Oregon Health Plan

Section 1115 Quarterly Report

10/1/2016 – 12/31/2016
Demonstration Year (DY): 15 (7/1/2016 – 6/30/2017)
Demonstration Quarter (DQ): 2/2017
Federal Fiscal Quarter (FQ): 1/2017

Table of Contents

I. Introduction

A. Letter from the State Medicaid Director

From September through December 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 647 recognized Patient Centered Primary Care Home (PCPCH) clinics. As of September 2016, 90.6 percent of coordinated care organization (CCO) members statewide were enrolled in a recognized PCPCH. OHA also released a final report comparing utilization and expenditure patterns of PCPCH patients vs. non-PCPCH patients. The findings indicate that the PCPCH program has been very successful in supporting the Triple Aim of better health, better care, and lower costs.
- **Lever 2: Implementing alternative payment methodologies (APMs)** – Recent CCO financial reports showed that 35.9 percent of all plan payments are non-fee-for-service (FFS), which is a decrease from the previous quarter. OHA also found that the current APM program for Federally Qualified Health Centers has produced improved services for their population. The Transformation Center also continued implementing the Comprehensive Primary Care Plus (CPC+) program, and provided support to six CCOs to develop value-based payments.
- **Lever 3: Integrating physical, behavioral and oral health care** – OHA is currently reviewing a final report on the three-year Behavioral Health Home Learning Collaborative. Launched in 2014 to help organizations integrate primary care into behavioral health settings, the collaborative ended in December 2016. CCO incentive measures related to integrated care continue to exceed benchmark targets.
- **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
    - Developmental Screening in the First 36 Months of Life
    - Adolescent Well-Care Visits
    - Hospital admissions for chronic obstructive pulmonary disease
- **Lever 5: Implementation of health-related flexible services –** The summative waiver evaluation will include flexible services to better understand how they are deterring higher-cost care. Our contractor, OHSU Center for Health Systems Effectiveness (CHSE), has formatted a detailed a detailed proposal for evaluating flexible services, which includes both quantitative and qualitative methods.
- **Lever 6: Innovations through the Transformation Center** – This quarter, the CCO learning collaborative met once and focused on opioids. Forty-seven people attended. Of evaluation respondents, 77% found the session valuable or very valuable to their work.

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

II. Title

Oregon Health Plan Section 1115 Quarterly Report
10/1/2016 – 12/31/2016
Demonstration Year (DY): 15 (7/1/2016 – 6/30/2017)
Demonstration Quarter (DQ): 2/2017
Federal Fiscal Quarter (FQ): 1/2017

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.	592
b) Plan unresponsive, not available or difficult to contact for appointment or information.	28
c) Provider's office too far away, not convenient	21
d) Unable to schedule appointment in a timely manner.	170
e) Providers office closed to new patients	20
f) Referral or 2nd opinion denied/refused by provider.	37
g) Referral or 2nd opinion denied/refused by plan	38
h) Unable to be seen in a timely manner for urgent/ emergent care	21
i) Provider not available to give necessary care	38
j) Eligibility issues	37
k) Female or male provider preferred, but not available	10
l) NEMT not provided, late pick up resulting in missed appointment, problems with coordination of transportation services	912
m) Dismissed by provider as a result of past due billing issues	1
n) Dismissed by clinic as a result of past due billing issues	1
INTERACTION WITH PROVIDER OR PLAN	
a) Provider rude or inappropriate comments or behavior	110
b) Plan rude or inappropriate comments or behavior	268
c) Provider explanation/instruction inadequate/incomplete	35
d) Plan explanation/instruction inadequate/incomplete	326
e) Wait too long in office before receiving care	126
f) Member not treated with respect and due consideration for his/her dignity & privacy	28
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available	15
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	5
i) Lack of coordination among providers	2
j) Wants to change providers; provider not a good fit	3
k) Member has difficulty understanding provider due to language or cultural barriers	65
l) Client dismissed by provider (member misbehavior, missed appointments, etc.)	43
m) Client dismissed by clinic (member misbehavior, missed appointments, etc.)	19
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)	23

Complaint or grievance type	Number reported
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.	104
d) No choice of clinician, or clinician of choice not available.	33
e) Fraud and financial abuse (services billed not provided, service provided in two appointments that should have been provided in one.)	13
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health marital status, Medicaid/Medicare)	30
g) Complaint/appeal process not explained, lack of adequate or understandable NOA	5
h) Not informed of consumer rights	3
i) Denied member access to medical records (other than as restricted)	7
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)	4
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.	130
b) Testing/assessment insufficient, inadequate or omitted	14
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.	109
d) Member neglect or physical, mental, or psychological abuse	23
e) Provider office unsafe/unsanitary environment or equipment	73
f) Lack of appropriate individualized setting in treatment	5
QUALITY OF SERVICE	
a) Delay in receiving, or concern regarding quality of materials and supplies (DME) or dental	68
b) Lack of access to medical records or unable to make changes	7
c) Benefits not covered	53
CLIENT BILLING ISSUES	
a) Co-pays	3
b) Premiums	5
c) Billing OHP clients without approved waiver	308
Miscellaneous	53
Total	**4,070**
Total resolved in the quarter	3,879
Total pending at the end of the quarter	191
Total average enrollment numbers as of 12/2016	862,040
Total rate per 1000 members	4.72

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

This quarter, the statewide total complaints and grievances rate is 4.72 per 1,000 members[1]. This is another slight increase from the previous quarter's rate (4.38 per 1000 members).

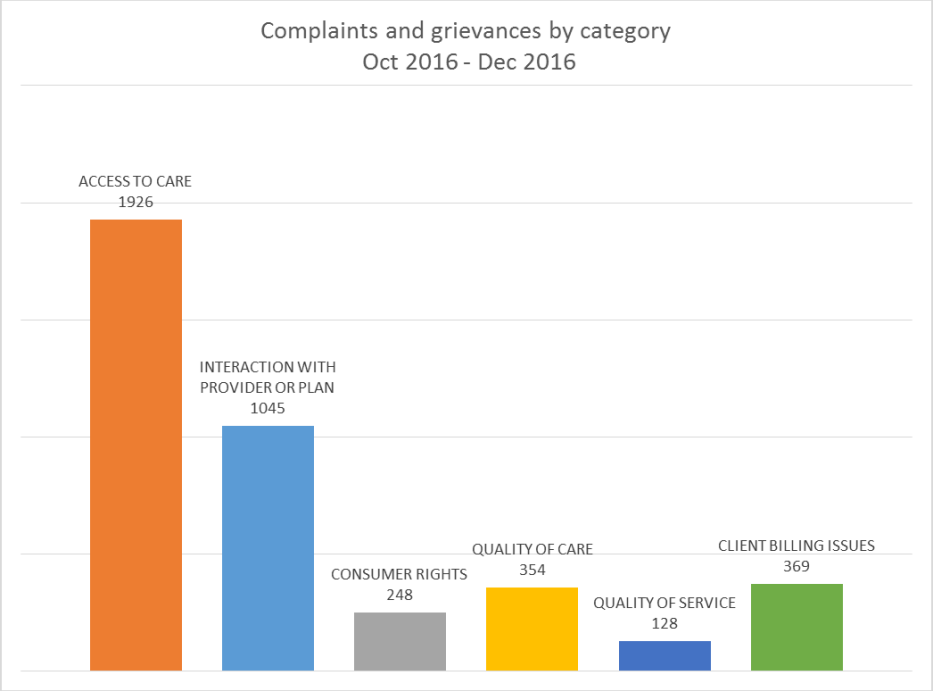
For total complaint rates among the individual 16 CCOs:

- The lowest rate was 0.50 per 1,000 members.
- The highest rate was 11.35 per 1,000 members. This is a decrease from last quarter, when the highest rate was 13.83 per 1000 members.

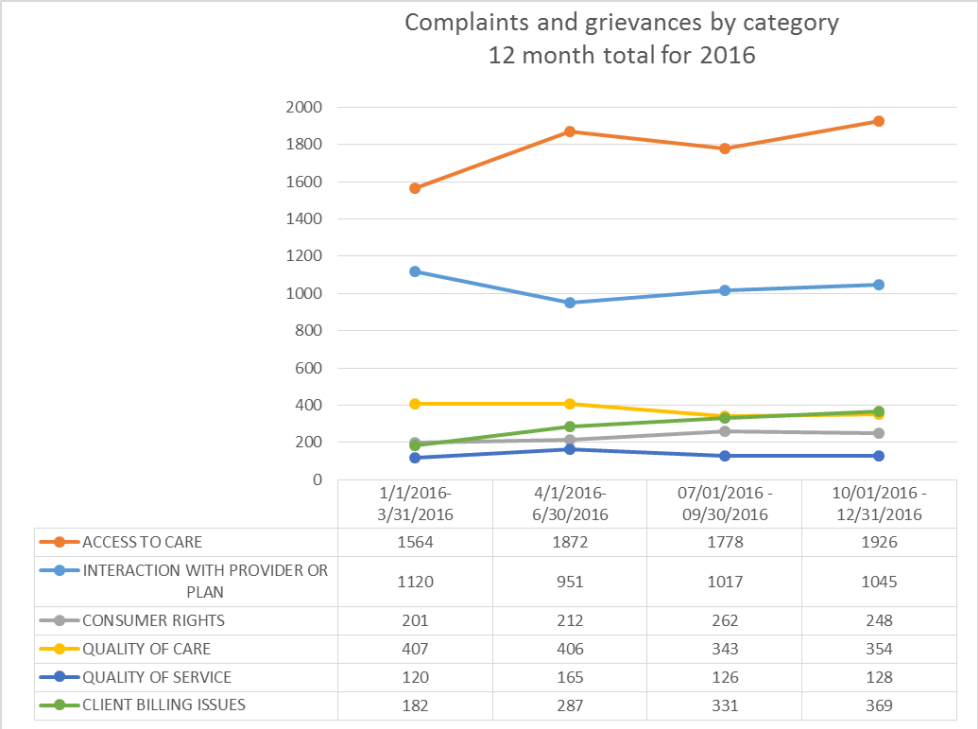
The Non-Emergency Transportation (NEMT) complaints continue to be an issue. However, due to extensive work in some CCOs, the rate of NEMT complaints decreased this quarter.

The rate of Access to Care complaints is still high because of the NEMT issue. However, the number of NEMT complaints decreased while other sub-categories within the main Access to Care category increased.

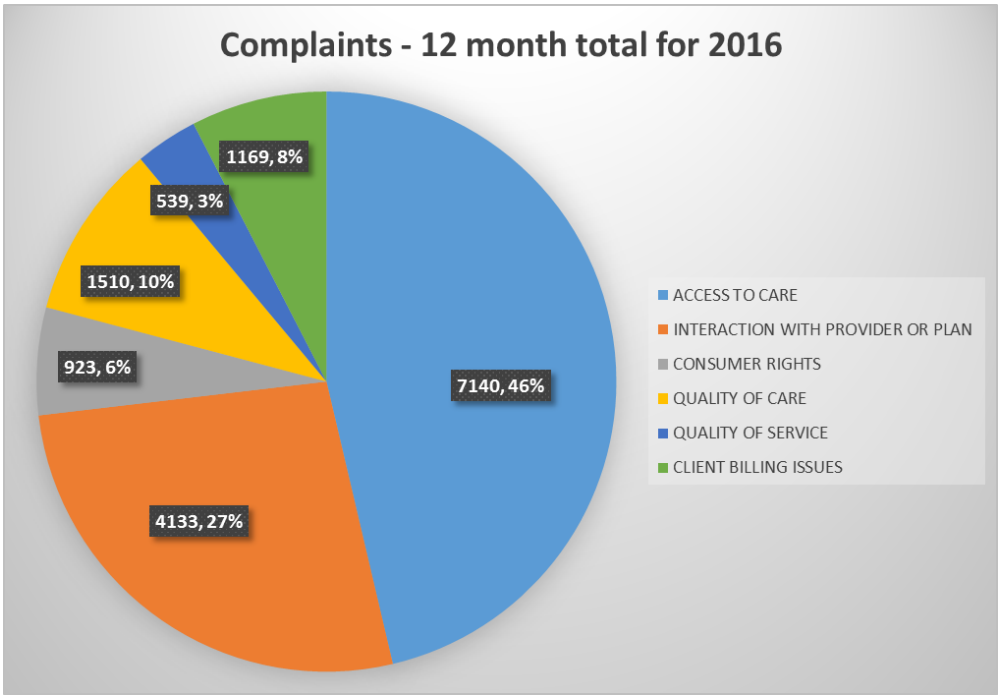
There is continued effort across the CCOs to improve and standardize data collection. CCOs report they are working closer with their delegated contractors to standardize reporting, and continuing work with their own member services staff to ensure standardization of how complaints are reported.



[1]The rate per 1000 members is based on an average of the monthly member enrollment totals for all 16 coordinated care organizations (CCOs) during the reporting period.



	1/1/2016-3/31/2016	4/1/2016-6/30/2016	07/01/2016 - 09/30/2016	10/01/2016 - 12/31/2016
ACCESS TO CARE	1564	1872	1778	1926
INTERACTION WITH PROVIDER OR PLAN	1120	951	1017	1045
CONSUMER RIGHTS	201	212	262	248
QUALITY OF CARE	407	406	343	354
QUALITY OF SERVICE	120	165	126	128
CLIENT BILLING ISSUES	182	287	331	369



Interventions

OHA staff continue to work on improving the reporting process for the CCOs. Collaborative work with the CCOs is being done to improve the reporting tool used to report data to OHA.

Applied Behavioral Analysis (ABA)

In response to an observed trend of concerns related to the delivery of Applied Behavioral Analysis this quarter, and specifically regarding CCO denials of ABA services, OHA has employed the following

strategies to improve the experience of families and children accessing ABA benefits in order that children will have the very best opportunity to be supported in their development.

OHA has:

- Resolved an issue with its administrative rules that inappropriately resulted in CCO denials.
- Issued denials based on the incorrect rule, rescinded incorrect denials and provided the appropriate authorizations.
- Worked toward completion of a comprehensive review of the status of ABA claims paid under its fee-for-service program and those paid by CCOs.
- Established a risk corridor when ABA benefits administration was transferred to the CCOs to encourage use of the ABA benefit.
- Committed to conducting follow up with CCOs in all cases of noncompliance and to require plans of correction, as necessary.

OHA also is implementing plans to:

- Schedule a learning collaborative at its Quality and Health Outcomes Committee to engage experts in sharing the evidence-based information about ABA, informing clinical leaders from CCOs about diagnosis and treatment.
- Schedule a learning collaborative through its Transformation Center for interested stakeholders, CCO staff, developmental disability program staff from the Department of Human Services (DHS), school districts and service delivery providers in order to educate attendees about ABA. The purpose of the Transformation Center is to spread best practices and innovation.

Fee-for-service (FFS) complaints

No report this quarter.

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.	29,356	1,168	12-178
b) Single PHP service area, denial to obtain services outside the PHP panel	191	10	0-7
c) Termination, suspension or reduction of previously authorized covered services	715	13	0-13
d) Failure to act within the timeframes provided in § 438.408(b)	4	18	0-18
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.	25,769	432	0-161
Total	**56,035**	**1,641**	**12-377**
Number per 1000 members	**65.00**	**1.90**	**1.02-3.33**
Number overturned at plan level		**557**	**3-113**
Appeal decisions pending		**13**	**0-7**
Number of contested case hearings requested		**633**	**6-132**

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
Overturned prior to hearing		**220**	**1-57**
Overturn rate		**34.76%**	**7.69-57.58**
Hearing decisions pending		**0**	**0**
Hearing requests per 1000 members		**0.73**	**0.40-1.52**

Contested case hearings

The following table[2] represents the contested case hearings that were processed during the quarter.

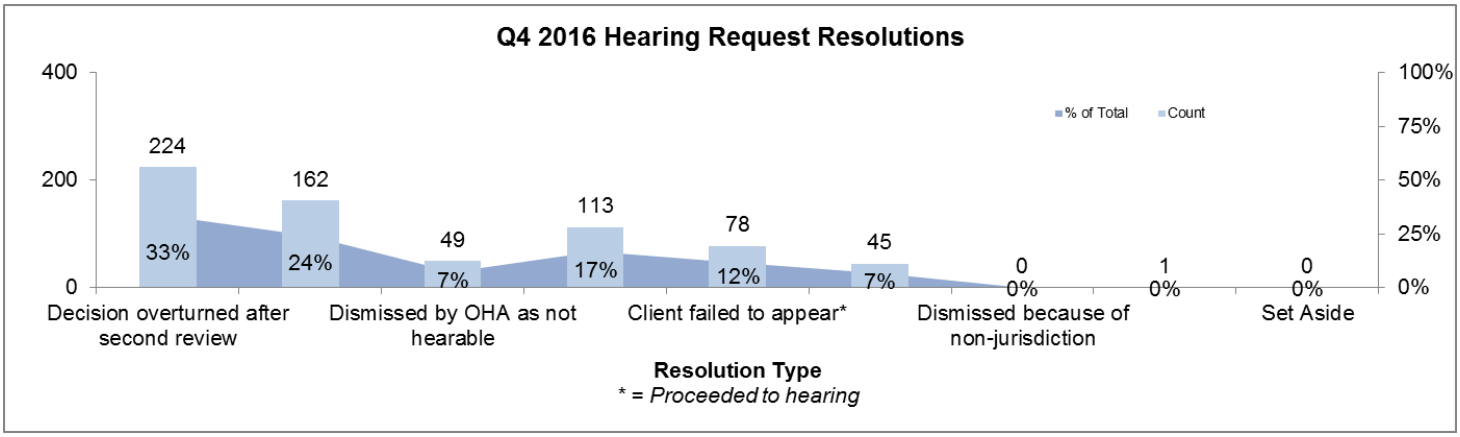
Plan Name	Total requests received	Average plan enrollment *	Per 1000 members
ALLCARE HEALTH PLAN, INC.	23	47,912	0.4801
CASCADE HEALTH ALLIANCE	13	16,042	0.8104
COLUMBIA PACIFIC CCO, LLC	19	23,553	0.8067
EASTERN OREGON CCO, LLC	18	46,767	0.3849
FAMILYCARE, CCO	99	115,003	0.8608
HEALTH SHARE OF OREGON	132	209,126	0.6312
INTERCOMMUNITY HEALTH NETWORK	25	51,800	0.4826
JACKSON CARE CONNECT	15	28,126	0.5333
PACIFICSOURCE COMM. SOLUTIONS	41	48,900	0.8385
PACIFICSOURCE COMM. SOLUTIONS - GORGE	8	12,233	0.6540
PRIMARYHEALTH JOSEPHINE CO CCO	6	10,327	0.5810
TRILLIUM COMM. HEALTH PLAN	79	86,200	0.9165
UMPQUA HEALTH ALLIANCE, DCIPA	38	25,894	1.4675
WESTERN OREGON ADVANCED HEALTH	18	19,228	0.9361
WILLAMETTE VALLEY COMM. HEALTH	86	94,029	0.9146
YAMHILL CO CARE ORGANIZATION	13	22,900	0.5677
ACCESS DENTAL PLAN, LLC		2,021	0.0000
ADVANTAGE DENTAL	3	22,463	0.1336
CAPITOL DENTAL CARE INC		14,129	0.0000
CARE OREGON DENTAL		2,051	0.0000
FAMILY DENTAL CARE		1,986	0.0000
MANAGED DENTAL CARE OF OREGON		2,062	0.0000
ODS COMMUNITY HEALTH INC	1	7,346	0.1361
FFS	26	294,291	0.0883
Total	**663**	**1,204,387**	**0.5505**

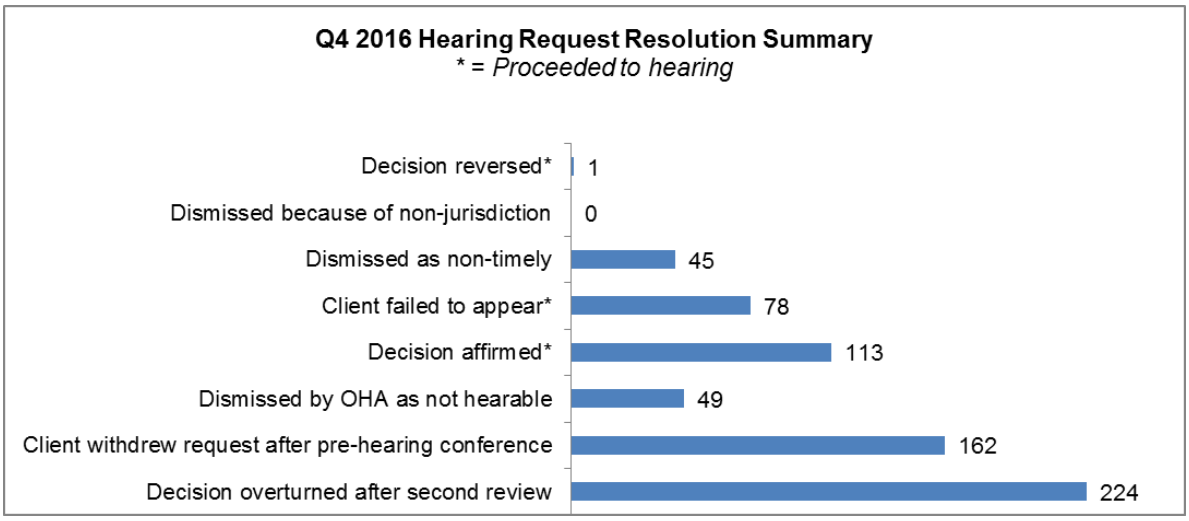
The following chart shows the outcomes of the hearings completed this quarter.

Outcome	Count	% of Total
Decision overturned after second review	224	33%
Client withdrew request after pre-hearing conference	162	24%
Dismissed by OHA as not hearable	49	7%
Decision affirmed	113	17%
Client failed to appear	78	12%
Dismissed as non-timely	45	7%
Dismissed because of non-jurisdiction	0	0%
Decision reversed	1	0%
Set aside	0	0%
Total outcomes	**672**	

[2] Data Source: New_HearingLog.mdb & DSSURS; Data Extraction Date: 02/19/2017

Trends[3]





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 March 2016 through May 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:

Table 3 – Summary

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

[3] Data Source: New_HearingLog.mdb & DSSURS; Data Extraction Date: 02/19/2017

Metric	Frequency	
	Quarterly	Annually
■ 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)		
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

No report this quarter.

Health professional graduates participating in Medicaid

No 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
-	-	-	-	-

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
-	-	-	-	-

G. Transformation Center

Table 6 - Innovator Agents – Summary of promising practices

Innovator Agent learning experiences

Summary of activities	The Innovator Agents participated in a variety of learning experiences during the last quarter to assist the CCOs as they continue to implement health care transformation. Many of these learning experiences were provided by local community agencies, CCOs, or CACs, to educate the general public about health care. IAs received training in the following areas: ■ Too Much Stuff – An In-Depth Look at Hoarding Behaviors, Presented by the Wellness and Education Board of Central Oregon ■ Bridges Out of Poverty – Ongoing Training for Central Oregon CAC members presented by Central Oregon Health Council ■ Altruism in Caregiving, Culturally Appropriate Language for the Caregiver, Trauma Informed Care for the Caregiver – a series of training for caregivers in the community. Presented by the Cascade Health Alliance CAC. ■ Eye to Eye – Improving the Adolescent Well Check Metric. Sponsored by Oregon School-Based Health Alliance and the Statewide Youth Action Council. ■ NEAR (neuroscience, epigenetics, ACES and resiliency) - three part training by ACE interface as part of ongoing investment into Trauma Informed Care. Presented through the collaboration of three CCOs, Jackson Care Connect, AllCare and Primary Health of Josephine County. ■ Oregon Rural Health Conference – information about efforts to improve rural supports for clinical care including recruitment mechanisms of providers, engagement of community and work between hospital, FQHCs and CCOS. Sponsored by Oregon Health Sciences University. ■ Collective Impact Summit by Tamarack Institute. An opportunity across Jackson and Josephine counties to explore and encourage collective impact work in the communities. ■ American Public Health Association conference with focus on community engagement, community health worker programs, and collective impact

	and health equity. ■ Ongoing participation in the Project ECHO Medicaid Collaborative with seven other states.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Learning collaborative activities

Summary of activities	No report this quarter.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Assisting and supporting CCOs with Transformation Plans

Summary of activities	■ Assisted and supported CCOs' access to technical assistance through the transformation center that addressed health equity in the transformation plan and CHIP. ■ Ongoing review of CHIP goals and objectives with CAC and assistance in using CHIP grant to achieve those goals and objectives. ■ Supported and attended meetings with partners from CCOs and DCOs to improve oral health through development of an awareness campaign on the access to oral health care for members on OHP and the awareness of school screening requirements per Oregon law. ■ Participated in OPIATE PIP subcommittee on member communications. ■ Participated in CCO Clinical Advisory Panel with ongoing discussion of metrics, work flow, quality issues and transformation changes related to clinical outcomes and community standards. ■ Participated in Early Learning Hubs ■ Participated in local community Regional Health Equity Coalitions ■ Engaged in local conversations related to mental health services ■ Provided technical assistance, feedback, and fielded questions regarding alignment of the CHA, CHIP and Transformation Plan. ■ Ongoing meetings with Population Health Teams and Grants Management to further assess Transformation Plan activities and better link them to other initiatives. ■ Participate in CCOs' Internal Quality Committees that focus on strategy and implementation of efforts to improve quality incentive metrics, the statewide PIP and other PIPs, as well as CHIP efforts. ■ Attended and participated in CCO health councils to review CHA, CHIP, Quality Incentive Metrics, and Transformation Plan activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Assist CCOs with target areas of local focus for improvement

Summary of activities	■ Worked with CCOs in the area of enrollment of foster children into CCOs ■ Participated in planning around Immunization Technical Assistance and Immunization metrics work to improve overall immunization rates ■ Participated in meetings related to other technical assistance work,

	including CAC engagement, organizational strategic planning and health equity. ■ Engaged in CCO/Transformation Center discussions related technical assistance bank opportunities, planning and next steps. ■ Engaged with CCOs and community partners in ongoing discussions around housing needs in the community. ■ Met with and coordinated efforts with public health directs, child welfare and behavioral health regarding barriers and development of solutions. ■ Provided consultation and research for proper understanding of quality incentive metrics and exceptions ■ Planned for improvement in Transformation Plan and CHIP ■ Participated with Early Learning Hubs and Help Me Grow initiatives. ■ Participated in Project Access Now Pathways project to assist in streamlining of data capture, State Public Health home visiting programs, etc. ■ Provided information to CCO about Project Echo to help with pilot and ongoing program. ■ Provided assistance with Alternative Payment Method training and connection to the Transformation Center for addition technical assistance. ■ Community voice inclusion in community health assessment survey activities ■ • Provided connections between CCO and Adults and Persons with Disabilities for long-term systems and supports.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Communications with OHA

Summary of activities	■ Transformation Center – regarding technical assistance opportunities for CCO, information gathering regarding issues around transformation plan and CHIP, participation in CAC recruitment meetings. ■ Attend Collaboratives with Regional Outreach Coordinators for updates on enrollment and the ONE system. ■ Public Health – planning for upcoming public health modernization forums and strategizing on how to engage the community. ■ Regular contact with Account Representatives to keep them updated on CCO activities and work through individual member issues. ■ OHA Quality Assurance and Improvement ■ Support Early Learning requests for HUB and CCO related stories and efforts for statewide report. ■ Support Transformation Center request for review and updating of CAC 101 tool for CACs. ■ Collect and support information gathering for OHA on various subjects including CHIP and Early Learning report for legislature. Legislative requests for additional information from CCOs, ABA requests from CCOs. ■ Bridge conversations with CCO staff related to CCO-G enrollment. ■ Provided updated information to OHA about community challenges in providing health care.

	■ Participated with the Oregon Health Policy Board listening tour that occurred in various communities. ■ Participated in person and/or by phone in QHOC, Metric TAG meetings, and weekly Collaborative Community Outreach planning meetings.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Communications among Innovator Agents

Summary of activities	Innovator Agents meet on Tuesdays for regular huddles. During these meetings they problem solve and share barriers and innovations of the CCOs they cover. IAs have regular Friday phone calls and invite OHA personnel and other outside agencies to give updates about their programs or to use the time as a venue to get information to the CCOs through the Innovator Agents.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Community advisory council activities

Summary of activities	■ Innovator Agents have provided support to CACs as they have received training and technical assistance and have engaged in extensive CHIP related work with the focus in the areas of social determinants of health, ACES, trauma informed care, poverty, transportation, tobacco use, school health programs Blue Zones project, housing, and health equity. ■ Innovator agents have provided support as many CACs have been focusing on recruitment and retention of CAC members with a focus on a more diverse membership. ■ Innovator agents provide a conduit between OHA and the CACs by providing updates, information and connections to technical assistance.
Promising practices identified	No report this quarter.
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	■ Innovator agents worked closely with Regional Outreach Coordinators and Account Representatives to resolve OHP member level issues. ■ IAs assisted CACs with community surveys to include in the Community Health Needs Assessment. ■ IAs recruited community members to attend the listening tour presented by the Oregon Health Policy Board. ■ An IA assisted the CCO's Community and Member Impact committee review member level data to inform best practices and return on investment opportunities for social determinants of health work such as healthy foods, exercise support programs and transportation needs.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

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

Summary of activities	No report this quarter.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Information sharing with public

Summary of activities	■ Maintain connections and act as a conduit between DHS Adults and Persons with Disabilities and Child Welfare and the CCOs. ■ Provide ongoing OHA updates to CCO staff, boards and CACs. ■ Work with stakeholders engaged in health equity, school health and high school graduation focus areas to improve systems and make connections for community and CCO resources. ■ Facilitate steering committees for the next Community Health Assessment work between hospital systems, CCOs, FQHCs, public and mental health, and other agencies. ■ Participate in Community Collaboratives to assist with system issues and specific community related projects. ■ Facilitated Behavioral Health Collaborative and related work groups ■ Participated in CMS site visit ■ Shared Pathways model and use of CLARA data system in other regions for potential alignment
Promising practices identified	No report this quarter.
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

September Legislative Days (September 21-23, 2016)

The Oregon Health Authority (OHA) provided updates to both the Senate and House Committees on Health Care. Topics included:

- Section 1115 Waiver Update
- Update on the OHA Behavioral Health Collaborative & United State Department of Justice (USDOJ) Mental Health Services Plan
- Oregon Health System Transformation Quarterly Report
- Oral Health Workgroup Update
- Oregon Health Information Technology (OHIT) Program Annual Report

December Legislative Days (December 12-14, 2016)

OHA also provided updates to both the Senate and House Committees on Health Care during December Legislative Days. Topics included:

- Oregon Health Plan (OHP) Enrollment (presentation and handout)
- OHA Behavioral Health Collaborative Update
- Oregon Opioid Prescribing Guidelines
- Patient Centered Primary Care Home (PCPCH) Program Implementation Report

I. Litigation status

No 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 patient-centered primary care home program (PCPCH) published an evaluation that examined utilization and expenditure patterns of patients who receive their care at a PCPCH vs at a non-PCPCH. The evaluation's findings indicate that the PCPCH program has been very successful in meeting the goals of cost-effective, system-wide care transformation embodied in the Triple Aim: better health, better health care, and lower health care costs.

Also this quarter, OHA continued monthly meetings 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 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 looked at utilization and expenditure patterns of patients who receive their care at a PCPCH vs at a non-PCPCH. The final report was released in Q4 2016[4]. The evaluation's findings indicate that the PCPCH program has been very successful in meeting the goals of cost-effective, system-wide care transformation embodied in the Triple Aim, better health, better health care, and lower health care costs.

Notable highlights from the PCPCH evaluation include:

- PCPCH program implementation has resulted in $240 million in savings to Oregon's health system over its first three years.
- For every $1 increase in primary care expenditures related to the PCPCH program, there is a $13 in savings in other services, such as specialty care, emergency department and inpatient care.
- For a clinic that has been a PCPCH for three years, the total cost of care per member, per month is lowered by $28. This is double the overall average savings of $14 per member, per month for a PCPCH in the first year of recognition.
- PCPCH program implementation encouraged clinics to embrace team-based care and continuous improvement, and to adopt a "patient centered lens."
- PCPCH program implementation helped clinics to shift towards population-based strategies that will improve the health of groups of patients who share a diagnosis or demographic characteristics.

Interim findings:

- In this quarter, there were 647 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 77.44% 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.

[4] https://www.oregon.gov/oha/pcpch/Pages/reports-and-evaluations.aspx

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 six webinars:

1. Patient Referrals to Self-Management Programs (34 attendees)
2. Clinician & Organizational Wellness (28 attendees)
3. Q&A with PCPCH Program Staff (49 attendees)
4. Preventing Falls in Primary Care (18 attendees)
5. Informing Community Projects with Community Health Assessments (15 attendees)
6. Mindfulness Training for Clinician & Organizational Vitality (39 attendees)

Additionally, The Oregon Health Care Quality Corporation (Q Corp) launched a new initiative called the Clinician Academy in Q3 2016. It is focused on pairing residents and new providers with seasoned providers 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 providers who have practical skill sets in this work, and enable a broader, statewide integration and support network of interested providers who can support each other's work and goals beyond the Clinician Academy's lifespan.

Recruitment for the Clinician Academy was completed in Q4 2016 and nine clinicians were enrolled in the program. A kick-off meeting was held in Q4 2016 and there are weekly project meetings. Final program meeting and report outs will occur in Q1-Q2 2017.

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

Evaluation activities:

Oregon's Coordinated Care Organizations

During this reporting period, OHA continued to provide updated metrics results to CCOs utilizing the automated metric reporting tool ("dashboard"), for periods covering July 2015 – June 2016, August 2015 – July 2016, and September 2015 – August 2016.

OHA also re-calculated 2016 mid-year performance for the *Childhood immunization status* and *Adolescent immunization* measures due to errors found in previously-reported data. Final CY 2015 performance was also recalculated accordingly to ensure appropriate comparisons when calculating improvements. Final specifications for the 2017 incentive measures were posted online in December (see Appendix E).

Hospital Transformation Performance Program

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

In November, hospitals received individual-level reports for the *Emergency Department Information Exchange (EDIE)* measure for review and validation. These data covered the period October 2015 – September 2016 (HTPP Year 3). Also in this quarter hospitals also received individual-level data and progress reports on the Follow-up after hospitalization for mental illness measure, with data through the third quarter of HTPP Year 3 (the data are lagged to allow for claims run-out) (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 1st 2015, and finally three more FQHCs joined on July 1st 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 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 engagement strategies.

OHA tracks several metrics on a quarterly basis including Uniform Data System (UDS) measures, and 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. These services are called "Engagement Touches" (ETs) and are captured within the FQHC's electronic health record. ET service categories include:

- 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 was selected as one of eight demonstration states to pilot the Certified Community Behavioral Health Clinic (CCBHC) program. Oregon's two-year demonstration program is scheduled to "go-live" on April 1, 2017. Beginning in April, CCBHCs will be eligible to begin billing for allowable costs, identified as "demonstration services." OHA is refining internal processes to support a timely payment process as well as comprehensive data collection. OHA will continue to monitor compliance with state and federal standards, as well as provide ongoing technical assistance to CCBHCs as they work toward the April 1st project launch date.

Interim findings:

CCO Financial Reports

In December, an internal analysis of the most recent financial reports available showed that 35.9% of all plan payments are non-fee-for-service (FFS). This is a decrease from the previous quarter, in which 40.5% of plan payments were non-FFS; however, in looking at historical trends this is normal deviation. 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

OHA saw that health centers were struggling to produce or report a high amount of Engagement Touches (ETs) in their first year on the program. However, each successive phase of FQHCs has produced improved

services for their population. This is due to the improved onboarding process, with technical assistance by the Oregon Primary Care Association (OPCA).

- Phase 1 began with about 200 ETs per 1000, on average. The Phase 1 cohort's production of ETs leveled out in Q1 2016 after significant gains throughout 2014 and into 2015.
- Phase 2 surpassed that amount beginning with 274 per 1000. Phase 2, the largest cohort consisted of five FQHCs, and began to see their amount of touches decrease, on average.
- Phase 3 health centers began the program with 425 ETs per 1000 members attributed. Three FQHCs began on the APM program on July 1st 2016, and their average amount of ET per 1000 members was 1372; more than doubling any prior cohort to begin on the program. Phase 3 health centers achieved the record for highest quarter-over-quarter growth in average touches from Q2 to Q3 2016, at 110% increase.

Phase 1 Average ETs per 1000 OHP Members Attributed

- Q2 2013 (baseline) = 200
- Q2 2015 = 484
- Q3 2015 = 589 (22% increase)
- Q4 2015 = 629 (7% increase)
- Q1 2016 = 618 (2% decrease)
- Q2 2016 = 596 (4% decrease)
- Q3 2016 = 676 (13% increase)
- Q4 2016 = 618 (9% decrease) – **209% increase over the baseline**

Phase 2 Average ETs per 1000 OHP Members Attributed

- Q3 2014 (baseline) = 274
- Q4 2014 = 261 (5% decrease)
- Q1 2015 = 249 (5% decrease)
- Q2 2015 = 210 (15% decrease)
- Q3 2015 = 245 (17% increase)
- Q4 2015 = 320 (31% increase)
- Q1 2016 = 348 (9% increase)
- Q2 2016 = 549 (58% increase)
- Q3 2016 = 412 (25% decrease)
- Q4 2016 = 401 (3% decrease) – **46% increase over the baseline**

Phase 3 Average ETs per 1000 OHP Members Attributed

- Q3 2015 (baseline) = 425
- Q4 2015 = 473 (11% increase)
- Q1 2016 = 445 (6% decrease)
- Q2 2016 = 468 (5% increase)
- Q3 2016 = 985 (110% increase) – **132% increase over the baseline**

Phase 4 Average ETs per 1000 OHP Members Attributed

- Q3 2016 (baseline) = 1372

Other evaluations occurring for the FQHC APM program include monitoring of clinical quality measures, estimating the value of Engagement Touches, measuring the total cost of care, and monitoring utilization trends.

Clinical quality measures remain steady or continue to improve, 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 ER and Inpatient utilization for Phase 1 FQHC's patient populations. This study also showed a direct correlation between increased touches and reduced ER and inpatient hospital utilization.

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.

OHA is currently working with the OPCA to rebrand the Touches as *Care STEPs* (services that engage patients), and reconstruct the definitions and tracking requirements around recording Care STEPs to make it more intuitive and meaningful for practitioners and care team members in the clinical setting.

OHA has commissioned *Optumas* to produce another utilization and total cost of care study on Phases 1, 2, and 3 FQHCs. It is anticipated that this will be complete by April 30th 2017.

Transformation Center

During this quarter OHA continued implementing Comprehensive Primary Care Plus (CPC+). Additionally, the Primary Care Payment Reform Collaborative, required through Senate Bill 231, met three times this quarter.

In December, members of this collaborative representing the provider, commercial payer and Medicaid payer perspectives, along with Dr. Jim Rickards, OHA's Chief Medical Officer, presented the collaborative's recommendations to the Oregon Health Policy Board. The recommendations cover technical assistance, measurement, data aggregation, primary care behavioral health integration, collaborative governance and a potential payment model. The board voted unanimously to approve the recommendations and share with the Legislature for possible legislative action.

During this quarter the Transformation Center provided support to six CCOs to develop value-based payments (VBPs).

1. Health Share of Oregon continues work with Bailit Health Purchasing, LLC, to develop VBP 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.
2. Jackson Care Connect worked with National Council on Behavioral Health to develop a reasonable payment methodology for former delegated managed care organization mental health providers.
3. Western Oregon Advanced Health began work with Lynnea Lindsey-Pengelly to develop quality and financial outcome metrics to measure performance of behavioral and physical health integration and provide recommendations for value-based contracting with insurers, including Medicare, to achieve full integration across payers.
4. FamilyCare, Inc., worked with Lynnea Lindsey-Pengelly to develop an implementation strategy and value-based payment for integrating behavioral health and addictions into primary care.

5. Trillium Community Health Plan began work with Dale Jarvis and Associates, LLC, to conduct an analysis of potentially avoidable costs for members with severe mental illness; complete a ROI analysis; suggest performance measures; develop value-based payment structures and options for each service type; transition payment models for each service type; and develop an implementation work plan.
6. 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 for primary, secondary and tertiary prevention activities; complete a return on investment analysis to project potential savings for primary care clinics that implement high-impact initiatives.

Finally, work by two payers continued on projects to advance value-based payment methods for integrated care funded by grants from the Transformation Center. Both projects will be complete at the end of April 2017.

1. PacificSource Community Solutions is advancing integration of value-based payment methods across its Medicaid, Medicare, and commercial lines of business to prepare to implement the payment models across provider networks starting in at least two practices in 2017. In this quarter the project has focused on assessing current levels of clinical integration among five provider partners. In late 2016 and early 2017 the payer will develop a cost data set for the entire spectrum of activities associated with levels of integration to position the payer to shape value-based payment with provider partners who demonstrate readiness to implement in 2017.
2. CareOregon has contracted with a consultant to evaluate pilot payment models to support behavioral health integration. Based on this evaluation, the payer will develop a sustainable value-based payment model to support 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) was launched in May 2014 to assist organizations integrating primary care into behavioral health settings. Supported by the Adult Medicaid Quality Grant, the BHHLC continued through the conclusion of the grant in December 2016.

In this quarter, Oregon Health & Science University's Oregon Rural Practice-based Research Network (ORPRN) continued to help sites collect and report data on four of the Adult Core Measures (Body Mass Index (BMI), hypertension, diabetes testing, and diabetes poor control). All sites successfully submitted aggregate data on the four measures by mid-November. The OHA grant manager for the AMQ grant and the research director of ORPRN reported the results to the CMS QualityNet Conference in December 2016 in a presentation entitled "Capturing Adult Core Quality Measures in Emerging Behavioral Health Homes" as part of the panel "Behavioral Health Homes: Improving Health for People with Serious Mental Illness." The slides and presentation are available for on-demand viewing.[5]

[5] https://event.on24.com/eventRegistration/EventLobbyServlet?target=reg20.jsp&referrer=&eventid=1313619&sessionid=1&key=4634F4744CADA9EB909E32C9A5D84F3E&regTag=&sourcepage=register

ORPRN also helped sites develop registries of Medicaid patients receiving integrated care. These registries were submitted to OHA through a secure process in late October. OHA used the registries to pull claims reports for each site on 10 additional Adult Core Measures.

Finally, ORPRN conducted exit interviews in late November and early December with key informants from each of the participating sites as part of the qualitative component of the evaluation. The recordings were transcribed and coded in December.

ORPRN submitted to OHA a final report on the three-year project on January 31, 2017. It is currently under internal OHA review.

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 18.6% 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 the 71.8% in CY 2014 to 78.1% in the 2015-2016 mid-year. The measure is just 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:

From May 2014-December 2016, the Behavioral Health Home Learning Collaborative (BHHLC) provided targeted technical assistance to organizations integrating primary care into behavioral health settings.

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 required working very closely with site staff to understand how to collate that information from their EHRs or chart reviews as necessary, although ORPRN staff did not have access to the patient-level information in conformance with HIPAA rules. OHA used these registries to pull claims reports for 10 Adult Core Measures. 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 were submitted by mid-November and the results were compiled and reported in a presentation to the CMS QualityNet Conference in December. ORPRN submitted a final report on the Learning Collaborative on January 31, 2017. It is currently under internal OHA review.

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 monthly meetings with OHSU Center for Health Systems Effectiveness (CHSE), the contractor for the summative evaluation. 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 received the final dental integration evaluation report from OHSU Center for Health Systems Effectiveness (CHSE). This report evaluates the integration of dental care, which has been at the forefront of the CCO design since its inception. CHSE used 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 report is under review at OHA, and will be submitted to CMS Q1 2017.

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 will be sent to CMS for review Q1 2017.

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 November and received technical assistance from OHA Public Health Division staff and identified contractors to assist in pilot planning and implementation, collection and reporting of project data elements, scalability of pilot projects and work plan milestones. SRCH grantees received technical assistance from the Quit Line to determine effective referral processes to the Quit Line via the CCOs and clinics.

Additionally, OHA Public Health Division staff coordinated with 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. OHA staff from the Public Health Division and Health Systems Division take part in monthly check-ins with NACDD to provide updates and identify areas of technical assistance for SRCH grantees (CCOs, local public health authorities and DPP provider organizations). SRCH grantees funded to work on the NACDD grant identified seven DPP provider organizations to contract with in order to enroll 300 CCO members into NDPP. These SRCH grantees implemented strategies for patient and provider engagement for NDPP. SRCH grantees have met with seven clinic providers in Multnomah, Washington and Clackamas County to review the NDPP program and promote referrals to the NDPP programs. Outreach materials for NDPP were created and distributed to patients and providers, including CCO member-facing materials translated into other languages (Spanish, Chinese, Vietnamese). SRCH grantees drafted eligibility requirements and ICD-10 codes to incorporate into their billing models for NDPP, using the CDC-eligibility requirements as guidance.

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 increased from 43.1 per 1,000 member months in CY 2015 to 46.6 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 60.7% in the 2015-2016 mid-year, exceeding the CY 2016 benchmark of 50.0%.
- Adolescent Well-Care Visits increased from 32.0% in CY 2014 to 39.9% in the 2015-2016 mid-year.
- Potentially avoidable hospital admissions and complications for the 2015-2016 mid-year include:
    - Chronic obstructive pulmonary disease admission decreased from 411.9 per 100,000 member years in CY 2015 to 410.9 per 100,000 member years in the 2015-2016 mid-year.
    - Diabetes short-term complications increased from 140.9 per 100,000 member years in CY 2015 to 161.0 per 100,000 member years in the 2015-2016 mid-year
    - Adult asthma increased from 48.4 per 100,000 member years in CY 2015 to 48.8 per 100,000 member years in the 2015-2016 mid-year.

- Congestive heart failure increased from 234.0 per 100,000 member years in CY 2015 to 244.3 100,000 member years in the 2015-2016 mid-year.

Improvement activities:

Sustainable Relationships for Community Health (SRCH) Program

Oregon Health & Science University Evaluation Core was brought on as the external evaluator for the SRCH 2016 project, and ongoing evaluation activities took place with the SRCH grantees and OHA staff. Grantees delivered data reports for short term success measures to track progress on their tobacco, Chronic Disease Self-Management, Colorectal Cancer Screening and Diabetes Prevention Program referral system development.

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 October-December 2016:

- Health information technology oversight council;
- Medicaid EHR incentive program;
- CareAccord;
- Edie/PreManage;
- Oregon Medicaid Meaningful Use Technical Assistance Program;
- Health Information Exchange Onboarding Program; and
- ONC Interoperable Cooperative Agreement

Health Information Technology Oversight Council

OHA's Office of Health IT (OHIT) convenes the Health Information Technology Oversight Council (HITOC), which his 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. HITOC met in October and December to work on updating Oregon's strategic HIT plan.

Medicaid EHR Incentive Program

Oregon's Medicaid Electronic Health Record (EHR) Incentive Program was approved by CMS to add pediatric optometrists as an eligible professional type to the program starting with program year 2016.

CareAccord

A Direct secure messaging system that allows providers to send protected health information over the internet safely, securely, and privately. CareAccord is administered by the Oregon Health Authority through the Office of Health Information Technology. CareAccord is a member of DirectTrust and is an accredited HISP by the Electronic Healthcare Network Accreditation Commission (EHNAC).The number of Direct exchange transactions nearly tripled in 2016. OHA has also initiated pilot with DHS Vocational Rehabilitation to use Direct secure messaging as one electronic option for taking the program paperless.

EDIE/PreManage

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. OHA's contract for PreManage is to 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. PreManage adoption has continued to increase across Oregon. Nine CCOs are live and five additional CCOs are in some stage of adoption. Three of nine DCOs are live, with two more expected in the next couple of months. Fourteen of twenty-three Assertive Community Treatment (ACT) teams are live. Four Aging and People with Disabilities (APD) field offices have had training and are live. KEPRO, the FFS Contractor for the state, went live in November.

The EDIE Utility Governing Committee (of which OHA is a member) has utilized the following methods to assess the impact of these tools and report on progress:

- An EDIE/PreManage Behavioral Health User Community is meeting quarterly to develop behavioral health use cases, share best practices, and network.
- A statewide EDIE/PreManage online Learning Community launched mid-December. It already has more than 250 users who are sharing use cases and best practices, and attending webinar presentations through the Learning Community.
- Oregon Health Leadership Council (OHLC), in partnership with Collective Medical Technologies (CMT), the vendor for EDIE/PreManage, completed a survey of nearly every hospital in Oregon to assess the use of EDIE. Nearly everyone interviewed expressed finding significant value in the EDIE notifications to support care of patients in the emergency department. Suggestions were made for some improvements. OHLC/CMT will be working in partnership with EDIE users to develop plans to address the opportunities identified.

Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP)

OMMUTAP provides technical support to providers who are participating in the Medicaid EHR Incentive Program. The program offers resources that help providers use their EHRs in ways that maximize the value of their investments in EHRs and to improve efficiency and coordination of care. As of December 2016, there are over 500 providers at 110 clinics participating in the program.

Health Information Exchange Onboarding Program

Oregon intends to leverage federal 90/10 HITECH funding to increase Medicaid providers' ability to exchange health information electronically by supporting the costs of an HIE entity (*e.g.*, regional HIEs) to onboard providers, with or without an EHR. Initially, priority providers will include behavioral health, oral health, and critical physical health. In later phases, Oregon plans to include long term care, social services, corrections, and other critical Medicaid providers. We engaged with numerous stakeholders via individual meetings and advisory groups this quarter to develop a framework. In addition, we released a Request for Information for HIE entities to inform program development. The program is anticipated to launch later summer/early fall.

ONC Interoperable Cooperative Agreement

In 2015, the Office of the National Coordinator for Health Information Technology (ONC) awarded OHA, and our program collaborator, Reliance eHealth Collaborative (formerly known as 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 and Reliance $625,000 in supplemental funds to expand multistate Admit Discharge Transfer (ADT) notifications. The project will support the routing of EDIE ADT messages through Reliance to facilitate more actionable data across care teams, through encounter notifications and provider directory lookup that improve patient outcomes and keep users within their workflows.

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 the following measures were updated to the latest version, validated, and added to the dashboard.

- PQI 01 (diabetes, short term complication admission rate);
- PQI 05 (chronic obstructive pulmonary disease admission);
- PQI 08 (congestive heart failure admission rate); and
- PQI 15 (adult asthma admission rate) were updated to the latest version, validated and added to the dashboard.

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

Evaluation activities:

The summative waiver evaluation will include flexible services to better understand how they are deterring higher-cost care. Our contractor, CHSE, has formatted a detailed a detailed proposal for evaluating flexible services, which includes both quantitative and qualitative methods.

Interim findings:

CHSE, OHA's summative waiver 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 the center's strategic plan initiatives. The center continues working in collaboration with Oregon Health and Science University to evaluate key activities. Initial data on key activities will be available in spring 2017.

As mentioned above in Lever 1, In September OHA released a report from Portland State University had some significant findings that highlight the overall savings of the Patient-Centered Primary Care Home (PCPCH) Program.

Finally, this quarter, the Transformation Center surveyed the first two cohorts of Clinical Innovation Fellow graduates to assess longer-term program impact (see results below in interim findings).

Interim findings/ Improvement activities:

This quarter, the CCO learning collaborative met once and focused on opioids. Forty-seven people attended. Of evaluation respondents, 77% found the session valuable or very valuable to their work. Respondents shared the most helpful aspect of the session was reviewing various approaches and interventions. Findings from the Transformation Center's ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives and technical assistance activities are below.

Twenty-seven of the 28 graduates responded to the Clinical Innovation Fellow graduates survey, and found:

- Graduates are continuing to move into leadership roles and spread what they've learned through trainings, presentations and mentorship.
- Respondents said that because of the fellowship, they have greater confidence in leadership, their projects were propelled, and they made valuable professional connections.
- Many graduates shared that they wished the leadership development support continued beyond graduation.
- The third cohort of Clinical Innovation Fellows convened for three meetings. On average, 93% of evaluation respondents rated the meetings as very valuable or valuable.

Reports for the Transformation Center's Community Health Implementation Grants to CCOs were due December 31, 2016. The CCOs that received grant extensions completed a second progress report, while the remaining seven completed final reports. Reports showed that two CCOs (13%) completed all grant activities and two CCOs (13%) had met all grant outcomes. Another eleven CCOs (69%) had made progress on all grant activities and ten CCOs (63%) had made progress on all grant outcomes. Final reports are due March 31, 2017, for CCOs that received a grant extension.

Additionally, this quarter the Transformation Center has provided:

- Targeted metrics technical assistance, including:
  - Colorectal Cancer Screening – One webinar, with 28 participants (and 10 more who watched the recording) from 13 CCOs; 100% of evaluation respondents rated the session as very valuable or valuable and effective in meeting their needs.
  - Adolescent Well-Care Visits – One in-person Eye-to-Eye training, with 19 CCO staff and providers attending. Ninety-four percent of evaluation respondents rated the training as very valuable or valuable.

- Health equity consultations with four CCOs:
  - 92% of evaluation respondents rated the consultation as very valuable or valuable and 83% said they planned to take action based on the consultation.
  - Ten CCOs have requested follow-up technical assistance.

- Support through the Technical Assistance Bank:
  - In year two of the TA Bank (October 2015 – December 2016), the center received 51 requests from CCOs for a total of 713 technical assistance hours.

TA Bank evaluation results for 19 of 35 completed projects show that 100% of CCOs rated the assistance as very valuable (76%) or valuable (24%), and 97% of CCOs rated the assistance as very effective (64%) or effective (33%) in meeting the project goals.

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:

- Mr. Rigsby 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.
- Mr. Rigsby expressed concern about the rate of churn in the OHP.
- Mr. Rigsby 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

October 4, 2016:

John Mullin from the Oregon Law Center spoke about the amount of complaints resolved as identified in the HST Quarterly report and non-emergency medical transportation complaint tracking as well as non-emergency medical transportation brokerage and provider issues.

November 1, 2016:

John Mullen of the Oregon Law Center testified regarding the CCO listening session, Oregon's waiver, community collaboration and transportation. His testimony may be viewed here.

December 6, 2016:

No public testimony.

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

Transition plan finalized and approved by CMS in 2015.

VIII. Appendices

Appendix A. Quarterly enrollment reports

1. SEDS reports

Attached separately.

2. State reported enrollment tables

Enrollment	October 2016	November 2016	December 2016
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	996,111	984,470	972,746
Title XXI funded State Plan	64,100	64,307	65,020
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH Funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A

Enrollment current as of	October 31, 2016	November 30, 2016	December 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%	42	85	-38.10%	-359.52%
		Pregnant Women FPL > 170%	13	33	-46.15%	-1492.31%
	Title 21	SCHIP FPL > 170	62,403	164,359	17.10%	67.70%
Optional	**Title 19**	PLM Women FPL 133-170%	305	843	-33.11%	-1187.21%
	Title 21	SCHIP FPL < 170%	56,373	143,071	-17.11%	-30.66%
Mandatory	**Title 19**	Other OHP Plus	161,965	462,867	-1.48%	-15.82%
		MAGI Adults/Children	799,244	2,188,623	-3.91%	-4.59%
		MAGI Pregnant Women	16,957	42,153	-14.27%	-20.82%
		QUARTER TOTALS	1,097,302			

** 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
October	990,970	833,196	786	850	37,380	50,322	4,197
November	980,907	838,906	837	746	36,448	50,041	4,121
December	970,047	825,212	861	723	35,229	48,813	3,955
Qtr Average	980,641	832,438	828	773	36,352	49,725	4,091
		84.89%	0.08%	0.08%	3.71%	5.07%	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 continued reporting on the 2016 coordinated care organization (CCO) and state performance measures 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 (September 2015 – October 2016) for a subset of measures for which data are available.

Also in this reporting period, OHA continued conversations with CMS regarding the request to extend the hospital transformation performance program (HTPP) for an additional year. Preliminary data for the first nine months of Year 3 of the Hospital Transformation Performance Program (HTPP) are presented.

CCO incentive metrics updates

CCO reporting

- During this reporting period, OHA continued to provide updated metrics results to CCOs utilizing the automated metric reporting tool ("dashboard"), for periods covering July 2015 – June 2016, August 2015 – July 2016, and September 2015 – August 2016.
- OHA also re-calculated 2016 mid-year performance for the *Childhood immunization status* and *Adolescent immunization* measures due to errors found in previously-reported data. Final CY 2015 performance was also recalculated accordingly to ensure appropriate comparisons when calculating improvements.
- Final specifications for the 2017 incentive measures were posted online in December.

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 and third years of the test (DY 12, 13 and 14).

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	Year 3 Test
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	-
Measures Signed Off (as of 12/31/16)	22	22	22	22	22	21*	17	11
Total Measures	22	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

In November, hospitals received individual-level reports for the *Emergency Department Information Exchange (EDIE)* measure for review and validation. These data covered the period October 2015 – September 2016 (HTPP Year 3).

In this quarter hospitals also received individual-level data and progress reports on the Follow-up after hospitalization for mental illness measure, with data through the third quarter of HTPP Year 3 (the data are lagged to allow for claims run-out).

Committee and technical advisory workgroup updates

The **CCO Metrics & Scoring Committee** held two regular meetings during this reporting period (October and December). The focus of these meetings were informational presentations on several "areas of interest" for 2018 measure development. Topics included Kindergarten readiness; obesity; pharmacy / medication therapy management; and oral health / dental measures. In addition, the Committee continued discussions around a potential equity measure for 2018.

- At its December meeting, the Committee voted to remove SBIRT from the 2017 measure set, due to unavoidable coding changes and the lack of time to implement changes prior to the start of the measurement year. The Committee charged staff to develop an EHR-based measure in time for SBIRT to be added back in 2018.
- In addition to its regular-business meetings, the Committee met for a half-day retreat in December to discuss measure alignment and overall program structure in 2018 and beyond. To incorporate a historical perspective in these discussions, Committee "alumni" were invited to participate.

There was no public testimony provided to the Metrics and Scoring Committee this quarter.

Meeting materials are available online at: http://www.oregon.gov/oha/analytics/Pages/Metric-Scoring-Committee-Archives.aspx

The **CCO Metrics Technical Advisory Group (CCO TAG)** met twice this quarter. Meetings focused primarily on measure development and shared learning for measures, including SBIRT, dental sealants, and CAHPS-based measures. Meeting materials are available online at: www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx

The **Hospital Performance Metrics Advisory Committee** did not meeting during this reporting period, pending continued discussions with CMS regarding Years 4 and beyond of the HTPP. Materials for meetings from previous quarters are available online here: http://www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx.

The **Hospital Metrics Technical Advisory Group (Hospital TAG)** met once during this reporting period (in November) to discuss and provide feedback on technical aspects of several measures, and to review the Year 3 closeout process and schedule.

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

Attached separately. Updated data on the core measures is from October 2015 –September 2016, unless otherwise noted. Additionally, 2015 final performance has been added in a new column.

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 Measures

Attached separately. This quarterly report includes preliminary progress report data from the first nine months of HTPP Year 3 (October 2015 – June 2016).

DY 14 Quality and Access Test

Under STC 52 and 54 of Oregon's 1115 demonstration waiver, OHA must conduct a quality and access test in each program year that the state achieves its cost control goal to determine whether the state's health system transformation efforts have caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen.

The test consists of two parts: part 1 is a relatively simple comparison of program period quality and access to historical baseline levels of quality and access; part 2 is a more complex counterfactual comparison that will only be undertaken if the state fails part 1 in a given program year.
For the first two years, part 1 of the test is passed if a composite score for the quality and access metrics remains constant or improves as compared to the historical baseline. In subsequent years, the composite score must improve. DY 13 is the second year Oregon's quality and access test applies.

Part 1 of the test consists of a single aggregate indicator constructed using the 33 agreed upon quality and access measures (although individual measures can be excluded from the composite with good reason). The test result is generated based on the difference between aggregate performance in the demonstration year and the baseline period (calendar year 2011). Full methodology is documented in the Oregon's Accountability Plan, online at http://www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf

DY 14 Test Results

OHA presents three sets of DY 14 test results for CMS consideration, depending on the level of independence in the measure production underlying the composite score and the number of measures included.

Regardless of which option selected, Oregon demonstrates aggregated improvement over the 2011 baseline on the quality and access measures.

DY 14 Test #	Description	# of Measures Included (of 39[6])	DY 14 Test Score
1	DY 14 Test #1 was conducted entirely by Q Corp; all measures included in the composite were independently calculated and validated. Note: • Several claims-based measures are still undergoing validation for the DY period, although results for prior measurement periods had been validated and included in previous reporting. • Q Corp can only independently calculate claims-based measures, resulting in less than half of the measures being included in the composite.		
2	DY 14 Test #2 was conducted jointly by Q Corp and OHA. 9 claims-based measures were independently calculated and validated by Q Corp; non-claims based measures were calculated by OHA. Remaining claims-based measures that are still undergoing validation are not included in Test #2.		
3	DY 14 Test #3 was conducted entirely by OHA; all measures included in the composite were produced by OHA. Slight differences in the code and data used between OHA and Q Corp result in different results for the individual claims-based measures, although the overall trend in improvement is similar. All other data reported in Appendix E was produced by OHA.		

See composite tables below for the specific results, included measures, and rationale for exclusions under each result.

DY 14 Test: #1

This iteration of the DY 14 test was conducted entirely by the Oregon Health Care Quality Corporation: all measures included in the composite score were independently produced and validated.

DY 14 Composite Score (#1)

[6] Note measures with multiple rates are treated as separate measures in the composite scoring, resulting in more than the 33 quality and access test measures. For example, the measure Ambulatory Care: Outpatient and Emergency Department Utilization is treated as two measures for the purposes of the composite.

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Adolescent well-care visits (NCQA)	X	X	**53.2%**	27.1 %	37.5 %	10.40%	26.10 %	39.8%	Y	
Alcohol or other substance misuse (SBIRT)	X	X	**13.0%**	0.02 %	15.7 %	15.68%	12.98 %	120.8%	Y	
Ambulatory Care - ED Visits per 1000	X	X	**44.4**	61.0	44.4	(16.6)	(16.6)	100.0%	Y	
Ambulatory Care - OP Visits per 1000		X	**439.0**	364.2	287.8	(76.4)	74.8	-102.1%	Y	
Appropriate testing for children with pharyngitis (NQF 0002)		X	**76.0%**	73.7 %		-73.70%	2.30%	-3204.3%		Validation not complete as of 2/8/17
CAHPS composite: access to care	x	x							N	OHA must provide
CAHPS composite: satisfaction with care	x	x							N	OHA must provide
Cervical cancer screening (NQF 0032)		X	**74.0%**	56.1 %		-56.10%	17.90 %	-313.4%		Validation not complete as of 2/8/17
Child and adolescent access to primary care practitioners (all ages) (NCQA)		X	**93.6%**	88.5 %	88.2 %	-0.30%	5.10%	-5.9%	Y	
Childhood immunization status (NQF 0038)		X							N	OHA must provide
Chlamydia screening in women ages 16-24 (NQF 0033)		X	**63.0%**	59.9 %		-59.90%	3.10%	-1932.3%		Validation not complete as of 2/8/17
Colorectal cancer screenings per 1000 members	X	X							N	OHA must provide; methodology change.
Comprehensive diabetes care: Hemoglobin		X	**86.0%**	78.5 %	80.4 %	1.90%	7.50%	25.3%	Y	

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
A1c testing (NQF 0057)										
Comprehensive diabetes care: LDL-C Screening (NQF 0063)		X	**80.0%**	67.2 %	61.5 %	-5.70%	12.80 %	-44.5%	Y	
Controlling hypertension	x	x							N	OHA must provide
Developmental screening in the first 36 months of life (NQF 1448)	X	X	**50.0%**	20.9 %	57.9 %	37.00%	29.10 %	127.1%	Y	
Depression screening and follow up plan	x	x							N	OHA must provide
Diabetes: HbA1c poor control	x	x							N	OHA must provide
Early elective delivery	x	x							N	OHA must provide
Electronic Health Record Adoption	X	X							N	OHA must provide
Follow-up after hospitalization for mental illness (NQF 0576)	X	X	**68.0%**	65.2 %		-65.20%	2.80%	-2328.6%		Validation not complete as of 2/8/17
Follow-up care for children prescribed ADHD meds - Initiation (NQF 0108)	X	X	**51.0%**	52.3 %		-52.30%	-1.30%	4023.1%	N	Negative result when baseline exceeds benchmark
Follow-up care for children prescribed ADHD meds - Continuation (NQF 0108)		X	**63.0%**	61.0 %		-61.00%	2.00%	-3050.0%		Validation not complete as of 2/8/17
Immunization for adolescents (NQF 1407)		X	**70.8%**						N	OHA must provide
Medical assistance with smoking cessation component 1		X	**81.4%**						N	OHA must provide

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Medical assistance with smoking cessation component 2		X	**50.7%**						N	OHA must provide
Medical assistance with smoking cessation component 3		X	**56.6%**						N	OHA must provide
PCPCH Enrollment	X	X	**100.0 %**						N	OHA must provide
Physician Workforce Survey: providers accepting new Medicaid patients		x	**N/A**						N	OHA must provide
Physician Workforce Survey: providers currently see Medicaid patients		x	**N/A**						N	OHA must provide
Physician Workforce Survey: percentage of Medicaid payer at practice		x	**N/A**						N	OHA must provide
Plan all-cause readmission (NQF 1768)		X	**10.5%**	12.3 %		-12.30%	-1.80%	683.3%		Validation not complete as of 2/8/17
PQI 01: Diabetes, short term complication admission rate (NQF 0272)		X	**173.6**	192.9		(192.9)	(19.3)	1000.0%		Validation not complete as of 2/8/17
PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)		X	**409.1**	454.6		(454.6)	(45.5)	1000.0%		Validation not complete as of 2/8/17
PQI 08: Congestive heart failure admission rate		X	**303.0**	336.7		(336.7)	(33.7)	1000.0%		Validation not complete as of 2/8/17

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
(NQF 0277)										
PQI 15: Adult asthma admission rate (NQF 0283)		X	**47.9**	53.2		(53.2)	(5.3)	1000.0%		Validation not complete as of 2/8/17
Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	X	X	**69.4%**						N	OHA must provide; methodology change.
Prenatal and postpartum care: Postpartum Care Rate (NQF 1517)		X	**66.0%**						N	OHA must provide; methodology change.
Well-child visits in the first 15 months of life (NQF 1392)		X	**77.3%**	58.4 %	62.0 %	3.60%	18.90 %	19.0%	Y	
Number of Measures Included in Composite:	**9**									
Average Percent Improvement in Rate (Composite Score):	**31.1 %**									

DY 14 Test: #2

This iteration of the DY 14 test was conducted jointly by the Oregon Health Care Quality Corporation and OHA: all claims-based measures were independently calculated and validated by Q Corp; non-claims based measures were calculated by OHA (methodology and calculations for non-claims based measures were also validated by Q Corp where possible).

DY 14 Composite Score (#2)

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp + OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp + OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Adolescent well-care visits (NCQA)	X	X	**53.2%**	27.1 %	37.5 %	10.40%	26.10 %	39.8%	Y	
Alcohol or other substance misuse (SBIRT)	X	X	**13.0%**	0.02 %	15.7 %	15.68%	12.98 %	120.8%	Y	
Ambulatory Care - ED Visits per 1000	X	X	**44.4**	61.0	44.4	(16.6)	(16.6)	100.0%	Y	
Ambulatory Care - OP Visits per 1000		X	**439.0**	364.2	287.8	(76.4)	74.8	-102.1%	Y	
Appropriate testing for children with pharyngitis (NQF 0002)		X	**76.0%**	73.7 %		-73.70%	2.30%	-3204.3 %		Validation not complete as of 2/8/17
CAHPS composite: access to care	x	x	**87.0%**	83.0 %	83.8 %	0.80%	3.97%	20.2%	Y	CY 2015 data; OHA calculated
CAHPS composite: satisfaction with care	x	x	**84.0%**	78.0 %	85.4 %	7.40%	5.95%	124.4%	Y	CY 2015 data; OHA calculated
Cervical cancer screening (NQF 0032)		X	**74.0%**	56.1 %		-56.10%	17.90 %	-313.4%		Validation not complete as of 2/8/17
Child and adolescent access to primary care practitioners (all ages) (NCQA)		X	**93.6%**	88.5 %	88.2 %	-0.30%	5.10%	-5.9%	Y	
Childhood immunization status (NQF 0038)		X	**82.0%**	66.0 %	67.7 %	1.70%	16.00 %	10.6%	N	OHA calculated; methodology change - not comparable to previous years
Chlamydia screening in women ages 16-24 (NQF 0033)		X	**63.0%**	59.9 %		-59.90%	3.10%	-1932.3 %		Validation not complete as of 2/8/17
Colorectal cancer screenings per	X	X	**10.9**	10.6					N	Methodology change; baseline /

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp + OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
1000 members										benchmark N/A
Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)		X	**86.0%**	78.5 %	80.4 %	1.90%	7.50%	25.3%	Y	
Comprehensive diabetes care: LDL-C Screening (NQF 0063)		X	**80.0%**	67.2 %	61.5 %	-5.70%	12.80 %	-44.5%	Y	
Controlling hypertension	x	x	**64.0%**	61.8 %	64.7 %	2.87%	2.17%	132.3%	Y	CY 2015 data; OHA calculated; CY 2013 baseline (statewide chart review)
Developmental screening in the first 36 months of life (NQF 1448)	X	X	**50.0%**	20.9 %	57.9 %	37.00%	29.10 %	127.1%	Y	
Depression screening and follow up plan	x	x	**25.0%**	1.4%	37.4 %	35.96%	23.56 %	152.6%	Y	CY 2015 data; OHA calculated; CY 2013 baseline (statewide chart review)
Diabetes: HbA1c poor control	x	x	**34.0%**	15.6 %	26.7 %	11.07%	18.37 %	60.3%	Y	CY 2015 data; OHA calculated; CY 2013 baseline (statewide chart review)
Early elective delivery	x	x	**5.0%**	10.0 %	1.9%	-8.11%	-5.01%	161.9%	Y	CY 2015 data; OHA calculated
Electronic Health Record Adoption	X	X	**49.2%**	28.0 %	76.5 %	48.50%	21.20 %	228.8%	Y	CY 2015 data; OHA calculated
Follow-up after hospitalization for mental illness (NQF	X	X	**68.0%**	65.2 %		-65.20%	2.80%	-2328.6 %		Validation not complete as of 2/8/17

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp + OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
0576)										
Follow-up care for children prescribed ADHD meds - Initiation (NQF 0108)	X	X	**51.0%**	52.3 %		-52.30%	-1.30%	4023.1 %	N	Negative results when baseline exceeds benchmark
Follow-up care for children prescribed ADHD meds - Continuation (NQF 0108)		X	**63.0%**	61.0 %		-61.00%	2.00%	-3050.0 %		Validation not complete as of 2/8/17
Immunization for adolescents (NQF 1407)		X	**70.8%**	49.2 %	65.1 %	15.90%	21.60 %	73.6%	Y	OHA calculated
Medical assistance with smoking cessation component 1		X	**81.4%**	50.0 %	49.6 %	-0.40%	31.40 %	-1.3%	Y	CY 2015 data; OHA calculated
Medical assistance with smoking cessation component 2		X	**50.7%**	24.0 %	26.9 %	2.90%	26.70 %	10.9%	Y	CY 2015 data; OHA calculated
Medical assistance with smoking cessation component 3		X	**56.6%**	22.0 %	23.1 %	1.10%	34.60 %	3.2%	Y	CY 2015 data; OHA calculated
PCPCH Enrollment	X	X	**100.0 %**	51.8 %	90.6 %	38.80%	48.20 %	80.5%	Y	OHA calculated
Physician Workforce Survey: providers accepting new Medicaid patients		x	**N/A**	86.3 %	87.9 %	1.60%	N/A	N/A	Y	CY 2015 data; OHA calculated; No benchmark
Physician Workforce Survey: providers currently see Medicaid patients		x	**N/A**	86.9 %	89.0 %	2.10%	N/A	N/A	Y	CY 2015 data; OHA calculated; No benchmark
Physician Workforce Survey:		x	**N/A**	17.0 %	31.5 %	14.50%	N/A	N/A	Y	CY 2015 data; OHA calculated; No

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp + OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
percentage of Medicaid payer at practice										benchmark
Plan all-cause readmission (NQF 1768)		X	**10.5%**	12.3 %		-12.30%	-1.80%	683.3%		Validation not complete as of 2/8/17
PQI 01: Diabetes, short term complication admission rate (NQF 0272)		X	**173.6**	192.9		(192.9)	(19.3)	1000.0 %		Validation not complete as of 2/8/17
PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)		X	**409.1**	454.6		(454.6)	(45.5)	1000.0 %		Validation not complete as of 2/8/17
PQI 08: Congestive heart failure admission rate (NQF 0277)		X	**303.0**	336.7		(336.7)	(33.7)	1000.0 %		Validation not complete as of 2/8/17
PQI 15: Adult asthma admission rate (NQF 0283)		X	**47.9**	53.2		(53.2)	(5.3)	1000.0 %		Validation not complete as of 2/8/17
Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	X	X	**69.4%**	65.3 %	84.7 %	19.40%	4.10%	473.2%	Y	CY 2015 data (baseline admin; CY 2014 hybrid)
Prenatal and postpartum care: Postpartum Care Rate (NQF 1517)		X	**66.0%**	40.0 %	51.0 %	11.00%	26.00 %	42.3%	Y	CY 2015 data (baseline admin; CY 2014 hybrid)
Well-child visits in the first 15 months of life (NQF 1392)		X	**77.3%**	58.4 %	62.0 %	3.60%	18.90 %	19.0%	Y	
Number of Measures Included in	**26**									

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	Q Corp + OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Composite:										
Average Percent Improvement in Rate (Composite Score):	**70.9 %**									

DY 14 Test: #3

This iteration of the DY 14 test was conducted entirely by OHA; all claims-based and non-claims based measures were produced by OHA. Results presented here align with data presented in Appendix E.

DY 14 Composite Score (#3)

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Adolescent well-care visits (NCQA)	X	X	**53.2%**	27.1 %	38.7 %	11.60%	26.10%	44.4%	Y	
Alcohol or other substance misuse (SBIRT)	X	X	**13.0%**	0.02 %	16.3 %	16.28%	12.98%	125.4%	Y	
Ambulatory Care - ED Visits per 1000	X	X	**44.4**	61.0	45.6	(15.4)	(16.6)	92.8%	Y	
Ambulatory Care - OP Visits per 1000		X	**439.0**	364.2	288.9	(75.3)	74.8	-100.7%	Y	
Appropriate testing for children with pharyngitis (NQF 0002)		X	**76.0%**	73.7 %	78.1 %	4.40%	2.30%	191.3%	Y	
CAHPS composite: access to care	x	x	**87.0%**	83.0 %	83.8 %	0.80%	3.97%	20.2%	Y	CY 2015 data
CAHPS composite: satisfaction with care	x	x	**84.0%**	78.0 %	85.4 %	7.40%	5.95%	124.4%	Y	CY 2015 data
Cervical cancer screening (NQF 0032)		X	**74.0%**	56.1 %	50.3 %	-5.80%	17.90%	-32.4%	Y	
Child and adolescent		X	**93.6%**	88.5 %	88.9 %	0.40%	5.10%	7.8%	Y	

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
access to primary care practitioners (all ages) (NCQA)										
Childhood immunization status (NQF 0038)		X	**82.0%**	66.0 %	67.7 %	1.70%	16.00%	10.6%	N	Methodology change, not comparable to baseline
Chlamydia screening in women ages 16-24 (NQF 0033)		X	**63.0%**	59.9 %	46.1 %	-13.80%	3.10%	-445.2%	Y	
Colorectal cancer screenings per 1000 members	X	X	**10.9**	10.6		(10.6)	0.3	-3333.3%	N	Methodology change, baseline / benchmark N/A
Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)		X	**86.0%**	78.5 %	82.6 %	4.10%	7.50%	54.7%	Y	
Comprehensive diabetes care: LDL-C Screening (NQF 0063)		X	**80.0%**	67.2 %	64.2 %	-3.00%	12.80%	-23.4%	Y	
Controlling hypertension	x	x	**64.0%**	61.8 %	64.7 %	2.90%	2.20%	131.8%	Y	CY 2015 data; CY 2013 baseline (statewide chart review)
Developmental screening in the first 36 months of life (NQF 1448)	X	X	**50.0%**	20.9 %	58.9 %	38.00%	29.10%	130.6%	Y	
Depression screening and follow up plan	x	x	**25.0%**	1.4%	37.4 %	36.00%	23.60%	152.5%	Y	CY 2015 data; CY 2013 baseline (statewide chart review)
Diabetes: HbA1c poor control	x	x	**34.0%**	15.6 %	26.7 %	11.10%	18.40%	60.3%	Y	CY 2015 data; CY 2013 baseline (statewide chart review)

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Early elective delivery	x	x	**5.0%**	10.0 %	1.9%	-8.11%	-5.01%	161.9%	Y	CY 2015 data
Electronic Health Record Adoption	X	X	**49.2%**	28.0 %	76.5 %	48.50%	21.20%	228.8%	Y	CY 2015 data
Follow-up after hospitalization for mental illness (NQF 0576)	X	X	**68.0%**	65.2 %	76.0 %	10.80%	2.80%	385.7%	Y	
Follow-up care for children prescribed ADHD meds - Initiation (NQF 0108)	X	X	**51.0%**	52.3 %	63.3 %	11.00%	-1.30%	-846.2%	N	Negative result when baseline exceeds benchmark.
Follow-up care for children prescribed ADHD meds - Continuation (NQF 0108)		X	**63.0%**	61.0 %	66.1 %	5.10%	2.00%	255.0%	Y	
Immunization for adolescents (NQF 1407)		X	**70.8%**	49.2 %	65.1 %	15.90%	21.60%	73.6%	Y	
Medical assistance with smoking cessation component 1		X	**81.4%**	50.0 %	49.6 %	-0.40%	31.40%	-1.3%	Y	CY 2015 data; OHA calculated
Medical assistance with smoking cessation component 2		X	**50.7%**	24.0 %	26.9 %	2.90%	26.70%	10.9%	Y	CY 2015 data; OHA calculated
Medical assistance with smoking cessation component 3		X	**56.6%**	22.0 %	23.1 %	1.10%	34.60%	3.2%	Y	CY 2015 data; OHA calculated
PCPCH Enrollment	X	X	**100.0 %**	51.8 %	90.6 %	38.80%	48.20%	80.5%	Y	OHA calculated
Physician Workforce Survey: providers accepting new Medicaid patients		x	**N/A**	86.3 %	87.9 %	1.60%	N/A	N/A	N	CY 2015 data; OHA calculated; No benchmark
Physician Workforce		x	**N/A**	86.9 %	89.0 %	2.10%	N/A	N/A	N	CY 2015 data; OHA

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Survey: providers currently see Medicaid patients										calculated; No benchmark
Physician Workforce Survey: percentage of Medicaid payer at practice		x	**N/A**	17.0 %	31.5 %	14.50%	N/A	N/A	N	CY 2015 data; OHA calculated; No benchmark
Plan all-cause readmission (NQF 1768)		X	**10.5%**	12.3 %		-12.30%	-1.80%	683.3%	N	Data not currently available
PQI 01: Diabetes, short term complication admission rate (NQF 0272)		X	**173.6**	192.9	159.5	(33.4)	(19.3)	173.1%	Y	
PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)		X	**409.1**	454.6	413.8	(40.8)	(45.5)	89.7%	Y	
PQI 08: Congestive heart failure admission rate (NQF 0277)		X	**303.0**	336.7	242.9	(93.8)	(33.7)	278.6%	Y	
PQI 15: Adult asthma admission rate (NQF 0283)		X	**47.9**	53.2	45.6	(7.6)	(5.3)	142.9%	Y	
Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	X	X	**69.4%**	65.3 %	84.7 %	19.40%	4.10%	473.2%	Y	CY 2015 data (baseline admin; CY 2014 hybrid)
Prenatal and postpartum care: Postpartum Care Rate (NQF 1517)		X	**66.0%**	40.0 %	51.0 %	11.00%	26.00%	42.3%	Y	CY 2015 data (baseline admin; CY 2014 hybrid)
Well-child visits in the		X	**77.3%**	58.4 %		-58.40%	18.90%	-309.0%	N	Data not currently

Measure Names	Incentive Measure	Q&A Test Measure	2013 Benchmark	OHA Baseline Result	OHA Year 3 Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
first 15 months of life (NQF 1392)										available
Number of Measures Included in Composite:	**31**									
Average Percent Improvement in Rate (Composite Score):	**94.6 %**									

Appendix F: Uncompensated Care Program

No report this quarter.