Division of Medical Assistance Programs

Kate Brown, Governor

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Ms. Vikki Wachino
Director, Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
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By electronic mail: Victoria.Wachino1@cms.hhs.gov

Dear Ms. Wachino:

Since July 1, 2014, the State of Oregon has operated a hospital incentive program, the Hospital Transformation Performance Program (HTPP), under its 1115 Demonstration, the Oregon Health Plan (Number: 21-W-00013/10 and 11-W-00160/10). The HTPP provides incentive payments to participating hospitals for reporting on and achieving benchmarks on metrics for quality improvement initiatives that transform and improve Oregon's health care system.

The program is based on the premise that the higher the quality of hospital performance, the better the health care and health care outcomes will be for those covered by the Oregon Health Plan (OHP), and beyond. The program compliments and aligns with our larger health system transformation efforts and supports the coordinated care model by facilitating reform in a major part of the health care delivery system.

While the initial CMS approval authorized the HTPP through June 2016, the 2015 Oregon Legislative Assembly has extended the program through September 30, 2019.

With this submittal, the State of Oregon is requesting two amendments related to the HTPP:

(1) An extension of the due date for the evaluation of the first two years of the HTPP, from March 31, 2016 to June 30, 2016.

(2) Extending the HTPP for an additional year under the current 1115 Demonstration. Oregon will later seek approval for an additional three years of the program as part of its waiver renewal discussions for the Demonstration beginning July 2017.

Evaluation

Per the current 1115 Demonstration Special Terms and Conditions (STCs), the State will conduct an interim evaluation of the HTPP to determine whether the goal of accelerating health system transformation has been met. Oregon will seek an extension of the evaluation due date, from March 31, 2016 to June 30, 2016, to ensure the data required to complete the evaluation are available. An extension of the due date for the interim evaluation report will allow the OHA to answer all of the required questions with more accuracy, and the timing will coincide with the availability of the coordinated care organization (CCO) Health System Transformation Report for calendar year 2015.

Approving HTPP Year 3 under the State's Current 1115 Demonstration

The HTPP is an integral aspect of health system transformation in Oregon. Oregon's vision for achieving health system transformation and the triple aim of better health, better care, and lower costs means that all aspects of the delivery system must coordinate their transformation efforts. Hospitals are an essential part of the State's delivery system. In recognition of this, the Oregon Legislature mandated the creation of a hospital incentive measure program, the HTPP, covering the 2013 – 2015 biennium. CMS approved these initial two years of HTPP under the State's current 1115 Demonstration, with the second performance year scheduled to end in September 2015.

In 2015, the Oregon Legislature solidified the importance of hospitals in transforming the healthcare system in Oregon by mandating the continuation of the HTPP for four additional years.

To maintaining measurement stability and allow hospitals time to fully implement improvement initiatives designed to improve performance and quality of care, the State proposes limited changes to the domains and measures included in the third year of the program. The third year of HTPP will serve as a transitional period during which the State will solidify the long-term vision of the program. The objective is a program that is fully integrated and aligned with Oregon's overall health system transformation goals. The State anticipates that a redesigned HTPP will be included in the State's proposal for a renewal of the 1115 Demonstration beginning July 2017.

Projected Payments and Budget Neutrality

Extending the HTPP through June 30, 2017, would allow the State to award performance payments for one additional year. While the State will request the annual HTTP limit to remain at $150 million Total Computable, projections indicate that the hospital assessment revenue will support approximately $100 million Total Computable in HTTP payments. Full Budget Neutrality calculations are attached to the request.

Public Notice and Tribal Consultation

The State has completed the required Tribal consultation and public notice process with Oregon's nine federally recognized Tribes. In addition, we have sought public comment via various formats, including the Secretary of State's web site, public news outlets statewide and meetings. While the

State continues to gather input from many general public and stakeholder sources, the primary required consultation and notices requirements were completed July 31, 2015.

Thanks to you and the staff for your ongoing assistance and collaboration on this program and these amendments, and for your consideration of this request. The State looks forward to your feedback and to continuing to work with you on this program. Please let us know if you have any questions or concerns or a need for further information or discussion.

Sincerely,

[redacted]

Leslie M. Clement
Director of Health Policy & Analytics and Interim State Medicaid Director

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Oregon Health Plan
Hospital Transformation Performance Program Year 3 Amendment Summary and Objectives

I. Summary of Requested Changes

The Oregon Health Authority (OHA) is requesting two amendments related to its hospital incentive program, the Hospital Transformation Performance Program (HTPP). The OHA has operated the HTPP under its 1115 Demonstration since July 1, 2014. The two requested amendments are summarized below, with more detailed requests and rationale later in the amendment summary and objectives:

(1) An extension of the due date for the evaluation of the first two years of the HTPP, from March 31, 2016 to June 30, 2016.

(2) Extending the HTPP for an additional year under the current 1115 Demonstration. OHA will later seek CMS approval for an additional three years of the program as part of its waiver renewal discussions for the Demonstration beginning July 2017.

II. Amendment Request 1: Evaluation Report Extension

Per the current 1115 Demonstration Special Terms and Conditions (STCs), the OHA will conduct an interim evaluation of the HTPP to determine whether the goal of accelerating health system transformation among targeted providers has been met. Oregon seeks an extension of the interim evaluation due date, from March 31, 2016, to June 30, 2016, to ensure the data required to complete the evaluation are available.

The waiver STCs require an independent interim evaluation of the HTPP to "determine whether the goal, to accelerate health system transformation among targeted providers, has been met." Per the STCs, the interim evaluation must answer the following questions:

- How have the Diagnosis Related Group (DRG) hospitals performed on all the HTPP metrics, as compared to baseline?
- How have the DRG hospitals performed on the metrics that are also CCO metrics, as compared to hospitals not receiving HTPP payments?
- What contributed to the success of those hospitals successfully meeting the HTPP measurement goals;
- What barriers prevented the successes of any hospitals not meeting HTPP measurement goals;
- What changes in hospital practice have been made as a result of HTPP;

- What, if any, changes to the incentive structure for the CCOs by the state and by the CCOs for the providers is the state considering, as a result of lessons learned from HTTP.

Hospitals are required to submit their final data for the second year of the program by March 31, 2016, which is also the current deadline for the OHA to submit the interim evaluation. The OHA, therefore, would not have the data available to compare performance in the second year of the program to the baseline, nor would it be able to compare performance on any metrics which are also CCO metrics as required in the STCs.

An extension of the due date for the interim evaluation report will allow the OHA to answer all of the required questions with more accuracy, and the timing will coincide with the availability of the coordinated care organization (CCO) Health System Transformation Report for calendar year 2015. The data for the CCO report will provide the information needed to answer the question on how non-DRG hospitals performed on any measures shared with the CCOs. If CMS approves continuation of the HTPP under the next Demonstration (beginning July 1, 2017), OHA will provide a final evaluation after or during Years 4-6.

While the independent evaluation of the program will not be available until 2016, please see Appendix A, which includes the baseline performance for each measure, as well as preliminary data showing the most recent performance available for each measure. As shown in Appendix A, of the eight measures for which a statewide average is available from Year 1 through the first nine months of Year 2, performance improved on four measures (hypoglycemia with insulin; excessive anticoagulation with Warfarin; HCAHPS providing discharge information; and, central line associated blood stream infections). This is significant in that hospitals did not begin targeted quality improvement efforts related to the program until Year 2.

Performance on adverse drug events due to opioids remained steady in the same time period, while performance on HCAHPS explaining medications declined very slightly; further quality improvement efforts are needed in relation to all-cause readmissions and catheter associated urinary tract infections. Switching from a measure of all-cause readmissions to a measure of potentially preventable readmissions in Year 3 (described further below) will allow hospitals to focus their efforts in reducing preventable readmissions. Further work will also be done in the next year to reduce catheter associated urinary tract infections. The State views these data as an indication that the program is beginning to improve quality at Oregon's hospitals, but that more time is needed to focus quality improvement efforts on these measures over the next year.

III. Amendment Request 2: Approving HTPP Year 3 under Current 1115 Demonstration

The HTPP is an integral aspect of health system transformation in Oregon. Oregon's vision for achieving health system transformation and the triple aim of better health, better care, and lower costs means that all aspects of the delivery system must coordinate their transformation efforts. Hospitals are an essential part of Oregon's delivery system. In recognition of this, the Oregon Legislature mandated the creation of a hospital incentive measure program, the HTPP, covering the 2013 – 2015 biennium. CMS approved these initial two years of HTPP under Oregon's current 1115 Demonstration, with the second performance year set to end in September 2015.

In 2015, the Oregon Legislature solidified the importance of hospitals in transforming the healthcare system in Oregon by mandating the continuation of the HTPP for four additional years. In addition, the Oregon Legislature's extension recognized the vital and intertwined roles hospitals and CCOs play in transforming the delivery system by passing legislation that equally splits the incentive pool funding between hospitals and CCOs beginning in the third year of the HTPP.

Because of the foundational role that hospital quality improvement plays in moving health system transformation forward in Oregon, the OHA seeks CMS approval of a one year extension of the HTPP under our current 1115 Demonstration. This third year of HTPP will serve as a transitional period during which the OHA will solidify the long-term vision of the program. The objective is a program which is fully integrated and aligned with our overall health system transformation goals. A redesigned HTPP will be included in the OHA's proposal for the 1115 Demonstration period which, subject to CMS approval, will begin in July 2017. We outline our proposal for year 3 of HTPP as well as our broader vision for the program below.

Year 3 Extension

The OHA proposes limited changes to the program during the Year 3 HTPP extension. This allows measurement stability and time for hospitals to fully implement quality improvement initiatives designed to improve performance on the HTPP measures and improve quality of care. In addition, there is growing enthusiasm for the next wave and maturation of the program, and the OHA would like time to work with partners to solidify both a long-term vision for the program and to develop a comprehensive plan for how this vision will be achieved. This also ensures that the vision for the HTPP, including additional domains and measures, is focused on the priority areas of the next 1115 Demonstration.

Year 3 Domains and Measures

As detailed in Table 1, the third year of the program is comprised of two overarching focus areas, hospital-focused domains and hospital-CCO collaboration focused domains. There are six domains in total, comprised of 11 measures. As appropriate, Year 2 benchmarks will be modified in Year 3 to ensure that performance is stretched in order for hospitals to qualify for incentive payments. The priority focus areas identified by the domains below continue to be integral to improving patient safety, quality, and reducing costs. For example, medication safety issues continue to permeate all care encounters within the care continuum, while reducing hospital acquired infections remains important in reducing healthcare costs and maintaining population health and quality of life. Furthermore, both the screening, brief intervention and referral to treatment (SBIRT) measure and sharing emergency department information with primary care providers measure are new efforts for hospitals, and time is needed to identify best practices and stabilize the data.

Table 1: Year 3 Focus Areas, Domains, Measures, and Benchmarks

Focus Area	Domains	Measures	Year 3 Benchmarks
Hospital focus	1. Readmissions	1. Potentially Preventable Readmissions	1. TBD
	2. Medication Safety	2. Hypoglycemia in inpatients receiving insulin 3. Excessive anticoagulation with Warfarin 4. Adverse Drug Events due to opioids	2. TBD 3. TBD 4. TBD
	3. Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166) 6. HCAHPS, Staff gave patient discharge information (NQF 0166)	5. National 90th percentile 6. National 90th percentile
	4. Healthcare-Associated Infections	7. CLABSI in all tracked units (adapted from NQF 0139) 8. CAUTI in all tracked units (adapted from NQF 0754)	7. TBD 8. TBD
Hospital-CCO collaboration focus	5. Sharing ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	9. 90th percentile, HTPP baseline
	6. Behavioral Health	10. Follow-up after hospitalization for mental illness (adapted from NQF 0576) 11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department	10. National Medicaid 90th percentile 11. TBD

To allow for stability in the program and for quality improvement efforts to mature, the OHA proposes limited changes to the domains and measures included in Year 3. However, after consultation with the Hospital Performance Metrics Advisory Committee, the Hospital Metrics Technical Advisory Group (which consists of representatives from all hospitals participating in the program), and partners at the Oregon Association of Hospitals and Health System Systems (OAHHS), beginning in Year 3 OHA plans to change the readmissions domain measure from all-cause readmissions to potentially preventable readmissions. The potentially preventable readmissions measure is advantageous for numerous reasons:

- The potentially preventable readmissions measure is risk adjusted, so hospitals with more acute cases will not be unfairly disadvantaged;
- Unlike the all-cause measure, the potentially preventable readmissions measure does not penalize hospitals for planned readmissions;
- And, the structure of the potentially preventable readmissions measure aids in focusing quality improvement efforts by allowing for the identification of populations most likely to suffer from a preventable readmission.

Calendar year 2015 will serve as the baseline year for the potentially preventable readmissions measure and used to calculate the benchmark and improvement targets for Year 3. Like all of the other measures included in the program, hospitals will have to meet either the benchmark or their improvement target to qualify for payment on this measure in Year 3. Progress on the potentially preventable readmissions measure to date is included in Appendix A.

While hospitals will continue to focus their efforts on the above priority areas during Year 3, the OHA can work with partners and the Hospital Performance Metrics Advisory Committee to identify additional focus areas for the future of the HTPP, and ensure that the program aligns with the vision of the broader 1115 Demonstration to begin in July 2017 (subject to CMS approval). The OHA and its stakeholders seek time to ensure that the domains capture needed efforts to transform the delivery system. Subject to CMS approval, changes to the program would begin in Year 4 (the preliminary long-term vision for the HTPP including Years 4-6 is described further below).

Year 3 Payment Structure

The quality pool distribution method occurs in two phases for both the hospital focused and the hospital-CCO collaboration focused domains. Phase 1 involves determining whether a hospital is eligible for the $500,000 floor (earned by achieving at least 75% of the measures). Phase 2 involves allocating the remaining funds to hospitals based upon performance against each measure. The domains are weighted so that each measure is worth a proportion of the

available funds; the proportions may shift if all measures are not achieved by at least one hospital (see Table 2, overleaf). The payments to individual hospitals are weighted based upon hospital size (defined as the proportion of statewide Medicaid discharges and patient days, 50 percent each).

Table 2: Share of Available Funds by Measure by Year after Floor Payment Allocation

Domains	Measures	Share of Available Funds Years 1-3*
Readmissions	1. Hospital-Wide All-Cause Readmissions (Years 1 & 2) / Potentially Preventable Readmissions (Year 3)	18.75%
Medication Safety	2. Hypoglycemia in inpatients receiving insulin	6.25%
	3. Excessive anticoagulation with Warfarin	6.25%
	4. Adverse Drug Events due to opioids	6.25%
Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166)	9.38%
	6. HCAHPS, Staff gave patient discharge information (NQF 0166)	9.38%
Healthcare-Associated Infections	7. CLABSI in all tracked units (modified NQF 0139)	9.38%
	8. CAUTI in all tracked units (modified NQF 0754)	9.38%
Sharing ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	12.50%
Behavioral Health	10. Follow-up after hospitalization for mental illness (modified NQF 0576)	6.25%
	11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department	6.25%

*Note this is share of funds available after allocation of the floor

Year 3 Performance Period

The performance periods for the first two years of the program ran the federal fiscal year, October – September. This was in large part due to when the program was initially approved by the Oregon legislature. However, to further alignment with the CCO incentive measure pool and ease administrative burden, in Year 3 the HTPP performance period will shift from the federal fiscal year to the calendar year. Thus, the performance period for the third year of the program will begin January 1, 2016 and end December 31, 2016. Details on the Year 3 program structure are included in a red-lined version of Attachment J to the waiver STCs (attached).

During the three month interim period between the end of the Year 2 performance period (September 30, 2015) and the beginning of the Year 3 performance period (January 1, 2016), hospitals are expected to continue quality improvement efforts related to the 11 measures included in Year 2 of the HTPP. While hospitals will not report these data to the OHA for payment on performance, they are still expected to track these metrics internally and report these data to the OAHHS. During this time period the Hospital Metrics Technical Advisory

Group, which is comprised of representatives from all of the hospitals participating in the program, will continue to meet to discuss the metrics and quality improvement efforts for Year 3. OHA will also use this time to liaise with hospitals regarding any changes to the measure specifications for Year 3, and to discuss and plan technical assistance needed to ensure hospitals are successful in improving quality in the third year of the program.

HTPP in the Future: Vision for Years 4 – 6

The OHA's vision for the HTPP is a program which is fully integrated with the 1115 Demonstration, which furthers collaboration between hospitals and CCOs, and leads to better health, better care, and lower costs. The OHA proposes that the details of the vision and the glide path to achieve the vision be developed during Year 3 of the HTPP and submitted to CMS as part of waiver renewal. This gradual approach also allows time for the Hospital Performance Metrics Advisory Committee (which provides recommendations on the measures included in the HTPP) to consult with the CCO Metrics & Scoring Committee (which advises on the incentive measures for the CCOs) on a shared vision and additional shared and collaborative measures. A comprehensive outline of this program will be included the OHA's request for renewal of our 1115 Demonstration beginning in July 2017, but the broad vision for the program is outlined below.

Years 4-6 Domains and Measures

The OHA would like to shift from the current structure of two focus areas (hospital and hospital-CCO collaboration focused) to one which integrates collaboration between hospitals and CCOs throughout the program. To this end, beginning in Year 4 the HTPP will include two measure sets: (1) The core measure set and (2) the hospital-specific 'menu' set. As in the CCO incentive measure program, these will be complimented by a challenge pool measure set, comprised of a subset of the most transformative domains and measures that are worth an additional incentive payment if benchmarks or improvement targets are achieved.

<u>Core Measure Set</u>

- Comprised of domains and measures that are applicable to all hospitals.
- All hospitals would be expected to report on all domains and associated measures in this set. Payment would be contingent upon achieving either a benchmark or improvement target.

Hospital-specific Menu Set

- Set of domains and measures from which hospitals would be required to choose XX number. Payment would be contingent upon achieving either a benchmark or improvement target.

Challenge Pool

- A set of the most transformative measures as selected by the Hospital Performance Metrics Advisory Committee. The incentive payment would be based on the dollars remaining after distribution of payments in the prior rounds. Payments would be contingent upon achieving either a benchmark or improvement target.

This approach would hold all hospitals accountable to a core set of domains and measures while allowing individual hospitals to identify locally relevant areas where they want to focus their quality improvement efforts. It is envisioned that hospitals could collaborate with their local CCOs on any hospital-specific measures that cut across the two systems. In addition, this approach takes into account the differing service arrays offered at hospitals (e.g., a core metric focused on maternity care would be inappropriate as not all DRG hospitals in Oregon perform deliveries).

This change could be implemented incrementally, with additional measures added to both the core and hospital-specific menu sets in each year. By Year 6, each set would include the maximal number of measures. As new measures are introduced, hospitals would be paid for reporting in the first year (to establish a baseline), but must achieve benchmarks or improvement targets to qualify for payments in subsequent years.

Year 4-6 Payment Structure

Beginning in Year 4 the OHA would like to modify the HTPP payment method to include a three-phased structure that includes a challenge pool. This will further incentivize quality improvement efforts focused on a subset of the most transformative HTPP measures and domains.

Phase 1: Floor Payment

- A hospital is eligible for a floor payment of $500,000 by achieving 75% of the measures for which it is eligible (consistent with current payment structure).
- If a hospital does not achieve 75% of the measures, then its floor payment will be reallocated to the challenge pool.

Phase 2: Payment per Measure Achieved

- After the floor payments are allocated, the remaining funds are included in the pool for Phase 2 allocation.
- The portion of Phase 2 quality pool funds that a hospital receives is based on whether it achieves an absolute benchmark or individual improvement target across the domains. This is similar to the payment structure in Years 1-3.
- However, beginning in Year 4, the funds not achieved by hospitals in Phase 2 will not be reallocated to the other hospitals or domains (as is done currently); instead, they will be reallocated to the challenge pool.

Phase 3: Challenge Pool

- Any unclaimed funds from Phases 1 and 2 will be used for the challenge pool.
- A set of the most transformative measures will be selected as the challenge pool measures. Hospitals achieving any of these measures will receive an additional incentive payment from the challenge pool funds.

Years 4-6 Performance Period

The HTPP performance periods would continue to be aligned with those for the CCOs, and would therefore be based on the calendar year. Year 4 would cover January 1, 2017 – December 31, 2017. Hospitals would submit data to OHA by April 15, 2018, and OHA would issue the Year 4 payment by June 30, 2018.

Year 5 would cover January 1, 2018 – December 31, 2018. Hospitals would submit data to OHA by April 15, 2019, and OHA would issue the Year 5 payment by June 30, 2019.

Year 6 would cover January 1, 2019 – December 31, 2019. Hospitals would submit data to OHA by April 15, 2020, and OHA would issue the Year 6 payment by June 30, 2020.

APPENDIX A

Hospital Transformation Performance Program (HTPP) Measures, *Preliminary* Progress from Baseline through First Nine Months of Performance Year[1]

Domain	Measures	Year 2 Targets (Oct. 2014 – Sep. 2015)		Baseline Performance (Oct. 2013 – Sep. 2014)	*Preliminary* Year 2 Performance (Oct. 2014 – June 2015)[2]
		Improvement from Baseline Target	Year 2 Benchmark		
Behavioral Health	Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) in the ED	(a) Brief Screen: MN method with a 3 percentage point floor	(a) Brief Screen: 75th percentile from HTPP baseline for brief screens (67.8%)	(a) Brief Screen: State: N/A[3] High hospital: 95.3% Low hospital: 5.5%	(a) Brief Screen: State: N/A[3] High hospital: 89.9% Low hospital: 12.1%
		(b) Full Screen: MN method with a 3 percentage point floor	(b) Full Screen: Alignment with CCO full screen benchmark (12.0%)	(b) Full Screen: State: N/A[3] High hospital: 59.8% Low hospital: 0.3%	(b) Full Screen: State: N/A[3] High hospital: 67.5% Low hospital: 0.2%
	Follow-up after hospitalization for mental illness (modified NQF 0576)	MN method with 3 percentage point floor	Alignment with CCO benchmark (National Medicaid 90th percentile, 2014 70.0%)	State: N/A[4] High hospital: 81.5% Low hospital: 60.0%	State: N/A[4, 5] High hospital: 81.0% Low hospital: 58.3%
Readmissions	**Years 1 and 2 only.** Hospital-Wide All-Cause Readmissions *Lower score is better.*	MN method with a 3 percent floor	State 90th percentile for DRG hospitals (8.0%, Oct. '13 – Sep. '14)	State: 10.9% (lower is better) High hospital: 17.5% Low hospital: 4.9%	State: 11.2% (lower is better) High hospital: 16.2% Low hospital: 5.1%

[1] Note performance year data are preliminary and subject to change.
[2] Range excludes three hospitals which had not implemented SBIRT in the ED by June 2015.
[3] Due to differences in screening and data capture, a statewide baseline is not available.
[4] Due to the performance attribution method used, a statewide baseline is not available.
[5] Performance year progress report data for follow-up after hospitalization for mental illness are for the 12 month period 4/1/2014 – 3/31/2015.

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Domain	Measures	Year 2 Targets (Oct. 2014 – Sep. 2015)		Baseline Performance (Oct. 2013 – Sep. 2014)	*Preliminary* Year 2 Performance (Oct. 2014 – June 2015)[2]
		Improvement from Baseline Target	Year 2 Benchmark		
Readmissions (continued)	**Year 3 only. 2015 data will serve as baseline for Year 3.** Potentially Preventable Readmissions *Lower score is better.*	N/A	N/A	N/A	**2015 to be used as baseline for Year 3 payments. Current progress[6]:** State: 5.5% (lower is better) High hospital: 6.5% Low hospital: 3.4%
Medication Safety	Hypoglycemia in inpatients receiving insulin (American Society of Health Systems Pharmacist Safe Use of Insulin measure) *Lower score is better.*	MN method with 1 percentage point floor	7.0% or below	State: 3.9% (lower is better) High hospital: 10.5% Low hospital: 0.4%	State: 3.7% (lower is better) High hospital: 8.5% Low hospital: 0.0%
	Excessive anticoagulation with Warfarin (Institute for Safe Medication Practices measure) *Lower score is better.*	MN method with 1 percentage point floor	5.0% or below	State: 1.5% (lower is better) High hospital: 5.9% Low hospital: 0.3%	State: 1.3% (lower is better) High hospital: 5.1% Low hospital: 0.0%
	Adverse Drug Events due to opioids (Institute for Safe Medication Practices measure) *Lower score is better.*	MN method with 1 percentage point floor	5.0% or below	State: 0.5% (lower is better) High hospital: 0.8% Low hospital: 0.1%	State: 0.5% (lower is better) High hospital: 1.2% Low hospital: 0.1%

[6] Potentially preventable readmission rates are calculated on a rolling 12 month basis; the data presented are for the months 4/1/2014 – 3/31/2015.

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Domain	Measures	Year 2 Targets (Oct. 2014 – Sep. 2015)		Baseline Performance (Oct. 2013 – Sep. 2014)	*Preliminary* Year 2 Performance (Oct. 2014 – June 2015)[2]
		Improvement from Baseline Target	Year 2 Benchmark		
Patient Experience	HCAHPS, Staff always explained medicines (NQF 0166)[7]	MN method with 2 percentage point floor	National 90th percentile (72.0%, April 2014)	State: 63.6% High hospital: 73.0% Low hospital: 44.8%	State: 63.5% High hospital: 69.4% Low hospital: 41.4%
	HCAHPS, Staff gave patient discharge information (NQF 0166)[8]	MN method with 2 percentage point floor	National 90th percentile (90.0% in April 2014)	State: 88.8% High hospital: 93.2% Low hospital: 73.2%	State: 89.0% High hospital: 93.7% Low hospital: 77.1%
Healthcare-Associated Infections	CLABSI in all tracked units (modified NQF 0139) *Lower score is better.*	MN method with 3 percent floor	2010 NHSN Data Summary Report 50th percentile (0.18 per 1000 device days)	State: 0.81 (lower is better) High hospital: 2.07 Low hospital: 0.00	State: 0.76 (lower is better) High hospital: 1.51 Low hospital: 0.00
	CAUTI in all tracked units (modified NQF 0754) *Lower score is better.*[9]	MN method with 3 percent floor	50th percentile from HTPP baseline (1.10 per 1000 catheter days)	State: 0.72 (lower is better) High hospital: 3.79 Low hospital: 0.00	State: 0.97 (lower is better) High hospital: 2.04 Low hospital: 0.00

[7] Note that the Child HCAHPS survey is under development. Therefore, Shriner's Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriner's performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey. The Press Ganey survey does not have a question about staff explaining medications, so Shriner's is not eligible for the HCAHPS staff explaining medication measure.

[8] Shriner's Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriner's performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey, and a separate benchmark has therefore been established for Shriners (it is the 90th percentile from the al PG Database Peer Group, 2/1/2014 – 7/31/2014, which is 92.7%).

[9] The Centers Disease Control and Prevention (CDC) changed the CAUTI specifications beginning in January 2015. Therefore, the original HTPP baseline (using data from October 2013 – September 2014) was only comparable to the first three months of the performance year (October 2014 – October 2015). The decision was made to use the updated CDC specifications for Years 1 and 2. This means that the new baseline period (reflected here) is for January – March 2015 (3 months). The benchmark remains the HTPP baseline 50th percentile, but the absolute number changes to 1.10 per 1000 catheter days (versus 1.13). The calculation of the 50th percentile excludes hospitals with no CAUTIs; this is because such a short baseline period could skew the data as there was relatively little opportunity for infections. The performance period will be April – September 2015 (6 months). The CAUTI performance data above are for April – June 2015.

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Domain	Measures	Year 2 Targets (Oct. 2014 – Sep. 2015)		Baseline Performance (Oct. 2013 – Sep. 2014)	*Preliminary* Year 2 Performance (Oct. 2014 – June 2015)[2]
		Improvement from Baseline Target	Year 2 Benchmark		
Sharing ED visit information	Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	MN method with 3 percentage point floor	75th percentile from HTPP baseline (78.6%)	State: N/A[10] High hospital: 91.7% Low hospital: 0.0%	State: N/A[9] High hospital: 89.9% Low hospital: 0.0%

[10] The Emergency Department Information Exchange (EDIE) system is the data source for this measure. Because hospitals were in different phases of implementing the EDIE system, they submitted data from different timeframes. Therefore, a statewide baseline is not available.

COSTS NOT OTHERWISE MATCHABLE

6. Expenditures Related to the Hospital Transformation Performance Program (HTPP). Beginning July 1, 2014, through June 30, 2017~~6~~, expenditures for incentive payments to participating hospitals for adopting initiatives for quality improvement of the Oregon health care system and the measurement of that improvement. The expenditures are limited to $150 million total computable for each demonstration year. HTPP expenditures are further limited pursuant to Section XI.

XI. HOSPITAL TRANSFORMATION PERFORMANCE PROGRAM

58. **Description.** Beginning July 1, 2014, through June 30, 2017~~6~~, the state will establish a hospital incentive pool, the Hospital Transformation Performance Program (HTPP), to issue incentive payments to participating hospitals for adopting initiatives for quality improvement of the Oregon health care system and the measurement of that improvement. During the administration of the HTPP, CMS and the state will continue to explore options to strengthen incentives that will accelerate health system transformation at the provider-level within the state's CCO structure. Standard terms for the HTPP shall apply as follows:

a. The non-federal share of payments to providers may be funded by a hospital reimbursement assessment compliant with the federal statute, regulation, and rules. All payments must remain with the provider and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

b. The state must report to CMS on the funding of HTPP in a quarterly payment report, in coordination with the quarterly reporting required by STC 67 and 73, which must be submitted to CMS within 60 days after the end of the each quarter. The state shall update the Attachment A, quarterly reports, and submit to CMS for review and approval 30-days post-approval of the HTPP.

c. When the state claims FFP for the HTPP, the state will make available to the CMS Regional Office appropriate supporting documentation in order to determine the appropriateness of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

d. Changes to the HTPP are subject to amendment under STC 7.

59. **Expenditure limits:** Only to the extent that the state does not exceed the limits in Section VIII, the state may draw down up to the following expenditure limits in total computable expenditures:

a. HTPP: Beginning July 1, 2014, the state may claim HTPP payments up to $150 million total computable.

b. Annual Limits: The expenditure limits are calculated per year. Should the state be unable to exhaust the entirety of the annual limits, the funds cannot be rolled over into the following year.

60. **Qualifications:** Hospitals eligible to participate in the HTPP must meet the state's criteria for a diagnosis-related group hospital. Diagnosis-related group hospitals are urban hospitals with bed capacity of greater than 50.

61. **HTPP Payments:** The state shall make payments to participating hospitals for implementing and reporting on health system reform initiatives that the hospitals will initiate to improve reporting and tracking of important health indicators that will supply the state with data on the health status of Medicaid enrollees.

i. Metrics: The state shall hold hospitals to the appropriate CCO and hospital-specific metrics outlined in Attachment J, Hospital Metrics and Incentive Payment Protocol
.

ii. Incentive Payment: In demonstration years 13, 14, and 15 ~~and 14,~~ the state shall make incentive payments to hospitals who have met the reporting and benchmark thresholds established by the state. Detail on incentive payment distribution methodology will be supplied through Attachment J, Hospital Metrics and Incentive Payment Protocol.

iii. Trend Reduction: The state shall be held to the terms in Section VIII of the STCs. The state shall update Section B, Expenditure Tracking for the Trend Reduction Test, of Attachment H to reflect the inclusion of the HTPP payments towards the trend for review and approval 30-days after the approval of the HTPP.

iv. Oregon Hospital Performance Metrics Committee: The development of the hospital-specific metrics, which will be used to assess the HTPP payments, shall incorporate input from a state-convened committee, the Oregon Hospital Performance Metrics Committee. This committee comprised of members from the hospitals, coordinated care organizations, and researchers will work with the state and CMS to develop a set of hospital-appropriate benchmark metrics and targets for which the state can measure progress towards the state's health system transformation goals.

v. Post-Approval Deliverable: Attachment J, Hospital Metrics and Payment Protocol to CMS for review and approval 30-days after the approval of the HTPP. Approval of this attachment is needed before payments can be made. Attachment J will include, at a minimum, the following information:

1. Metrics that will be used in DY 13, 14, and 15 ~~and 14~~ and supporting narrative;
2. Timeline for when performance targets will be set; and
3. Timeline for when incentive payments will be made.

62. **Evaluation**: The state will conduct an interim independent evaluation of the HTPP to determine whether the goal, to accelerate health system transformation among targeted providers, has been met.

a. The evaluation must include, but is not limited to, the following questions and comparisons:

i. How have the DRG hospitals performed on all the HTPP metrics, as compared to baseline?

ii. How have the DRG hospitals performed on the metrics that are also CCO metrics, as compared to hospitals not receiving HTPP payments?

iii. What contributed to the success of those hospitals successfully meeting the HTPP measurement goals;

iv. What barriers prevented the successes of any hospitals not meeting HTPP measurement goals;

v. What changes in hospital practice have been made as a result of HTPP ;

vi. What, if any, changes to the incentive structure for the CCOs by the state and by the CCOs for the providers is the state considering, as a result of lessons learned from HTTP.

vii. The interim evaluation will be due -June 30, 2016~~March 31, 2016~~.

Exhibit 2.1
Health Transformation Performance Program
BASE
OHP Section 1115 Demonstration
Summary In Total Funds

Calendar Year	Neutrality Ceiling	Actual/Projected Expenditures	Surplus/Deficit
Original Waiver Period			
1994 Actual	$ 390,951,750	$ 346,190,634	$ 44,761,116
1995 Actual	$ 818,988,036	$ 827,254,935	$ (8,266,899)
1996 Actual	$ 892,465,451	$ 885,011,152	$ 7,454,299
1997 Actual	$ 1,040,624,108	$ 895,762,310	$ 144,861,798
1998 Actual	$ 1,224,165,720	$ 1,051,592,807	$ 172,572,913
Jan-99	$ 112,450,962	$ 95,260,442	$ 17,190,520
Total Original Waiver	$ 4,479,646,027	$ 4,101,072,280	$ 378,573,747
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)	$ 1,236,961,227	$ 1,071,151,312	$ 165,809,915
2000 Actual	$ 1,448,108,685	$ 1,275,376,104	$ 172,732,581
2001 Projection (1)	$ 1,602,109,256	$ 1,398,528,881	$ 203,580,375
Jan-02	$ 152,138,992	$ 132,715,597	$ 19,423,395
Total First Waiver Extension	$ 4,439,318,160	$ 3,877,771,894	$ 561,546,266
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)	$ 1,253,756,577	$ 1,051,310,479	$ 202,446,098
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)	$ 1,987,913,110	$ 1,542,201,604	$ 445,711,506
DY 2 (FFY 04 Actual)	$ 2,093,044,450	$ 1,494,082,316	$ 598,962,134
DY 3 (FFY 05 Actual)	$ 2,278,562,238	$ 1,733,929,530	$ 544,632,708
DY 4 (FFY 06 Actual)	$ 2,454,368,136	$ 1,558,038,076	$ 896,330,060
DY 5 (FFY 07 Actual)	$ 2,588,680,697	$ 1,488,456,119	$ 1,100,224,578
Total Second Waiver	$ 11,402,568,631	$ 7,816,707,645	$ 3,585,860,986
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)	$ 3,047,303,332	$ 1,980,350,291	$ 1,066,953,041
DY 7 (FFY 09 Actual)	$ 3,210,937,225	$ 1,857,765,840	$ 1,353,171,385
DY 8 (FFY 10 Actual)	$ 3,882,351,591	$ 2,275,008,353	$ 1,607,343,238
DY 9 (FFY 11 Actual)	$ 4,521,446,161	$ 2,847,833,594	$ 1,673,612,567
DY 10 (FFY 12 Actual)	$ 3,717,258,708	$ 2,034,387,873	$ 1,682,870,835
Total OHP2 Waiver Extension	$ 18,379,297,017	$ 10,995,345,951	$ 7,383,951,066
DY 11 (SFY 13 Actual)	$ 5,068,429,196	$ 3,035,739,903	$ 2,032,689,293
DY 12 (SFY 14 Actual)	$ 6,141,016,279	$ 4,572,687,190	$ 1,568,329,089
DY 13 (SFY 15 Actual	$ 10,258,848,642	$ 6,024,979,658	$ 4,233,868,984
DY 14 (SFY 16 Projection)	$ 10,217,055,955	$ 5,789,443,820	$ 4,427,612,135
DY 15 (SFY 17 Projection)	$ 10,900,328,900	$ 5,782,659,041	$ 5,117,669,859
Total Waiver Extension	$ 42,585,678,972	$ 25,205,509,612	$ 17,380,169,360
Cumulative Total	**$ 82,540,265,384**	**$ 53,047,717,861**	**$ 29,492,547,523**

Exhibit 2.2
Hospital Transformation Performance Program
BASE
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17
MEMBER MONTHS			
Base Populations Member Months (1)			
AFDC (Parent, Caretaker, Relative)	775,343	604,244	562,318
PLM-A Pregnant Women	258,696	188,931	181,418
PLM-C (Children's Medicaid Program)	4,167,270	3,804,000	3,792,000
Old Age Assistance	466,345	494,183	513,082
Aid to Blind/Disabled	991,201	1,009,728	1,010,880
Foster Care & Sub-Adoptive Care	228,623	224,780	225,293
New ACA Adults	4,810,790	4,411,207	4,446,799
BCCP	7,707	6,032	5,197
Total Member Months	**11,705,975**	**10,743,105**	**10,736,987**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)			
Base Population PMPM			
AFDC (Parent, Caretaker, Relative)	$ 553.83	$ 578.95	$ 605.22
PLM-A Pregnant Women	$ 2,117.88	$ 2,221.76	$ 2,330.74
PLM-C (Children's Medicaid Program)	$ 798.32	$ 828.98	$ 860.81
Old Age Assistance	$ 786.23	$ 855.19	$ 928.47
Aid to Blind/Disabled	$ 2,673.57	$ 2,946.88	$ 3,241.11
Foster Care & Sub-Adoptive Care	$ 977.06	$ 1,021.43	$ 1,067.77
New ACA Adults	$ 559.88	$ 600.50	$ 644.07
BCCP	$ 2,750.12	$ 2,873.87	$ 3,003.20
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)			
Base Population Expenditures			
AFDC (Parent, Caretaker, Relative)	$ 429,408,215	$ 349,827,064	$ 340,326,100
PLM-A Pregnant Women	$ 547,887,084	$ 419,759,339	$ 422,838,189
PLM-C (Children's Medicaid Program)	$ 3,326,814,986	$ 3,153,439,920	$ 3,264,191,520
Old Age Assistance	$ 366,654,430	$ 422,620,360	$ 476,381,245
Aid to Blind/Disabled	$ 2,650,045,257	$ 2,975,547,249	$ 3,276,373,277
Foster Care & Sub-Adoptive Care	$ 223,378,389	$ 229,597,035	$ 240,561,107
New ACA Adults	$ 2,693,465,107	$ 2,648,929,804	$ 2,864,049,832
BCCP	$ 21,195,174	$ 17,335,184	$ 15,607,630
Total Base	$ 10,258,848,642	$ 10,217,055,955	$ 10,900,328,900
Total Base + Expansion Allowable Expenditures	**$ 10,258,848,642**	**$ 10,217,055,955**	**$ 10,900,328,900**

* As of November 1st, 2007; General Assistance, Adults/Couples, FHIAP Non-Medicaid & FHIAP Existing, do not count toward Allowable Expenditures.

Exhibit 2.3
Hospital Transformation Performance Program
BASE
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17
MEMBER MONTHS			
Base Populations Member Months (1)			
AFDC (Parent, Caretaker, Relative)	775,343	604,244	562,318
PLM-A Pregnant Women	258,696	188,931	181,418
PLM-C (Children's Medicaid Program)	4,167,270	3,804,000	3,792,000
Old Age Assistance	466,345	494,183	513,082
Aid to Blind/Disabled	991,201	1,009,728	1,010,880
Foster Care & Sub-Adoptive Care	228,623	224,780	225,293
ACA Adults	4,810,790	4,411,207	4,446,799
BCCP	7,707	6,032	5,197
Total Member Months	**11,705,975**	**10,743,105**	**10,736,987**
PER MEMBER PER MONTH COSTS (PMPM) (1)			
Base Populations PMPM			
AFDC (Parent, Caretaker, Relative)	$ 520.15	$ 571.26	$ 595.21
PLM-W	$ 977.26	$ 1,188.96	$ 1,232.51
PLM-C (Children's Medicaid Program)	$ 214.42	$ 225.52	$ 232.28
Old Age Assistance	$ 316.04	$ 328.16	$ 335.33
Aid to Blind/Disables	$ 1,049.16	$ 1,075.33	$ 1,097.08
Foster Care & SAC	$ 634.80	$ 604.08	$ 622.83
New ACA Adults	$ 569.47	$ 596.48	$ 613.08
BCCP	$ 2,655.02	$ 2,405.99	$ 2,543.21
TOTAL EXPENDITURES (1)			
Base Populations Expenditures			
AFDC (Parent, Caretaker, Relative)	$ 403,296,504	$ 345,178,296	$ 334,699,871
PLM-W	$ 252,814,222	$ 224,632,044	$ 223,600,363
PLM-C (Children's Medicaid Program)	$ 893,534,287	$ 857,889,451	$ 880,816,866
Old Age Assistance	$ 147,384,288	$ 162,170,916	$ 172,052,984
Aid to Blind/Disables	$ 1,039,930,976	$ 1,085,786,632	$ 1,109,014,068
Foster Care & SAC	$ 145,129,519	$ 135,784,221	$ 140,319,558
New ACA Adults	$ 2,739,593,547	$ 2,631,195,255	$ 2,726,233,714
BCCP	$ 20,462,260	$ 14,512,948	$ 13,217,065
Total Leverages	$ 17,058,017	$ 55,640,986	$ 55,640,986
Total Base	$ 5,659,203,620	$ 5,512,790,750	$ 5,655,595,476
Hospital Transformation Performance Program	$ 149,999,999	$ 150,000,000	$ -
Tribal Uncompensated Care Program	$ -	$ 18,902,320	$ 19,312,815
DSHP FFP (STC 55)	$ 122,654,457	$ 68,000,000	$ 68,000,000
DSHP State Share	$ 93,121,582	$ 39,750,750	$ 39,250,250
DSHP Total Computable	$ 215,776,039	$ 107,750,750	$ 107,750,750
Total Base + Expansion Expenditures	**$ 6,024,979,658**	**$ 5,789,443,820**	**$ 5,782,659,041**

Exhibit 2.1
Hospital Transformation Performance Program
CHANGE
OHP Section 1115 Demonstration
Summary In Total Funds

Calendar Year	Neutrality Ceiling	Actual/Projected Expenditures	Surplus/Deficit
Original Waiver Period			
1994 Actual	$ -	$ -	$ -
1995 Actual	$ -	$ -	$ -
1996 Actual	$ -	$ -	$ -
1997 Actual	$ -	$ -	$ -
1998 Actual	$ -	$ -	$ -
Jan-99	$ -	$ -	$ -
Total Original Waiver			
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)	$ -	$ -	$ -
2000 Actual	$ -	$ -	$ -
2001 Projection (1)	$ -	$ -	$ -
Jan-02	$ -	$ -	$ -
Total First Waiver Extension	$ -	$ -	$ -
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)	$ -	$ -	$ -
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)	$ -	$ -	$ -
DY 2 (FFY 04 Actual)	$ -	$ -	$ -
DY 3 (FFY 05 Actual)	$ -	$ -	$ -
DY 4 (FFY 06 Actual)	$ -	$ -	$ -
DY 5 (FFY 07 Actual)	$ -	$ -	$ -
Total Second Waiver	$ -	$ -	$ -
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)	$ -	$ -	$ -
DY 7 (FFY 09 Actual)	$ -	$ -	$ -
DY 8 (FFY 10 Actual)	$ -	$ -	$ -
DY 9 (FFY 11 Actual)	$ -	$ -	$ -
DY 10 (FFY 12 Actual)	$ -	$ -	$ -
Total OHP2 Waiver Extension	$ -	$ -	$ -
DY 11 (SFY 13 Actual)	$ -	$ -	$ -
DY 12 (SFY 14 Actual)	$ -	$ -	$ -
DY 13 (SFY 15 Actual/Projection)	$ -	$ -	$ -
DY 14 (SFY 16 Projection)	$ -	$ -	$ -
DY 15 (SFY 17 Projection)	$ -	$ 150,000,000	$ (150,000,000)
Total Waiver Extension	$ -	$ 150,000,000	$ (150,000,000)
Cumulative Total	**$ -**	**$ 150,000,000**	**$ (150,000,000)**

Exhibit 2.2
Hospital Transformation Performance Program
CHANGE
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17
MEMBER MONTHS			
Base Populations Member Months (1)			
AFDC (Parent, Caretaker, Relative)	-	-	-
PLM-A	-	-	-
PLM-C (Children's Medicaid Program)	-	-	-
Old Age Assistance	-	-	-
Aid to Blind/Disabled	-	-	-
Foster Care & SAC	-	-	-
New ACA Adults	-	-	-
BCCP	-	-	-
Total Member Months	**-**	**-**	**-**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)			
Base Population PMPM			
AFDC (Parent, Caretaker, Relative)			
PLM-W			
PLM-C (Children's Medicaid Program)			
Old Age Assistance			
Aid to Blind/Disabled			
Foster Care & SAC			
New ACA Adults			
BCCP			
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)			
Base Population Expenditures			
AFDC (Parent, Caretaker, Relative)	$ -	$ -	$ -
PLM-W	$ -	$ -	$ -
PLM-C (Children's Medicaid Program)	$ -	$ -	$ -
Old Age Assistance	$ -	$ -	$ -
Aid to Blind/Disabled	$ -	$ -	$ -
Foster Care & SAC	$ -	$ -	$ -
New ACA Adults	$ -	$ -	$ -
BCCP	$ -	$ -	$ -
Total Base	$ -	$ -	$ -
Total Base + Expansion Allowable Expenditures	**$ -**	**$ -**	**$ -**

Exhibit 2.3
Hospital Transformation Performance Program
CHANGE
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17
MEMBER MONTHS			
Base Populations Member Months (1)			
AFDC (Parent, Caretaker, Relative)	-	-	-
PLM-W	-	-	-
PLM-C (Children's Medicaid Program)	-	-	-
Old Age Assistance	-	-	-
Aid to Blind/Disables	-	-	-
Foster Care & SAC	-	-	-
New ACA Adults	-	-	-
BCCP	-	-	-
Total Member Months	**-**	**-**	**-**
PER MEMBER PER MONTH COSTS (PMPM) (1)			
Base Populations PMPM			
AFDC (Parent, Caretaker, Relative)			
PLM-W			
PLM-C (Children's Medicaid Program)			
Old Age Assistance			
Aid to Blind/Disables			
Foster Care & SAC			
New ACA Adults			
BCCP			
TOTAL EXPENDITURES (1)			
Base Populations Expenditures			
AFDC (Parent, Caretaker, Relative)	$ -	$ -	$ -
PLM-W	$ -	$ -	$ -
PLM-C (Children's Medicaid Program)	$ -	$ -	$ -
Old Age Assistance	$ -	$ -	$ -
Aid to Blind/Disables	$ -	$ -	$ -
Foster Care & SAC	$ -	$ -	$ -
New ACA Adults	$ -	$ -	$ -
BCCP	$ -	$ -	$ -
Total Leverages	$ -	$ -	$ -
Total Base	$ -	$ -	$ -
Hospital Transformation Performance Program	$ -	$ -	$ 150,000,000
Tribal Uncompensated Care Program	$ -	$ -	$ -
DSHP FFP (STC 55)	$ -	$ -	$ -
DSHP State Share	$ -	$ -	$ -
DSHP Total Computable	$ -	$ -	$ -
Total Base + Expansion Expenditures	**$ -**	**$ -**	**$ 150,000,000**

Exhibit 2.1
Hospital Transformation Performance Program
COMBINED
OHP Section 1115 Demonstration
Summary In Total Funds

Calendar Year	Neutrality Ceiling	Actual/Projected Expenditures	Surplus/Deficit
Original Waiver Period			
1994 Actual	$ 390,951,750	$ 346,190,634	$ 44,761,116
1995 Actual	$ 818,988,036	$ 827,254,935	$ (8,266,899)
1996 Actual	$ 892,465,451	$ 885,011,152	$ 7,454,299
1997 Actual	$ 1,040,624,108	$ 895,762,310	$ 144,861,798
1998 Actual	$ 1,224,165,720	$ 1,051,592,807	$ 172,572,913
Jan-99	$ 112,450,962	$ 95,260,442	$ 17,190,520
Total Original Waiver	$ 4,479,646,027	$ 4,101,072,280	$ 378,573,747
First Waiver Extension (beginning February 1999)			
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2000 Actual	$ 1,448,108,685	$ 1,275,376,104	$ 172,732,581
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Total First Waiver Extension	$ 4,439,318,160	$ 3,877,771,894	$ 561,546,266
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2002 Actuals (Feb to Sept)	$ 1,253,756,577	$ 1,051,310,479	$ 202,446,098
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)	$ 1,987,913,110	$ 1,542,201,604	$ 445,711,506
DY 2 (FFY 04 Actual)	$ 2,093,044,450	$ 1,494,082,316	$ 598,962,134
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DY 4 (FFY 06 Actual)	$ 2,454,368,136	$ 1,558,038,076	$ 896,330,060
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Total Second Waiver	$ 11,402,568,631	$ 7,816,707,645	$ 3,585,860,986
OHP2 Waiver Extension			
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DY 8 (FFY 10 Actual)	$ 3,882,351,591	$ 2,275,008,353	$ 1,607,343,238
DY 9 (FFY 11 Actual)	$ 4,521,446,161	$ 2,847,833,594	$ 1,673,612,567
DY 10 (FFY 12 Actual)	$ 3,717,258,708	$ 2,034,387,873	$ 1,682,870,835
Total OHP2 Waiver Extension	$ 18,379,297,017	$ 10,995,345,951	$ 7,383,951,066
DY 11 (SFY 13 Actual)	$ 5,068,429,196	$ 3,035,739,903	$ 2,032,689,293
DY 12 (SFY 14 Actual)	$ 6,141,016,279	$ 4,572,687,190	$ 1,568,329,089
DY 13 (SFY 15 Actual)	$ 10,258,848,642	$ 6,024,979,658	$ 4,233,868,984
DY 14 (SFY 16 Projection)	$ 10,217,055,955	$ 5,789,443,820	$ 4,427,612,135
DY 15 (SFY 17 Projection)	$ 10,900,328,900	$ 5,932,659,041	$ 4,967,669,859
Total Waiver Extension	$ 42,585,678,972	$ 25,355,509,612	$ 17,230,169,360
Cumulative Total	**$ 82,540,265,384**	**$ 53,197,717,861**	**$ 29,342,547,523**

Exhibit 2.2
Hospital Transformation Performance Program
COMBINED
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17
MEMBER MONTHS			
Base Populations Member Months (1)			
AFDC (Parent, Caretaker, Relative)	775,343	604,244	562,318
PLM-A	258,696	188,931	181,418
PLM-C (Children's Medicaid Program)	4,167,270	3,804,000	3,792,000
Old Age Assistance	466,345	494,183	513,082
Aid to Blind/Disabled	991,201	1,009,728	1,010,880
Foster Care & SAC	228,623	224,780	225,293
New ACA Adults	4,810,790	4,411,207	4,446,799
BCCP	7,707	6,032	5,197
Total Member Months	**11,705,975**	**10,743,105**	**10,736,987**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)			
Base Population PMPM			
AFDC (Parent, Caretaker, Relative)	$ 553.83	$ 578.95	$ 605.22
PLM-W	$ 2,117.88	$ 2,221.76	$ 2,330.74
PLM-C (Children's Medicaid Program)	$ 798.32	$ 828.98	$ 860.81
Old Age Assistance	$ 786.23	$ 855.19	$ 928.47
Aid to Blind/Disabled	$ 2,673.57	$ 2,946.88	$ 3,241.11
Foster Care & SAC	$ 977.06	$ 1,021.43	$ 1,067.77
New ACA Adults	$ 559.88	$ 600.50	$ 644.07
BCCP	$ 2,750.12	$ 2,873.87	$ 3,003.20
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)			
Base Population Expenditures			
AFDC (Parent, Caretaker, Relative)	$ 429,408,215	$ 349,827,064	$ 340,326,100
PLM-W	$ 547,887,084	$ 419,759,339	$ 422,838,189
PLM-C (Children's Medicaid Program)	$ 3,326,814,986	$ 3,153,439,920	$ 3,264,191,520
Old Age Assistance	$ 366,654,430	$ 422,620,360	$ 476,381,245
Aid to Blind/Disabled	$ 2,650,045,257	$ 2,975,547,249	$ 3,276,373,277
Foster Care & SAC	$ 223,378,389	$ 229,597,035	$ 240,561,107
New ACA Adults	$ 2,693,465,107	$ 2,648,929,804	$ 2,864,049,832
BCCP	$ 21,195,174	$ 17,335,184	$ 15,607,630
Total Base	$ 10,258,848,642	$ 10,217,055,955	$ 10,900,328,900
Total Base + Expansion Allowable Expenditures	**$ 10,258,848,642**	**$ 10,217,055,955**	**$ 10,900,328,900**

* As of November 1st, 2007; General Assistance, Adults/Couples, FHIAP Non-Medicaid & FHIAP Existing, do not count toward Allowable Expenditures.

Exhibit 2.3
Hospital Transformation Performance Program
Combined
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17
MEMBER MONTHS			
Base Populations Member Months (1)			
AFDC (Parent, Caretaker, Relative)	775,343	604,244	562,318
PLM-W	258,696	188,931	181,418
PLM-C (Children's Medicaid Program)	4,167,270	3,804,000	3,792,000
Old Age Assistance	466,345	494,183	513,082
Aid to Blind/Disables	991,201	1,009,728	1,010,880
Foster Care & SAC	228,623	224,780	225,293
New ACA Adults	4,810,790	4,411,207	4,446,799
BCCP	7,707	6,032	5,197
Total Member Months	**11,705,975**	**10,743,105**	**10,736,987**
PER MEMBER PER MONTH COSTS (PMPM) (1)			
Base Populations PMPM			
AFDC (Parent, Caretaker, Relative)	$ 520.15	$ 571.26	$ 595.21
PLM-W	$ 977.26	$ 1,188.96	$ 1,232.51
PLM-C (Children's Medicaid Program)	$ 214.42	$ 225.52	$ 232.28
Old Age Assistance	$ 316.04	$ 328.16	$ 335.33
Aid to Blind/Disables	$ 1,049.16	$ 1,075.33	$ 1,097.08
Foster Care & SAC	$ 634.80	$ 604.08	$ 622.83
New ACA Adults	$ 569.47	$ 596.48	$ 613.08
BCCP	$ 2,655.02	$ 2,405.99	$ 2,543.21
TOTAL EXPENDITURES (1)			
Base Populations Expenditures			
AFDC (Parent, Caretaker, Relative)	$ 403,296,504	$ 345,178,296	$ 334,699,871
PLM-W	$ 252,814,222	$ 224,632,044	$ 223,600,363
PLM-C (Children's Medicaid Program)	$ 893,534,287	$ 857,889,451	$ 880,816,866
Old Age Assistance	$ 147,384,288	$ 162,170,916	$ 172,052,984
Aid to Blind/Disables	$ 1,039,930,976	$ 1,085,786,632	$ 1,109,014,068
Foster Care & SAC	$ 145,129,519	$ 135,784,221	$ 140,319,558
New ACA Adults	$ 2,739,593,547	$ 2,631,195,255	$ 2,726,233,714
BCCP	$ 20,462,260	$ 14,512,948	$ 13,217,065
Total Leverages	$ 17,058,017	$ 55,640,986	$ 55,640,986
Total Base	$ 5,659,203,620	$ 5,512,790,750	$ 5,655,595,476
Hospital Transformation Performance Program	$ 149,999,999	$ 150,000,000	$ 150,000,000
Tribal Uncompensated Care Program	$ -	$ 18,902,320	$ 19,312,815
DSHP FFP (STC 55)	$ 122,654,457	$ 68,000,000	$ 68,000,000
DSHP State Share	$ 93,121,582	$ 39,750,750	$ 39,250,250
DSHP Total Computable	$ 215,776,039	$ 107,750,750	$ 107,750,750
Total Base + Expansion Expenditures	**$ 6,024,979,658**	**$ 5,789,443,820**	**$ 5,932,659,041**

Draft Attachment J: Hospital Metrics and Incentive Payment Protocol
HTPP Year 3 Extension

Introduction

Oregon's Hospital Measurement Strategy (STC 62) outlines how the Oregon Health Authority (OHA) will make payments to participating Diagnosis-Related Group (DRG) hospitals for implementing and reporting on health system reform initiatives within a three~~two~~ year program. The metrics are integral to the effort to monitor and correct pathways towards improvements in the quality of care and access to care for Medicaid beneficiaries under health system transformation efforts. The work in this area forms Oregon's Hospital Transformation Performance Program (HTPP).

Hospital Performance Metrics Advisory Committee

In 2013, Oregon House Bill 2216, Section 1, established the nine-member Hospital Performance Metrics Advisory Committee, appointed by the Director of OHA, and in 2015 Oregon House Bill 2395 extended the Committee's work through 2019. The Committee is comprised of four hospital representatives, three health outcomes measurement experts, and two representatives of Coordinated Care Organizations (CCOs). The Committee was charged with using a public process to identify three to five performance standards (incentive measures and targets) for DRG hospitals that are designed to advance health system transformation, reduce hospital costs, and improve patient safety.

Incentive Measures

The Oregon Hospital Performance Metrics Advisory Committee has identified hospital-specific metrics, which will be used to assess the HTPP payments through 2016~~5~~ from a share of Oregon's hospital assessment revenue. See Appendix A: Hospital Quality Pool Structure for a detailed description of the hospital quality pool design and funding algorithm. Building on work completed by the Metrics and Scoring Committee, the Hospital Performance Metrics Advisory Committee considered several core principles when selecting these measures. Among other principles, any selected measures should:

- Meet standard scientific criteria for reliability and face validity;
- Help drive system change;
- Be aligned with health system transformation underway by CCOs;
- Align with evidence-based or promising practices;

- Be nationally validated, a required reporting element in other health care quality initiatives, or align with national or other benchmarks for performance.~~; and~~

- ~~Be able to accomplish change in the measure within two years.~~

The hospital quality measures are captured in two overarching focus areas, hospital-focused and hospital-CCO coordination-focused. These focus areas are comprised of domains and measures, many of which overlap with the state test for quality and access measures (Attachment H). There are six ~~seven~~ domains, comprised of 11 measures. Table 1 below shows the incentive measures selected by the Hospital Performance Metrics Advisory Committee and agreed by OHA and CMS. All measures but follow-up after hospitalization for mental illness relate to patients from all payer-types; follow-up after hospitalization for mental illness, however, relates only to Medicaid patients enrolled in a CCO. Specifications, benchmarks, and improvement targets for the incentive measures can be found in Appendix B and more detailed rationale for each of these incentive measures can be found in Appendix C.

Table 1: Agreed Domains and Measures

Focus Area	Domains	Measures
Hospital focus	1. Readmissions	1. Hospital-Wide All-Cause Readmission (Years 1 & 2) / Potentially Preventable Readmissions (Year 3)[1]
	2. Medication Safety	2. Hypoglycemia in inpatients receiving insulin 3. Excessive anticoagulation with Warfarin 4. Adverse Drug Events due to opioids
	3. Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166) 6. HCAHPS, Staff gave patient discharge information (NQF 0166)
	4. Healthcare-Associated Infections	7. CLABSI in all tracked units (adapted from NQF 0139) 8. CAUTI in all tracked units (adapted from NQF 0754)
Hospital-CCO collaboration focus	5. Sharing ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits
	6. Behavioral Health	10. Follow-up after hospitalization for mental illness (adapted from NQF 0576) 11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department

[1] The readmissions measure will change to Potentially Preventable Readmissions in Year 3.

Benchmarks and Improvement Targets

The Hospital Performance Metrics Advisory Committee worked with OHA and CMS to develop a set of hospital-appropriate benchmarks and improvement targets for which the state can measure progress towards the state's health system transformation goals. In year one, hospitals ~~will~~ received payment for submitting baseline data to OHA (pay for reporting). In years two and three hospitals will only receive payment for submitting data to OHA *and* achieving the established benchmarks or improvement targets. In years two and three, hospitals that do not meet the benchmark for a given measure will be assessed against their improvement from their own baseline ("improvement target"). If hospitals meet either the benchmark or their improvement target on a given measure, they will be awarded the quality pool funds associated with that measure[2]. As HTPP is meant to foster continuous improvement across all measures for all hospitals, all benchmarks in year two will be evaluated each year ~~against year one baseline data~~ and amended as appropriate to ensure continuous improvement. Details on the hospital measures, benchmarks, and improvement targets can be found in Appendix B.

[2] OHA will use the methodology established for the CCO improvement targets in calculating the hospital improvement targets. These improvement targets are based on the Minnesota Department of Health's Quality Incentive Payment System (hereafter referenced as the "MN method"). This method requires at least a 10 percent reduction in the gap between the baseline and the benchmark to be eligible for incentive payments. Detailed specifications on the improvement target calculations used can be found here: http://www.oregon.gov/oha/CCOData/Forms/AllItems.aspx.

Appendix A: HTTP Quality Pool Structure

Hospital Quality Pool Funding

The total funding allocated for the Hospital Transformation Performance Program quality pool for years one and two will be equivalent to the federal match of state dollars generated by one percent of the Hospital Provider Tax Program, limited to a maximum of $150,000,000 per year or the maximum allowed under the 2% test. As required by House Bill 2395 (Oregon Laws 2015), the total funding allocated for the year three quality pool will be equivalent to the federal match of state dollars generated by 0.5 percent of the Hospital Provider Tax Program, limited to a maximum of $150,000,000 per year or the maximum allowed under the 2% test. The total quality pool funding available to be earned through achievement of the performance metrics may therefore vary based upon the amount available from the Hospital Provider Tax Program. All funds will be distributed each year; there will be no carryover.

Hospital Quality Pool Timing

HTPP funds will be distributed three times ~~twice~~, with two measurement years spanning the federal fiscal year; to further align with the CCO quality metrics, the measurement period for the third year of the program will transition to the calendar year. The first measurement period is October 1, 2013 – September 30, 2014, which is the federal fiscal year 2014. For this period, hospitals will receive payment based on baseline data submission of all measures for that period. Year one data must be submitted to OHA by February 28, 2015, and OHA will issue the first payment by April 30, 2015.

The second measurement year will cover the period October 1, 2014 – September 30, 2015. Hospitals will submit data to OHA by March 31, 2016, and OHA will issue the second payment by June 30, 2016. Year two payment will be contingent upon performance across the hospital quality measures.

The third year of the program will move to a calendar year measurement period and cover January 1, 2016 – December 31, 2016. Hospitals will submit data to OHA by April 15, 2017, and OHA will issue the third payment by June 30, 2017.

Ensuring Continuous Improvement

OHA is committed to continuous improvement. The third year of the program will serve as a transitional period during which the State will work with both CMS and Oregon's hospital partners to solidify the long-term vision of the program. The objective is a program that is fully integrated and aligned with Oregon's 1115 health system transformation goals. As part of this work the Hospital Metrics Advisory Committee has been reconvened to reassess the improvement targets and benchmarks for the third year of the program with the goal of ensuring ~~The fact that the HTPP is only a two year program precludes changes to the measure set itself over those two years; however, OHA will be reviewing hospital performance in relation to the established benchmarks to ensure that improvement targets and benchmarks are set to a standard that ensures continued quality improvement. When baseline data for year one are submitted, the measures and any pre-existing benchmarks for year two performance will be reassessed to ensure~~ that hospital performance ~~must be~~is appropriately stretched in order to receive the year ~~two~~ three performance payments. ~~The Hospital Metrics Advisory Committee may be reconvened as required to provide guidance in this area.~~ In addition, the hospital measures which overlap with the CCO incentive measures will ~~need to~~ be aligned with any changes that occur in the CCO measure specifications. ~~Furthermore, as HTPP is meant to foster continuous improvement across all measures for all hospitals, all benchmarks in year two will be evaluated against year one baseline data and amended as appropriate to ensure continuous.~~

During this period OHA will also work with hospital partners, CMS, and the Hospital Performance Metrics Advisory Committee to identify additional metrics that align with the long-term vision of the program for years four and beyond (subject to CMS approval).~~While the year two benchmarks may be amended as needed to ensure quality improvement, the measure set itself will not be amended within the two years of the HTPP. There may be interest in continuing the hospital quality pool beyond the two year program approved in the waiver.~~ It will be essential to take future hospital performance into account and continue to provide stretch goals that hospitals must achieve before being eligible for any quality pool funds available.

Allocation Methodology

OHA has set a floor such that each hospital will be eligible to earn $500,000 in each year of the program, contingent upon maximal performance, defined as achieving credit for at least 75% of the measures. This strategy ensures that hospitals have sufficient motivations for making necessary investments in quality improvement. As with the funding available for HTPP as a

whole, the availability of floor funds is subject to the amount allowed under the 2% test. The funds remaining after allocation of the possible $500,000 per hospital floor will be allocated to each domain based upon weighting agreed with CMS (detailed further below). After this, the amount each hospital achieving a measure will actually receive will be weighted according to its Medicaid volumes, as below:

- Fifty percent will be based upon each hospital's total Medicaid discharges as a percent of all DRG hospitals for a 12 month period. In years one and two this was held constant at ~~for~~ the 12 months ending September 2012 ~~as a percent of all DRG hospital for that 12 month period~~. In year 3 this will be the 12 month period spanning calendar year 2015.
- Fifty percent will be based upon each hospital's total Medicaid patient days as a percent of all DRG hospitals for a 12 month period. In years one and two this was held constant at ~~for~~ the 12 months ending September 2012 ~~as a percent of all DRG hospitals for that 12 month time period.~~ In year 3 this will be the 12 month period spanning calendar year 2015.

The discharge data are from the Hospital Inpatient Discharge Data hospitals are required to submit to OHA. ~~This weighted distribution will be held constant for the two years that the hospital quality pool is in effect. Holding the weighted distribution constant avoids penalizing hospitals that reduce Medicaid discharges and/or inpatient days proportionally better than other hospitals, which would decrease their share of total Medicaid discharges and inpatient days.~~

~~Though the methodology for determining the estimated amount a hospital can earn will be held constant for the two years of the program (to ensure there is no disincentive for hospitals making quality improvement efforts to appropriately decrease Medicaid discharges and hospital days),~~ Tthe amount available for each hospital to earn will vary based upon the final total hospital quality pool availability, changes in the number of DRG hospitals in the HTPP program, and how each hospital performs against the quality metrics. Hospitals will only receive quality pool payments for providing baseline data (in year one), or attaining benchmarks or improvement targets in years two and three.

This allocation methodology has been chosen as it is felt it is the most equitable in terms of hospital effort, performance, and size in terms of use by Medicaid members. OHA bases this on its experience with the CCO incentive metric pool. The inclusion of the improvement targets (in addition to the benchmarks) for the CCO incentive pool allowed CCOs which engaged in quality improvement activities to successfully achieve the measures and receive incentive payments. In the first performance year, all CCOs saw improvement on at least some measures, and 11 of 15

CCOs earned 100% of their quality pool. Furthermore, at least half of the CCOs met either the benchmark or the improvement target on most of the CCO incentive measures. OHA expects a similar experience with hospital performance and quality pool distribution.

Quality Pool Distribution

The quality pool distribution method occurs in two phases, for both the hospital focused and the hospital-CCO collaboration focused domains. Phase 1 involves determining whether a hospital is eligible for the $500,000 floor (earned by achieving at least 75% of the measures. Phase 2 involves allocating the remaining funds to hospitals based upon performance against each measure.

In cases in which a hospital does not have the relevant ward (e.g., hospitals which do not perform deliveries for the early elective deliveries measure, or hospitals without psychiatric wards for the follow-up after hospitalization for mental illness measure), OHA will utilize an attribution methodology in which the CCO rate will be applied to relevant hospitals during the pay-for-performance years (year two and three).

Phase 1: Floor Allocation

The first step in distributing the hospital quality pool funds involves determining the number of instances in which a hospital has achieved a measure. In year one, achieving the measure is defined as submitting baseline data that meets OHA approval, and in years two and three it means achieving the improvement target or benchmark. Hospitals achieving at least 75% of the measures will be allocated a $500,000 floor. Phase I allocation is pass/fail; hospitals will not receive partial credit. Hospitals must achieve at least 75% of the measures to be allocated the floor payment. This will impact the amount remaining in the pool for Phase II allocation. Table 1 illustrates how Phase 1 works:

Table 1: Example of Phase 1 Floor Allocation

Total HTPP available funds – one year	$133 million
Available funds – floor for 27 hospitals (assuming all achieve at least 75% of the measures) ($500,000 * 27)	$13.5 million
Remaining to earn in Phase 2 allocation (payment per measure achieved) (Total – floor)	$119.5 million

Phase 2: Allocation per Measure Achieved

The portion of Phase 2 quality pool funds that a hospital receives is based on the number of measures on which it reports baseline data (in year one), or the number of measures on which it achieves an absolute benchmark or demonstrates improvement over its own baseline or performance in the previous year ("improvement target") in years two and three. The benchmarks are the same for all hospitals[3], regardless of geographic region and patient mix (see Appendix B for measures and benchmarks).

Hospital performance on these measures is treated on a pass/fail basis and all measures are independent from one another. In year one, if data are submitted and accepted by OHA for a particular measure, the hospital receives all credit for that measure, regardless of submission of data for the other measures. In years two and three, if the benchmark is met or the improvement target reached for a specific measure, the hospital receives all of the credit available for that measure, regardless of performance on other measures.

Once OHA has determined each hospital's level of performance against the measure targets and reporting requirements, then OHA ~~will~~ calculates the amount of the Phase 2 incentive funds each hospital will receive. The number of measures achieved by hospitals will impact the 'base amount' that each measure is worth after the Phase 1 floor allocation. In Phase 2 the base amounts are computed after any floor allocations are subtracted from the quality pool. The proportions in Table 2, below, will be applied to the remaining hospital quality pool funds. The proportions may shift if all measures are not achieved by at least one hospital. The base amount for each measure will then be allocated to the hospitals achieving that measure based upon the proportion of Medicaid discharges and patient days at each hospital that achieved the target, 50% based on discharges and 50% based on patient days.

[3] An exception to this is the HCAHPS patient discharge measure. Shriner's Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriner's performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey, and a separate benchmark has been established for Shriners.

Table 2: Share of Available Funds by Measure by Year after Floor Payment Allocation

Domains	Measures	Share of Available Funds by Year*		
		YR 1	YR 2	YR 3
Readmissions	1. Hospital-Wide All-Cause Readmission (Years 1 & 2) / Potentially Preventable Readmissions (Year 3)	18.75%	18.75%	18.75%
Medication Safety	2. Hypoglycemia in inpatients receiving insulin	6.25%	6.25%	6.25%
	3. Excessive anticoagulation with Warfarin	6.25%	6.25%	6.25%
	4. Adverse Drug Events due to opioids	6.25%	6.25%	6.25%
Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166)	9.38%	9.38%	9.38%
	6. HCAHPS, Staff gave patient discharge information (NQF 0166)	9.38%	9.38%	9.38%
Healthcare-Associated Infections	7. CLABSI in all tracked units (modified NQF 0139)	9.38%	9.38%	9.38%
	8. CAUTI in all tracked units (modified NQF 0754)	9.38%	9.38%	9.38%
Sharing ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	12.50%	12.50%	12.50%
Behavioral Health	10. Follow-up after hospitalization for mental illness (modified NQF 0576)	6.25%	6.25%	6.25%
	11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department	6.25%	6.25%	6.25%

*Note this is share of funds available after allocation of the floor

Table 3, below, is an example of how the hospital quality pool distribution for the Readmissions domain would work in a scenario where there are only three hospitals, with total available HTTP funds the maximum $150,000,000, and the assumption that two of the three hospitals achieved at least 75% of the measures (meaning these hospitals are allocated the floor payment of $500,000). This example operates in the same manner for ~~both~~ years one, two, and three ~~and two~~: In year one, 'achieving the measure' is defined as providing baseline data that is approved by OHA, and in years two and three 'achieving the measure' is defined as meeting either the benchmark or improvement target.

Table 3: Example of Hospital Quality Pool Distribution for Readmissions Domain

Total HTTP Funds Available (one year)	$150,000,000
Number of Hospitals Achieving at least 75% of measures (eligible for floor allocation)	2
Phase 1 Amount (floor allocation - 500,000*2)	$1,000,000
Funds Remaining for Phase 2 Allocation (total - floor)	$149,000,000
Readmissions	
Share of Available Funds	18.75%
Base Amount - total available to earn for measure (share of funds*funds for Phase 2 allocation)	$27,937,500

Phase 2 Allocation per Hospital Achieving Domain (Readmissions Example)

Hosp	Achieve Measure?	Discharges		Days		Adjustment Factor (% discharges*0.5) + (% days*0.5)		Amount Earned for Measure (Total Available for Measure * Adjustment Factor)	
		#	%	#	%				
A	Y	5,000	33.3%	2,000	20.0%	(33.3%*0.5) + (20.0%*0.5) =	0.27	$27,937,500 * 0.27 =	**$7,450,000**
B	Y	5,000	33.3%	1,000	10.0%	(33.3%*0.5) + (10.0%*0.5) =	0.22	$27,937,500 * 0.22 =	**$6,053,125**
C	Y	5,000	33.3%	7,000	70.0%	(33.3%*0.5) + (70.0%*0.5) =	0.52	$27,937,500 * 0.52 =	**$14,434,375**
Totals		**15,000**	**100.0%**	**10,000**	**100.0%**		**1.00**		**$27,937,500**

Data Collection

As detailed in Appendix B, OHA and its partner, the Oregon Association of Hospitals and Health Systems (OAHHS), share responsibility for collecting data on all measures selected. OHA and OAHHS will ensure the accuracy and validity of the data, with review by an independent third party.

Data Reporting

OHA is committed to transparency in health system transformation efforts. All measures will be reported on the OHA website on an at least annual basis, and will be available at the hospital level. This will allow OHA to work with hospital partners to track overall progress, and identify and address any areas needing additional attention.

Monitoring hospital performance ties in with the overall evaluation and ongoing quality improvement efforts for the waiver. Moreover, this work has a direct impact on OHA's overarching health system transformation goals of better health, better care, and lower costs for all Oregonians~~, not just the Medicaid population~~. ~~Part of this work involves aligning and~~

~~tracking metrics across different payers and populations. There may therefore be interest in continuing to monitor these metrics beyond the two years of the HTPP approved in the waiver.~~

Appendix B: Oregon Hospital Transformation Performance Program Measures Matrix

Note that in year one (October 1, 2013 – September 30, 2014), hospitals will receive payment for submitting baseline data that meets OHA approval. In year two (October 1, 2014 – September 30, 2015) and year three (January 1, 2016 – December 31, 2016), hospitals will receive payment for submitting data to OHA and achieving the benchmark or improvement target. Specifications for the measures which overlap with the CCO state test for quality and access are aligned with those in Attachment H (see http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx for measure specification sheets). Here, however, all measures but follow-up after hospitalization for mental illness relate to patients from all payer-types; follow-up after hospitalization for mental illness relates only to Medicaid patients enrolled in a CCO. All benchmarks in year two will be evaluated against year one baseline data and amended as appropriate to ensure they foster continuous improvement.

Hospital Measures	Waiver Measure Set			Target Calculations		Targets			Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Year 2 Benchmark	Year 3 Benchmark	
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) in the ED	√			Measure set broken down as follows: **1. Alcohol and Other Drug Use Screening in the ED**- Patients in ED age 12+ screened for alcohol and other substance use using an age-appropriate, validated instrument.	Measure set broken down as follows: **1. Alcohol and Substance Use Screening** - ED patients age 12+.	1. (a) Brief Screen: MN method with a 3 percentage point floor 1. (b) Full Screen: MN method with a 3 percentage point floor	1.(a) Brief Screen: 67.8% (75th percentile from HTPP baseline for brief screens) 1.(b) Full Screen: 12.0% (alignment with CCO full screen benchmark)	1.(a) Brief Screen: TBD 1.(b) Full Screen: TBD	OAHHS will collect and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets			Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Year 2 Benchmark	Year 3 Benchmark	
				2. Alcohol and Other Drug Use Brief Intervention Provided – ED patients age 12+ who received a brief intervention.	**2. Alcohol and Other Drug Use Brief Intervention Provided** – ED patients age 12+ who screen positive for unhealthy alcohol or drug use.	~~1. MN method with a 3% floor~~ 2. N/A - reporting only (no target)	~~1. 13% (alignment with CCO benchmark) Note: Will change with any updates to CCO benchmark or if year one performance exceeds benchmark.~~ 2. N/A – reporting only (no benchmark)		
Follow-up after hospitalization for mental illness (modified NQF 0576)	√			Discharges for Medicaid members enrolled in a CCO age 6 years of age and above at hospital of interest who were	Discharges from acute inpatient settings (including acute care psychiatric facilities) for members age 6 years of age and above at hospital of	MN method with 3 percentage point ~~%~~ floor (alignment with CCO improvement	68.8% 2013 National Medicaid 90th percentile (alignment with CCO benchmark;	National Medicaid 90th percentile (alignment with CCO	OHA MMIS – OHA will calculate rates

Hospital Measures	Waiver Measure Set			Target Calculations		Targets			Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Year 2 Benchmark	Year 3 Benchmark	
				hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization within 7 days of discharges.	interest who were hospitalized for treatment of selected mental health disorders.	target; will change with any updates to CCO target)	~~will change with any updates to CCO benchmark or as needed to foster continuous improvement~~)	benchmark)	for this measure through encounters/claims
Hospital-Wide All-Cause Readmissions (Years 1 & 2) / Potentially Preventable Readmissions (PPR) (Year 3)		√		Yrs 1/2: Number of readmissions, defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. Yr 3: Number of PPRs (return hospitalization within the 30 days) that is clinically-	Yrs 1/2: Admissions to acute care facilities for all patients ~~aged 18 years or older~~ Yr 3: Admissions to acute care facilities for all patients	MN method with a 3~~1~~% floor	8.0% ~~S~~(state 90th percentile for DRG hospitals) ~~all hospital types~~	TBD	OAHHS will calculate and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets			Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Year 2 Benchmark	Year 3 Benchmark	
				related to the initial hospital admission.					
Hypoglycemia in inpatients receiving insulin (American Society of Health Systems Pharmacist Safe Use of Insulin measure)			√	All patients with hypoglycemia (blood glucose of 50mg per dl or less)	All patients receiving insulin during the tracked time period	MN method with 1 percentage point~~%~~ floor	5% or below Note: Will change if year one performance exceeds benchmark	TBD	OAHHS will collect and report to OHA
Excessive anticoagulation with Warfarin (Institute for Safe Medication Practices measure)			√	Number of patients experiencing excessive anticoagulation (INR > 6)	All inpatients receiving warfarin anticoagulation therapy during tracked period	MN method with 1 percentage point~~%~~ floor	5% or below ~~Note: Will change if year one performance exceeds benchmark~~	TBD	OAHHS will collect and report to OHA
Adverse Drug Events due to opioids (Institute for Safe Medication Practices measure)			√	Number of patients treated with opioids who also received naloxone	Number of patients who received an opioid agent during tracked period	MN method with 1 percentage point~~%~~ floor	5% or below ~~Note: Will change if year one performance exceeds benchmark~~	TBD	OAHHS will collect and report to OHA
HCAHPS, Staff always explained medicines (NQF 0166)			√	Number of clients reporting 'top box' responses for this measure domain.	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point~~%~~ floor	72.0% (National 90th percentile, April 2014)	National 90th percentile	OAHHS will collect and

Hospital Measures	Waiver Measure Set			Target Calculations		Targets			Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Year 2 Benchmark	Year 3 Benchmark	
									report to OHA
HCAHPS, Staff gave patient discharge information (NQF 0166)			√	Clients answering 'Y' to Q19 and Q20	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point~~%~~ floor *Shriners : MN method with 2 percentage point floor*[4]	90.0% (National 90th percentile, April 2014) *Shriners: 90th percentile, all PG Database Peer Group, 2/1/2014 – 7/31/2014 (92.7%)*	National 90th percentile	OAHHS will collect and report to OHA
CLABSI in all tracked units (modified NQF 0139)			√	Total number of observed CLABSI in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	Total number of central line days in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	MN method with 3% floor	0.18 per 1000 device days (2010 NHSN Data Summary Report 50th percentile from Partnership	TBD	OAHHS will collect and report to OHA

[4] Shriner's Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriner's performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey, and a separate benchmark has therefore been established for Shriners. The Press Ganey survey does not have a question about staff explaining medications, so Shriner's is not eligible for the HCAHPS staff explaining medication measure.

Hospital Measures	Waiver Measure Set			Target Calculations		Targets			Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Year 2 Benchmark	Year 3 Benchmark	
							for Patients Scoring Criteria for CMS, 2014) ~~TBD~~		
CAUTI in all tracked units (modified NQF 0754)			√	Total number of observed healthcare-associated CAUTIs in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	Total number of catheter days for all patients that have an indwelling urinary catheter in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	MN method with 3% floor	~~TBD~~1.13 per 1000 catheter days (50th percentile from HTPP baseline)	TBD	OAHHS will collect and report to OHA
Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits			√	1. Number of outreach notifications to primary care providers for patients with 5+ ED visits in past 12 months ~~Number of care guidelines completed for patients with 5+ ED~~	1. Number of patients with five+ ED visits in the past 12 months	~~TBD~~1. MN method with 3 percentage point floor	1. 78.6% (75th percentile from HTPP baseline)	1. 90th percentile from HTPP baseline	OAHHS will collect and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets			Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Year 2 Benchmark	Year 3 Benchmark	
				~~visits in past 12 months~~ 2. Number of care guidelines completed for patients with 5+ ED visits in past 12 months ~~Number of outreach notifications to primary care providers for patients with 5+ ED visits in past 12 months~~	2. Number of patients with five+ ED visits in the past 12 months	2. N/A – reporting only	2. N/A – reporting only~~TBD~~		

Appendix C: Rationale for Incentive Measures

Domain and Measures	Brief Description	Rationale for Domain/Measure
Readmissions – ~~Hospital-wide All-Cause Readmission~~ Potentially Preventable Readmissions	This measure estimates the hospital-level ~~,~~ ~~risk-standardized~~ rate of potentially preventable readmissions~~all-cause readmission~~ after admission for any eligible condition within 30 days of hospital discharge ~~(RSRR)~~ for all patients ~~aged 18 and older~~.	Reducing readmissions has value as an indicator of quality. Unnecessary readmissions may reflect poor coordination of services and transitions of care at discharge or in the immediate post-discharge period. The change to a measure of potentially preventable readmissions will aid hospitals in focusing their quality improvement efforts on the types of discharges resulting in the greatest levels of unnecessary readmissions. Reducing readmissions is a function of both hospitals and primary care; the measure will therefore incentivize more integrated care across the hospital outpatient continuum.
Medication safety – (a) Hypoglycemia in inpatients receiving insulin (b) Excessive anticoagulation with Warfarin (c) Adverse Drug Events due to opioids	This measure focuses on preventing harm from high alert medication, which increases the risk of injury to patients if the dosage is not correct. The medications focused on are insulin, Warfarin, and opioids.	Adverse drug events (ADEs) are defined as any injuries resulting from medication use, including physical harm, mental harm, or loss of function. ADEs comprise the largest single category of adverse events experienced by hospitalized patients, accounting for about 19 percent of all injuries. The occurrence of ADEs is associated with increased morbidity and mortality, prolonged hospitalizations, and higher costs of care. The Institute of Medicine (IOM) estimates that 1.5 million preventable ADE occur each year[5]. The occurrence of ADEs

[5] "How-to Guide: Prevent Harm from High-alert Medications." Cambridge, MA: Institute for Healthcare Improvement, 2012. Web February 2013. http://www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventHarmfromHighAlertMedications.aspx

Domain and Measures	Brief Description	Rationale for Domain/Measure
		in hospitalized patients varies between 2 and 52 ADEs per 100 admissions. An estimated 15% to 59% of these ADEs are considered preventable[6].
Patient experience – (a) HCAHPS, Staff always explained medicines (NQF 0166) (b) HCAHPS, Staff gave patient discharge information (NQF 0166)	This measure focuses on measuring patients' perspectives on hospital care. This is a composite measure that includes: 1. Communication about medicine 2. Discharge information The measure is the percent reporting positively in the above areas.	This is a national, standardized way of assessing patients' perspectives of hospital care. It is aligned with CMS public reporting, including the Hospital Value-based Purchasing Program. The measure creates an incentive for hospitals to improve quality of care and patient experience. It will support improvements in internal customer service and quality-related activities.
Healthcare Associated Infections (HAIs) – (a) CLABSI in all tracked units (modified NQF 0139) (b) CAUTI in all tracked units (modified NQF 0754)		CDC's HAI prevalence survey[7] shows: –On any given day, about 1 in 25 hospital patients has at least one healthcare-associated infection. –Estimated 722,000 HAIs in U.S acute care hospitals in 2011 –About 75,000 hospital patients with HAIs died during their hospitalizations. –More than half of all HAIs occurred outside of the intensive care unit.
Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	Hospitals who have implemented the EDIE program in Oregon or other Health Information Exchange technology that allows hospitals to share ED visit information with primary care providers and other hospitals.	Coordination of care between systems such as outpatient services and hospitals is important for better management and care of patients, particularly for patients who are 'high utilizers' of the health care system. By promoting the use of EDIE or other technologies, hospitals can better inform

[6] Cano FG, Rozenfeld S: Adverse drug events in hospitals: a systematic review**.** *Cad Saude Publica* 2009, **25**(Suppl 3)**:**S360-S372.

[7] Magill SS, Edwards JR, Bamberg W, et al. Multistate Point-Prevalence Survey of Health Care–Associated Infections. *N Engl J Med* 2014;370:1198-208.

Domain and Measures	Brief Description	Rationale for Domain/Measure
	The EDIE program allows clinicians to identify patients who visit EDs throughout the state more than five times in a 12 month period.	primary care of patient visits to the ED. Additionally, hospitals and primary care providers can begin to identify patients who are regularly accessing the health care system through the ED and work to better meet their needs. One of the seven CCO focus areas is to reduce over-use of care by 'super utilizers'. One focus of implementing the EDIE system is to reduce unnecessary use of the ED.
Behavioral health - Follow-up after hospitalization for mental illness (modified NQF 0576)	Percentage of Medicaid members age 6+ and mental health diagnosis with a follow-up visit within 7 days after hospitalization.	Oregon's 2013 baseline for follow-up after hospitalization for mental illness is 67.6%, which is just under the 90th percentile nationally (68.0%, 2012 Medicaid benchmark). Research has found patient access to follow-up care within 7 days of discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmissions.[8] In addition to potential cost savings from reducing readmissions, focusing on the integration between physical and behavioral health is a key component of Oregon's Health System Transformation. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

[8]Fortney J, Sullivan G, Williams K, Jackson C, Morton SC, Koegel P. Measuring Continuity of Care for Clients of Public Mental Health Systems. *Health Services Research*.2003; 38: 1157-1175.

Domain and Measures	Brief Description	Rationale for Domain/Measure
Behavioral health – Screening for alcohol and drug misuse, brief intervention, and referral for treatment in the ED (SBIRT)	Percentage of patients age 18+ with an ED visit in the measurement year screened for substance abuse and referred as necessary.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health. Research shows that the ED can be an effective place to screen and refer patients for substance use services: One study found that 26% of patients screened in the ED exceeded the low-risk limits set by the National Institute of Alcohol Abuse and Alcoholism[9].

[9] Academic ED SBIRT Research Collaborative. The Impact of Screening, brief intervention and referral for treatment (SBIRT) on Emergency Department patients' alcohol use. Annals of Emergency Medicine. 2007;50:699–710. http://www.bu.edu/bniart/files/2011/02/SBIRT-emergency-alcohol.pdf

Oregon Bulletin
July 1, 2015

OTHER NOTICES

REQUEST FOR COMMENTS
PROPOSAL TO EXTEND THE OREGON HEALTH AUTHORITY'S HOSPITAL TRANSFORMATION PERFORMANCE PROGRAM THROUGH JUNE 30, 2017

COMMENTS DUE: July 15, 2015

PROPOSAL: The Oregon Health Authority (OHA) is proposing to request approval from the federal Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) to extend Oregon's Hospital Transformation Performance Program through June 30, 2017. The program began in July 2014, and federal approval is currently due to expire June 30, 2016. The 2015 Oregon Legislative Assembly, however, has extended the program through September 30, 2019; thus, the federal approval is necessary in order to meet Legislative requirements for the next biennium.

The Hospital Transformation Performance Program (HTPP) rewards hospitals for improved performance, which the state believes leads to better health care and better health care outcomes for the more than 1.3 million people covered by the Oregon Health Plan (OHP) and for others throughout Oregon. The program compliments Oregon's larger health system transformation efforts and supports coordinated health care by facilitating reform in hospitals, a major part of the health care delivery system.

BACKGROUND: Since July 1, 2014, under its 1115 Demonstration, the state has operated a hospital "incentive pool," the HTPP, to issue payments to participating hospitals for adopting initiatives to improve the quality of Oregon's health care system and to measure that improvement. Specific quality metrics were developed by the Hospital Performance Metrics Advisory Committee, OHA, and CMS as a way to measure progress towards the state's health system transformation goals. For more information on the HTPP, go to: http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx.

EFFECTIVE DATE: July 1, 2016

HOW TO COMMENT: Send written comments by fax, mail or email to:

Janna Starr, 1115 Demonstration Manager

Division of Medical Assistance Programs

500 Summer Street NE

Salem, Oregon 97301

Fax: 503-373-7689

Email: janna.starr@state.or.us

Division of Medical Assistance Programs
Kate Brown, Governor

Oregon Health Authority

500 Summer Street NE, E49
Salem, Oregon 97301-1079
Voice – (503) 945-5772
FAX – (503) 373-7689
TTY - (503) 378-6791
www.oregon.gov/OHA

May 28, 2015

To: Oregon Tribal Representatives

From: Judy Mohr Peterson, Medicaid Director
State of Oregon

Subject: Opportunity to comment on Oregon Health Plan (OHP) changes

This letter is to give you information and an opportunity to comment on the state's upcoming request to the federal Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) to extend Oregon's Hospital Transformation Performance Program through June 30, 2017.

Since July 1, 2014, under its 1115 Demonstration, the State of Oregon has operated a hospital "incentive pool", the Hospital Transformation Performance Program (HTPP), to issue payments to participating hospitals for adopting initiatives to improve the quality of Oregon's health care system and to measure that improvement. Quality metrics were developed by the Hospital Performance Metrics Advisory Committee, OHA, and CMS as a way to measure progress towards the state's health system transformation goals.

The program is based on the premise that the higher the quality of hospital performance, the better the health care and health care outcomes will be for those covered by the Oregon Health Plan (OHP), and beyond. The program complements and aligns with Oregon's larger health system transformation efforts and supports the coordinated care model by facilitating reform in hospitals, a major part of the health care delivery system.

Initially, CMS approved the HTPP through June 2016. The 2015 Oregon Legislative Assembly, however, has extended the program through September 30, 2019. Thus, the State is developing an amendment request that would extend HTPP

provisions in the State's 1115 Demonstration for the full period of the State's current Demonstration approval, through June 30, 2017. The State will also suggest changing the measurement period from the federal fiscal year to the calendar year in order to be consistent with coordinated care organization (CCO) metrics reporting.

The additional year of the program will serve as an interim period during which OHA will work with stakeholders including the tribes, hospitals and other interested parties to solidify the State's vision of the program through September 2019, and to align it with the State's larger transformation and coordinated care efforts. You can find out more about the program, the goals of the program and how they are being measured at: http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx.

This amendment and program extension will affect Oregon's American Indians and Alaska Natives to the same extent that it will affect anyone covered by the OHP or being served in participating hospitals. It will continue and enhance a program that tangibly encourages hospitals to provide the best and most coordinated care possible, to the benefit of all Oregonians, and will continue to build on the State's long history of providing the most vulnerable residents with effective, efficient, evidence-based health care.

OHA appreciates your interest in the OHP and its impact on Tribal members and entities. The State will consider all feedback as we develop the request for these changes. Please share this information with any individuals or groups who may be interested in or affected by the changes.

Please send written comments by June 30, 2015 to Janna Starr; Medical Assistance Programs; Oregon Health Authority; 500 Summer St. NE; Salem, OR 97301-1079 or Janna.Starr@state.or.us.

Oregon's Tribal and Public Notice and Consultation regarding the Extension of the Hospital Transformation Performance Program (HTPP)

Tribal Notice and Requests for Comment

Method of Tribal Consultation	Date	Comments
Tribal 770 Quarterly Health Cluster Meeting	May 13, 2015 Salem, Oregon	Medicaid Director, Judy Mohr Peterson, informed the attendees that the State was developing a request to extend the Hospital Transformation Performance Program (HTPP) and that the Tribes would be receiving a written request for comments in the near future.
Tribal Consultation Meeting	August 20, 2015 Salem, Oregon	Medicaid Director, Leslie Clement, and OHA policy staff, Janna Starr, reported that OHA will send a formal request to CMS in the next few weeks for approval to extend the HTPP through the end of the current Waiver and referenced the written consultation sent to the Tribes in May. The HTPP is scheduled to end this summer if not extended. The attendees discussed the issue and reported interest in the data and seeing what kind of positive impact the hospital incentives have had on tribal health entities and members. Interest was also expressed in coordinating these incentives with IHS incentives.
Letter with amendment description and links[1]	**Sent:** May 28, 2015 **Comments due:** June 30, 2015	No comments were received as a result of the letter.

[1] Attached

Public Notices and Request for Comment [2]

Medium	Date	Comments
Newspapers ➢ Bend Bulletin ➢ Eugene Register-Guard ➢ Portland Oregonian ➢ Salem Statesman Journal ➢ Daily Journal of Commerce ➢ Medford Mail Tribune ➢ Corvallis Gazette Times	**Published:** June 14 & 15, 2015 **Comments due:** July 15, 2015	No comments were received as a result of these publications.
Oregon Bulletin (Secretary of State Website)	**Posted:** July 1, 2015 **Comments due:** July 15, 2015	No comments were received as a result of this public notice.
General Public and Targeted survey	**In progress** **Sent out:** September 4, 2015 **Open until:** October 7, 2015	To gather feedback on the current domains and measures included in the program, as well suggestions for other areas to focus quality improvement efforts. The survey is open to the public, but OHA is specifically engaging both the Hospital Transformation Performance Program Advisory Committee and the CCO Metrics & Scoring Committee, as well as the technical advisory groups for both the hospital and CCO metrics programs. The survey is web-based. The link is available on the program webpage, as well as the webpage devoted to the Hospital Performance Metrics Advisory Committee. The link was sent via email to the Committees and technical advisory groups noted above.

[2] Attached

Targeted Public Comment and Consultation

Method of Consultation	Date	Comments
Hospital Performance Metrics Advisory Committee[3]	February through July 2014	The committee used a public process to identify a set of performance standards (measures and targets) for hospitals that are designed to advance health system transformation, reduce hospital costs, and improve patient safety. The committee met four times between February and July, 2014, and made a formal recommendation which is now being used to determine incentive payments to DRG hospitals through the new Hospital Transformation Performance Program. The Committee has begun meeting again in 2015. Specifically, the Committee has met five times thus far in 2015, and OHA is consulting with the committee on: • The program structure for Year 3 (2017) • The extension we're currently seeking – and • The vision for subsequent years of the program (to be included in the next Demonstration period, per CMS approval)
Oregon Association of Hospitals and Health Systems		Weekly calls to ensure that hospitals are receiving the technical assistance they need to be successful on their quality improvement efforts as part of the HTPP

[3] In 2013, Oregon House Bill 2216, Section 1, established the nine-member hospital performance metrics advisory committee appointed by the Director of the Oregon Health Authority.

Method of Consultation	Date	Comments
Hospital Metrics Technical Advisory Committee[4]		This group is a venue for discussion, brainstorming, and solution-finding regarding the HTPP quality improvement metrics. It identifies solutions and provides advice to OHA and the Committee regarding specifics around measurement (coding, technical specifications, addressing feedback from hospitals) and data collection.
CCO Metrics & Scoring Committee	October session planned	To foster coordination between CCOs and hospitals in achieving health system transformation and quality improvement, we are holding a joint learning session on behavioral health in October. The objective is to have common understanding of issues and work on behavioral health around the state, and to begin conversations regarding a cross-committee vision for how incentive metrics can support this work.

[4] Established July 2015 - comprised of representatives from all of the hospitals participating in the program