Oregon Health Plan

Section 1115 Quarterly Report

7/1/2016 – 9/30/2016
Demonstration Year (DY): 15 (7/1/2016 – 6/30/2017)
Demonstration Quarter (DQ): 1/2017
Federal Fiscal Quarter (FQ): 4/2016

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I. Introduction

A. Letter from the State Medicaid Director

From July through September 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 639 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 74% since 2012.
- **Lever 2: Implementing alternative payment methodologies (APMs)** – During this quarter, OHA conducted an internal analysis of the most recent CCO financial reports. The analysis shows that 40.5% of all plan payments are non-fee-for-service (FFS). This is an increase of from the previous quarter, in which 35.1% of plan payments were non-FFS. A new reporting template will allow more accurate reporting of this information for 2017.
- **Lever 3: Integrating physical, behavioral and oral health care** – Five of the CCO incentive measures relate to physical and behavioral health care integration:
    - Alcohol or Other Substance Misuse (SBIRT) increased from 6.3% in CY 2014 to 16.3% in 2015-2016 mid-year. The measure was above the 2016 benchmark target of 12%.
    - Follow-Up After Hospitalization for Mental Illness increased from 71.8% in CY 2014 to 76.0% in the 2015-2016 mid-year.
    - Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody has increased from 27.9% in CY 2014 to 67.5% in the 2015-2016 mid-year.
    - Screening for Clinical Depression and Follow-Up Plan increased from 27.9% in CY 2014 to 37.4% in CY 2015, and was above the target of 25.0% for CY2015.
    - Follow-Up Care for Children Initially Prescribed ADHD Medications increased from 52.3% in 2011 to 63.6% in the 2015-2016 mid-year for the initiation phase, which exceeds the CY 2016 benchmark target of 51%.
- **Lever 4: Increased efficiency in providing care** – The following measures of efficient and effective care improved in the 2015-2016 mid-year (see Appendix E for details):
    - Emergency department visits per 1,000 member months decreased by 3.6 % (from 47.3 per 1,000 member months in CY 2014 to 45.6 per 1,000 member months in 2015-2016 mid-year).
    - Developmental Screening in the First 36 Months of Life increased from 42.6% in CY 2014 to 58.9% in the 2015-2016 mid-year, exceeding the CY 2016 benchmark of 50.0%.
- **Lever 5: Implementation of health-related flexible services:** OHA met with the contracted waiver evaluation team, Oregon Health & Sciences University (OHSU) Center for Health Systems Effectiveness (CHSE) to inform them about data available on flexible services. OHSU CHSE will then formulate a more detailed proposal for evaluating flexible services, which may include qualitative analysis of member experience, quantitative analysis of CCO data, and other methods.
- **Lever 6: Innovations through the Transformation Center** - This quarter, an average of 84% of respondents found the Center's CCO learning collaborative sessions valuable or very valuable to their work and 78% said the sessions were 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.*, 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 in 2013 a loan repayment program for primary care physical, oral and behavioral health providers who agree to work in clinics that see a high percentage of Medicaid patients. To date, more than 50 providers have been provided loan repayment under this program. Oregon also agreed to complete training for 300 community health workers by 2015, and this was accomplished. As mandated by House Bill 3396 (2015 Regular Session), The Oregon Health Policy Board, through its Workforce Committee conducted 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. A report to the legislature was provided in November 2016. The OHA is continuing to implement the Legislature's statutory changes around incentives for health care professionals.

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 program will offer hospitals incentive payments to support quality improvement.

C. State contacts

Demonstration and Quarterly Reports

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

State Plan

Jesse Anderson, State Plan Manager
503-945-6958 phone
503-947-1119 fax

Coordinated Care Organizations

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

Quality Assurance and Improvement

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

For mail delivery, use the following address

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

II. Title

Oregon Health Plan Section 1115 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.	107
b) Plan unresponsive, not available or difficult to contact for appointment or information.	29
c) Provider's office too far away, not convenient	21
d) Unable to schedule appointment in a timely manner.	119
e) Providers office closed to new patients	21
f) Referral or 2nd opinion denied/refused by provider.	65
g) Referral or 2nd opinion denied/refused by plan	47
h) Unable to be seen in a timely manner for urgent/ emergent care	13
i) Provider not available to give necessary care	32
j) Eligibility issues	42
k) Female or male provider preferred, but not available	22
l) NEMT not provided, late pick up resulting in missed appointment, problems with coordination of transportation services	1249
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	11
INTERACTION WITH PROVIDER OR PLAN	
a) Provider rude or inappropriate comments or behavior	158
b) Plan rude or inappropriate comments or behavior	307
c) Provider explanation/instruction inadequate/incomplete	48
d) Plan explanation/instruction inadequate/incomplete	248
e) Wait too long in office before receiving care	113
f) Member not treated with respect and due consideration for his/her dignity & privacy	11
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available	24
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	3
i) Lack of coordination among providers	6
j) Wants to change providers; provider not a good fit	3
k) Member has difficulty understanding provider due to language or cultural barriers	61
l) Client dismissed by provider (member misbehavior, missed appointments, etc.)	17
m) Client dismissed by clinic (member misbehavior, missed appointments, etc.)	18
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)	1
b) Concern over confidentiality	25
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.	172
d) No choice of clinician, or clinician of choice not available.	24

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.)	6
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health marital status, Medicaid/Medicare)	25
g) Complaint/appeal process not explained, lack of adequate or understandable NOA	4
h) Not informed of consumer rights	0
i) Denied member access to medical records (other than as restricted)	1
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)	3
k) Advanced or Mental Health Directive not discussed or offered or followed	0
l) Restraint or seclusion used other than to assure member's immediate safety	1
QUALITY OF CARE	
a) Received appropriate care, but experienced adverse outcome, complications, misdiagnosis or concern related to provider care.	154
b) Testing/assessment insufficient, inadequate or omitted	27
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.	116
d) Member neglect or physical, mental, or psychological abuse	11
e) Provider office unsafe/unsanitary environment or equipment	33
f) Lack of appropriate individualized setting in treatment	2
QUALITY OF SERVICE	
a) Delay in receiving, or concern regarding quality of materials and supplies (DME) or dental	62
b) Lack of access to medical records or unable to make changes	15
c) Benefits not covered	49
CLIENT BILLING ISSUES	
a) Co-pays	8
b) Premiums	0
c) Billing OHP clients without approved waiver	290
Miscellaneous	15
Total	**3857**
Total resolved in the quarter	**3785**
Total pending at the end of the quarter	**72**
Total average enrollment numbers as reported by the CCOs as of 3/31/2016	**880,662**
Total rate per 1000 members	**4.380**

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

Total rate per 1000 members statewide this quarter in all categories is 4.38. This is another slight increase from the previous quarter at 4.178 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 0.95 and the highest was 13.83 for another CCO. The highest rate is a decrease from last quarter, when the highest rate was 17.10 per 1000 members.

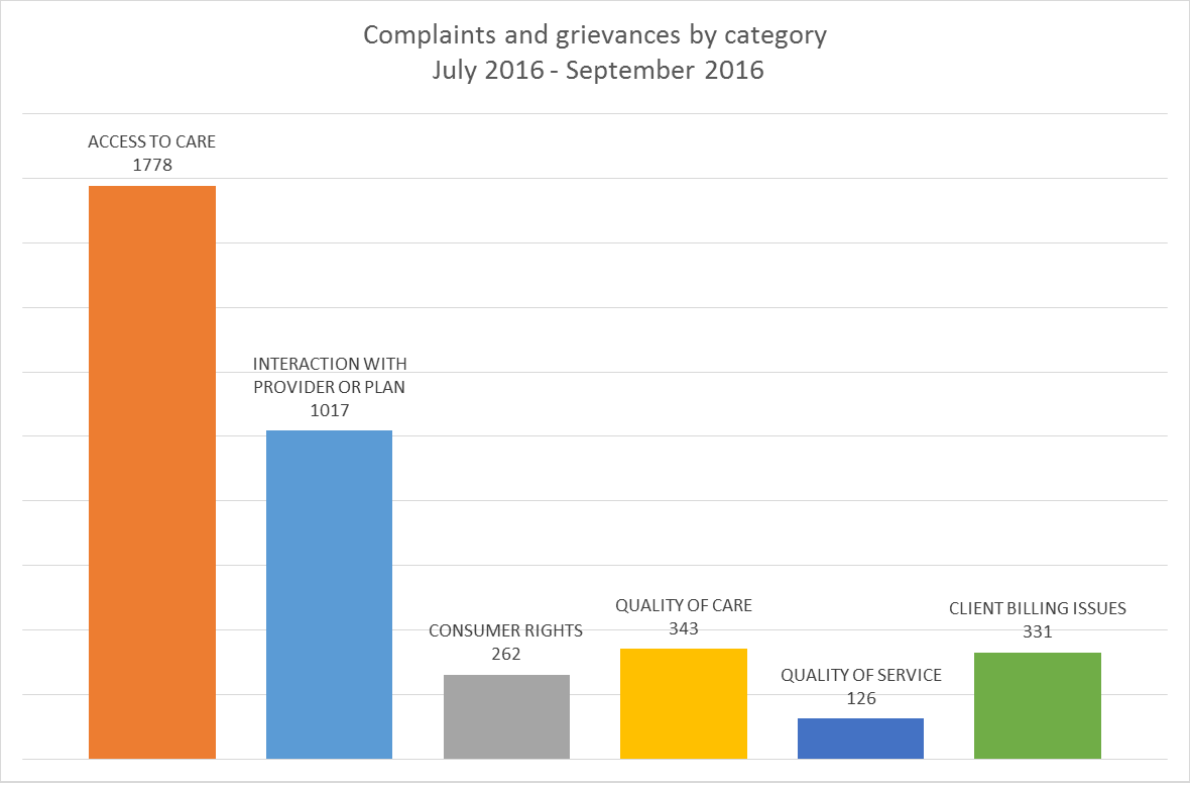
Review of the data shows that overall, complaints decreased by a small margin of about 1 percent compared to last quarter.

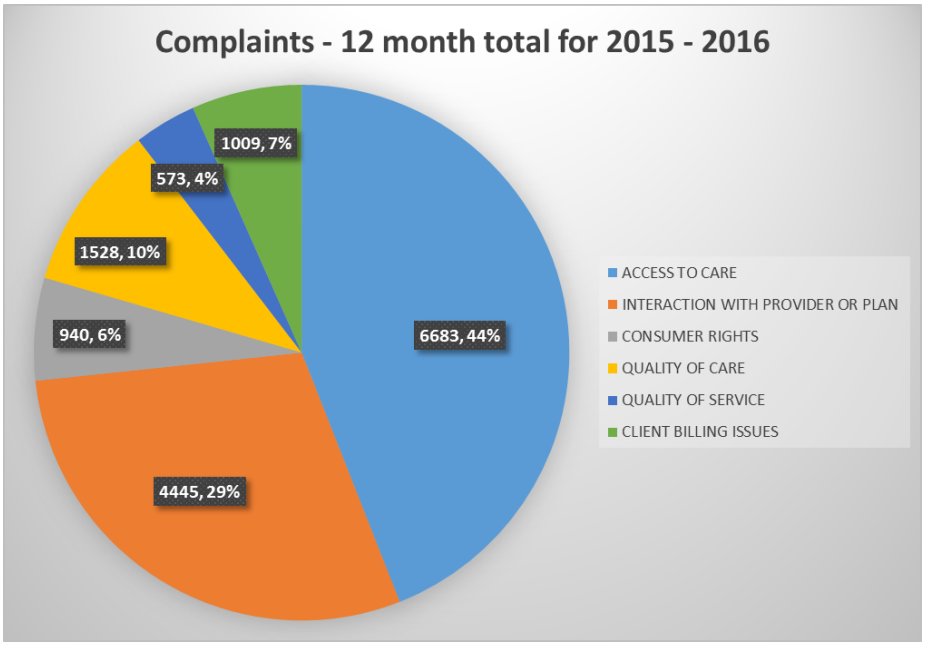
There is continued effort across the CCOs to improve and standardize data collection. One CCO reported they continue to work with their member services staff to improve how data is collected. Other CCOs continue to work with contracted delegates to improve data collection.

The Non-Emergency Transportation (NEMT) complaints continue to be an issue, although NEMT complaints increased less than 1 percent in this quarter as compared to last quarter.

- Complaints are both rural and urban. A preliminary *Analysis of Non Emergent Medical Transportation Services for Older Adults and Adults with Disabilities in the Tri-County Area* by Metro-area Disability Services Advocacy Committee (DSAC) members, for example, has found that NEMT provider transitions have been characterized by consumers as "fragmented" and consistently changing since CCO integration of NEMT.
- Both CCO-contracted and Fee-for-Service transportation broker restrictions, however, show consumer concerns.
- The full DSAC member report will be available in October 2016. The CCOs and OHA's Health Systems Division are continuing to work with NEMT brokers and providers to resolve issues.

The Access to Care category continues to be at a high level, also largely due to the NEMT issue. However, there was a less than 1 percent decrease overall in the Access to Care category from last quarter. There was approximately a 6 percent increase in the Interaction with Provider or Plan category.





Interventions

The OHA staff is continuing to work on improving the reporting process for the CCOs. Technical Assistance Webinars have been provided and CCO staff are providing input on the process.

Fee-for-service (FFS) complaints

Fee for Service data shows a total of 11,724 calls were taken this past quarter. Enrollment and Disenrollment issues continue to be the highest number of calls received. Calls regarding general information were third highest.

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.	29,237	1364	19-276
b) Single PHP service area, denial to obtain services outside the PHP panel	345	6	0-3
c) Termination, suspension or reduction of previously authorized covered services	276	25	0-22
d) Failure to act within the timeframes provided in § 438.408(b)	8	0	0
e) Failure to provide services in a timely manner, as defined by the State	0	0	0
f) Denial of payment, at the time of any action affecting the claim.	56,445	509	0-204
Total	**86,311**	**1,904**	**19-395**
Number per 1000 members	**98.01**	2.16	**0.66-4.42**
Number overturned at plan level		742	**4-161**
Appeal decisions pending		50	**0-28**

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
Number of contested case hearings requested		700	**7-128**
Overturned prior to hearing		226	**1-46**
Overturn rate		32.29%	**14.29-47.69%**
Hearing decisions pending		0	**0**
Hearing requests per 1000 members		0.79	**0.33-1.71**

Contested case hearings

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

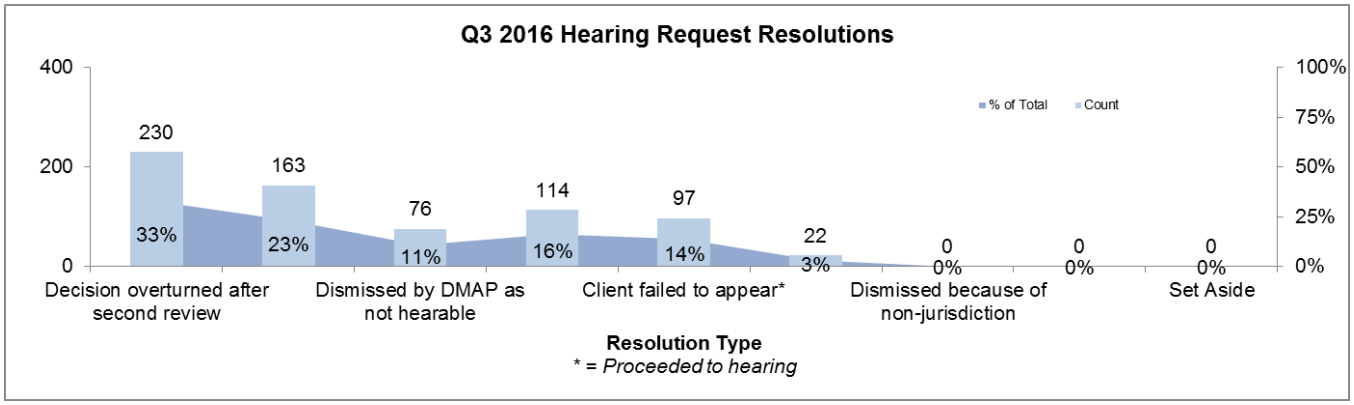
Plan Name	Total requests received	Average plan enrollment *	Per 1000 members
ALLCARE HEALTH PLAN, INC.	35	48,361	0.7237
CASCADE HEALTH ALLIANCE	17	16,181	1.0506
COLUMBIA PACIFIC CCO, LLC	16	24,019	0.6661
EASTERN OREGON CCO, LLC	16	47,123	0.3395
FAMILYCARE, CCO	97	119,006	0.8151
HEALTH SHARE OF OREGON	128	215,595	0.5937
INTERCOMMUNITY HEALTH NETWORK	18	53,103	0.3390
JACKSON CARE CONNECT	17	28,478	0.5970
PACIFICSOURCE COMM. SOLUTIONS	65	49,999	1.3000
PACIFICSOURCE COMM. SOLUTIONS - GORGE	13	12,381	1.0500
PRIMARYHEALTH JOSEPHINE CO CCO	7	10,762	0.6504
TRILLIUM COMM. HEALTH PLAN	66	88,248	0.7479
UMPQUA HEALTH ALLIANCE, DCIPA	43	26,111	1.6468
WESTERN OREGON ADVANCED HEALTH	29	19,398	1.4950
WILLAMETTE VALLEY COMM. HEALTH	124	95,360	1.3003
YAMHILL CO CARE ORGANIZATION	9	22,912	0.3928
ACCESS DENTAL PLAN, LLC		2,086	0.0000
ADVANTAGE DENTAL	2	23,023	0.0869
CAPITOL DENTAL CARE INC		14,578	0.0000
CARE OREGON DENTAL		2,093	0.0000
FAMILY DENTAL CARE		2,063	0.0000
MANAGED DENTAL CARE OF OREGON		2,128	0.0000
ODS COMMUNITY HEALTH INC	2	7,263	0.2754
FFS	27	271,738	0.0994
Total	731	1,202,009	0.6081

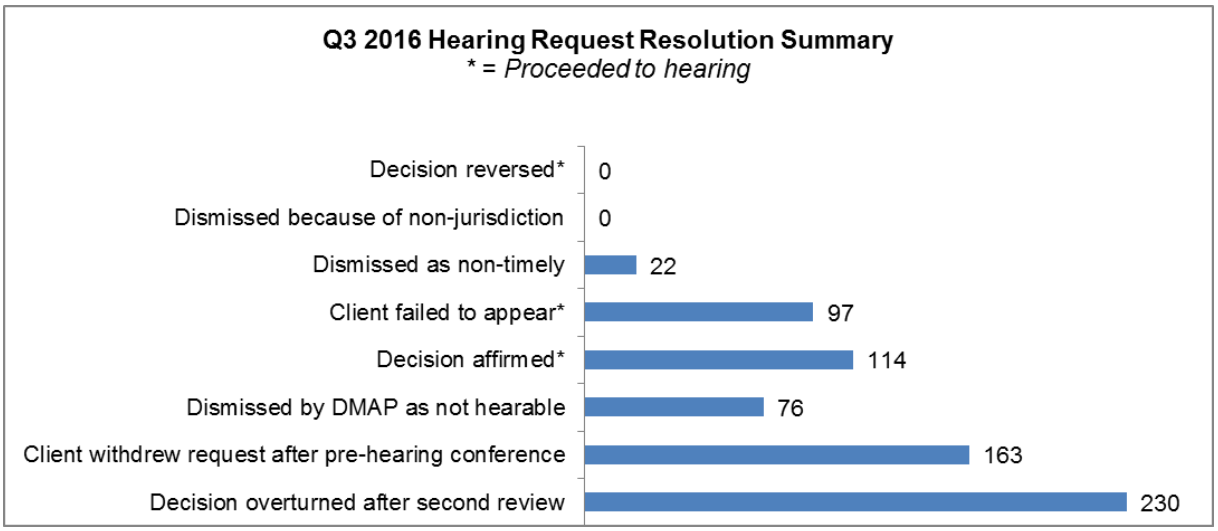
The following chart shows the outcomes of the hearings completed this quarter.

Outcome	Count	% of Total
Decision overturned after second review	230	33%
Client withdrew request after pre-hearing conference	163	23%
Dismissed by OHA as not hearable	76	11%
Decision affirmed	114	16%
Client failed to appear	97	14%
Dismissed as non-timely	22	3%
Dismissed because of non-jurisdiction	0	0%
Decision reversed	0	0%
Set aside	0	0%
Total outcomes	702	

[1] Data Source: New_HearingLog.mdb & DSSURS; Data Extraction Date: 11/14/2016

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 December 2015 through February 2016. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred. Future reports may contain the following information:

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

Table 3 – Summary

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

Rate certifications	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
All 7 DCO and 1 MHO, contracts had a rate amendment July 1, 2016				

Enrollment/disenrollment	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
	-	-	-	-

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
	-	-	-	-

Other	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
All 16 CCO contracts were amended July 1, 2016 to add language for ABA Risk Corridor and rate adjustment.	-	-	-	-

G. Transformation Center

Table 6 - Innovator Agents – Summary of promising practices

Innovator Agent learning experiences

Summary of activities	The Innovator Agents have been involved in the following learning activities over the past quarter: • Health Equity Technical Assistance for CCOs • Eye to Eye Training – Improving Adolescent Well-Child Visits • Advancing Culturally Responsive Care for LGBTQ Individuals • Regional Achievement Collaborative • "Hi-5 Initiative" Webinar • "Nursing Visits" Webinar • Oregon Health Policy Board Listening Session • American Dental Association Webinar "CDT Codes for Dental Case Management." • Cultural Sensitivity training for CAC • Josephine County Childhood Immunization Forum • NEAR (Neuroscience, Epi Genetics, ACEs and Resiliency) Training • Rural Health Conference
Promising practices identified	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	6

Learning collaborative activities

Summary of activities	During this quarter the learning collaborative were: • 07/11/2016 Oregon's Health System Transformation CCO Metrics Final Report • 09/12/2016 Childhood Immunization Status
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 IAs generally support more than one CCO, the broad wealth of information gleaned from a wide array of training helps the IAs support each CCO's specific needs. In addition, IAs regularly connect CCOs to share innovative practices and promote innovation.
Participating CCOs	16
Participating IAs	6

Assisting and supporting CCOs with Transformation Plans

Summary of activities	Most of the CCOs received technical assistance around health equity and their transformation plans during this quarter. The IAs coordinated with the transformation center in arranging for the TA and attended the meetings. During the next several months, the IAs will be assisting their CCOs implement suggestions they received. IAs also provided support to CCOs as they completed their 2015-2017 Transformation Plan Milestone Report during this quarter.
Promising practices identified	Transformation across all CCOs continues as each CCO incorporates the ongoing information and insights they have through training and collaboration.
Participating CCOs	16
Participating IAs	6

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 that can assist them. In addition, the IAs act as a connection between the CCOs and the local community which facilitates better relationships and integration of health services.
Promising practices identified	During this quarter CCOs were accessing their allotted technical assistance hours through the Transformation Center. IAs assisted their CCOs in determining which technical assistance would be of the most benefit to them and coordinated it with the Transformation Center. Assistance received included but was not limited to the areas of: behavioral health integration, motivational interviewing, alternative payment methods, organizational development, and health equity.
Participating CCOs	16
Participating IAs	6

Communications with OHA

Summary of activities	The Innovator Agents convene a weekly phone call and monthly in-person meeting that include updates from different OHA programs. During this quarter, the IAs have been collaborating with the public health division as they roll out Public Health Modernization across the state. They have been coordinating with the Transformation Center in planning technical assistance for their CCOs. The Innovator Agents have continued to work closely with their

	Regional Outreach Coordinators in supporting eligibility efforts. In addition, the IAs maintain close contact with their account representatives from OHA to help resolve individual member issues.
Promising practices identified	The monthly meetings and weekly phone calls allow Innovator Agents to build and sustain relationships 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	6

Communications among Innovator Agents

Summary of activities	Innovator Agents have a weekly phone huddle to update each other on innovative practices that are occurring in their CCOs or to help problem solve issues that are occurring state-wide. They have also stay connected through e-mail and during other phone calls and meetings.
Promising practices identified	Regular communication between IAs allows them to keep up to date on current trends throughout the state. CCOs have become accustomed to having their IA check with peers about how other CCOs are approaching certain challenges and issues.
Participating CCOs	16
Participating IAs	6

Community advisory council activities

Summary of activities	The Innovator Agents continue to provide support for each of their CACs and assist with the implementation and monitoring of their CHIPs. Two Innovator Agents have participated in CAC recruitment calls facilitated by the Transformation Center to work on ways of recruiting more diverse members as this continues to be a struggle for most CACs. Innovator Agents have collaborated with some CACs and the Transformation Center to access technical assistance. In addition, some CACs received a CHIP grant and have been using the monies to improve upon and implement their CHIP.
Promising practices identified	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 are able to 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.
Participating CCOs	16
Participating IAs	6

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 also participate in frequent contact with other OHA staff such as the account representatives and regional outreach coordinators to resolve issues.
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 movement toward change. CCOs continue to broaden their focus as they increasingly address health equity and social determinates of health.
Participating CCOs	16
Participating IAs	6

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	-
Participating CCOs	16
Participating IAs	6

Information sharing with public

Summary of activities	Innovator Agents provided information to the public in the following settings: • OHSU RN-Baccalaureate program students at Chemeketa Community College about health transformation in Oregon, quality pool metrics, social determinants of health, and CCO efforts related to coordinated care and the role of the Innovator Agent. • AARP representatives about CCO efforts and engagement in transition planning and supports for caregivers. • WIC Conference • Health Birth Initiative in Multnomah County • Academy Health in Columbia Gorge Meeting • Project ECHO Medicaid Collaborative
Promising practices identified	-
Participating CCOs	16
Participating IAs	6

Table 7 - Innovator Agents – Measures of effectiveness

No data for this quarter. Other evaluation results from Transformation Center learning collaborative can be found in Section V, Table 9.

H. Legislative activities

Nothing to report this quarter.

I. Litigation status

Nothing to report this quarter.

J. Two-percent trend data

See Appendix C.

K. DSHP terms and status

See Appendix D.

IV. Status of Corrective Action Plans (CAPs)

Table 8 – Status of CAPs

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, the Oregon Health Authority (OHA) was one of 14 regions selected by CMS to implement Comprehensive Primary Care Plus (CPC+). CPC+ is designed to encourage outcomes and provide financial incentives for health care providers when they meet performance measures. This will further Oregon's work by aligning payment methods, with a focus on alternative payment methodologies, engage patients, and support better care coordination.

Additionally, OHA finalized the contract with Oregon Health & Science University Center for Health Systems Effectiveness (OHSU CHSE) to summatively evaluate the 1115 waiver Demonstration, and OHSU CHSE and Providence Center for Outcomes Research and Education (CORE) finalized their work on the State Innovation Model (SIM) Grant evaluation.

Finally, contracted evaluations of OHA's Patient Center Primary Care Home (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 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 at the impact of the PCPCH program on the utilization and expenditure patterns of patients. Also as part of this effort, the program is looking in-depth at 20 top-performing or exemplary practices to determine which aspects of the PCPCH model are most important to successful practice transformation. The report was released in September, 2016 and can be found at: http://www.oregon.gov/oha/pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf.

Interim findings:

- In this quarter, there were 639 recognized clinics in the state, surpassing Oregon's goal of 500 clinics by 2015. This represents approximately 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%. As of September 2016, 90.6% of CCO members statewide were enrolled in a recognized PCPCH, which is a 74% increase in the proportion of members enrolled 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 seven webinars:

- Comprehensive Primary Care (CPC+) Practice Application Info Session (151 attendees)
- Nurse Visits – A "Tasting" Flight of Visit Model (71 attendees)
- Comprehensive Primary Care (CPC+) Office Hours (41 attendees)
- Identifying Children & Youth with Special Health Care Needs (25 attendees)
- Depression Screening & Treatment in Primary Care: Part One (50 attendees)
- Screening & Treating Chlamydia in Primary Care (35 attendees)
- Ready, Set, Share! Tool for Implementing Shared Decision Making (34 attendees)

Additionally, The Oregon Health Care Quality Corporation (Q Corp) launched a new initiative called the Physicians Academy in Q3 2016. It will focus on pairing residents and/or new physicians with seasoned Family Practice and Pediatric physicians to work on a community focused project for their region.

The goal is to increase and enhance mentorship relationships, extend the health reach outside the clinic in a way that mirrors and supports community need, create community-minded physicians who have practical skill sets in this work, and enable a broader, statewide integration and support network of interested clinicians who can support each other's work and goals beyond the Physician Academy's lifespan.

Recruitment for the Physicians Academy is currently underway and will be completed in Q4 2016. The Physicians Academy replaces the work that the Institute was planning on completing through the Primary Care Extension Program discussed in last quarter's report.

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 began reporting on the 2016 coordinated care organization (CCO) and state performance measures, completed the benchmark setting process for 2017 with the Metrics & Scoring Committee, and continued measure development and validation work. This quarterly report continues to include the final 2013, 2014, and 2015 results for the 18 CCO incentive measures and 33 quality and access test measures, and provides data for a new rolling 12-month window (July 2015 – June 2016) for a subset of measures for which data are available (see Appendix E).

Hospital Transformation Performance Program

In this quarter, OHA calculated and shared official Year 3 improvement targets with each hospital involved in the Hospital Transformation Performance Program (HTPP), OHA's hospital incentive measure program. OHA also continued conversations with Center for Medicaid and Medicare services regarding the future of the HTPP, and worked with Hospital Performance Metrics Advisory Committee and Hospital Performance Metrics Advisory Committee and the Hospital Technical Advisory Workgroup on measure development for potential future years of the program (see Appendix E).

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, three more joined the program on July 1, 2015, and finally three more FQHCs joined on July 1, 2016.

The FQHC APM Program provides an *Advanced Payment and Care Model* by paying per-member per-month (PMPM) payments for each health center's (HC) attributed patient population, rather than the traditional PPS encounter rates. This allows practitioners to get off the treadmill of churning out office visits, and engage their communities in more patient-centered health strategies.

Three additional health centers joined the FQHC APM Program on July 1, 2016. OHA continues to collect quarterly *Touches Reports* from APM health centers, and consistent with our Q2 2016 waiver update, these new APM health center's Q3 2016 reports show that they are producing more touches per 1000 members than any prior cohort of health centers.

Finally, FQHCs track twelve metrics on a quarterly basis for APM FQHCs. The measures include:

- Childhood Immunization
- Colorectal Cancer Screenings
- Depression Screening and Follow-up Plan
- Diabetes HbA1c poor control
- Controlling High Blood Pressure
- Patient Satisfaction with Care
- Alcohol or Other Substance Misuse Screenings (SBIRT)
- Medical Assistance with Smoking and Tobacco Use Cessation: Strategies to Quit
- Adolescent Well Child Visits
- Cervical Cancer Screenings
- Weight Control for Adults
- Weight Control for Children

See "interim findings" below for results.

Certified Community Behavioral Health Clinics

Oregon has completed the one year federal Certified Community Behavioral Health Clinics (CCBHC) Planning Grant. The grant established standards for CCBHCs and Oregon added requirements to align with the Oregon Behavioral Health Home standards. Twenty clinics applied to be certified under these standards and participated in site reviews.

In the end 14 programs were certified. In addition Oregon established a Prospective Payment process for the clinics and developed data collection strategies to comply with federal requirements if selected as a demonstration state. Oregon will apply in October to become one of eight states to be included in the two year demonstration starting January 2017.

Interim findings:

CCO Financial Reports

In September, an internal analysis of the most recent financial reports available shows that 40.5% of all plan payments are non-fee-for-service (FFS). This is an increase from the previous quarter, in which 35.1% of plan payments were non-FFS. In 2016, OHA held another round of Financial Reporting Workgroup meetings with CCOs to better standardize reporting and definitions resulting in more accurate reporting by CCOs. The revised Financial Reporting template will be effective for 2017 reporting.

Federally Qualified Health Center Alternative Payment Methodology Program

As discussed above in Lever 2 "Evaluation Activities," FQHCs track twelve metrics on a quarterly basis. In this quarter, nine health centers produced quality metric reports. OHA analyzed the number of health centers meeting the benchmarks, and also the average percentage change in metric performance over the prior year. It is important to note that four of the 12 measures did not have complete reporting by all nine health centers.

Health centers performed well on all measures in Q3 except for Diabetes Control. Health centers also performed well in reaching the benchmarks on Depression Screenings with Follow-up, Diabetes Control, Blood Pressure Control, Screenings for Brief Intervention and Referral to Treatment (SBIRT), and Tobacco Screenings with Cessation Therapies.

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.

Finally, OHA has commissioned Optumas to produce another report on Phase 1, 2, and 3 FQHCs utilization trends, and incorporate a Total Cost of Care measurement as well. Optumas has projected that the report will be finalized by February 2017.

Transformation Center

In this quarter, Oregon was one of 14 regions selected by CMS to implement Comprehensive Primary Care Plus (CPC+), a national model that is designed to improve the quality of care patients receive and their overall health, while spending health care dollars better. To encourage outcomes, CPC+ provides financial incentives for health care providers when they meet performance measures. This will further Oregon's work

of aligning payment methods, with a focus on alternative payment methodologies, engage patients, and support better care coordination.

Additionally, the Primary Care Payment Reform Collaborative, required through Senate Bill 231, has met three times this quarter. This collaborative has discussed recommendations to the Oregon Health Policy Board related to a governance model, technical assistance, measurement, data aggregation and behavioral health integration. Payment recommendations will be discussed at the October and November meetings.

During this quarter the Transformation Center provided support to five CCOs to develop alternative payment models (APMs)/value-based payments (VBPs).

1. Cascade Health Alliance completed work 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.

2. PacificSource Community Solutions completed work with the National Council on Behavioral Health to develop a fair value of behavioral health services for sub-capitated community mental health program providers and is continuing work with Dale Jarvis and Associates, LLC to develop an APM for providers outside of the sub-capitated arrangement.

3. Health Share of Oregon continues work 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.

4. Intercommunity Health Network completed work with Bailit Health Purchasing, LLC to develop an options analysis and recommendations for CCO primary care payment risk-adjustment and primary care payment models that involve downside risk.

5. Yamhill Community Care began work with Dale Jarvis and Associates, LLC to develop appropriate cost parameters to estimate per member per month costs for different types of primary care practices that would be staffed to meet the range of needs including primary, secondary and tertiary prevention activities; complete a Return on Investment Analysis to allow projection of the savings that could potentially be achieved if primary care clinics are able to implement high impact initiatives in their clinics.

Finally, work by two payers commenced on projects to advance alternative payment methods for integrated care funded by grants from the Transformation Center.

1. PacificSource Community Solutions is advancing integration alternative payment methodologies across its Medicaid, Medicare, and commercial lines of business to prepare to implement the alternative payment models across provider networks starting in at least two practices in 2017. In this quarter the project has focused on an assessment of current levels of clinical integration among five provider partners. In Q4 2016 and Q1 2017 the payer will develop a cost data set that reflects a close approximation of true costs along the entire spectrum of activities associated with levels of integration and gain an understanding of these important elements to position the payer to shape alternative payment with provider partners who demonstrate readiness to implement in 2017.

2. CareOregon has contracted with an evaluation partner to evaluate pilot payment models to support behavioral health integration. Based on this evaluation, the payer will develop a sustainable alternative payment model to support behavioral and physical health integration that is capable of

cross-regional and bi-directional implementation. Both projects will be complete at the end of Q1 2017.

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) worked with the sites on collecting and submitting data on four of the Adult Core Measures (Body Mass Index (BMI), hypertension, diabetes testing, and diabetes poor control). By the end of September, seven of the sites had completed the RedCap Survey, with the remaining three sites set to submit by mid-October. At the same time, ORPRN helped sites develop their registries of Medicaid patients receiving integrated care to be submitted to OHA through a secure process in late October. OHA will use the registries to pull claims reports for each site on 10 additional Adult Core Measures.

The draft report for the first two years of the learning collaborative is being reviewed internally by OHA. ORPRN will update this draft with additional qualitative and quantitative data collected for Year 3, with a revised report to be submitted to OHA by January 31, 2017. In September, the OHA project manager and the head of the ORPRN team submitted a joint proposal to present the findings from the first two years of the BHHLC at the CMS QualityNet Conference in December.

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 the 2015-2016 mid-year (Jul 2015-June 2016) the most recent reporting period.

- Alcohol or Other Substance Misuse (SBIRT) increased from 6.3% in CY 2014 to 16.3% in 2015-2016 mid-year. The measure was above the 2016 benchmark target of 12%. 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 71.8% in CY 2014 to 76.0% in the 2015-2016 mid-year. The measure is below the 79.9% 2014 CCO 90th percentile benchmark target. 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 67.5% in the 2015-2016 mid-year. The measure was below the 2016 benchmark target of 90%. 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; however, there is no 2015-2016 mid-year

update, as this measure is only updated annually. 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 63.6% in the 2015-2016 mid-year for the initiation phase, which exceeds the CY 2016 benchmark target of 51%.The measure increased from 61.0% in 2011 to 66.1% in the 2015-2016 mid-year for continuation and maintenance phase, which exceeds the CY 2016 benchmark target of 63.0%. In the 2015-2016 mid-year the measure ranged from 56.1% to 66.7% across CCOs for initiation phase, and 54.3% to 91.7% 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) 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. Using a template developed in collaboration with OHA staff, ORPRN worked with each site to create a registry of their Medicaid clients receiving integrated care. This has required working very closely with site staff to understand how they can collate that information from their EHRs or chart reviews as necessary.

At the same time, ORPRN helped the sites to complete a RedCap Survey on four Adult Core Measures (BMI, hypertension, diabetes testing, and diabetes poor control), ensuring compliance with the complicated measure specifications. These data will be incorporated into the final updated evaluation of the Learning Collaborative at the end of the grant period. ORPRN also worked with OHA staff in planning and organizing the final all-day, in-person learning session for the sites, including securing external speakers to present on national and local examples of bi-directional integration.

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 finalized contract negotiations for the summative evaluation with OHSU Center for Health Systems Effectiveness (CHSE). The summative evaluation will improve on the waiver midpoint evaluation and other preliminary efforts to assess the implementation and impacts of Oregon's Medicaid waiver: 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 OHA by the end of CY 2017.

Dental Integration Evaluation

In this quarter, OHA finalized its contract with OHSU Center for Health Systems Effectiveness (CHSE) to evaluate the integration of dental care, which has been at the forefront of the CCO design since its inception. CHSE will use Medicaid claims data from 2012 through 2015 to better understand access, utilization, emergency department visits for dental conditions, and standardized expenditures for dental services. The final report will be delivered to OHA in December 2016.

State Innovation Model Self-Evaluation

In this quarter, OHSU CHSE and Providence Center for Outcomes Research and Education (CORE) finalized the State Innovation Model (SIM) Self-Evaluation report, which examines the adoption, spread, and spillover of the Coordinated Care Model. The report includes surveys and interviews to assess the adoption and spread of the coordinated care model among CCOs, commercial health plans, hospitals, and other provider organizations.

In addition to surveying payer and provider organizations, CORE conducted in-depth interviews with representatives at a small number of organizations that responded to the survey to better understand organizations' *motivation* and *mechanisms* for transformation. Finally, an analysis of health care claims and encounters data was conducted 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. OHA is reviewing the report, which is expected to be sent to CMS for review by the end of 2016.

Sustainable Relationships for Community Health Program

In this quarter, Sustainable Relationships for Community Health (SRCH) Program 2016 grantee consortia attended a two-day learning institute in July and received technical assistance from OHA Public Health Division staff to assist collection and reporting of project data elements.

Additionally, OHA Public Health Division staff coordinated with national evaluators for the National Association of Chronic Disease Directors Promoting Medicaid Delivery Models for the National Diabetes Prevention Program (NDPP) Through Managed Care Organizations and/or Accountable Care Organizations grant, which seeks to identify promising practices for NDPP referral and payment systems. Staff hosted a two-day project evaluation meeting in September with external evaluators from the Centers for Disease Control and Prevention (CDC), National Association of Chronic Disease Directors (NACDD), and the Research Triangle Institute (RTI); OHA staff from the Public Health Division and Health Systems Division; grantees (CCOs, local public health authorities and DPP provider organizations) to provide feedback on the draft evaluation plan. In September, OHA staff prepared for pre-IRB review, and began contracting processes for system upgrades for evaluation data collection systems.

Finally, OHSU's Evaluation Core was brought on as the external evaluator for the SRCH 2016 project, and an evaluation plan was finalized in August. Grantees developed short term success measures to track progress on their tobacco and Diabetes Prevention Program referral system development, and prepared for baseline reporting, which is due in October.

Interim findings:

Measures of efficient and effective care collected by OHA

The following measures of efficient and effective care improved in the 2015-2016 mid-year (see Appendix E for details):

- Emergency department visits per 1,000 member months decreased by 3.6 % (from 47.3 per 1,000 member months in CY 2014 to 45.6 per 1,000 member months in 2015-2016 mid-year).

- Developmental Screening in the First 36 Months of Life increased from 42.6% in CY 2014 to 58.9% in the 2015-2016 mid-year, exceeding the CY 2016 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 increased from the 2015-2016 mid-year for the following conditions:
    - Chronic obstructive pulmonary disease increased by 31% (from 411.9 per 100,000 member years in CY 2015 to 540.9 100,000 member years in the 2015-2016 mid-year)
    - Diabetes short-term complications increased in by 11.9% (from 140.9 per 100,000 member years in CY 2015 to 157.7 100,000 member years in the 2015-2016 mid-year)
    - Adult asthma increased by 20% (from 48.4 per 100,000 member years in CY 2015 to 58.3 100,000 member years in the 2015-2016 mid-year)
    - Congestive heart failure increased by 4% (from 234.0 per 100,000 member years in CY 2015 to 243.6 100,000 member years in the 2015-2016 mid-year)

Sustainable Relationships for Community Health Program Evaluation

The Sustainable Relationships for Community Health (SRCH) 2016 interim evaluation findings will be available in January 2017. Until then, program improvements are being implemented based on the following recommendations from the SRCH 2015 evaluation:

1. 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 Sustainable Relationships for Community Health (SRCH) 2016 consortia grantees began designing sustainable tobacco cessation referral and payment systems, and two grantees (Clackamas and Lane counties) began work with their CCOs (HealthShare, FamilyCare, and Trillium) to develop referral and payment systems for the National Diabetes Prevention Program (NDPP). Grantees attended a two-day learning institute in July and received technical assistance from OHA Public Health Division staff to assist collection and reporting of project data elements.

Future initiatives will focus on referrals of patients with diabetes or hypertension to the Stanford Chronic Disease Self-Management Program (Klamath and Columbia county grantees), 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 (CDC), National Association of Chronic Disease Directors (NACDD), 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 health information technology initiatives to ensure OHA's efforts align with and support CCO needs through various activities that include stakeholder support and programmatic activities. Major HIT activities in July through September 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.
- Completing telehealth pilots in four communities. One pilot will continue until May 2017.

OHA recently increased adoption of PreManage, a tool that brings real-time hospital notifications to Medicaid 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 Medicaid providers including: CCO care coordinators, long-term care discharge planners, the contractor for the fee for service 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 July 2016 as well as September 2016. The July HITAG meeting was a collaboration with the Health IT/Health Information Exchange Community and Organizational Panel, which is composed of representatives from a variety of organizations across Oregon that are actively engaged in implementing or operating HIT and HIE programs. 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 August 2016.

OHA has contracted with OCHIN to provide technical assistance to CCO priority practices to meaningfully use their Electronic Health Records (EHRs). Clinics are at different stages of the technical assistance work, with some still finalizing plans and others having already received 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 for Health Information Technology (ONC) 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. In September 2016, ONC awarded OHA with an additional $625,000 to enhance the work being done under the original $1.6 million grant, with a focus on expanding health information exchange between Oregon and neighboring states.

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 HITECH funding recently identified in the State Medicaid Director letter 16-003. This program will help with onboarding of Medicaid providers to Health Information Exchanges in order to assist in the meeting of Meaningful Use measures. In July–September 2016, OHIT conducted initial project planning, including meetings with other states and stakeholders, as well as planning for an advisory group to assist staff with developing criteria for participation in the HOP. These activities will also support the work of the Coordinated Health Partnerships as described in Oregon's proposed 1115 Medicaid Demonstration waiver.

CCO metrics "dashboards"

OHA continues to release quality metric progress reports for CCOs using the automated metric reporting tool ("dashboard") developed by Providence's Center for Outcomes Research and Education (CORE). During this reporting period, an additional measure was included in the dashboard, Ambulatory Care – Outpatient Utilization, and several mental health sub-filters were added to allow CCOs to stratify measures by mental health diagnosis category (see Appendix E).

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

Evaluation activities:

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 met with the contractor's evaluation team, OHSU CHSE, to inform them about data available on flexible services. OHSU CHSE 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 summative waiver evaluation report, which will be delivered to OHA by the end of CY 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 strategic plan initiatives for 2016. The center continues working in collaboration with Oregon Health and Science University (OHSU) to implement this evaluation plan. Most of the center's current 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.

Also in September, evaluators from OHSU completed a qualitative analysis of final reports from the second cohort of Clinical Innovation Fellows. Findings included that the fellowship's multi-pronged approach to training new innovation leaders appeared synergistic by combining a strong curriculum, hands-on experience with project implementation, and support from mentors and others across a range of disciplines.

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

Interim findings/ Improvement activities:

This quarter, the CCO learning collaborative met twice. The sessions focused on the 2016 CCO metrics final performance and immunization. Seventy-nine people attended in July, and 58 attended in September. Of evaluation respondents for the two sessions, an average of 84% found the sessions valuable or very valuable to their work and 78% said the sessions were effective for meeting the needs of their CCO or organization. Respondents identified the most helpful aspect of the sessions as hearing best practices from other CCOs.

In September, the third cohort of Clinical Innovation Fellows convened for their first in-person meeting focused on leadership, measurement and project management. 100% of evaluation respondents rated the two-day meeting as very valuable or valuable.

Additionally, this quarter the Transformation Center has provided:

- Targeted metrics technical assistance, including:
- Colorectal Cancer Screening – One webinar, with 23 participants from eight CCOs; 100% of evaluation respondents rated the session as very valuable or valuable and effective in meeting their needs. Ten CCOs also participated in individual follow-up consultations.
- Adolescent Well-Care Visits – Six webinars, with an average of 10 participants per webinar with 14 CCOs represented; 89% of evaluation respondents rated the sessions as very valuable or valuable and effective in meeting their needs. Two in-person Eye-to-Eye trainings were also held, with 50 CCO staff and providers attending. Ninety-five percent of evaluation respondents rated the training as very valuable or valuable.
- Health equity consultations with ten CCOs:
    - 97% of evaluation respondents rated the consultation as very valuable or valuable and 80% said they planned to take action based on the consultation.
    - Seven CCOs have requested follow-up technical assistance.
- Support through the Technical Assistance Bank:
    - In year two of the TA Bank (October 2015 – September 2016), the center received 37 requests from CCOs for a total of 503 technical assistance hours.
    - TA Bank evaluation results for 19 of 35 completed projects show that 100% of CCOs rated the assistance as very valuable (78%) or valuable (22%), and 94% of CCOs rated the assistance as very effective (61%) or effective (33%) in meeting the project goals.

Other findings

Attached separately is a summary of CCO statewide Performance Improvement Project (PIP) interventions, compiled by OHA's External Quality Review Organization, HealthInsight, based on October 2016 quarterly reports.

VI. Public forums

Public comments received

Medicaid Advisory Committee

Jeremiah Rigsby, Senior Manager for State and Federal Regulatory Affairs at Care Oregon

Mr. Rigsby provided public testimony, highlighting three issues:

- Jeremiah thanked the Medicaid Advisory Committee for its input and discussion with regard to the future of CCOs. As someone connected to a CCO, he appreciates hearing from community advisory members who are not connected with CCOs about how the model is working. The MAC is often a voice for challenges and issues in the Medicaid program that CCOs and OHA may not be aware of.
- Jeremiah expressed concern about the rate of churn in the OHP.
- Jeremiah also asked the committee take a closer look at the role of community health workers/traditional health workers and consider the best ways to use community health workers in the OHP delivery system.

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	July 2016	August 2016	September 2016
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,030,827	1,014,916	998,359
Title XXI funded State Plan	61,305	62,044	63,112
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	July 31, 2016	August 31, 2016	September 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%	58	153	-12.07%	-418.97%
		Pregnant Women FPL > 170%	19	51	-21.05%	-1894.74%
	Title 21	SCHIP FPL > 170	51,730	128,778	32.06%	63.08%
Optional	**Title 19**	PLM Women FPL 133-170%	406	1,099	-29.56%	-1850.25%
	Title 21	SCHIP FPL < 170%	66,016	165,722	-10.24%	13.21%
Mandatory	**Title 19**	Other OHP Plus	164,365	468,967	-1.15%	-48.08%
		MAGI Adults/Children	830,471	2,282,019	-3.27%	-0.30%
		MAGI Pregnant Women	19,377	46,383	-8.29%	7.31%
		QUARTER TOTALS	1,132,442			

** 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	1,018,823	870,336	1,794	1,094	36,227	52,641	4,078
August	1,005,897	860,226	1,154	1,020	38,519	51,621	4,275
September	992,067	840,024	856	904	38,866	50,287	4,278
Qtr Average	1,005,596	856,862	1,268	1,006	37,871	51,516	4,210
		86.94%	0.13%	0.10%	3.77%	5.12%	0.42%

**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 period, OHA began reporting on the 2016 coordinated care organization (CCO) and state performance measures, completed the benchmark setting process for 2017 with the Metrics & Scoring Committee, and continued measure development and validation work.

This quarterly report continues to include the final 2013, 2014, and 2015 results for the 18 CCO incentive measures and 33 quality and access test measures, and provides data for a new rolling 12-month window (July 2015 – June 2016) for a subset of measures for which data are available. Preliminary data for the first nine months of Year 3 of the Hospital Transformation Performance Program (HTPP) are also presented.

Also in this reporting period, OHA calculated and shared official Year 3 improvement targets with each hospital involved in the Hospital Transformation Performance Program, OHA's hospital incentive measure program. OHA also continued conversations with Center for Medicaid and Medicare services regarding the future of the HTPP, and worked with the Hospital Performance Metrics Advisory Committee and Hospital Technical Advisory Group on measure development for potential future years of the program..

CCO incentive metrics

CCO reporting and validation

During this reporting period, OHA continued to provide updated metrics to CCOs utilizing the automated metric reporting tool ("dashboard"), for periods covering April 2015 – March 2016, May 2014 – April 2016, and June 2014 – May 2016.

During this reporting period, OHA also re-calculated 2015 performance for the Follow-up after hospitalization for mental illness measure due to substantial changes to the 2016 HEDIS specifications. CY 2015 performance was recalculated using the 2016 specifications to ensure appropriate comparisons when calculating improvements

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, 2014 and 2015, 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.

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	21*	-
Measures Signed Off (as of 9/30/16)	22	22	22	22	22	21*	17
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

During this reporting period, OHA continued discussions with CMS regarding Years 4 and beyond of the HTPP.

Hospital reporting

Any final revisions to Year 2 data had to be submitted by hospitals in July. These final revisions had to be approved by OHA on a case-by-case basis, and were used to calculate Year 3 improvement targets (Year 2 payment was not affected).

During this reporting period, OHA also re-calculated Year 2 performance for the Follow-up after hospitalization for mental illness measure due to substantial changes to the 2016 HEDIS specifications. Year 2 (October 2014 – September 2015) performance was recalculated using the 2016 specifications to ensure appropriate comparisons when calculating improvements for Year 3.

During this reporting period, OHA finalized and distributed hospitals' individual Year 3 improvement targets and final Year 3 measure specifications. Year 3 of the HTPP ended during this reporting period (September 30).

Progress report data for the other hospital measures are self-reported by the hospitals to OHA via the Oregon Association of Hospitals and Health Systems (OAHHS) each quarter. These preliminary data are presented in Addendum 3.

Hospital metric specifications

OHA continued to work with the Hospital Metrics Technical Advisory Group on draft measure specifications for developmental measures. These measures were originally recommended by the Committee to be added in Year 4, but as per current discussions with CMS, will likely be proposed for later years. Measure development work included:

- Report writing workgroup for the draft opioid prescribing in the Emergency Department measure specifications.
- Reducing cesarean-sections

- C-difficile infections

Committee and workgroup updates

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

- In July, the Committee reviewed final 2015 performance and quality pool payout, and began 2017 benchmark selection.
- In August, the Committee welcomed three new members, finalized 2017 benchmarks, and revisited equity measure concepts for future years of the program.
- In September, the Committee selected 2017 challenge pool measures, replacing HbA1c poor control with effective contraceptive use; and heard presentations on potential new measures for 2018: Kindergarten Readiness and Medication Therapy Management.

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

The **Hospital Metrics Technical Advisory Workgroup (Hospital TAG)** met twice this quarter and meetings focused primarily on measure development and shared learning for measures including food insecurity screening and cigarette smoking prevalence. The CCO TAG provided input to the Committee on a developmental Equity measure concept, and select 2017 measure specifications.

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

The **Hospital Performance Metrics Advisory Committee** met once during this reporting period, in September. At that meeting, the Committee continued discussion about future program structure; made decision related the proposed Year 4 Opioid prescribing measure; and selected draft Year 4 benchmarks for proposed measures.

The Committee also welcomed four new members who were appointed in July.

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

The **Hospital Metrics Technical Advisory Group (Hospital TAG)** met monthly during this reporting period. Work was focused on draft specification development for measures proposed by the Committee (see "Hospital Metric Specifications" on page 2 above). The Hospital TAG also heard a presentation on the HTPP Years 1 and 2 evaluation (which was published in the previous quarter), shared best practices, and discussed an OAHHS sponsored Learning Series focused on improving processes related to HTPP measures. The Learning Series will begin in October.

A website including meeting dates and materials for the Hospital TAG is available here: http://www.oregon.gov/oha/analytics/Pages/Hospital-Metrics-Technical-Advisory-Group.aspx

Core Performance Measures

Several of the core performance measures that overlap with the 33 quality and access test measures have been updated; data is available in the measures matrix below. OHA will provide an update on the additional core performance measures in next quarter's report.

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 3 Performance

Attached separately. This quarterly report has been updated to include preliminary progress report data from the first nine months of HTPP Year 3 (October 2015 – June 2016). In addition, the Year 2 Performance column has been updated to reflect final Year 2 rates as of August 2016. Small changes were made to the data from the time the Year 2 report was published in June and when this report was prepared for CMS; these changes are tracked below. Hospitals were allowed to make corrections to their Year 2 data through July 2016.

Appendix F: Uncompensated Care Program

Nothing to report this quarter.