,912	$165,608
SFY 16 Quarter 2	$1,692,578	$3,059,185
SFY 16 Quarter 3	$5,082,480	$9,186,134
SFY 16 Quarter 4	$61,224,942	$110,658,668
TOTALS*	$68,092,912	$123,069,595

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

E. Oregon Measures Matrix

Attached separately.

F. Hospital Transformation Performance Program (HTPP) data

Attached separately. This report includes the final baseline data for the period covering October 2013 – September 2014, as well final Year 2 data for the period covering October 2014 – September 2015. Data reported here may differ from previous quarterly reports. Baseline and Year 2 reports are available online at http://www.oregon.gov/oha/Metrics/Pages/Hospital-Reports.aspx.

G. Uncompensated Care Program

Nothing to report. OHA is currently implementing system updates to support collection of UCCP claim data.

H. Transformation Center Flexible Services review and Learning Collaborative summaries

Attached separately.