Oregon Health Plan

Section 1115 Quarterly Report

4/1/2016 – 6/30/2016
Demonstration Year (DY): 14 (7/1/2015 – 6/30/2016)
Demonstration Quarter (DQ): 4/2016
Federal Fiscal Quarter (FQ): 3/2016

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I. Introduction

A. Letter from the State Medicaid Director

From April through June 2016, the Oregon Health Authority (OHA) continued to move forward in meeting the goals of the Oregon Health Plan (OHP) demonstration.

- **Lever 1: Improving care coordination** – In this quarter, there were 629 recognized patient-centered primary care home (PCPCH) clinics in the state (surpassing Oregon's goal of 500 clinics by 2015). This represents 60% of the estimated number of primary care clinics in Oregon. Among coordinated care organizations (CCOs), PCPCH enrollment has increased 69 % since 2012. Oregon's Patient-Centered Primary Care Institute (PCPCI) coordinated a variety of learning events and technical supports to help support the PCPCH model.
- **Lever 2: Implementing alternative payment methodologies (APMs)** – During this quarter, the Transformation Center awarded grants to two health care payers to advance an alternative payment method for integrated care. Additionally, 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.
- **Lever 3: Integrating physical, behavioral and oral health care** – The Behavioral Health Home Learning Collaborative (BHHLC) assists organizations with integrating primary care into behavioral health settings. In this quarter, Oregon Health & Science University's Oregon Rural Practice-based Research Network (ORPRN) completed a draft evaluation of the first two years of the learning collaborative that OHA is currently reviewing.
- **Lever 4: Increased efficiency in providing care** – 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 younger 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 37.5% in CY 2015.
- **Lever 5: Implementation of health-related flexible services** – The revised evaluation plan delivered by OHA's prospective contractor for the waiver summative evaluation includes a proposal to evaluate the impact of flexible services on health care spending and other key outcomes. As a first step, OHA will meet with the contractor's evaluation team to inform the contractor about data available on flexible services.
- **Lever 6: Innovations through the Transformation Center** - In this quarter, the Transformation Center continued work on its external learning collaboratives. From April through June 2016, the CCO learning collaborative met once. The session focused on low back pain and 74 people attended. Of evaluation respondents, 80% found the session valuable or very valuable to their work and 80% said the session was effective for meeting the needs of their CCO or organization.

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, now known as Temporary Assistance to Needy Families/TANF) populations. One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.

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

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

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

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

DY	Time Period	FFP Limit
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 model of care within CCOs, Oregon established a loan repayment program for primary care physicians who agree to work in rural or underserved communities in Oregon, and will complete 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 and Quarterly Reports

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II. Title

Oregon Health Plan Section 1115 Quarterly Report
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III. Events affecting health care delivery

A. Overview of significant events across the state

Category of event	Impact? (Yes/No)			Interventions or actions taken? (Yes/No)
	Demonstration goals	Beneficiaries	Delivery system	
A. Enrollment progress	No	No	No	
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	

Detail on impacts or interventions

Nothing to report this quarter.

B. Complaints and grievances

For this quarter, all CCOs reported using the updated complaint categories as reflected in the chart below. (Complaints received internally within OHA are reported in the narrative portion of this report.)

There are six main categories:

1. Access to providers and services;
2. Interaction with provider or plan;
3. Consumer rights;
4. Clinical care,
5. Quality of services
6. Client billing issues.

These categories are required under the Special Terms and Conditions of Oregon's current 1115 demonstration.

CCO complaints

Table 2 – Complaints and grievances

This chart shows the individual line items that are required under each main category. Some of the line item categories have been updated and implemented as of 10/01/2015. All CCOs are reporting in these updated categories for this quarterly report. The chart includes:

- The total of all complaints reported statewide by the sixteen coordinated care organizations (CCOs) for the quarter.
- Total number of statewide complaints that were resolved within 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.

Complaint or grievance type	Number reported
ACCESS TO PROVIDERS AND SERVICES	
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	114
b) Plan unresponsive, not available or difficult to contact for appointment or information.	40
c) Provider's office too far away, not convenient	45
d) Unable to schedule appointment in a timely manner.	152
e) Providers office closed to new patients	92
f) Referral or 2nd opinion denied/refused by provider.	57
g) Referral or 2nd opinion denied/refused by plan	17
h) Unable to be seen in a timely manner for urgent/ emergent care	30
i) Provider not available to give necessary care	39
j) Eligibility issues	56
k) Female or male provider preferred, but not available	12
l) NEMT not provided, late pick up resulting in missed appointment, problems with coordination of transportation services	1213
m) Dismissed by provider as a result of past due billing issues	0
n) Dismissed by clinic as a result of past due billing issues	5
INTERACTION WITH PROVIDER OR PLAN	
a) Provider rude or inappropriate comments or behavior	261
b) Plan rude or inappropriate comments or behavior	34
c) Provider explanation/instruction inadequate/incomplete	161
d) Plan explanation/instruction inadequate/incomplete	125
e) Wait too long in office before receiving care	43
f) Member not treated with respect and due consideration for his/her dignity & privacy	25
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available	5
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	34
i) Lack of coordination among providers	34
j) Wants to change providers; provider not a good fit	151
k) Member has difficulty understanding provider due to language or cultural barriers	7
l) Client dismissed by provider (member misbehavior, missed appointments, etc.)	57
m) Client dismissed by clinic (member misbehavior, missed appointments, etc.)	14
CONSUMER RIGHTS	
a) Provider's office has physical barrier(s), is not ADA compliant (preventing access from street level or to lavatory or to examination room or no special adaptations or doors)	3
b) Concern over confidentiality	32
c) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group.	97
d) No choice of clinician, or clinician of choice not available.	23

Complaint or grievance type	Number reported
e) Fraud and financial abuse (services billed not provided, service provided in two appointments that should have been provided in one.)	16
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health marital status, Medicaid/Medicare)	17
g) Complaint/appeal process not explained, lack of adequate or understandable NOA	11
h) Not informed of consumer rights	4
i) Denied member access to medical records (other than as restricted)	3
j) Did not respond to member's request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)	5
k) Advanced or Mental Health Directive not discussed or offered or followed	1
l) Restraint or seclusion used other than to assure member's immediate safety	0
CLINICAL CARE changed to Quality of Care	
a) Received appropriate care, but experienced adverse outcome, complications, misdiagnosis or concern related to provider care.	153
b) Testing/assessment insufficient, inadequate or omitted	57
c) Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider.	152
d) Member neglect or physical, mental, or psychological abuse	14
e) Provider office unsafe/unsanitary environment or equipment	16
f) Lack of appropriate individualized setting in treatment	14
QUALITY OF SERVICE	
a) Delay in receiving, or concern regarding quality of materials and supplies (DME) or dental	76
b) Lack of access to medical records or unable to make changes	14
c) Benefits not covered	75
CLIENT BILLING ISSUES	
a) Co-pays	14
b) Premiums	2
c) Billing OHP clients without approved waiver	256
Miscellaneous	15
Total	**3893**
Total resolved in the quarter	**3806**
Total pending at the end of the quarter	**72**
Total average enrollment numbers as reported by the CCOs as of 3/31/2016	**931,586**
Total rate per 1000 members	**4.178**

Attached separately is a summary of the statewide complaints and grievances reported by the CCOs in the six main categories. The chart includes the following:

- Summary totals per main category, per CCO,
- Number of complaints pended per category, per CCO at the end of this quarterly reporting period,
- Number of complaints resolved per category, per CCO at the end of this quarterly reporting period,
- The range of number of complaints and grievances per category, per CCO in this quarterly reporting period. (range indicates the following: **lowest number** = lowest number of complaints received in the category; **highest number** = highest number of complaints received in the category.)

Trends related to complaints and grievances

Trends: Total rate per 1000 members statewide this quarter in all categories is 4.178. This is a slight increase from the previous quarter at 3.67 rate per 1000 members. The rate per 1000 members statewide averages enrollment for all 16 coordinated care organizations (CCOs) during the reporting period.

Rates per 1000 members among the individual 16 CCOs show the lowest rate per 1000 members for one CCO was .40 and the highest was 17.10 for another CCO. The highest rate is an increase from last quarter, when the highest rate was 11.68 rate per 1000 members.

Review of the data shows that overall, complaints increased approximately 7.5 percent compared to last quarter. This is due to several issues reported by the CCOs to the Oregon Health Authority (OHA).

CCOs report they are continuing to work with their providers to standardize the reporting. One CCO is taking appropriate measures to ensure the reporting tool is not changed, therefore standardizing how each of the plans report to the CCO. Some CCOs report they are working with customer service front line staff to ensure all complaints are recorded and categorized appropriately. These types of improvements have resulted in some increase in the number of overall complaints reported.

The Non-Emergency Transportation (NEMT) complaints continue to be an issue as the CCOs work to resolve issues between the NEMT providers and the Oregon Health Plan (OHP) members. Review of the Non-Emergency Transportation (NEMT) data indicates the complaints increased from 16% of the total complaints in the previous quarter to 31% of the total complaints this quarter. One CCO reported that their NEMT provider is now reporting complaints appropriately, which has resulted in an increase of NEMT complaints compared to last quarter. OHA staff continues to assist CCOs in taking appropriate steps to resolve the issue statewide.

The Access to Providers and Services category continues to have the highest range of complaints. The rate per 1000 members for the Access to Providers and Services category increased slightly from 1.50 to 2.00 per 1000 members. One CCO reports an issue with lack of providers in their service area. In reviewing the data, there is an increase in the "provider offices being closed to new patients" category. The CCO reports there are some new providers that have opened in their service area.

The Interaction with the Provider or Plan category rate per 1000 members is 1.02 this quarter, which is a decrease from 1.14 last quarter.

Interventions

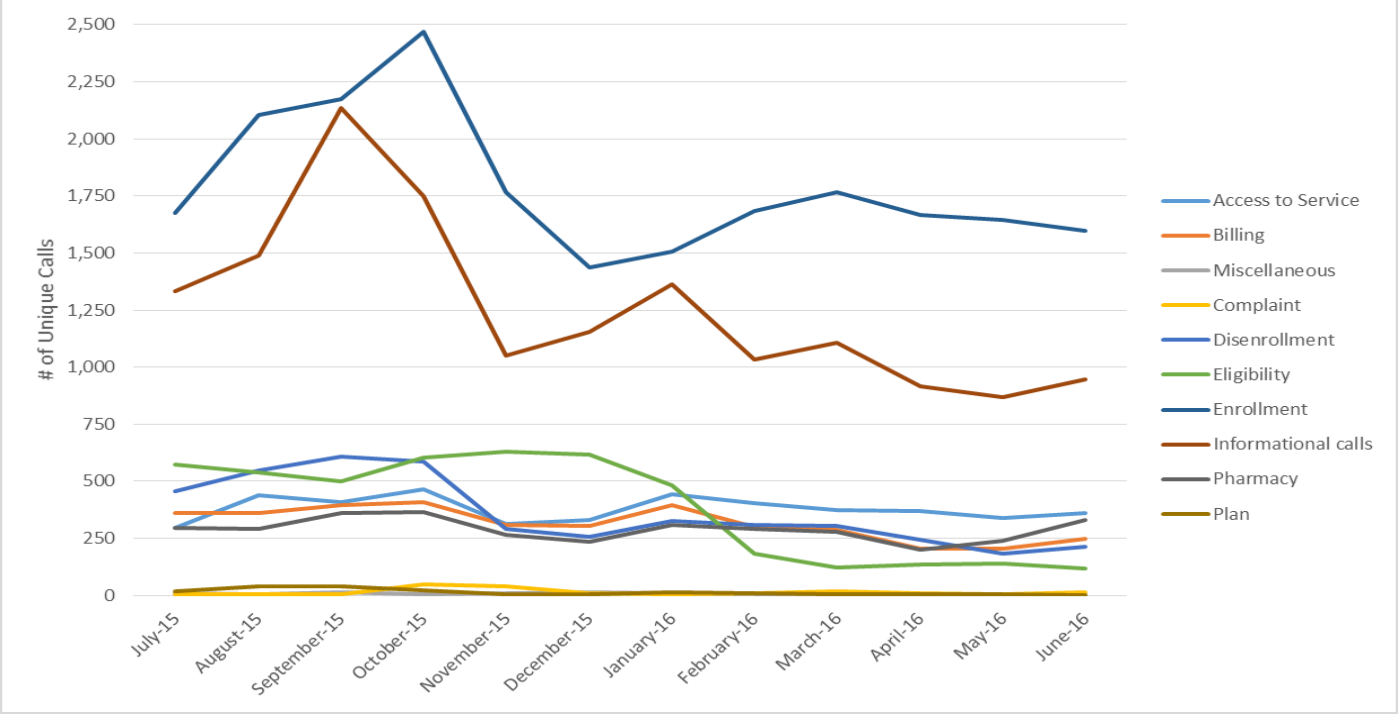
The OHA staff is continuing to provide Technical Assistance Webinars each quarter, prior to submission of the data to the OHA. These Technical Assistance Webinars provide instructions and assistance in submitting the data appropriately to the OHA. In addition, the OHA is working with a small workgroup of CCO complaint and grievance staff to work on clarification of reporting requirements.

Fee-for-service (FFS) complaints

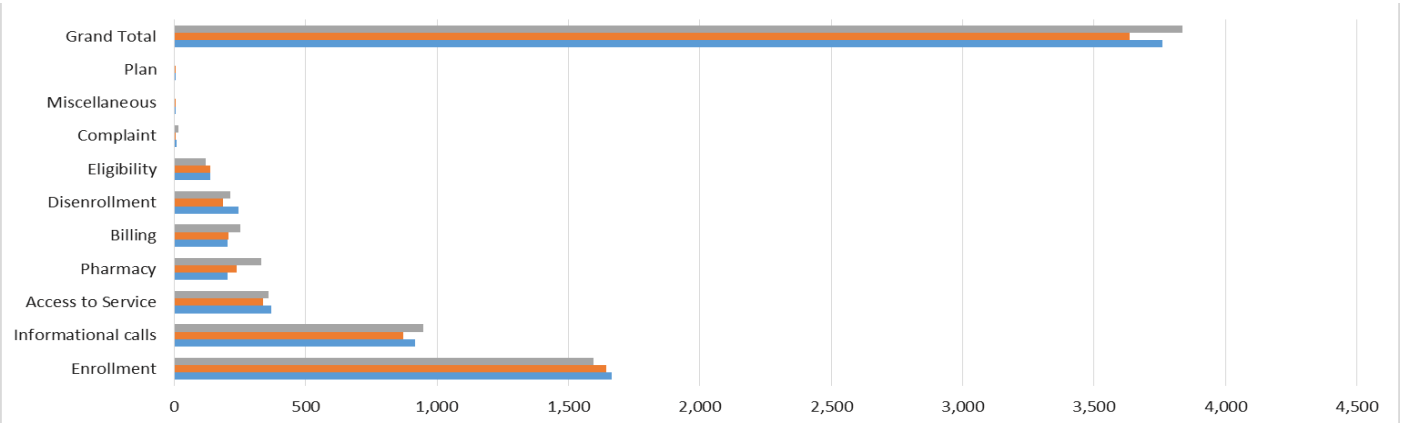
The OHA Client Services Unit is changing how they are reporting their data. Please see the following charts about CSU call volume for more information.

For a detailed review of complaints and grievances and a summary of all services provided by the Oregon Health Authority's Ombudsperson, as well as recommendations for improving access to or quality of care under the OHP, please find he OHA Ombudsperson's report for April-June 2016 at www.oregon.gov/oha/Documents/Quarterly%20Ombudsperson%20Report.pdf.

12-month rolling average by call category

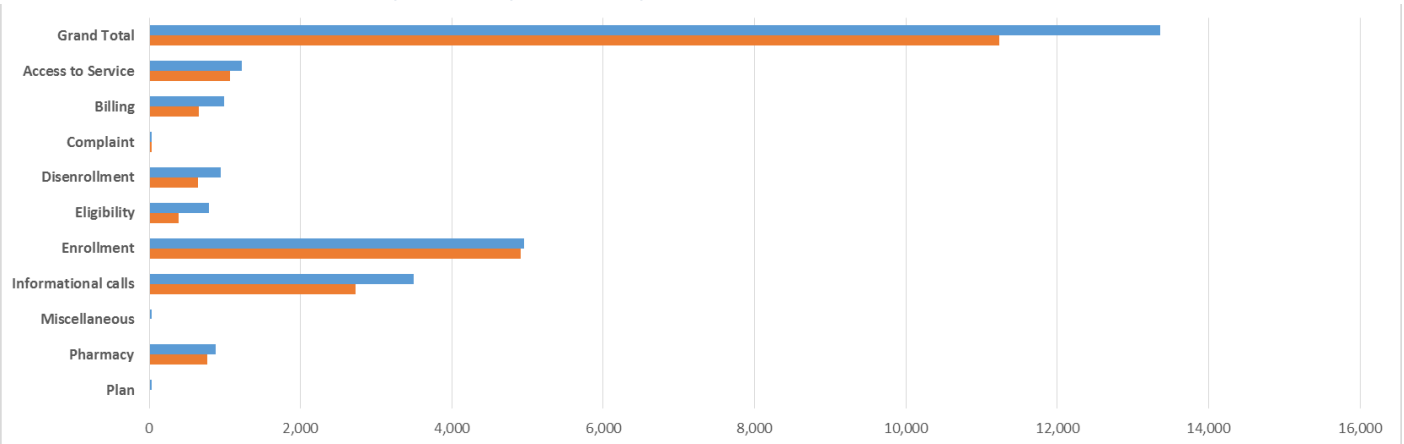


Comparison of total monthly calls by category – April-June 2016



	Enrollment	Informational calls	Access to Service	Pharmacy	Billing	Disenrollment	Eligibility	Complaint	Miscellaneous	Plan	Grand Total
June-16	1,596	946	359	331	250	214	119	15	3	2	3,835
May-16	1,644	870	338	239	206	184	138	5	4	6	3,634
April-16	1,666	916	369	202	204	245	137	10	6	5	3,760

Comparison of total quarterly calls by category – 1st and 2nd Quarter 2016



	Plan	Pharmacy	Miscellaneous	Informational calls	Enrollment	Eligibility	Disenrollment	Complaint	Billing	Access to Service	Grand Total
Q1 2016	28	881	29	3,500	4,956	788	941	33	986	1,221	13,363
Q2 2016	13	772	13	2,732	4,906	394	643	30	660	1,066	11,229

C. Appeals and hearings

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

The following table lists the total number of Notices of Action (NOAs) issued by CCOs for the quarter by NOA reason, followed by the total number of appeals and contested case hearings requested in response to these NOAs, and the range reported across all CCOs.

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
a) Denial or limited authorization of a requested service.	28029	1650	14-336
b) Single PHP service area, denial to obtain services outside the PHP panel	282	1	0-1
c) Termination, suspension or reduction of previously authorized covered services	700	28	0-25
d) Failure to act within the timeframes provided in § 438.408(b)	77	0	0
e) Failure to provide services in a timely manner, as defined by the State	1	0	0
f) Denial of payment, at the time of any action affecting the claim.	23903	659	0-238
Total	**52992**	**2364**	**14-469**
Number per 1000 members	**53.93**	**2.41**	**0.79-4.66**
Number overturned at plan level	**-**	**783**	**1-186**
Appeal decisions pending	**-**	**47**	**0-19**
Number of contested case hearings requested	**-**	**749**	**0-142**
Overturned prior to hearing	**-**	**261**	**0-69**
Overturn rate	**-**	**34.85%**	**0-50%**
Hearing decision pending	**-**	**-**	**-**
Hearing requests per 1000 members	**-**	**0.76**	**0-1.50**

Contested case hearings

The following table[1] represents the contested case hearings that were processed during the second quarter of 2016.

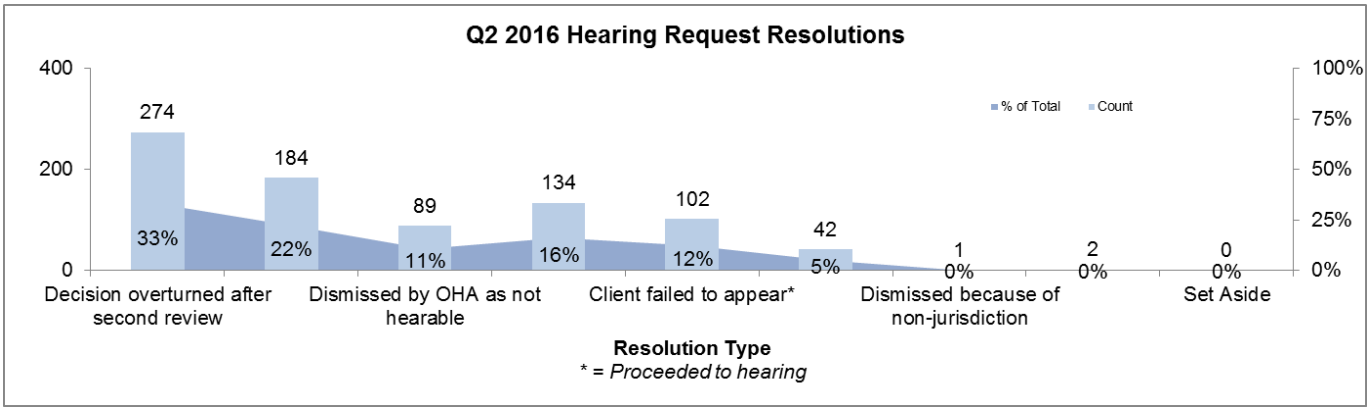
Plan Name	Total requests received	Average plan enrollment *	Per 1000 members
ALLCARE HEALTH PLAN, INC.	37	49,996	0.7401
CASCADE HEALTH ALLIANCE	10	16,899	0.5918
COLUMBIA PACIFIC CCO, LLC	18	25,231	0.7134
EASTERN OREGON CCO, LLC	29	49,023	0.5916
FAMILYCARE, CCO	115	126,649	0.9080
HEALTH SHARE OF OREGON	140	228,659	0.6123
INTERCOMMUNITY HEALTH NETWORK	29	55,800	0.5197
JACKSON CARE CONNECT	30	29,784	1.0073
PACIFICSOURCE COMM. SOLUTIONS	77	52,638	1.4628
PACIFICSOURCE COMM. SOLUTIONS - GORGE		12,992	0.0000
PRIMARYHEALTH JOSEPHINE CO CCO	4	11,390	0.3512
TRILLIUM COMM. HEALTH PLAN	63	92,938	0.6779
UMPQUA HEALTH ALLIANCE, DCIPA	25	27,095	0.9227
WESTERN OREGON ADVANCED HEALTH	18	20,241	0.8893
WILLAMETTE VALLEY COMM. HEALTH	142	99,349	1.4293
YAMHILL CO CARE ORGANIZATION	12	23,665	0.5071
ACCESS DENTAL PLAN, LLC		2,169	0.0000
ADVANTAGE DENTAL	3	24,358	0.1232
CAPITOL DENTAL CARE INC		15,694	0.0000
CARE OREGON DENTAL		2,247	0.0000
FAMILY DENTAL CARE	1	2,190	0.4566
MANAGED DENTAL CARE OF OREGON		2,250	0.0000
ODS COMMUNITY HEALTH INC	2	7,839	0.2551
FFS	39	259,647	0.1502
Total	**794**	**1,238,743**	**0.6410**

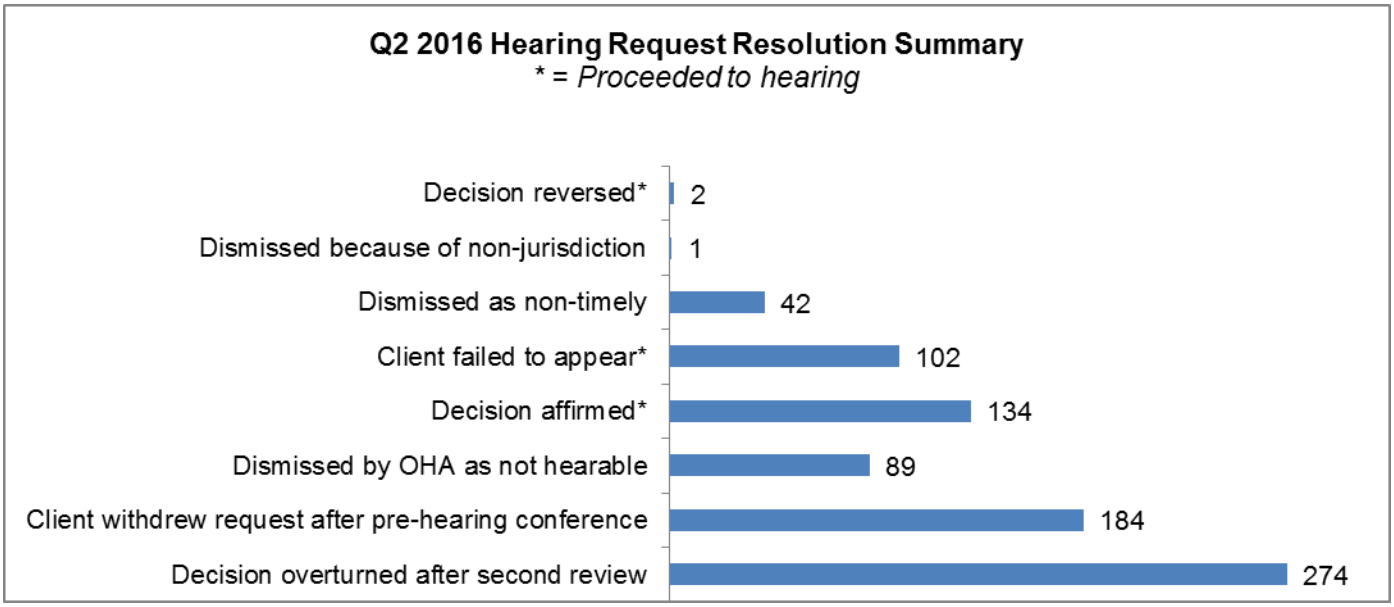
The following chart shows the outcomes of the hearings completed this quarter.

Outcome	Count	% of Total
Decision overturned after second review	274	33%
Client withdrew request after pre-hearing conference	184	22%
Dismissed by OHA as not hearable	89	11%
Decision affirmed	134	16%
Client failed to appear	102	12%
Dismissed as non-timely	42	5%
Dismissed because of non-jurisdiction	1	0%
Decision reversed	2	0%
Set aside	0	0%
Total outcomes	**828**	

[1] Data Source: New_HearingLog.mdb & DSSURS; Data Extraction Date: 07/06/2016

Trends[2]





Interventions

No report this quarter.

D. Implementation of 1% withhold

During this quarter, OHA analyzed encounter data received for completeness and accuracy for the subject months of April 2015 through June 2015. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred. Future reports may contain the following information:

Table 3 – Summary

Metric	Frequency	
	Quarterly	Annually
Actual amount paid of monthly PMPM capitation rate broken out by: ■ Average/mean PMPM	X	X

[2] Data Source: New_HearingLog.mdb; Data Extraction Date: 04/22/2016

Metric	Frequency	
	Quarterly	Annually
■ Eligibility group ■ Admin component ■ Health services component For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy)		
Actual amount paid in incentives monthly broken out by: ■ Total by CCO ■ Average/mean PMPM incentive ■ The over/under 100% of capitation rate by CCO and by average enrollee PMPM	X	X
Best accounting of the flexible services provided broken out by: ■ Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers) ■ Services that are not reflected in encounter data (e.g., air-conditioners, sneakers)	X	X
CCO sub-contractual payment arrangements – narrative ■ Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network		X
Encounter data analysis ■ Spending in top 25 services by eligibility group and by CCO ■ To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well	X	X

E. Statewide workforce development

Traditional Health Workers

Nothing to report this quarter.

Health professional graduates participating in Medicaid

Nothing to report this quarter. This data is produced semi-annually and reflected in the appropriate Quarterly Reports.

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

Approval and contracting with new plans	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
-				

Changes in CCO/MCO networks	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
EOCCO added children's wrap around services by amendment	Better coordination of care	Increase in access	1	Unknown

Rate certifications	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
-				

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

CCO/MCO contract compliance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
-	-	-	-	-

Relevant financial performance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No changes – all CCO's performing to standards	-	-	-	-

Other	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
-	-	-	-	-

G. Transformation Center

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

Key highlights from this quarter:

Behavioral health integration

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

- The **behavioral health integration resource library** is now live at www.pcpci.org under "Resources." The formal launch will be in late July, and by September the site will include 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.
- Eleven CCOs have been matched with appropriate consultants to provide **behavioral health integration technical assistance**. Topic areas include trauma informed care; behavioral health homes; workflow; metrics; alternative payment models; screening, brief intervention and referral to treatment (SBIRT); and team development.
- Practice recruitment began for the Transformation Center-funded Oregon Health and Science University **Project ECHO** tele-mentoring clinic focused on behavioral and mental health issues affecting children. The response was overwhelming, with forty practices requesting to participate in the clinic, which was designed for twenty practices. OHSU is selecting practices and exploring ways to include more.

Population health

Community Advisory Council support

The Transformation Center is providing targeted support to CCO community advisory councils (CACs) for CAC member recruitment and engagement. With the guidance of a CAC recruitment and engagement committee, the Transformation Center convened a recruitment and engagement-focused event for CAC leaders on May 24, 2016, in Eugene, OR. 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 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 community health improvement plans. 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, health and early learning program expansions, and member education through social marketing. An overview of all 16 grant projects is available on the Transformation Center website. The CCOs will 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 six CCOs (46%) had completed at least one grant activity. Reports also showed that nine CCOs (69%) had started to make progress toward grant outcomes, and three CCOs (23%) had completed at least one grant outcome. Progress reports for the remaining three CCOs are due September 30, 2016, and all final reports are due December 31, 2016.

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, a national expert in health equity technical assistance, 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.

Clinical delivery support

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

This quarter, the Transformation Center facilitated one statewide CCO learning collaborative session. In May, the collaborative focused on low back pain management with the goals of 1) identifying and sharing emerging best practices, 2) discussing the role of CCOs in supporting strategies, and 3) identifying tools to share or develop for use across CCOs.

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

Council of Clinical Innovators: Clinical Innovation Fellows

During this quarter, the Clinical Innovation Fellows program held two online meetings focused on collective impact, business planning and team interventions. The program also held its final in-person meeting, which included a panel of state legislators, a panel of Oregon health policy leaders and mentor group presentations. In addition, each month fellows met with their faculty mentors individually and in small groups with two to three other fellows. Many of the fellows took advantage of the 10 hours of technical assistance offered through the Technical Assistance Bank and are working with consultants on topics like alternative payment models, return on investment analysis, behavioral health integration and evaluation plans.

In May, fellows 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. 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 second cohort graduated from the program. Health Share of Oregon CCO hosted the event. To learn more about the graduates, see their bios and final project abstracts: www.oregon.gov/oha/Transformation-Center/Pages/Council-Clinical-Innovators-Fellows-2015-2016-Bios.aspx

Applications for the third cohort were due this quarter, and the 12 applicants selected will start the program in August. The program is considering ways to connect previous and future cohorts to build the network of clinical innovation leaders in Oregon.

More information about the Council of Clinical Innovators is available at transformationcenter.org/cci.

Alternative (Value-based) Payment Method support

Alternative Payment Method technical assistance

The Transformation Center is providing support to three CCOs to develop alternative payment models (APMs)/value-based payments (VBPs). One CCO is working with the Center for Evidence-based Policy to create an APM development process to apply across all provider types and expand current VBP models from primary care to hospitals and specialist providers. Another CCO is working with the National Council on Behavioral Health and Dale Jarvis and Associates, LLC, to develop a fair value of behavioral health services for sub-capitated community mental health program providers and develop an APM for providers outside of the sub-capitated arrangement. The third CCO is working with Bailit Health Purchasing, LLC, to develop APM options for an integrated maternal health and substance use disorder project including: operational considerations, pros and cons for each of the models, and opportunities and challenges with implementing the options from the plan and provider perspective.

Primary Care Payment Reform Collaborative

As required through Senate Bill 231, the Transformation Center convened a Primary Care Payment Reform Collaborative. This collaborative is convening payers and providers to share best practices on primary care alternative payment methods and initiative alignment. This quarter the Transformation Center convened the group 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

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.

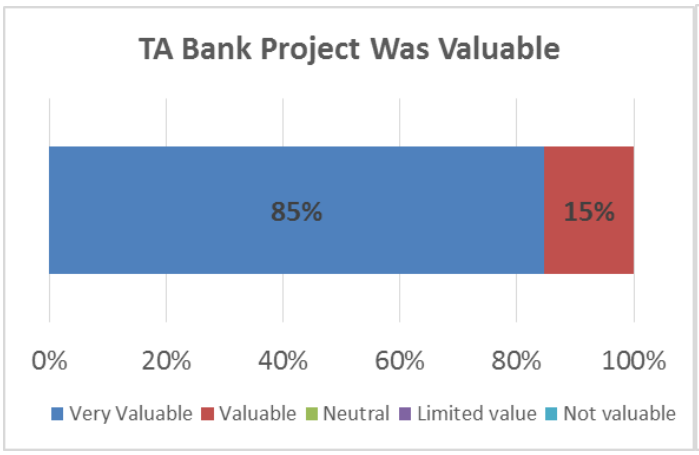
Behavioral Health Integration Alternative Payment Method Grants

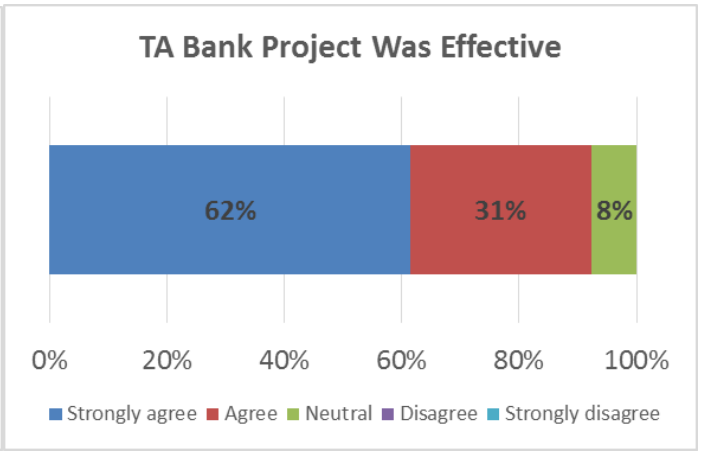
The Transformation Center awarded two grants totaling $300,000 to two health care payers to advance alternative payment methods for integrated care. Work outlined in these grants will be complete by the end of December 2016.

Transformation Center CCO Technical Assistance Bank

As a result of requests from CCOs and their CACs, in October 2014 the Transformation Center began offering CCOs and their CACs 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 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 a variety of topics, including CAC member engagement, program evaluation, value-based payments, behavioral health integration, health information technology and tobacco cessation. TA Bank evaluation results for thirteen 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.



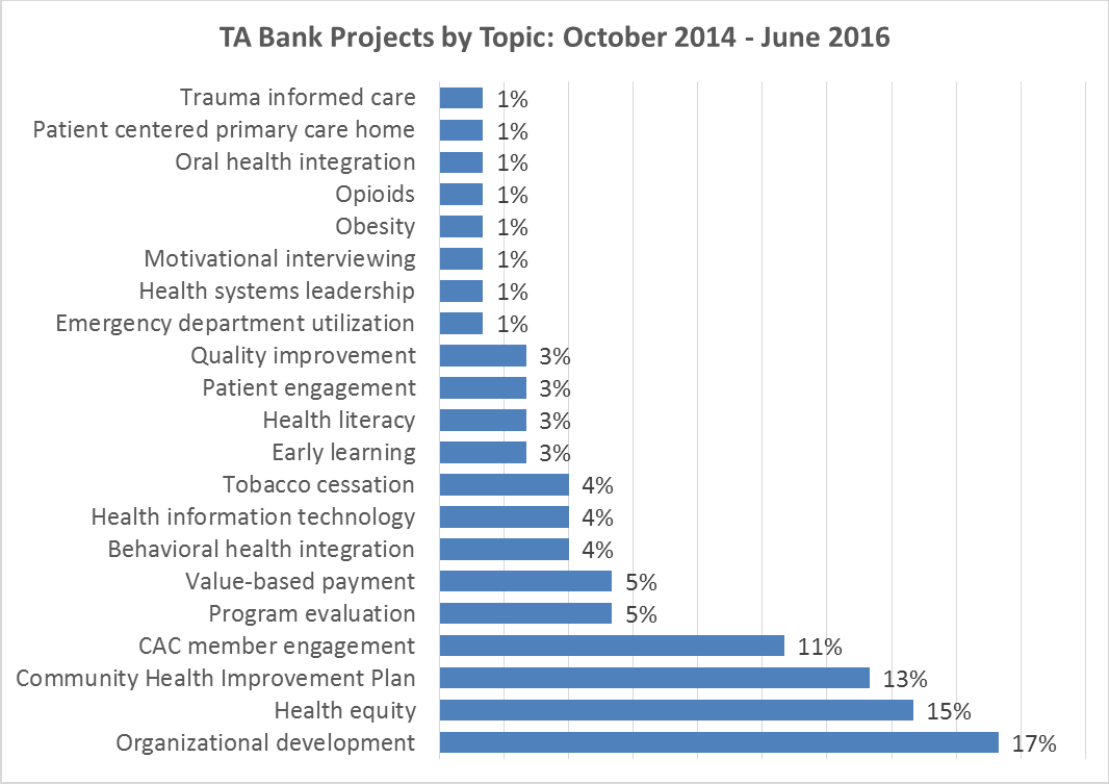


To continue to provide technical assistance through December 2016, in May 2015 the Transformation Center released a request for applications (RFA) for consultants to contract as technical assistance providers. The RFA has resulted in over 60 contractors being available to provide technical assistance on a variety of topics. The Transformation Center continues to communicate 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. Alternative payment methods
2. Behavioral health integration
3. Community health improvement plan (CHIP) review, implementation and evaluation
4. Early learning systems and strategies
5. Engagement strategies for person and family-centered health care systems
6. Health information technology
7. Health systems leadership
8. Improving childhood immunization**
9. Improving health equity
10. Oral health integration
11. Organizational development for CCOs and/or CCO community advisory councils
12. Primary care transformation, including patient-centered primary care homes
13. Program Evaluation
14. Project management
15. Public health integration
16. Quality improvement science
17. Tobacco cessation
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.

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 will be opened up to all 16 CCOs in July. Activity includes a facilitated root cause analysis, prioritization of root causes, and technical assistance in identifying and creating an implementation plan to address prioritized root causes.

Community convening 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 focusing on improving adolescent well-care visit 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 two in-person, youth-led Eye-to-Eye trainings in August and September. 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.

Table 6 - Innovator Agents – Summary of promising practices

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. This quarter, the Innovator Agents met three out of the three months and the meetings included updated information about behavioral health integration, strategic planning with the Transformation Center around technical assistance for community advisory councils, quality improvement discussions, and information about the Women, Infants and Children's program from Public Health. In addition, the Innovator Agents met with the new director of the Health Services Division to plan strategically about the Innovator Agent role as the agency has reorganized.
Promising practices identified	The monthly meetings allow Innovator Agents to build and sustain relationships with executive leadership across OHA and other state divisions, which in turn facilitates the relationships with CCOs. Innovator Agents are able to share information gained from trainings and collaboratives with CCOs, the CACs and the communities they support to promote health transformation across the state. It is also an opportunity to network and gain knowledge about cutting-edge practices from other participants.
Participating CCOs	16
Participating IAs	100%

Learning collaborative activities

Summary of activities	The Innovator Agents participate in monthly peer-to-peer collaborative learning opportunities that are attended by CCOs and OHA. These collaboratives offer an opportunity to share best practices or gain up-to-date information about health trends within the state and nation. During this quarter, peer-to-peer collaborative topics included behavioral health integration and transgender health.
Promising practices identified	Innovator Agent engagement with learning collaboratives and statewide trainings are a key strategy to ensure that innovations are identified and shared across CCOs. Because Innovator Agents generally support more than one CCO, the broad wealth of information gleaned from a wide array of training helps the Innovator Agents support each CCO's specific needs. In addition, Innovator Agents regularly connect CCOs to share innovative practices and promote innovation.
Participating CCOs	16
Participating IAs	100%

Assisting and supporting CCOs with Transformation Plans

Summary of activities	During this quarter, Innovator Agents continued to support their CCOs' Transformation Plans by reviewing the plans periodically and connecting CCOs to the expertise and resources that help them obtain their transformation plan goals. This was achieved with technical assistance, connections to expertise within OHA, or through information gained through learnings and collaboratives.
Promising practices identified	Transformation across all CCOs continues as each CCO incorporates the ongoing information and insights they have through training and collaboration. During this quarter three CCOs received technical assistance around alternative payment methods, and plans for behavioral health integration technical assistance were developed with most of the CCOs.

Participating CCOs	16
Participating IAs	100%

Assist CCOs with target areas of local focus for improvement

Summary of activities	As health transformation continues, CCOs are continually stretching to address all areas of health. Innovator Agents keep a finger on the pulse of how CCOs can improve their delivery of health services and connect them to the resources. In addition, the Innovator Agents act as a connection between the CCOs and the local community, which facilitates better relationships and integration of health services.
Promising practices identified	Behavioral health integration: All CCOs were given 30 hours of technical assistance around behavioral health integration. The Innovator Agents have assisted CCOs in developing a plan around how they can best use the technical assistance.
Participating CCOs	16
Participating IAs	100%

Communications with OHA

Summary of activities	Innovator Agents meet regularly with leaders across OHA to strategize how to collaborate and stay informed about OHA programs and policies. For example, this quarter Innovator Agents met with a contracted technical assistance provider about behavioral health integration. In addition, the Innovator Agents meet regularly with OHA quality improvement staff and receive updates on metrics and scoring so they can better assist the CCOs in those areas. Additionally, Innovator Agents communicate routinely with Health Systems Division staff on specific issues and concerns. Innovator Agents attend a weekly meeting when possible for update and problem solving around the new eligibility system.
Promising practices identified	Regular and frequent communication with the Health Systems Division staff helps the Innovator Agents support continuous quality improvement efforts within OHA related to Oregon's health system transformation implementation. Innovator Agents have recently moved their monthly meeting place so they can be closer to Health Services Division staff and increase collaboration.
Participating CCOs	16
Participating IAs	100%

Communications among Innovator Agents

Summary of activities	Regular meetings by phone and monthly in-person meetings have provided a critical link between Innovator Agents and have also helped keep them align with the Transformation Center and OHA. Since each Innovator Agent is located within their region and do not (in general) work out of a state office, these regular connections have provided direction and essential support.
Promising practices identified	In addition to their monthly meetings, Innovator Agents huddle once a week and have regularly scheduled phone conferences where they invite other experts within and outside OHA. During this quarter, the Innovator Agents have phone conferenced with the Office of Equity and Inclusion, Office of Rural Health, the Child and Behavioral Health Program and regularly with the Transformation Center.
Participating CCOs	16
Participating IAs	100%

Community advisory council activities

Summary of activities	Innovator Agents continue to provide a key link between community advisory councils and OHA. All Innovator Agents regularly attend CAC meetings and most CAC meetings have time on the agenda for OHA updates from the Innovator Agents. Innovator Agents continue to clarify the CAC's role within health transformation. Recently, CAC member engagement has been at the forefront. Innovator Agents have assisted CACs as they implement initiatives toward this goal.
Promising practices identified	As community advisory councils become more empowered within health care transformation, they are understanding better how to implement and refine their community health improvement plans (CHIPs) and maintain them as a live, working document. Many CACs are also actively working toward becoming more inclusive and diverse and have used technical assistance from the Transformation Center to help them recruit and maintain members. Innovator Agents are central to connecting the partnerships, identifying common data sources and linking with the CCOs' CHIP and CAC.
Participating CCOs	16
Participating IAs	All 7 Innovator Agents attend the CAC meetings associated with their CCO(s).

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	At the direction of their CCO, each Innovator Agent pursues specific issues related to challenges and barriers to health system transformation. Topics raised this quarter ranged from specific operational issues (such as billing codes) to reporting challenges (such as duplicate or unclear reporting requirements) to policy or rule making questions. In this area, the Innovator Agent role functions primarily as the bridge between the CCO perspective and the OHA perspective, and endeavors to facilitate an efficient and effective solution if possible. Innovator Agents have also participated in weekly meetings with other Health System Division staff to help resolve issues as they arise with the new eligibility system.
Promising practices identified	The role of the Innovator Agent to assist with integration of new services and adopting innovations can be an effective tool to increase stakeholder engagement and move toward change. Many communities and Innovator Agents have been working with housing integrators around the issue of safe and affordable housing for members.
Participating CCOs	16
Participating IAs	100%

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	100%

Information sharing with public

Summary of activities	Innovator Agents continue to play an active part in their communities. They serve on numerous boards, attend community meetings and provide ongoing information about health transformation
Promising practices	Communicating with community advisory councils and community health

identified	improvement plan work groups is a good way to more broadly disseminate information to community members about health care transformation.
Participating CCOs	16
Participating IAs	100%

Table 7 - Innovator Agents – Measures of effectiveness

Measure 1: Surveys rating IA performance

Data published for current quarter? Type?	Innovator Agents designed a survey to capture feedback about the original intent of the Innovator Agent program, its successes, challenges and possibilities for the future. The survey was distributed to a wide range of people representing coordinated care organizations, including CCO staff, community organizations and advisory council members. The survey was vetted by Oregon Health Authority leadership, with distribution in October 2015. Results of the survey have been shared with OHA leadership and will be used in future discussions about the role of Innovator Agents and how they can best be used within OHA, CCOs and the communities they represent.
Web link to Innovator Agent quality data	-

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

Data published for current quarter? Type?	Examples of meetings and events attended by Innovator Agents during this quarter: ■ Weekly phone calls with Innovator Agents ■ Weekly phone call with Transformation Center, OHA ■ Monthly in-person meeting ■ Representation at the monthly CCO work group meetings ■ Representation on numerous OHA committees ■ Community forum on housing – Jackson County ■ CCO Contract meeting ■ Seeing Color: Conversations on Race – Jackson and Josephine counties ■ Legacy Health Literacy Conference ■ Governor's Transportation Vision Panel – White City ■ Poverty Forum – Klamath Falls
Web link to Innovator Agent quality data	-

Measure 3: Innovations adopted

Data published for current quarter? Type?	CCOs continue to implement innovative practices including trauma-informed care, telehealth and behavioral health integration.
Web link to Innovator Agent quality data	Learning collaboratives website: http://www.oregon.gov/oha/Transformation-Center/Pages/CCO-Learning-Collaborative.aspx

Measure 4: Progress in adopting innovations[3]

Data published for current quarter? Type?	CCOs have sought technical assistance through the Transformation Center and are taking action to implement the learnings, including evaluating the impact of programs that target social determinant issues, engaging members, integrating behavioral health and designing and implementing alternative payment methods.
Web link to Innovator Agent quality data	Technical assistance projects are described in a separate section of this report.

Measure 5: Progress in making improvement based on innovations[1]

Data published for current quarter? Type?	Incentive payments for 2015 performance were distributed during this quarter, resulting in a heightened focus on 2016 performance targets and improvement. Clinical advisory panels and boards of directors, along with CCO quality improvement staff, are highly engaged in identifying interventions to improve performance.
Web link to Innovator Agent quality data	Oregon's Health System Transformation 2015 CCO Metrics Performance Report is available at: www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx.

Measure 6: CCO Transformation Plan implementation

Data published for current quarter? Type?	As CCOs mature, the Transformation Plans are becoming more integrated into the CCO administration and structure. Increasingly, CCOs are organizing their strategic planning efforts to incorporate the Transformation Plan domains. Innovator Agents are assisting their CCOs in determining their areas of need for technical assistance for this year.
Web link to Innovator Agent quality data	Transformation Plan Reports available online: http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx

Measure 7: Learning collaborative effectiveness

Data published for current quarter? Type?	More stakeholders participated in the Transformation Center's Statewide CCO Learning Collaborative, with an average of 78 attendees at the three sessions in 2016 (compared to an average of 72 participants in 2015, 70 participants in 2014 and 61 participants in 2013). Participant evaluations for Q1 and Q2 2016 indicate a continued high percentage of participants who found sessions valuable or very valuable (88% in Q1 and Q2 2016; 92% in 2015; and 90% in 2014) while close to half of participants planned to take action based on the learning collaborative (41% in Q1 and Q2 2016; 50% in 2015; and 52% in 2014).
Web link to Innovator Agent quality data	-

Measure 8: Performance on Metrics and Scoring Committee metrics

Data published for current quarter? Type?	Innovator Agents work closely with CCOs and providers to support development of strategies toward the new incentive metrics added in 2015 including dental sealants and effective contraceptive use.

[3] This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

Web link to Innovator Agent quality data	Oregon's Health Systems Transformation: CCO Metrics 2015 Performance Report is located here: www.oregon.gov/oha/Metrics/Documents/2015_Performance_Report.pdf

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

H. Legislative activities

The Oregon Health Authority presented its first quarterly report to the Legislature on Oregon's Health System Transformation progress. This report was for January—March 2016.

I. Litigation status

Nothing to report this quarter.

J. Two-percent trend data

See Appendix C.

K. DSHP terms and status

See Appendix D.

IV. Status of Corrective Action Plans (CAPs)

Table 8 – Status of CAPs

Entity (CCO or MCO)	Columbia Pacific CCO
Purpose and type of CAP	To ensure the children's fidelity wraparound requirements are being met
Start date of CAP	3/3/2016
Action sought	Get CCO in line with contract requirements (Exhibit B, part 2, sections m and n
Progress during current quarter	OHA currently monitoring the CCO's CAP and have updates scheduled until CAP is completed
End date of CAP	To be determined
Comments	

V. Evaluation activities and interim findings

In this quarter, OHA published two key reports on Oregon's Health System Transformation: one that examined the Coordinated Care Organization (CCO) metrics, and the other that examined the performance of the Oregon Hospital Transformation Performance Program (HTPP). Oregon Health & Science University Center for Health Systems Effectiveness (CHSE) and Providence Center for Outcomes Research and Education (CORE) are finalizing work on the State Innovation Model (SIM) Grant evaluation, which included a second round of surveys and interviews to assess the adoption of Oregon's coordinated care model among CCOs and other health care organizations. Contracted evaluations of OHA's PCPCH Program, Behavioral Health Home Learning Collaborative (BHHLC), Sustainable Relationships for Community

Health (SRCH) Program, Federally Qualified Health Center Alternative Payment Methodology Program (FQHC, APM), and Transformation Center also continued.

Table 9 - Evaluation activities and interim findings

In the narrative 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:

As part of its evaluation effort, the PCPCH Program is looking in-depth at 20 recognized clinics considered top-performing or exemplary practices. This will help determine which aspects of the PCPCH model are most important to successful practice transformation.

Interim findings:

In this quarter, there were 629 recognized clinics in the state (surpassing Oregon's goal of 500 clinics by 2015). This represents 60% of the estimated number of primary care clinics in Oregon.

PCPCH enrollment is a CCO inventive metric. The statewide baseline (for 2012) for this measure is 51.8%.

- Updated CCO performance metrics (see Appendix E) show that coordinated care organizations continue to increase the proportion of members enrolled in recognized PCPCHs. Enrollment has increased 69 % since 2012.
- 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 the last quarter they have:

- Hosted several in-person learning events. The Oregon Health Care Quality Corporation (Q Corp) has partnered with content experts to host the following events:
    - Focused Acceptance and Commitment Therapy (FACT) Workshop: FACT is a brief, powerful, contextual behavioral intervention approach rooted in the three principles of acceptance, mindfulness, and values based change. Clinicians are being faced with the ever growing pressures of how to optimize client outcomes with as few treatment sessions as possible. FACT is useful for clinicians who work in settings that require brief interventions, such as hospitals, jails, primary care clinics, and some mental health clinics. Members of the Integrated Behavioral Health Alliance of Oregon (IBAHO), a workgroup formed to define the scope and standards of excellent, evidence-based behavioral health provision in the state of Oregon requested this training be hosted through the Institute to ensure it reached a large number of behavioral health providers in Oregon. One hundred and ten participants attended the workshop.
    - Practice Coaching for Primary Care Transformation (PCPCT) Training: Developed by Institute TA Partner CareOregon, PCPCT is a multi-faceted training program designed for leaders at all levels who have a formal or informal coaching role in primary care transformation efforts. The course is an orientation to, and comprehensive review of, the science of change in primary care practice and equips participants with practical tools and coaching skills necessary to engage and support teams as they evolve into high performing

Patient-Centered Medical Homes. Focused on the 10 Building Blocks of High Performing Primary Care, the course explores national best practices implemented in high-performing clinics in areas such as team-based care, prompt access to care and population-based care. Eighteen participants attended the training.

- Hosted nine webinars:
  - Metrics Monday: Developmental Screening, 26 attendees.
  - ACEs & Resilience for Better Health Care, 42 attendees.
  - Institute Resource Orientation, two attendees.
  - Integrating Community Health Workers into our Practice, 61 attendees.
  - Planning Ahead for the Next Reporting Cycle, 42 attendees.
  - Improve Colorectal Cancer Screening Rates and Save Lives, 46 attendees.
  - Technical Assistance Learning Network Forum, 65 attendees.
  - Referral Coordination: Primary Care & Community-Based Resources, 55 attendees.
  - Institute Resource Orientation, four attendees.

- Offered support to communities interested in hosting conversations to identify important multi-organization pathways to achieve goals.
  - Q Corp has partnered with other organizations to convene stakeholders around critical transformation topics, and will continue to do so through contracts or grants. For example, through a contract with Willamette Valley Community Health (WVCH) CCO, Q Corp hosted a Community Connections Café, an event to connect primary care practices with community based resources. Using surveys collected during the event, as well as information gathered through other work with the CCO, Q Corp made a series of recommendations to the CCO on how they could help improve the coordination of care between medical and nonmedical organizations.

- Q Corp is leading the development, testing, and implementation of a Primary Care Extension Program in Oregon with the goal of supporting, expanding, evaluating, and disseminating primary care practice supports and developing sustainable infrastructure for data driven quality improvement in primary care practices.
  - During Quarters 1 and 2 Q Corp engaged with a variety of stakeholders to describe the extension program and get feedback on various aspects of the pilot.

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 quarter, OHA finalized the CCO incentive and state performance measures for CY 2015. Additionally, OHA made its third annual quality pool payments to CCOs in June 2016. Under the coordinated care model, the quality pool was funded based on four percent of CCOs' monthly payments. To earn their full payment for CY 2015, CCOs had to meet the benchmark or improvement target on at least 12 of 17 incentive measures, and have at least 60% of their members enrolled in a PCPCH. Fifteen of the 16 CCOs earned 100 percent of their quality pool. The remaining CCO earned 60%. CCOs were able to earn more than 100 percent of their quality pool once the challenge pool funds were distributed (see Appendix E).

Hospital Transformation Performance Program

In June, OHA made its second quality pool payments to hospitals as part of the Hospital Transformation Performance Program (HTPP). Per the program's establishing legislation, the quality pool was funded with one percent of the hospitals' provider assessment funds. Hospitals were eligible for a $500,000 floor payment if they achieved at least 75% of the measures for which they were eligible; three hospitals achieved the floor payment. Then hospitals were awarded quality pool funds based on the number of measures for which they met benchmarks or improvement targets (see Appendix E).

Also in this quarter, CMS finalized approval of an extension of the Hospital Transformation Performance Program for the third year (October 2015 – September 2016), including final benchmarks for Year 3.

Federally Qualified Health Center Alternative Payment Methodology Program

In March of 2013, OHA launched the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) Program with three FQHCs. Since that time, five additional health centers began in late 2014. The FQHC APM Program provides an Advanced Payment and Care Model by paying 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 incentive measures to hold clinics accountable for the quality of care offered. Each FQHC also submits a Touches Report on a quarterly basis which tallies the total amount of non-billable alternative/enabling services occurring for their OHP patient populations (see interim findings below). These services are called "Engagement Touches" (ETs) and are captured within the FQHC's electronic health record. ET service categories include, but are not limited to:

- Telephone Visits
- Online Portal Communications
- Health Screenings
- Coordinating Transitions in the Care Setting
- Coordinating Clinical Follow-up after Hospitalization
- Assisting Patients with Accessing Community Resources/Services
- Support Group Participation
- Warm Hand-offs
- Transportation Assistance

Certified Community Behavioral Health Clinics

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

Interim findings:

Medicaid Transformation

In June, 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 permance 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, hopsital readmissions, access to primary care for children and adolscents, rates of dental sealants, use of effective contraceptives, blood sugar testing for adults with diabetes, PCPCH enrollment, and increased member satisfaction (see Appendix E).
- Oregon Hospital Tranformation 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, centeral-line bloodstream infection rates, and patient expereinces reproted through the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey (See Appendix E).

CCO Financial Reports

In June, an internal analysis of the most recent financial reports available shows that 35.1% of all plan payments are non-fee-for-service (FFS). This is an decrease of 17.7% from the previous quarter, 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

Phase 1 began with about 200 "Engagement Touches" (ETs) per 1000. Phase 2 surpassed that amount beginning with 274 per 1000. As the program becomes more efficient, and technical assistance for health centers improves, we see that Phase 3 began the program with 425 ETs per 1000 members attributed. Although the Phase 1 cohort's production of ETs seems to have leveled out in Q1 2016 after significant gains throughout 2014 and into 2015, the latter cohorts continue to grow their amount of ETs for their patient populations.

Phase 1 Average ETs per 1000 OHP Members Attributed:

- Q2 2013 (baseline) = 200
- Q2 2015 = 484
- Q3 2015 = 589 (22% increase over the previous quarter)
- Q4 2015 = 629 (7% increase over the previous quarter)
- Q1 2016 = 618 (2% decrease over the previous quarter)
- Q2 2016 = 596 (4% decrease over the previous quarter) – 198% increase over the baseline

Phase 2 Average ETs per 1000 OHP Members Attributed:

- Q3 2014 (baseline) = 274
- Q4 2014 = 261 (5% decrease over the previous quarter)
- Q1 2015 = 249 (5% decrease over the preivous quarter)
- Q2 2015 = 210 (15% decrease over the previous quarter)

- Q3 2015 = 245 (17% increase over the previous quarter)
- Q4 2015 = 320 (31% increase over the previous quarter)
- Q1 2016 = 348 (9% increase over the previous quarter)
- Q2 2016 = 549 (58% increase over the preivous quarter) – 100.4% increase over the baseline

Phase 3 Average ETs per 1000 OHP Members Attributed:

- Q3 2015 (baseline) = 425
- Q4 2015 = 473 (11% increase over the previous quarter)
- Q1 2016 = 445 (6% decrease over the previous quarter) – 5% increase over the baseline

Other evaluations occurring for the FQHC APM program include monitoring clinical quality measures, estimating the value of ETs, 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. Oregon has contracted with actuarial consulting firm Optumas, who has released 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

Each quarter, the Oregon Primary Care Association (OPCA) hosts an Advanced Payment & Care Model (APCM) Learning Collaborative. These events focus 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 has commissioned Optumas to produce another report on Phase 1, 2, and 3 FQHCs on the program, and include a Total Cost of Care measurement.

Transformation Center

During this quarter, the Transformation Center awarded grants to two health care payers to advance an alternative payment method for integrated care. Additionally, 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. CEbP is assisting Cascade Health Alliance to create an APM development process to apply across all provider types, and expand current value-based purchasing (VBP) models from primary care to hospitals and specialist providers.

OHA has contracted with Bailit Health Purchasing to provide technical assistance for developing APMs to two CCOs. Bailit Health has also assisted Intercommunity Health Network CCOs to develop an options analysis and recommendations for CCO primary care payment risk-adjustment, and primary care payment models that involve downside risk.

PacificSource Community Solutions – Columbia Gorge is receiving assistance from the National Council on Behavioral Health and Dale Jarvis and Associates to develop a fair value of behavioral health services for sub-capitated Community Mental Health Programs providers, and develop an APM for providers outside of the sub-capitated arrangement. PacificSource Community Solutions – Central Oregon and Columbia Gorge is also preparing to implement a behavioral health integration (BHI) alternative payment methodology across provider networks (Medicaid, commercial and Medicare) starting in at least two practices in 2017 by 1) assessing verifying current levels of clinical integration among select provider partners and 2) developing a cost data set that reflects a close approximation of true costs along the entire spectrum of activities associated

with level of fidelity to BHI practice. The National Council on Behavioral Health is also assisting Jackson Care Connect to develop a reasonable payment methodology for former delegated MCO mental health provider.

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.

The Primary Care Payment Reform Collaborative has met three times, once per month between April and June, 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. Over the course of the three meetings the group has discussed payment methodology, structure, measurement, data aggregation, technical assistance, and behavioral health integration. In addition to playing an integral role in the implementation of Oregon as a CPC+ region, the collaborative will work to incorporate all payers, pediatrics, behavioral health, FQHCs, and RHCs.

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 quarter, Oregon Health & Science University's Oregon Rural Practice-based Research Network (ORPRN) submitted a draft of its evaluation of the first two years of the learning collaborative, including both qualitative and quantitative data. The report is currently undergoing OHA internal review. ORPRN continues to collect qualitative data and are working with the participating sites to develop their capacity to collect data on the Adult Core Measures that will be incorporated in an update to the evaluation at the end of the grant period.

Also in this quarter, ORPRN developed instruments to assist the sites in developing their capacity to collect and use data to improve population health management, focusing in particular on three of the Adult Core Measures (Body Mass Index (BMI), hypertension, diabetes). In addition, ORPRN has worked with OHA to develop a template for the sites to create registries of their Medicaid clients receiving integrated care. Once the secure process for submittal is in place, the sites will begin submitting their client lists, allowing OHA to pull claims reports for each site on the Adult Core Measures.

Interim findings:

Oregon's Coordinated Care Organizations

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. The narrative below compares performance on these measures between CY 2014 and CY 2015 the most recent reporting period.

- 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%. Among CCOs in CY 2015, SBIRT ranged from 3.3% to 23.7%. The CY 2014 measure was rebased to include adolescents ages 12 to 17; however, they weren't officially part of the measure until CY 2015.
- 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%. The measure ranged from 60.0% to 90% among CCOs in CY 2015. Beginning in the CY 2015 reporting period, the measure included follow-up services occurring on the same day of discharge.
- 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 90%. The measure ranged from 40.3% to 76.7% among CCOs in CY 2015. Beginning in the CY 2015 reporting period, the measure included dental assessments.
- 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. The measure ranged from 0.5% to 62.8% across CCOs in CY 2015, with some of the variation likely due to challenges capturing data from electronic health records.
- 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%. In CY 2015 the measure ranged from 54.7% to 77.3% across CCOs for initiation phase, and 53.5% to 100% across CCOs in the continuation and maintenance phase. 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:

The Behavioral Health Home Learning Collaborative (BHHLC) assists organizations with integrating primary care into behavioral health settings. Under a no-cost extension, the BHHLC will continue through December 2016.

In this quarter, Oregon Health & Science University's Oregon Rural Practice-based Research Network (ORPRN) completed a draft evaluation of the first two years of the learning collaborative that OHA is currently reviewing. ORPRN continued to provide ongoing practice coaching to 10 participating sites, focusing in particular on helping them develop the capacity to collect and use data to improve population health management. This has included working with OHA staff to develop a template for the site registries of their Medicaid clients receiving integrated care and helping the sites understand how they can collate that information from their EHRs or chart reviews as necessary. ORPRN also 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. These data will be incorporated into the final updated evaluation of the Learning Collaborative at the end of the grant period. In addition to structured opportunities for sites to share their current activities with their colleagues and request assistance with specific challenges, 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.

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 quarter, OHA continued contract negotiation for the summative evaluation with CHES. 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: It 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 of Coordinated Care in Oregon

In this quarter, CORE completed a second round of surveys and interviews to assess spread of the coordinated care model among CCOs, commercial health plans, hospitals, and other provider organizations. The surveys assess the extent of transformation in 11 domains identified by OHA, CORE, and CHSE:

- Cross-sector partnerships
- Community involvement in governance
- Integrated and shared health care data
- Using data for population health management
- Integrated physical, behavioral, and dental care
- Better coordination (right care in the right place)
- Prevention and social-determinants-of-health-informed care
- Workforce transformation and diversification
- Ownership of risk
- Integrated risk
- Aligning incentives and value

CORE administered surveys to 103 organizations, including 12 CCOs, that participated in the first round of surveys and interviews conducted February – April 2015.

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:

- What kinds of factors motivated organizations to adopt specific elements of the coordinated care model? Factors may include direction from governing bodies, pressure from community organizations and other external stakeholders, competition in one or more market segments, and transformation in other states.
- What kinds of mechanisms did organizations use to implement specific elements of the coordinated care model? Mechanisms may include outreach and education, financial incentives, or mandates for staff and contractors; investment in new staff, systems, or technologies; or other mechanisms.

Findings from spillover analysis will be included in the State Innovation Model (SIM) Grant evaluation report from CHSE and CORE to be delivered September 2016.

Tracking "Spillover" from Medicaid's Coordinated Care Model

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 if clinics that are working to improve care management and coordination for Medicaid patients also adopt these improvements for other patients. In this quarter, CHSE analyzed the association between the percentage of a clinic's patients that are covered by Medicaid and the clinic's score on a variety of health care quality measures, and the association between changes in quality for Medicaid and non-Medicaid patients over time. Findings from spillover analysis will be included in the SIM Grant evaluation report from CHSE and CORE to be delivered September 2016.

Sustainable Relationships for Community Health Program

In this quarter, Sustainable Relationships for Community Health (SRCH) 2015 grantees (Deschutes, Clackamas, and Lane counties and AllCare and Intercommunity Health Network (IHN) CCOs) continued work on implementing sustainable self-management program referral and payment systems. They received technical assistance from OHA Public Health Division staff to assist collection and reporting of project data elements, and finalization of agreements (see evaluation results below).

Interim findings:

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 younger 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 37.5% in CY 2015.

Potentially Avoidable hospital 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.

Sustainable Relationships for Community Health Program Evaluation

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 the following findings and recommendations. Findings included:

1. The dedicated time and space to co-create approaches to address chronic conditions was the most valuable part of the SRCH process.
2. The project management and improvement tools helped the five consortium teams set goals, organize tasks and stay focused; however, some tools were confusing and duplicative.
3. A thorough orientation with grantees is needed prior to the institutes to ensure roles, goals and expectations are clear and that the right decision makers are involved in SRCH.
4. OHA program staff were critical to progressing the grantees' CDSMP and DPP work.
5. External technical expertise helps teams to ideate, formulate and implement their plans.

6. Five months was insufficient to conduct the SRCH work. Several grantees communicated that they had just begun their work after the conclusion of the third and final SRCH institute. Each consortium indicated that it had more work to do before its new system was sustainable.

Recommendations included:

1. Continue to provide dedicated time and space for teams to work collaboratively away from daily distractions.
2. 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.
3. Meet at least once with each grantee consortium prior to the first face-to-face institute to ensure each team is starting with an appropriate level of understanding regarding goals and expectations.
4. Continue to have OHA program staff assigned to each grantee to help with maintaining direction and momentum between institutes.
5. Bring in more external technical experts with applicable experiences to help teams ideate, formulate and implement their plans.
6. Extend the SRCH timeframe to allow grantees to co-create and pilot sustainable referral and financing systems.

Improvement activities:

Sustainable Relationships for Community Health (SRCH) Program

In this quarter, five grants were awarded to local consortia consisting of coordinated care organizations (CCOs), local public health authorities and chronic disease self-management delivery organizations. Lead agencies are Clackamas, Lane, Klamath, and Columbia counties and IHN CCO. All grantees developed plans and identified quality improvement initiatives focusing on tobacco cessation referrals. Future initiatives will focus on referrals of patients with prediabetes or at high risk to the Diabetes Prevention Program (Lane and Clackamas), referral of patients with diabetes and/or hypertension to the Stanford Chronic Disease Self-Management Program (Columbia and Klamath), and referral of patients aged 50+ to colorectal cancer screening (IHN/Lincoln). Grantees will create joint agreements and coordinate key performance indicators to implement the work moving forward. These efforts are funded by the Centers for Disease Control and Prevention and Tobacco Master Settlement Agreement funds and align with Oregon's CCO incentive measures and statewide performance improvement project.

Summary of Health Information Technology (HIT) initiatives

OHA's Office of Health Information Technology (OHIT) continues to make progress on state HIT initiatives and ensure OHA's efforts align with and support CCO needs through various activities that include stakeholder support and programmatic activities. Major HIT activities in April – June 2016 include:

- Bringing real-time hospital event notifications to CCOs and care teams.
- Engaging CCOs in the development of technical assistance for Medicaid practices related to their EHRs and meaningful use.
- Implementing telehealth pilots in five communities.

OHA recently increased adoption of PreManage, a tool that brings real-time hospital notifications to CCOs and care coordinators. OHA is pleased to be a co-sponsor of this effort and is responsible for coordinating CCO use of the tool. All 59 Oregon hospitals contribute admit, discharge, and transfer (ADT) data (both emergency department and inpatient data) to the Emergency Department Information Exchange (EDIE), which serves as the data infrastructure for PreManage. CCOs, health plans, and providers can subscribe to PreManage to access the hospital event data and better manage their populations who are high utilizers of hospital services. Currently, several commercial health plans and eleven of the CCOs are using (or in process

of launching) a PreManage subscription, and nearly 100 clinics in Oregon are subscribers. OHA recently signed a contract with the PreManage vendor for a statewide subscription to the tool that will cover the Medicaid population. This will support basic subscription access for CCO care coordinators, long-term care discharge planners, the contractor for the FFS population, and assertive community treatment teams. The EDIE Utility Governing Committee (of which OHA is a member) is considering ways to assess the impact of these tools and report on progress.

OHIT convenes the Health Information Technology Advisory Group (HITAG) comprised of CCO representatives to guide HIT activities that support CCOs. OHIT held a HITAG meeting in May 2016. In addition, OHIT convenes the Health Information Technology Oversight Council (HITOC) that is tasked with setting goals and developing a strategic HIT plan for the state, overseeing implementation of the HIT plan, and monitoring progress with HIT goals. OHIT held a HITOC meeting in June 2016.

In December 2015, OHA executed a contract with OCHIN to provide technical assistance to CCO priority practices to meaningfully use their Electronic Health Records (EHRs). Work is currently ongoing with practices to develop plans for the delivery of technical assistance services. The technical assistance helps providers capture Clinical Quality Measures (CQM) data in a format that can be submitted electronically to OHA and better position CCOs to meet electronic health record adoption benchmarks.

In 2015, 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. A primary goal of the grant is to overcome barriers to information sharing and care coordination across care settings and integrate behavioral and physical health data for more robust health information exchange. Five CCOs are participating, which will allow them to access their patients' information from providers, including data on behavioral health, controlled substance prescriptions, hospital event notifications, ambulatory care, and notifications on significant life events.

OHIT is coordinating 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. The intent is to bring together stakeholders in an advisory group that works with OHIT staff to develop criteria for participation in the HOP. This program will help with onboarding of providers to Health Information Exchanges in order to assist in the meeting of Meaningful Use Electronic Health Record Incentive Program measures. These activities will also support the work of the Coordinated Health Partnerships as described in the waiver.

CCO metrics "dashboards"

OHA continues 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. (see Appendix E).

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

Evaluation activities:

The revised evaluation plan delivered by OHA's prospective contractor for the waiver summative evaluation includes a proposal to evaluate the impact of flexible services on health care spending and other key outcomes. As a first step, OHA will meet with the contractor's evaluation team to inform the contractor about data available on flexible services. The contractor will then formulate a more detailed proposal for

evaluating flexible services, which may include qualitative analysis of member experience with flexible services, quantitative analysis of data from select CCOs as available, and other methods.

Interim findings:

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 (see Lever 5, Evaluation Activities, above). In addition, the contractor will provide recommendations for evaluating flexible services following the end of the 2012 – 2017 demonstration period.

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

Evaluation activities:

The Transformation Center's evaluation plan is aligned with new strategic plan initiatives for 2016. The center continues to work in collaboration with OHSU to implement this evaluation plan. Most of the center's new strategic plan initiatives, including targeted technical assistance for selected CCO incentive metrics, behavioral health integration consultations with CCOs, and grants to support community health improvement plan implementation, launched in the first and second quarters of 2016. Initial data on key activities will be available in early 2017.

Findings from the Transformation Center's ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives are below.

Interim findings/ Improvement activities:

In this quarter, the Transformation Center continued work on its external learning collaboratives. From April through June 2016, the CCO learning collaborative met once. The session focused on low back pain and 74 people attended. Of evaluation respondents, 80% found the session valuable or very valuable to their work and 80% said the session was effective for meeting the needs of their CCO or organization. Respondents identified the most helpful aspects of the session as learning which low back guidelines were not understood by CCOs and discussing implementation barriers.

In May, the 2015-2016 Clinical Innovation Fellows 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. 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.

Additionally, the Transformation Center has provided:

- Targeted metrics technical assistance, including:
    - Colorectal Cancer Screening – Four webinars, with an average of 27 participants from 15 CCOs; 90% of evaluation respondents rated the sessions as very valuable or valuable and 76% of respondents planned to take action based on session content. Ten CCOs also participated in individual follow-up consultations.
    - Adolescent Well-Care Visits – Four webinars, with an average of nine participants from 13 CCOs; all evaluation respondents rated the sessions as very valuable or valuable and effective in meeting their needs.
    - Childhood Immunizations – A pilot root cause analysis with one CCO, with the requestor evaluating the activity as very valuable and effective for meeting the CCO's needs.

- Support through the Technical Assistance Bank, including:
  - In year two (October-June), the Transformation center fulfilled 22 TA Bank requests from CCOs for a total of 402 technical assistance hours.
  - TA Bank evaluation results for thirteen 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.

VI. Public forums

Public comments received

Medicaid Advisory Committee

Lynn Knox, Health Care Partnerships Coordinator, Oregon Food Bank;

Lynn Knox, Health Partnerships Coordinator for Oregon Food Bank testified with regard to the 1115 Waiver Renewal. Written comments were submitted to OHA. The Oregon Food Bank encouraged OHA to pay special attention to food insecurity issues in the waiver, including as part of the flexible services policy. Ms. Knox addressed food insecurity as a social determinant and encouraged the state to incorporate these programs into the CCO global budgets as flexible services and/or community benefit funding.

- Screening for food insecurity
- Data
- Diabetes education and prevention
- On-site nutrition & gardening resources

Ms. Knox also suggested that food banks and other food insecurity resources be partners in the Community Health partnerships project that is part of the 1115 Waiver Renewal.

Lesa Dixon Gray of the Oregon Public Health Division

Comment by webinar: “What about stronger partnerships between CCO's and the rental housing community, not just low income federal housing, but with the Rental Associations. There seems to be a large divide between landlords and renters, and the renters aren't always the ones at fault. At the higher systems level, it might be beneficial for CCOs or the health care community to maintain those relationships with Rental Associations, instead of leaving that coaching to individuals to work better with their landlords.”

Oregon Health Policy Board

No report this quarter.

VII. Transition Plan, related to implementation of the Affordable Care Act

No updates to the Transition Plan.

VIII. Appendices

Appendix A. Quarterly enrollment reports

1. SEDS reports

Attached separately.

2. State reported enrollment tables

Enrollment	April 2016	May 2016	June 2016
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,076,784	1,061,013	1,048,000
Title XXI funded State Plan	61,028	61,609	61,321
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	NA	NA	NA
Title XXI funded Expansion Populations 16, 20	NA	NA	NA
DSH Funded Expansion	NA	NA	NA
Other Expansion	NA	NA	NA
Pharmacy Only	NA	NA	NA
Family Planning Only	NA	NA	NA

Enrollment current as of	April 30, 2016	May 31, 2016	June 30, 2016

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Expansion	**Title 19**	PLM Children FPL > 170%	65	181	-13.85%	-1220.00%
		Pregnant Women FPL > 170%	23	61	-21.74%	-2895.65%
	Title 21	SCHIP FPL > 170	35143	84,170	39.96%	45.16%
Optional	**Title 19**	PLM Women FPL 133-170%	526	1,396	-28.90%	-2470.72%
	Title 21	SCHIP FPL < 170%	72,775	185,518	2.84%	19.33%
Mandatory	**Title 19**	Other OHP Plus	166262	468,935	-1.28%	-66.61%
		MAGI Adults/Children	857,599	2,353,161	2.63%	5.17%
		MAGI Pregnant Women	20,984	51,400	4.39%	30.91%
		QUARTER TOTALS	1,153,377			

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

OHP eligibles and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
July	1,059,042	906,030	1,176	55,579	4,155	3,013	35,590
August	1,045,896	899,119	1,128	52,872	4,072	1,139	36,416
September	1,034,640	892,255	1,132	52,219	4,111	1,013	37,174
Qtr Average	1,046,526	899,135	1,145	53,557	4,113	1,013	37,174
		85.92%	0.11%	5.12%	0.39%	0.10%	3.55%

**Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/ Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.*
***CCOA: Physical, Dental and Mental Health; CCOB: Physical and Mental Health; CCOE: Mental Health only; CCOG: Mental and Dental*

Appendix B. Neutrality reports

1. Budget monitoring spreadsheet

Attached separately.

2. CHIP allotment neutrality monitoring spreadsheet

Attached separately.

Appendix C. Two-percent trend reduction tracking

Attached separately.

Appendix D. DSHP tracking

Attached separately.

Appendix E. Oregon Measures Matrix

Attached separately. In this reporting period, OHA finalized the CCO incentive and state performance measures for CY 2015 and paid out the third CCO quality pool, and finalized Year 2 measures and paid out the second hospital quality pool for the Hospital Transformation Performance Program (HTPP). OHA also finalized details of a Year 3 extension to HTPP with CMS.

This quarterly report includes final 2015 performance at both state and CCO levels for the incentive and state performance measures, performance by race and ethnicity, performance for members with disability and mental health diagnoses, and the results of the third CCO quality pool distribution.

This report includes final Year 2 performance from the second annual report at both state and hospital levels for the HTPP measures, and the results of the second hospital quality pool distribution.

CCO incentive metrics

CCO reporting and validation

During this reporting period, OHA provided final CY 2015 metrics to CCOs utilizing the automated metrics reporting tool ("dashboard"). All claims-based incentive measures were provided in the dashboard format, and OHA made supplemental files available for the non-claims based measures.

CCOs were given the month of May to complete any validation activities prior to finalizing the CY 2015 results and payment of the 2015 CCO quality pool. OHA received approximately 75 questions or validation requests from CCOs during this period, slightly down from May 2014's validation period.

Public reporting

On June 23, 2016, OHA published a public report comparing calendar year 2015 performance on the CCO incentive, state performance, and core performance measures with 2014, 2013, and 2011 baseline performance. The report is available online at: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx This report is the first to provide more detailed demographic information about Oregon Health Plan members at the CCO level, and to provide overall summaries of performance across multiple measures in an "at-a-glance" display. This is the second report to also show a subset of measures reported for Oregon Health Plan members with disability, and with severe and persistent mental illness (SPMI) or broader mental health conditions.

This report continues to indicate that through the coordinated care model, there have been continued improvements in a number of areas, including:

- 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.
- 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 have 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 Medicaid members in 2014.
- Increased blood sugar testing for adults with diabetes: the percent of adults with diabetes who received at least one blood sugar test during the year has increased 6 percent since 2011.
- Patient-centered primary care home enrollment continues to increase: coordinated care organizations continue to increase the proportion of members enrolled in recognized patient-centered primary care homes. PCPCH enrollment has increased 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.

2015 Quality Pool

OHA made its third annual quality pool payments to CCOs in June 2016 (see table E1 below). Under the coordinated care model, the quality pool was funded based on four percent of CCOs' monthly payments. To earn their full payment for CY 2015, CCOs had to meet the benchmark or improvement target on at least 12 of 17 incentive measures (including EHR adoption), and have at least 60 percent of their members enrolled in a patient-centered primary care home.

Money left over from the quality pool formed the challenge pool. To earn challenge pool funds, CCOs had to meet the benchmark or improvement target on a subset of four measures: depression screening and follow up plan, diabetes HbA1c poor control, SBIRT, and PCPCH enrollment.

In summary: 15 of the 16 CCOs earned 100 percent of their quality pool. The remaining CCO earned 60 percent. CCOs were able to earn more than 100 percent of their quality pool once the challenge pool funds were distributed; the table below shows distribution with and without the challenge pool.

Table E1: 2015 Quality Pool Distribution by CCO

Coordinated Care Organization	Number of measures met (of 17)	Percent of quality pool funds earned		Total dollar amount earned
		Without challenge pool	+ challenge pool funds	
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 of Oregon	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 Oregon	14.9	100%	100.7%	$10,192,492
PacificSource - Gorge	16.9	100%	100.7%	$2,491,148
PrimaryHealth of Josephine County	15.0	100%	100.8%	$2,088454
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

Year Three Clinical Quality Measures

During this reporting period, all 16 CCOs successfully submitted their year three data for the Clinical Quality Measures (depression screening, diabetes HbA1c poor control, and hypertension control). The year three data were used to calculate the statewide and CCO level rates, which were published in the 2015 final report (see above).

OHA continued planning for procurement of a clinical quality metrics registry (CQMR) solution, which will collect, aggregate, display and export clinical quality measure data. A notice of the upcoming procurement was posted online.

Measure Validation Updates

OHA has contracted with the Oregon Health Care Quality Corporation (Q Corp) to independently calculate and conduct a multi-directional validation process on the 33 quality and access test measures. This has been an ongoing process, with Q Corp calculating and validating the 2011 baseline, calendar years 2013 and 2014, the "dry run" period (July 2012 – June 2013), and the first and second years of the test (DY 2 and 3).

The status of validation of the 22 measures that are computed using administrative claims data is shown below for each measurement period. As of 6/30/16, no CY 2015 measures had been validated pending issues with substance use claims and member months.

Time Period	Baseline	Dry Run	CY 2013	Year 1 Test	CY 2014	Year 2 Test	CY 2015
Measures Signed Off (as of 9/30/15)	22	22	22	22	21	TBD	-
Measures Signed Off (as of 12/31/15)	22	22	22	22	22	13	-
Measures Signed Off (as of 3/31/16)	22	22	22	22	22	21*	-
Measures Signed Off (as of 6/30/16)	22	22	22	22	22	22	-
Total Measures	22	22	22	22	22	22	22

**OHA specifications for Plan All-Cause Readmission (NQF 1768) did not conform to HEDIS 2015. OHA agreed to update specifications for the CY 2015 measurement period, but elected not to rerun and validate for the Year 2 Test Period.*

Hospital incentive metrics

Implementation of the Hospital Transformation Performance Program (HTPP), Oregon's hospital incentive measure program, continued in this quarter with the publication of the Year 2 report and second distribution of quality pool payments to hospitals.

Public reporting

In the second year of HTPP (for the measurement period October 2014 – September 2015), hospitals earned quality pool payments for meeting benchmarks or improvement targets.

On June 9, 2016, OHA published a public report of hospital performance on the 11 HTPP measures. These measures indicate how well hospitals are advancing health system transformation by improving quality of care, improving patient safety, and coordinating with CCOs. The report provides data for the second year of the program, October 2014 – September 2015, compared to the baseline year (October 2013 – September 2014). Key findings include:

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.

The report is available online at: http://www.oregon.gov/oha/Metrics/Documents/HTPP_Year_2_Report.pdf

Year 2 Quality Pool Distribution

OHA made its second quality pool payments to hospitals in June 2016 (see table E2 below). As per the program's establishing legislation, the quality pool was funded with one percent of the federal match on hospitals' provider assessment funds. Hospitals were eligible for a $500,000 floor payment if they achieved at least 75 percent of the measures for which they were eligible; three hospitals achieved the floor payment. Then hospitals were awarded quality pool funds based on the number of measures for which they met benchmarks or improvement targets.

Table E2: Year 2 Quality Pool Distribution by Hospital

Hospital	Number of Measures Met[4]	Floor Payment Earned	Total Dollar Amount Earned
Adventist	10	$500,000	$22,348,818
Asante Rogue Regional	6	$0	$3,182,101
Asante Three Rivers	8	$0	$3,558,612
Bay Area Hospital	7	$0	$1,644,740
Good Samaritan Regional	9	$500,000	$9,245,218
Kaiser Sunnyside	5	$0	$582,691
Kaiser Westside	8	$0	$166,111
Legacy Emanuel	7	$0	$10,849,549
Legacy Good Samaritan	8	$0	$3,042,635
Legacy Meridian Park	8	$0	$1,327,708
Legacy Mount Hood	7	$0	$1,953,871
McKenzie-Willamette	7	$0	$3,507,095
Mercy	7	$0	$2,159,594
OHSU Hospital	8	$0	$18,631,079
PeaceHealth Sacred Heart – RiverBend	6	$0	$10,598,245
PeaceHealth Sacred Heart – University	7	$0	$2,728,082
Providence Medford	7	$0	$1,635,377
Providence Milwaukie	6	$0	$869,925
Providence Portland	7	$0	$12,636,697
Providence St. Vincent	7	$0	$6,665,237
Providence Willamette Falls	8	$0	$5,207,162
Salem Hospital	7	$0	$6,373,034
Samaritan Albany General Hospital	7	$0	$1,959,740
Shriners Hospital for Children	8	$500,000	$1,917,536
Sky Lakes	7	$0	$7,464,029
St. Charles Bend	7	$0	$5,836,486
Tuality Healthcare	8	$0	$2,149,195
Willamette Valley	8	$0	$1,759,434

[4] Of 11 measures possible, with the exception of Shriners Hospital for Children, which is only eligible for 8 measures.

Discussions with CMS Regarding Year 3 of HTPP

During this reporting period, CMS finalized approval of an extension of the Hospital Transformation Performance Program for the third year (October 2015 – September 2016), including final benchmarks for Year 3. Benchmarks and additional Year 3 guidance is posted online at http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx.

HTPP evaluation

In this reporting period, OHA's contractor, Oregon Health & Science University's Center for Health Systems Effectiveness (OHSU, CHSE) completed its independent evaluation of the first two years of the Hospital Transformation Performance Program. The evaluation report was submitted to CMS in late June 2016. The evaluation estimated the impact of the HTPP on hospital performance, quality improvement activities, and collaboration with CCOs. Key findings include:

- All CCO representatives reported that HTPP has increased collaboration between hospitals and CCOs, and nearly all hospitals reported that HTPP has helped their quality improvement efforts and programs.
- One third of hospitals said they increased collaboration with local CCOs to improve performance on targeted measures. Those hospitals that increased collaboration experienced statistically significant improvements in the following activities:
    - +30.5% overall increase in outreach notification to primary care for emergency department use.
    - +14% overall increase in alcohol and substance use screening in the emergency department;
    - -0.2% overall reduction in adverse drug events due to opioids.

Committee and workgroup updates

The **CCO Metrics & Scoring Committee** met three times during this period.

- In April, the Committee focused on measuring equity and ways to incentivize CCOs to reduce disparities.
- In May, the Committee considered the results of the stakeholder survey with feedback on the current incentive measures, and suggested future incentive measures.
- In June, the Committee began their selection of the 2017 incentive measures.

Meeting materials are available online at www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx.

The **CCO Metrics Technical Advisory Workgroup (CCO TAG)** met three times this quarter. Meetings included continued discussion and specification development on health equity and food insecurity screening, as well as technical modifications to the effective contraceptive use and SBIRT measures. Meeting materials are available online at: www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx

The **Hospital Performance Metrics Advisory Committee** met twice during this reporting period.

- In April, the Committee heard presentations on potential topics for future years of the program: measures for maternal and child health, and opioid prescribing in the emergency department.
- In May, the Committee heard additional presentations and continued their discussion on a measure of screening and referral to home visiting programs, and opioid prescribing in the emergency department.

Meeting materials are available online here: www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx.

The **Hospital Metrics Technical Advisory Workgroup (Hospital TAG)** met three times in this reporting period. Meetings focused on validating and finalizing Year 2 data, and measure development for opioid prescribing, EDIE, and screening and referral to home visiting programs.

Meeting materials are available online here: www.oregon.gov/oha/analytics/Pages/Hospital-Metrics-Technical-Advisory-Group.aspx

Core Performance Measures

Core Performance Measures are reported at the state level, by race/ethnicity, and by CCO where possible in the final CY 2015 report, available online at: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx. See page 8 of the report PDF for an appendix specific to the core performance measures.

HTPP Measures Matrix

This matrix is available in the Measures and Benchmarks Table online at: http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx.

HTPP Year 2 Performance

Attached separately. This quarterly report includes the data from the second annual report for the period covering October 2013 – September 2015 (Year 2 of HTPP). The Year 2 report, published in June 2016, is available here: http://www.oregon.gov/oha/Metrics/Documents/HTPP_Year_2_Report.pdf.

Appendix F: Uncompensated Care Program

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