DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

David Simnitt
Interim State Medicaid Director
Oregon Health Authority
421 SW Oak Street, Suite 875
Portland, OR 97204

MAY 3 1 2018

Dear Mr. Simnitt:

The Centers for Medicare & Medicaid Services (CMS) is approving two attachments for Oregon's section 1115(a) demonstration, entitled "Oregon Health Plan" (21-W-00013/0 and 11-W-00160/0). Specifically, CMS is approving Attachment H entitled, "Calculating the Impact of Health Systems Transformation" and Attachment E, entitled, "Menu Set of Quality Improvement in Focus Areas." The Special Terms and Conditions (STCs) will be updated on Medicaid.gov to incorporate the enclosed approved Attachments.

Your CMS project officer for this demonstration is Robin Patrice Magwood. She is available to answer any questions regarding your section 1115 demonstration. Her contact information is:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0130
Email: Robin.Magwood1@cms.hhs.gov

Please send any official communication regarding program matters simultaneously to Mr. David Meacham, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations Program, in the Seattle Regional Office. Mr. Meacham's contact information is as follows:

Mr. David Meacham
Associate Regional Administrator
Division of Medicaid and Children's Health Operations Program
Centers for Medicare & Medicaid Services
701 Fifth Ave, Suite 1600
Seattle, WA 98104
Email: David.Meacham@cms.hhs.gov

We look forward to continuing to partner with you and your staff on the Oregon Health Plan section 1115 demonstration.

Sincerely,

[redacted]

Kim Howell
Director
Division of State Demonstrations and Waivers

Enclosures

cc: Mr. David Meacham, Associate Regional Administrator, Seattle Regional Office,
Gary Ashby, Oregon State Lead, Seattle Regional Office

Attachment E: Menu Set of Quality Improvement in Focus Areas

As per STC 24b.ii, OHA will continue to contractually require each Coordinated Care Organization (CCO) to address four of the quality improvement focus areas listed below.

The ability of PIPs to affect change are primarily driven by use of information, monitoring of information, and bridging the gaps. It is OHA's position that PIPs will impact change in the health system. PIPs will have even greater impact through coordination across the CCOs' efforts and alignment with their strategies, transformation, and measurement plans. Coordination of this work increases the ability to influence and engage health systems, delivery sites, providers, and patients. Moreover, the outcomes are improved when the work is targeted, collaborative, and addresses identified need. Coordination of PIPs across the health system transformation efforts also addresses the concern of metric/improvement fatigue in the system.

Requirements

All CCOs in Oregon are required to participate in the statewide performance improvement project for the integration of health focus area (Area #4). For the remaining focus areas, CCOs will have the flexibility to determine their quality project and measures with approval, quality monitoring, and technical assistance from OHA. The purpose for these focus areas is to reduce costly, inappropriate, and unnecessary care where possible while increasing the quality of care. Also, CCOs are to work directly with OHA on the approval of PIP projects, therefore the agency will have the ability to direct measurement alignment with a potential changing OHA measurement strategy; if applicable.

Monitoring

Monitoring process includes, but not limited to, quarterly reporting by CCOs, OHA review and analysis, technical assistance through learning collaboratives, presentations, and/or on-site review and support.

Modifications

The state may wish to add to this menu to account for how we will measure access and quality for individuals receiving care in FFS—including populations receiving costly long term care and supportive services. Additionally, based upon the maturing and lessons learned from the monitoring of the PIPs, OHA may submit additions and removal of focus areas and/or recommended measures.

Lessons from the 2012-2017 1115 demonstration

The lessons from 2012-2017 resulted in a better understanding by OHA the role of the PIPs in health system transformation and ensuring quality of care. These lessons supported changes in the process, collection tool, and support for the CCOs, such as areas of measurement and goal setting. Therefore, standardized process of collection, analysis and feedback has been developed in

accordance with waiver and CFR requirements. Furthermore, the collective impact of CCOs working on the most recent statewide PIP has proven successful. The results of the statewide PIP can be followed through CMS 1115 quarterly reporting, the annual EQR report and via the OHA Statewide PIP website.

Goal	Example Measures	Example Interventions
1. Reducing re-hospitalizations	Hospital readmissions (across age groups); Plan all-cause readmissions; hospital cost per patient and total cost of care per patient over specific time periods for patients enrolled in care transition programs; care plan for members with long-term care benefits; follow-up after hospitalization for mental illness; medication reconciliation post-discharge; timely transmission of transition record.	Financial penalties for high rates of re-hospitalizations and/or incentives for low rates (must remove the financial incentive to re-hospitalize through incentives and penalties), care transition programs. Also see "super-utilizers" interventions.
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned	These will vary depending on issue identified, but could include disease specific measures such as Diabetes Care measure, pediatric asthma hospitalization, tobacco cessation and counseling, and colorectal cancer screening.	Activities for improving the selected discrete health issue could be integrated with existing efforts at the community level through local public health, local health initiatives with community health centers. Specific intervention examples would be national diabetes prevention programs, million hearts campaign, and case management program, including targeted outreach calls.

federal and state programs.		
3. Reducing utilization by "super-utilizers"	Cost of care measures (total cost of care per patient over specific time period), and the hospital readmissions measures mentioned above, rate of ambulatory care sensitive hospitalizations (Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators); rate of avoidable Emergency Department (ED) visits; and outpatient and ED utilization.	Community-based outreach programs to better address the needs of high utilizers. Successful programs have consisted of community-based outreach programs (including in person programs beyond telephonic case management), nurse care coordination, home visits, same day appointments, and data sources adequate to target the super-utilizers. Additionally includes pieces of these, community health workers to help beneficiaries navigate the system and access resources; narcotics registries, targeted case management for frequent ED users, coordination with long-term care case workers and providers for individuals receiving long-term care and/or developmental disabilities supports and services; and CCO efforts to integrate information flow across providers. It is critical that a CCO appropriately target these services in order to realize improvements possible for this Focus Area.
4. Integration of health: physical health, oral health, and/or behavioral health	Screening for clinical depression & follow-up plan; screening and referral for alcohol or drug misuse; initiation and engagement with alcohol and drug treatment; follow-up after hospitalization for mental illness; mental and oral health assessment for children in DHS custody, chronic use opioid care strategies.	Global budget and single point of accountability for physical, behavioral and oral health; co-location of mental health and primary care which includes collaborations between the mental health and primary care providers to develop and execute a shared treatment plan, including coaching and counseling, improved systems for records sharing. Care coordination between physical health and oral health treatments (e.g. oral health care during pregnancy). Additional interventions targeted towards reducing chronic opioid use includes, but is not limited to, pain management schools in the community, and expansion of medication assisted treatment in primary care settings.

5. Ensuring appropriate care is delivered in appropriate settings	Rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); of avoidable ED visits; outpatient and ED utilization, Screening primary care access measures (including Adolescent well-care visits).	Connect vulnerable patients with appropriate behavioral health, social services and community services. Increase utilization of preventive visits to minimize inappropriate utilization of ED/hospitals.
6. Improving perinatal and maternity care	Prenatal and Postpartum Care (Health Effectiveness Data Information Set (HEDIS)), Timeliness to prenatal care, preterm deliveries, perinatal measures such as screening for tobacco use, tobacco cessation counseling, breastfeeding at discharge.	Collaboration with Strong Start program on early elective delivery, interconception care, home visiting programs for first time mothers, connection with local WIC program, development of maternal medical home models.
7. Improving primary care for all populations	Proportion of individuals with a patient-centered primary care home (PCPCH) and proportion of certified PCPCHs in a CCO's network, and level of certification; rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization; ratio of primary care spending to specialty & hospital spending over time, well-child visits, tobacco use screening and cessation counseling for patients >12 years old, Body Mass	CCO strategies to encourage their providers to attain highest levels of PCPCH recognition; development of community health workers to help increase access to culturally and linguistically appropriate primary care; CCO requirements for health assessments and person-centered care plans, certified Electronic Health Record (EHR) adoption and meaningful use; Patient Centered Primary Care Home participation incentives; shared incentives across primary, specialty, long-term, and acute care; improved access (e.g., after-hours physician availability, 24/7 access to a Nurse Practitioner (NP) or doctor); PHRs; open-access scheduling and sick hours.

	Index recorded (and appropriate counseling), drug-to-drug and drug allergy checks, and maintain active medication list (including allergies)	
8. Addressing social determinants of health	Food insecurity screening, supportive housing services, kindergarten readiness	Community partnerships is key in developing a broad project which addresses the social impacts to health outcomes. Coordinating with local community resources in practice screening and documentation in electronic health record. Intervention strategies could include collaborating with local food bank, early learning hubs, education system partners, regional health equity coalitions, and community advocates. Development and sharing of standard screening tools and methods for documentation, creating community referral pathways, and coordination of community resources to support members are integral for overall community health improvement.

Attachment H: Calculating the Impact of Health Systems Transformation

Driving towards the Triple Aim, Oregon continues to mature in the development of the Coordinated Care Model through innovative approaches to transform the health systems while maintaining quality assurance and fidelity of ensuring high quality care for Oregonians. Improving the connection between health system transformation and quality will build upon the initial gains in transforming into a community driven model of accountability, care and coordination. Initial goals to the synergy of health transformation and quality are: aligning of work for spread and outcomes achievement, reducing administrative burden, supporting collaborative systems within CCOs and community based organizations, and incorporating performance management methods in health transformation and quality.

A visual tool to connect the considerable efforts across health transformation, quality and metrics is displayed in Appendix E logic model. Relying on the foundation and structures set up under the 2012-2017 waiver, OHA provides the logic model to show how it plans to support transformation under the theory of change model.

The agency proposes to support health system transformation and quality alignment through the updated Transformation and Quality Strategy (TQS). With the initial CCO Transformation Plans, a significant amount of effort was expended at the CCO and community level. Some of the work would cross over to quality areas of quality; such as case management and health equity. For example, one CCO took on the following two discrete areas of work: a diabetic case management program for behavioral health populations with the statewide performance improvement project, and the development of case management programs for integration. Under the TQS, the CCO would be able to connect these efforts – which would have been reported separately in the Transformation Plan and the Quality Assessment and Performance Improvement (QAPI) – into the TQS, which will be a better use of CCO resources, provide synergy for the work, reduce confusion for provider networks, and allow for comprehensive strategic impact. Additionally, a combined TQS submission will allow for OHA to view health transformation work across the CCO, which will support in standard evaluations across quality and transformation and targeted technical assistance with OHA resources. Specific information regarding TQS areas, and TQS methods are detailed below.

Section A: Oregon Accountability Plan
Part I: Support for Health System Transformation

Introduction

To meet the goals of the triple aim, Oregon's coordinated care model and fee-for-service delivery system rely on six key levers to generate savings and quality improvements, and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that the Oregon Health Authority (OHA) will take through the supports described in this document, they comprise a roadmap for achieving Oregon's vision for better health, better care, and lower costs.

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex health conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes (PCPCH).

Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes.

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

Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources.

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

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

Supports include the Oregon Health Authority's Transformation Center, Innovator Agents, Patient-Centered Primary Care Home program, and programs and activities across the agency, including the Office of Equity and Inclusion, the Public Health Division, and the Office of Health Information Technology.

Transformation Center

Launched in 2013, the Oregon Health Authority's Transformation Center serves as the state's hub for innovation, quality improvement and learning for Oregon's health system in support of the triple aim: better health and better care at lower costs for all Oregonians. The Transformation Center (Center) helps good ideas travel faster through learning collaboratives, targeted technical assistance and other methods for sharing best practices and innovations. OHA intends for the

Transformation Center to continue this role, with a priority of delivering more focused and targeted support to meet coordinated care organizations' (CCO) evolving needs. Specifically, the Center will focus on identifying, strategically supporting, and sharing innovation at the system, community and practice levels within the following topic areas: primary care, value-based payment, behavioral health integration, oral health integration, and community health.

Activities to be performed by the Transformation Center

Examples of the types of activities that the Transformation Center will implement include:

- Technical assistance strategies to connect CCOs with resources for advancing work on behavioral health integration and oral health integration;
- Technical assistance to support performance improvement on the CCO incentive measures;
- Technical assistance to support the development and implementation of value-based payments within CCOs;
- Technical assistance to CCO Community Advisory Councils (CAC) to improve the effectiveness in areas such as member recruitment, engagement and retention; Support for implementation of Community Health Improvement Plan priorities;
- Convenings between early learning hubs and CCOs;
- Coordination of the Council of Clinical Innovators Fellowship Program to support local clinical leadership development and the spread of innovation across Oregon;
- Developing a "Good Ideas Bank" to document and spread best practices to further advance health system transformation;
- Technical assistance to CCOs to address the social determinants of health through mechanisms such as health-related services; and
- Conducting learning collaboratives, as described below.

For more information, see Appendix A.

Learning Collaboratives

The Transformation Center intends to continue convening learning collaboratives. In alignment with the evolution of Oregon's health system transformation efforts in general, the focus of these learning collaboratives—which take the form of either ongoing meetings or one-day learning events—will become more targeted to meet CCOs' needs. Specifically, during the early stages of health system transformation, the Transformation Center's learning collaboratives were a vehicle for supporting relationship-building between CCOs and promoting learning about a broad range of topics related to transformation. The future learning collaboratives will hone in on the CCOs' specific, technical needs related to, for example, reaching targets for specific incentive metrics; behavioral health integration; and enhancing the effectiveness of CACs by supporting recruitment and retention of Oregon Health Plan membership. In addition, a number of emerging

topics may result in future learning collaboratives, such as value-based payments for specific populations and/or settings; oral health integration; and moving upstream to promote population health by expanding the use of health-related services (i.e., flexible services and community-benefit initiatives) such as housing.

Of note, the Transformation Center is planning to host an "Innovation Café" that will allow CCOs and clinic representatives to share successes and lessons learned related to three CCO incentive metrics identified as requiring additional support: smoking cessation, effective contraceptive use, and emergency department use with a focus on behavioral health. In addition, the event will include keynote speakers that share strategies for incorporating a health equity lens across the delivery system.

Finally, the Oregon Clinical Innovation Fellows Program – which strives to build the capacity of health system transformation leadership within Oregon – will continue over the coming years. In the future, this program will focus on bringing prior cohorts of Fellows together to promote shared learning.

Convening Stakeholders

The Transformation Center convenes a Statewide CCO learning collaborative as required by STC 24d, the purpose of which is to promote innovations and activities that contributes to the objectives of health system transformation and accountability for achievement of the triple aim. The Statewide CCO learning collaborative enables CCOs to share best and emerging practices on the CCO incentive measures and in areas such as value-based payments; opiates and pain management; leading change; health equity; and quality improvement. The purpose of the collaborative is to facilitate peer-to-peer learning and networking; identify and share information on evidence-based best practices and emerging best practices; and help advance innovative strategies in all areas of health care transformation.

Sessions take place within the OHA Quality and Health Outcomes Committee, a monthly public meeting. Most attendees participate in person and some attend by phone. The Collaborative convenes bi-monthly. The CCO contract also requires that when a CCO is identified by OHA as underperforming in access, quality or cost against established metrics, the CCO will be required to participate in an intensified innovator/learning collaborative intervention.

Technical Assistance

The Transformation Center will continue to offer CCOs and their CACs the opportunity to receive technical assistance through external consultants, with an additional focus on behavioral health integration, oral health integration, value-based payment, and population health, in conjunction with OHA's priorities over the next waiver period. In an effort to further streamline

the Center's work, the technical assistance provided has evolved from being solely driven by CCO requests of Technical Assistance Bank consultants to the addition of specific technical assistance initiatives that are offered to the CCOs to help them achieve success in areas critical to health system transformation. For example, the Transformation Center will continue to develop programs for delivering targeted technical assistance around incentive metrics that are particularly problematic for the CCOs, as well as any new metrics that are added over the coming years. For example, to help CCOs achieve their cigarette smoking prevalence metric targets, the Center is offering online modules to train providers across the state on how to provide smoking cessation counseling to their patients. In addition, the Center plans to offer technical assistance to the CCOs to help them achieve their Transformation and Quality Strategy benchmarks in areas such as behavioral health integration, oral health integration, social determinants of health and population health, and value-based payment. This process will entail individual needs assessment conversations with CCOs about their goals in these areas, followed by pairing the CCOs with consultants who can effectively support the CCOs' goals.

For example, to support CCOs' efforts to support population health and move upstream to address the social determinants of health, the Transformation Center has contracted with consultants with expertise in community health to develop a curriculum for CCOs to follow in developing their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs), which serve as a strategic population health and health care system service plan for the community served by the CCO. Center staff are planning to use this curriculum as the basis for CCO CHA/CHIP trainings to all CCOs that submit a request by December 2018. In addition, the Center plans to deliver technical assistance to CCOs on how to use health-related services to address their members' needs related to the social determinants of health, such as short-term housing or rental assistance. The current plan is for the Center to work closely with the Medicaid Advisory Committee on this technical assistance, using the results of a survey being fielded by the MAC on what areas pose the most challenges for the CCOs related to supporting social determinants of health as a starting place for developing the technical assistance program.

The Center also plans to continue to provide technical assistance to CCOs to help them achieve their goals related to behavioral health integration. During the previous biennium, Center staff met with each CCO to discuss their behavioral health integration goals as laid out in their Transformation Plans, then matched all interested CCOs with consultants who provided them with technical assistance to help them reach their goals. Moving forward, the Center intends to follow a similar technical assistance approach for the CCOs' behavioral health goals. The Center also plans to provide technical assistance for CCOs' implementation of value-based payment in the area of behavioral health integration, and the implementation of the Regional Behavioral Health Collaboratives (more detail provided below).

In addition, the Center intends to dedicate more resources to supporting oral health integration within CCOs. Due to the fact that oral health was integrated into the CCOs' global budget in July

2014, which was almost two years after CCOs were stood up, the CCOs are not as far along with their oral health integration efforts. Consequently, the Center plans to provide technical assistance related to integration, with a possible focus on value-based payment for oral health. Target populations for this technical assistance will focus on integrating physical and oral health care for people with mental illness and diabetes. The Center is also considering developing a learning collaborative for CCOs and their oral health providers to collectively identify strategies for enhancing integration.

Finally, the Center will provide technical assistance to CCOs to help them achieve their value-based payment goals as laid out in the *CCO Value-based Payment Roadmap* that will be developed by OHA, in partnership with the CCOs, by the second quarter of 2018. Once the CCO targets have been identified, the Center will bring in external VBP experts to provide technical guidance to support the CCOs in meeting their targets.

While the specific details for the various TA programs the Center will be offering over the waiver period have not been fleshed out, the Regional Behavioral Health Collaborative (RBHC) TA described below—which will be offered in 2018—provides a typical example of the Center's TA programs

In 2016, the OHA convened the Behavioral Health Collaborative of stakeholders to develop recommendations to chart a new course for behavioral health in Oregon. OHA released the Behavioral Health Collaborative Report in the spring of 2017 with a set of recommendations to transform Oregon's behavioral health system, resulting in the formation of RBHCs.

The Center will provide TA to CCOs and their partners to develop these RBHCs. Following are details about the TA that will be offered,

Regional Behavioral Health Collaborative Technical Assistance Process

Who	What	When	How
TA opportunity for CCOs, community mental health providers, local mental health authorities, and local public health authorities	Support to collaboratively develop RBHCs. TA support options include: -Coordinating submission of the Letter of Intent	Requests due by August 31, 2018 TA available January 1, 2018 - April 30, 2019, with	The CCO and its RBHC partners will select a TA Consultant from the Center's TA Bank, and develop a work plan with tasks/deliverables.

	-Facilitating selection of priority topic areas -Facilitating development of Action Plan		

OHA and DHS anticipate working closely with the Transformation Center to develop a learning collaborative conversation at the Quality and Health Outcomes Committee to specifically address Duals Passive Enrollment implementation with CCOs. We hope to impact the enhanced communication between CCOs and long-term care (LTC) and long-term services and supports (LTSS) programs. This is part of OHA's overall goal to build more seamless care coordination and focus on enhanced outcomes into our overall transformation work.

In 2017, two DHS Aging and People with Disabilities offices began piloting implementation of Emergency Department Information Exchange (EDIE)/PreManage to increase notifications and information sharing with local CCOs and hospitals. In 2018, the Health Information Technology team anticipates a greater deployment of this technology across to other DHS offices so more LTC and LTSS case managers will have auto-notifications of hospitalizations. This is part of our overall goal to build more seamless care coordination and focus on enhanced outcomes into our overall transformation work.

OHA and DHS are building a stakeholder engagement plan to ensure member care coordination and to support transition (i.e. stakeholder communications and periodic stakeholder meetings), and we already have a working communications plan to share information with CCOs, community advocates, and members. Communication is geared to ensure members understand their enrollment options.

Measures of Effectiveness

The Transformation Center's evaluation measures will vary according to the specific technical assistance activities provided. Examples of possible measures include:

- Percent of Transformation Center planning interviews or consultations that result in CCOs receiving technical assistance.
- Percent of CCOs that receive consultant support on a variety of topics, including behavioral health integration, population health integration, and health-related services and that report implementing some/all of what they learned.
- Percent of all technical assistance evaluations identifying the support provided as effective/very effective in meeting the technical assistance project goal(s).

- Number of CCOs that made changes to how they approach achieving their metrics' goals as a result of the Center support.
- Number of CCOs that receive metrics-related technical assistance that meet the benchmark or improvement target, or make progress toward achieving those targets.
- Number of CCOs receiving value-based payment technical assistance that implement a new value-based payment.
- Learning collaborative evaluation surveys to measure what actions participants took as a result of the collaborative.

The Center works closely with the Innovator Agents to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities.

Innovator Agents

Senate Bill 1580 (2012) required OHA to provide CCOs with Innovator Agents to provide a key point of contact between the CCO and OHA and to help champion and share innovation ideas, within the CCOs and the state agency. During the current waiver period, the Innovator Agents have promoted innovation and implementation of the coordinated care model within the CCOs, providers and community partners by:

- Providing an effective and immediate line of communication that allows streamlined reporting and reduced duplication of requests and information;
- Identifying and facilitating resolution on CCO questions and issues with OHA;
- Actively supporting the Community Advisory Councils; and
- Fostering vital connections with the CCOs and community partners to build partnership and support for innovation.

Innovator Agents, initially part of the Transformation Center, were transitioned to the newly created Health Systems Division in 2015. The transition helps to ensure that Innovator Agents provide a direct linkage between the CCO and Medicaid program staff and leadership. This linkage provides a direct avenue to identify key technical assistance needs and develop strategies to effectively increase the rate of transformation throughout the state. The Innovator Agents work closely with the Transformation Center to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities. In moving the Innovator Agents to the Health Systems Division (HSD), an opportunity was created to move the Innovator Agents closer to other staff such as the Account Representatives that work directly with the CCOs. This allowed the Innovator Agents to work with others and leverage work that helped move healthy system transformation priorities forward.

Each Innovator Agent is uniquely positioned within their assigned CCOs and communities to have first-hand, on-going observations and participation in CCO health system transformation success and challenges.

Innovator Agents work closely with CCOs to innovate local health systems in numerous areas and are actively involved in areas such as: integration of behavioral health, oral health and physical health services, quality metrics, alternative payment methodologies, health information technology, Community Health Improvement Plans and Transformation Plans, testing ways to impact social determinants and reduce health disparities, integrating Non-Emergent Medical Transportation, increasing the use of Traditional Health Workers, developing CCO transformation initiatives, developing new partnerships and services to achieve greater population wellness, promoting clinical innovation, developing approaches to trauma informed care, and assisting development implementation of changing contract, policy, and benefit structures.

Innovator Agent Role

Under the waiver renewal period (2017-2022), the role of the innovator agents will be to:

1. Serve as a point of contact between OHA & CCOs to provide an effective line of communication and streamlined reporting, reducing the duplication of requests and information, and identifying and facilitating resolution on CCO questions and issues with OHA.

    a. Facilitate problem solving between OHA and CCOs.

    b. Facilitate the flow of information between OHA and CCOs through regular contact with OHA and CCO leadership.

    c. Partner with HSD Account Representatives to ensure positive customer service for CCOs.

2. Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. Attend Community Advisory Council meetings. Provide assistance for the development of the CCO's Community Health Assessment. Provide resources, consultation and support in addressing local health disparities.

    a. Attend all CAC meetings and work with CCO staff and CAC chair on work associated with the CAC.

    b. Actively participate in work related to the CHA, CHIP, and Transformation and Quality Strategy.

3. Innovator Agents will work in collaboration with the Transformation Center to identify key technical assistance needs and develop strategies to effectively spread the rate of transformation throughout the state and to ensure that learning and improvement strategies are identified and implemented.

    a. Engage with Transformation Center and facilitate technical assistance and training needs
    for CCO.

    b. Provide regular updates on transformation happening both nationally and locally.

    c. Attend in person Innovator Agent meetings monthly and virtually twice weekly with OHA leadership and stakeholders

    d. Collaborate and share best practices with other Innovator Agents, CCOs, community stakeholders and/or OHA.

4. Inform and work in partnership with OHA leadership and staff regarding opportunities and obstacles related to system and process improvements propose solutions, and track opportunities, recommendations, and results.

    a. Partner with OHA Managed Care Delivery System unit to ensure positive customer service for CCO.

5. Assist and support the CCOs in developing and implementing their transformation plans as stipulated in the CCO/OHA contract.

    a. Actively participate in work related to the Transformation Plan, including the CHA and CHIP.

6. Assist CCOs in the implementation of innovative projects and pilots.

    a. Ensure rapid-cycle stakeholder feedback to identify and solve barriers.

    b. Assist with adapting innovations to simplify and/or improve rate of adoption.

    c. Engage and facilitate stakeholder involvement.

7. Support the CCO in developing strategies to support quality improvement and the adoption of innovations in care through facilitating collaboration and knowledge sharing across the state.

8. Participate in community meetings or other gatherings that are required or beneficial to OHA and the CCO.

a. Build and facilitate partnerships and collaboration between OHA, the CCOs, stakeholders, and other government entities to support effective innovation.

9. Assist the CCO in managing and using information to accelerate innovation, quality and health system improvement.

    a. Actively participate in work related to the CHA, CHIP, and Transformation Plan.

    b. Engage with Office of Equity and Inclusion on health equity related work.

    c. Work directly with Health Analytics in OHA and CCO to assist with problem solving and clarification of OHA incentive metrics.

    d. Actively participate in CCO quality strategies and implementation.

10. Attain and maintain knowledge about health system innovation in consultation with state and national leaders and models.

    a. Provide regular updates on transformation happening both nationally and locally to CCO and OHA.

    b. Disseminate information and models of transformation locally and nationally.

11. Actively participate in collaboration and projects related to population or member health that intersects with other agencies such as public health, seniors and people with disabilities, child welfare, community safety, housing, etc.

    a. Provide best practice information that is occurring in other communities around the state.

    b. Provide updated information from OHA and other agencies.

Methods for Sharing Information

A critical role of the innovator agents will be to share information with OHA, the CCO, other innovator agents and community stakeholders. Information will be shared through the following mechanisms:

- Weekly in-person meetings and/or phone conversations with OHA and other innovator agents.
- Daily contact with the CCO and/or community stakeholders.
- Community meetings and/or forums.
- Not less than once every month, all of the innovator agents must meet in person to discuss the ideas, projects and creative innovations planned or undertaken by their

assigned coordinated care organizations for the purposes of sharing information across CCOs and with OHA.

Office of Equity and Inclusion

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain communities. These communities are often less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider. It is critical to address equity in these areas that impact a person's health. The connections among the CCO, its Community Advisory Council, community health workers, and local community health and community advocacy organizations will further this goal.

OHA's Office of Equity and Inclusion (OEI), in an effort to improve the cultural competence of health care professionals (providers) in the state:

- Collects and compiles cultural competency continuing education (CCCE) participation data from regulating bodies of 23 types of health care professionals.
- Reports to the Oregon Legislative Assembly biennially on participation levels of health care professionals in cultural competence continuing education.
- Established and works with an advisory committee to:
    - Develop a process for approving cultural competence continuing education opportunities/trainings;
    - Develop criteria to approve CCCE opportunities for the OHA list
    - Recommend cultural competence continuing education trainings to OHA for approval; and
    - Implement the CCCE approval process with OHA.
- Established and maintains a list of OHA approved continuing education trainings.

OEI maintains a list of OHA-approved continuing education trainings for health care professionals and providers, and the list is posted on their website. Cultural competency trainers may submit an application to determine if their training meets high quality standards of excellence in cultural competency education.

Traditional Health Worker Program

Traditional health workers (THWs) include five primary worker types, including: Community Health Workers (CHWs), Peer Support Specialists (PSS) (e.g., addictions and mental health), Peer Wellness Specialists, Personal Health Navigators (PHN), and Doulas. The utilization of

THWs assures delivery of high-quality, culturally competent care which is instrumental in achieving Oregon's Triple Aim. The THWs provide critical services in outreaching and mobilizing patients, community and cultural liaising, managing and coordinating care, assisting in system navigation, and health promotion and coaching. HB 3650 set out the requirements for Oregon to develop and establish a) criteria and descriptions of THWs to be utilized by CCOs, and b) education and training requirements for THWs. In 2013 HB 3407 was passed to establish a THW Commission, an advisory body predominantly comprised of THWs.

Key focal areas for THWs in Oregon include pursuing strategies to integrate THWs into the CCOs, advancing community engagement opportunities, and developing and implementing ongoing revisions to the THW scope in the context of health system transformation. These targeted areas require engagement of CCOs to define the role and use of THWs in community settings, and to increase the percentage of CCOs and their providers who employ THWs, to the extent needed within a community.

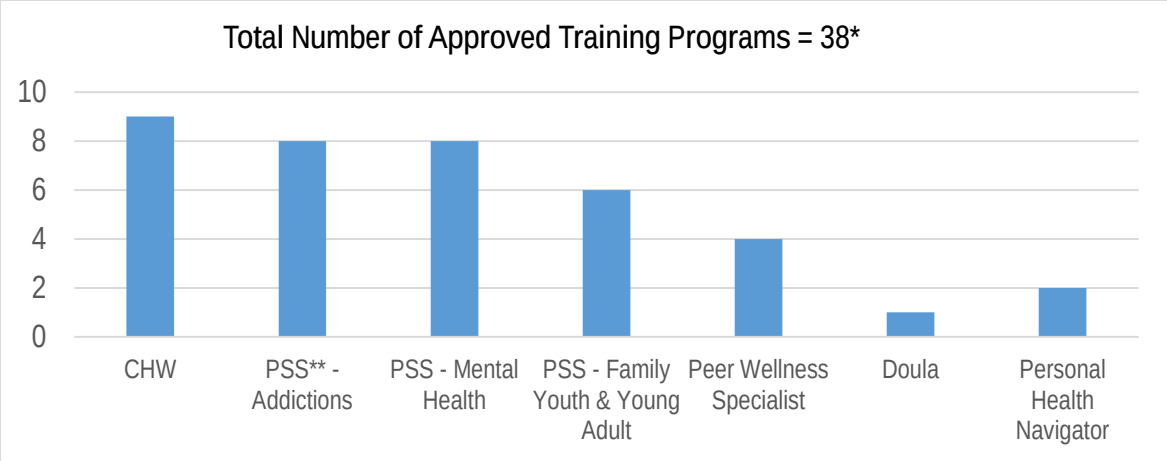
OHA's Office of Equity and Inclusion (OEI) continues to support the training and certification of THWs by:

- Enrolling certified workers on the state registry;
- Approving quality training programs; and
- Developing processes and procedures to facilitate seamless integration of THW workforce in the health system.

As of December 2016, OHA has certified a total of 1,506 THWs and approved 35 training programs.

Traditional Health Workers Certified as of December 2016

THW Program	**Total number certified statewide**
Community Health Workers (CHW)	422
Personal Health Navigators (PHN)	6
Peer wellness/support specialists	1011
Other THW (Doulas)	28
TOTAL	**1506**



***Note: Three of the training programs are in the process of being approved**

****Note: Peer Support Specialist (PSS)**

Health Care Interpreter (HCI) program

The HCI program is essential for complying with federal laws, health system transformation, the Triple Aim, and also, reducing inequities and health disparities. Title VI of the Civil Rights Act requires all health systems and service providers - including the CCOs, health plans, hospitals, and clinics - that receive any federal funds (i.e., Medicaid, Medicare) to provide language access services that include interpretation and translation of materials for all Limited English Proficient (LEP) clients. As part of meeting these federal requirements, Oregon law (413.550-560) required OHA to set up the HCI program to focus on developing an HCI workforce for providing culturally and linguistically appropriate care and services. This is important because the state has seen its minority population grow from 6 percent in 1980 to 22 percent in 2015, and is projected to double to 44 percent, by 2060 (Teixeira, Frey & Griffin, 2015).

Oregon law (413.550-560) requires OHA to establish and implement a process for HCIs to meet qualification and certification standards defined by the state and to be entered into a state registry that is available to the public. The HCI program currently supports approximately 363 qualified and certified interpreters who speak and interpret in about 15 different languages. This number will increase as OHA's HCI program has recruited and trained interpreters through a learning collaborative approach.

The HCI Learning Collaborative was set up by OEI with support from a CMMI SIM grant and six learning collaboratives were held. Applicants to the learning collaboratives went through sixty hours of health care interpreter training that prepared interpreters to work effectively in a health care environment. Part of the sixty hours training was done online but a majority of this

training is in-person. OHA/OEI has a list of approved trainers who partner with us to organize this training. Applicants who successfully completed their training were tested in English and the language they would interpret in after being qualified. Some of the trained interpreters would also go for the certification test to complete the process of becoming Oregon certified health care interpreters.

The table below provides a summary of the six learning collaboratives, including the number of trained interpreters and the languages they interpret in:

			Target Language												
Venue	Number of Trianees	Completed Training	Hispanic	Russian	Korean	Vietnamese	Arabic	Persian	Serbian	Burmese	Chinese	Somali	Amharic/Tigrinya	Cambodia	Hindi/Punjabi
Bend	17	17	16						1						
Portland	39	35	21	3		4	2	2		1	2				
Pendleton	21	21	18	2	1										
Medford	40	29	29												
Wilsonville	32	32	16	4	6	1		1			4	1			
Portland	40	36	16	1	1	2	2				1		1	1	2
Total	189	170	116	10	8	7	4	3	1	1	7	1	1	1	2

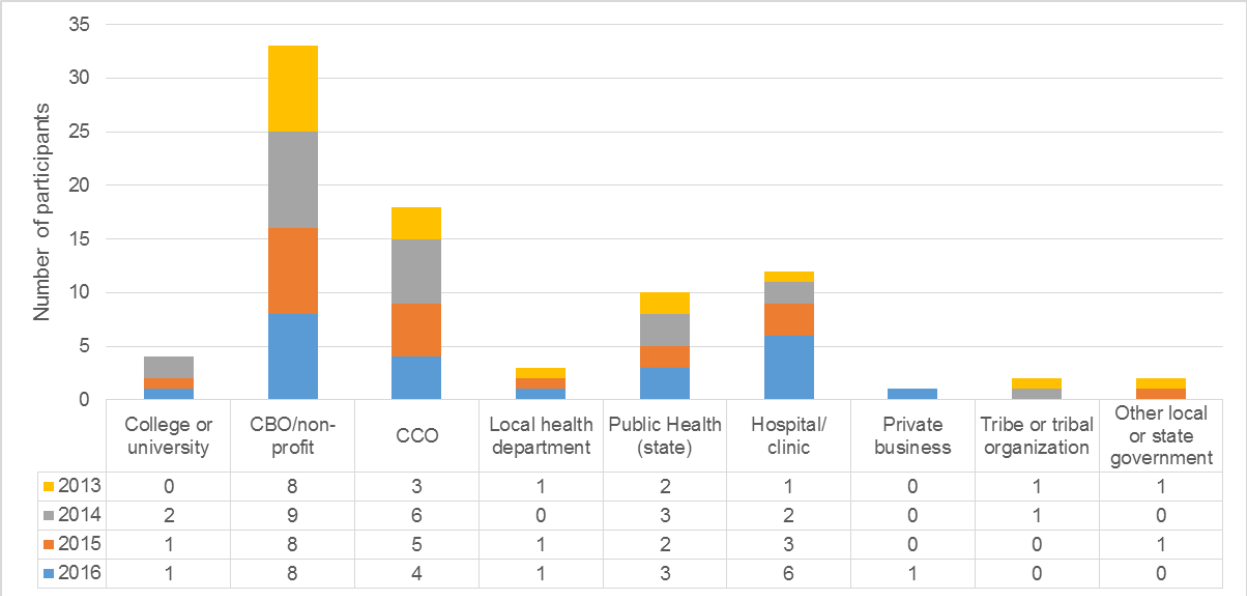
Developing Equity Leadership through Training and Action (DELTA)

Developing Equity Leadership through Training and Action (DELTA) is a 9-month long comprehensive leadership training initiative for building and strengthening capacity of Oregon's healthcare system, including the CCOs, clinics and hospitals, in health equity and diversity development. A cohort of 25 individuals representing community leaders, policy makers, administrators and clinicians are recruited each year from communities of color, the Oregon Health Authority, hospitals and health systems and coordinated care organizations CCOs for participation in the program, which includes training, project work implementing the national Standards for Culturally and Linguistically Appropriate Services (CLAS), coaching/mentorship and application of skills for nine months.

Upon completion of the program, this cohort will act as drivers of equity and inclusion within Oregon's health promoting systems. Cohort members are eligible for up to 42 Continuing Medical Education credits and apply the skills they acquire from the training to facilitate the development and institutionalization of health equity and inclusion strategies in their

organizational settings. In doing so, health equity, diversity development and inclusion is built into planning, policies, programs, practices, and resource distribution of these organizations.

The following chart provides a snapshot of the composition of the statewide a total of 85 DELTA cohort members from 2013 to 2016. Please note that starting in 2015, the DELTA cohort expanded to include non-health organizations (education, environment, housing & law enforcement) to build a stronger understanding of the social determinants of health.



	College or university	CBO/non-profit	CCO	Local health department	Public Health (state)	Hospital/ clinic	Private business	Tribe or tribal organization	Other local or state government
2013	0	8	3	1	2	1	0	1	1
2014	2	9	6	0	3	2	0	1	0
2015	1	8	5	1	2	3	0	0	1
2016	1	8	4	1	3	6	1	0	0

Regional Health Equity Coalitions

The Regional Health Equity Coalitions (RHECs) are community-driven, cross-sector, collaborative groups organized at a regional level to identify policy, system and environmental solutions that increase health equity for underserved and underrepresented communities experiencing health disparities. There are currently six RHECs spanning 11 Oregon counties and the Warm Springs Tribe. The majority (5 out of 6) coalitions' regions cover mostly rural areas, and have high proportions of diverse, underserved communities that are often considered "difficult to reach" or even "invisible" populations.

All six of the RHECs interface with their local CCOs in various ways. Some RHECs have CCOs involved as members of their general coalition membership, while others are part of RHEC leadership/steering committees.

Regional Health Equity Coalition (RHEC)	RHEC Region	Coordinated Care Organization Involvement
Klamath Regional Health Equity Coalition (KRHEC)	Klamath County	• *Cascade Health Alliance*: RHEC leadership team and coalition membership • Provided feedback on the Cascade Health Alliance CHIP
Let's Talk Diversity (LTD)	Confederated Tribes of Warm Springs & Jefferson County	• *PacificSource*: RHEC membership • Provided input on the *PacificSource* CHA and CHIP • Provided health care interpreter training for *PacificSource* providers • This RHEC has participated in the *PacificSource* Health Equity Task Force
Linn Benton Health Equity Alliance (LBHEA)	Linn & Benton Counties	• *Intercommunity Health Network (IHN)*: RHEC leadership team and coalition membership • This RHEC has been participating in IHN's Delivery System Transformation (DST) group. • Collaborated with IHN on their CHA/CHIP work
Mid-Columbia Health Equity Advocates (MCHEA)	Hood River & Wasco Counties	• *Columbia River Gorge*: RHEC membership • *PacificSource Community Solutions*: RHEC membership • RHEC member appointed to *PacificSource* Community Solutions CAC
Oregon Health Equity Alliance (OHEA)	Multnomah, Clackamas & Washington Counties	• *CareOregon*: RHEC membership • This RHEC has a CCO Committee which is specifically focused on

Regional Health Equity Coalition (RHEC)	RHEC Region	Coordinated Care Organization Involvement
		fostering relationships between OHEA, its partners, and local CCOs to promote a health equity framework.
Southern Oregon Health Equity (SO Health-E)	Jackson & Josephine Counties	• *Jackson Care Connect*: RHEC leadership team and coalition membership • *AllCare Health*: RHEC leadership team and coalition membership

Patient-Centered Primary Care Home (PCPCH) Program

The Patient-Centered Primary Care Home (PCPCH) Program was created by the Oregon Legislature through passage of House Bill 2009 as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon's vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon's version of the "medical home" which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

PCPCHs are an important part of healthcare transformation in Oregon, and are a foundational component of the Coordinated Care Model (CCM) Oregon has adopted as the basis for this transformation.

The impact of the PCPCH Program was evaluated through a multi-year study conducted by Portland State University.[1] Key findings are:

- $240 million in savings to the Oregon health care system over three years.
- Average savings of $14 per member per month at recognized PCPCH clinics. And, clinics that were PCPCH-recognized at least 3 years averaged a savings of $28 per member per month.
- Every $1 increase in primary care spending yielded a ROI of $13.
- Reduction in Emergency Department visits, Hospitalizations and utilization of Specialty Care.

[1] Gelmon, S., Wallace. N., Sandberg, B., Petchel, S., and Bouranis, N. (2016). Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings. Portland State University. Submitted to the Oregon Health Authority.

There are five core functions supported by OHA's PCPCH Program: (1) practice recognition, (2) PCPCH Standards refinement, (3) technical assistance and resource development, (4) communication and provider engagement, and (5) aligning payment with quality.

The PCPCH Program has achieved a number of critical milestones since its inception and during our current 1115 Waiver. Oregon's 16 CCOs have embraced the program with the vast majority of OHP members enrolled in a provider site that's recognized as a PCPCH in a CCO network. The adoption of Patient-Centered Primary Care Homes has been integral to transforming the health system and is supported by Oregon's statewide PCPCH standards and measures.

Following the legislative directive of HB 3650, as a component of the coordinated care model, CCOs are required to use PCPCHs for primary care delivery to the greatest extent possible in their networks and must report to OHA the number of members enrolled in a PCPCH. From 2012 – 2017, CCOs were eligible for financial incentives if at least 60 percent of their members were enrolled in a PCPCH. See Part III: Measurement Strategy for additional details about monitoring PCPCH enrollment.

Notable Achievements during 1115 Waiver Period

By the end of end of 2016 there were 647 recognized PCPCHs, representing over 50 percent of all eligible clinics in Oregon and serving approximately 2 million Oregonians (over half the state's population). More than 95 percent of clinics recognized as PCPCHs chose to reapply for recognition to maintain their PCPCH status.

As of September 2016, 90.6 percent of CCO members statewide were enrolled in a recognized PCPCH, which is a 74 percent increase in the proportion of members enrolled since 2012. Through the ACA Section 2703, recognized clinics received an increase per-member per-month payment for OHP members.

Through our partnership with Oregon Health Care Quality Corporation, the Patient-Centered Primary Care Institute (PCPCI) is advancing practice transformation state-wide through technical assistance opportunities and resources. To date, PCPCI has hosted 72 webinars on a variety of transformation topics that have been viewed more than 10,000 times, 101 blog posts, multiple technical assistance learning events, and a virtual behavioral health resource library. Also, through March 31, 2017, PCPCI is leading a Clinician Academy aimed at equipping healthcare providers to lead transformation efforts within their communities.

PCPCH Program staff conduct on-site visits to verify that clinic operations and patient experience in the practice accurately reflect the measures a clinic attested to on their PCPCH application. By the end of 2016 over 130 site visits had been completed in Oregon with post-visit technical assistance provided to the majority of clinics visited.

Accelerating the Spread of PCPCH

OHA is working with payers across Oregon to pursue innovative payment methods that move us toward a health care system that rewards quality, patient-centered care. For example, OHA's Public Employee's Benefit Board (PEBB) provides an age-adjusted, per-member-per-month incentive payment to Tier 2 or Tier 3 recognized primary care homes in the PEBB Statewide plan, administered by Providence Health & Services. A number of CCOs offer incentive payments for recognized primary care homes and have incorporated alternative payment methodologies (APMs). Additionally, Oregon is one of 14 regions selected to participate in CMS' Comprehensive Primary Care Plus (CPC+) medical home initiative. Nearly 160 Oregon primary care practices were selected to participate and many are recognized as a PCPCH. OHA has convened a Primary Care Payment Reform Collaborative focused on developing transformative recommendations to continue driving innovation and support payment strategies that reward quality healthcare.

Looking Ahead to 2017 and Beyond

In 2015, the PCPCH Standards Advisory Committee was convened to assist the OHA with revising the PCPCH model. Proposed changes were implemented on January 1, 2017 to clarify and strengthen existing standards and measures. Changes to the model include the addition of one new "must pass" measure, and a redistribution of total available points across five tiers. The changes are designed to incrementally adapt the model to the changing health care needs of the state, align the model with the best evidence where it is available, and also to improve the effectiveness of the standards and measures overall, with a focus on fostering integration of physical and behavioral health care services.

Detailed information about the PCPCH Program is available at: www.oregon.gov/oha/pcpch/

Other Support

Community Advisory Councils

Community Advisory Councils (CACs) are statutorily and contractually required of each CCO to ensure that the health care needs of the consumers and the community are being addressed. At least one member of the CAC sits on the governing board of the CCO, and the CCO's assigned Innovator Agent is required to attend CAC meetings. The CAC must:

- Include representatives of the community and of each county government served by the CCO, but consumer representatives must constitute a majority of the membership;
- Meet no less frequently than once every three months; and
- Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the CCO and members of the governing body of the CCO.

The duties of the council include, but are not limited to:

- Identifying and advocating for preventive care practices to be utilized by the CCO;
- Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the CCO; and
- Annually publishing a report on the progress of the community health improvement plan.

Community Health Assessments and Community Health Improvement Plans

Community health assessments and the resulting community health improvement plan are required of each CCO. In addition, the CCOs are required to submit an annual community health improvement plan progress report. As mentioned above, the community health assessment and community health improvement plan serve as a strategic population health and health care system service plan for the community served by the CCO.

The community health improvement plan adopted by the CAC should describe the scope of the activities, services and responsibilities that the CCO will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- Health policy;
- System design;
- Outcome and quality improvement;
- Integration of service delivery;
- Reduction of health disparities; and
- Workforce development.

Internal Coordination and Coordination with Other State Agencies

OHA Public Health Division

Many of the factors that lead to poor health outcomes are caused by social conditions beyond the immediate control of a single individual or coordinated care organization – such as persistent mental illness, addiction, homelessness, unemployment, lack of transportation and lack of quality education. Community interventions are needed to address the root causes of poor health outcomes as well as corresponding risk factors such as tobacco use, poor nutrition and physical inactivity. Oregon's health system transformation initiative supports CCOs in addressing the root causes of poor health outcomes through the community health assessment and community health

improvement plan process, which is overseen by the CCO Community Advisory Council and developed in collaboration with state and local public health agencies and community partners.

In collaboration with the OHA Transformation Center, the OHA Public Health Division will provide opportunities for CCOs, Community Advisory Councils, local public health authorities and their partners to develop the skills necessary to complete robust community health assessments and community health improvement plans that utilize evidence-based practices to ensure maximum population health impact. The division will provide access to county and CCO-level community health improvement plan goals. The division provides annual updates to its State Health Profile indicators and manages the Oregon Public Health Assessment Tool, an online database that allows CCOs and local public health authorities access to a variety of population data sets and lets users create and save their own customizable queries.

The OHA Public Health Division will also provide CCOs, Community Advisory Councils, local public health authorities and their partners with information about evidence-based population health interventions that can be included in community health improvement plans. Using Oregon's State Health Improvement Plan as a guide, the division will provide leadership for statewide interventions that aim to reduce the prevalence of the leading causes of death and disability in Oregon. Together with the OHA Transformation Center, the OHA Public Health Division will provide opportunities for local partners to convene and share strategies for improving population health by collaborating across health systems and public health.

Finally, the OHA Public Health Division will provide resources and expertise to CCOs in pursuit of improvement on their incentive measures, specifically those that focus on a population health issue or leverage the public health system for best performance. Technical assistance will be provided individually, at regular meetings of CCO medical directors and quality improvement specialists, and through written guidance documents. The division will equip local public health authorities to provide this type of support to their CCOs at the local level as well.

Oversight for Oregon's governmental public health system is provided by the Public Health Advisory Board, which is a subcommittee of the Oregon Health Policy Board. This relationship ensures that health system transformation and public health are consistently working towards the same goals and leveraging every opportunity to improve population health in Oregon.

Early Learning Council and Oregon Department of Education

Early investments in human capital that improve skill and health formation are critical to ensure long-term health outcomes and cost-savings for Oregon. Educational achievement level, particularly high school graduation and higher education is strongly associated with longer life and better health outcomes at the population level. This powerful relationship impacts the health of families for generations. As a result, the OHA-Public Health Division is invested in partnership with the education sector. OHA-Public Health Division has established a high level Memorandum of Understanding to formalize the partnership and has been working with the

Oregon Department of Education to address health related barriers to learning and attendance. The partnership has also supported effective collaboration around acute health concerns such as lead in the water of schools and childcare facilities.

Concurrent with its health reform efforts, Oregon is undergoing education system reform from preschool through higher education. Specific attention has been given to the reorganization of Oregon's early learning services for children ages 0-6.

Oregon's Early Learning Council (ELC) is legislatively charged with developing and overseeing a unified system of early childhood services centered on improving child outcomes. In order to redesign and integrate existing services into a high functioning early learning system, adaptive change across multiple sectors is required and the directors of OHA, the Oregon Department of Human Services, Oregon Early Learning Division and Oregon Department of Education all have seats on the ELC. Through the ELC as well as numerous agency- and program-level connections, OHA is coordinating with the Early Learning Division to ensure that a broad view of early learning is adopted and integrated into the state's work. This view encompasses more than traditional pre-school environments, but rather includes all settings where children are served from childcare to health and human services. Working together, the Early Learning Division and OHA are seeking shared opportunities for coordination of services, workforce training, data sharing, quality measurement, and accountability for child outcomes.

Oregon Health Information Technology

The vision for Oregon is a transformed health system where health information technology (IT) and health information exchange (HIE) efforts ensure that the care all Oregonians receive is optimized by health IT. In a health IT-optimized health care system:

1. Oregonians have their core health information available where needed so their care team can deliver person-centered, coordinated care.

2. Clinical and administrative data are efficiently collected and used to support quality improvement, population health management, and incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.

3. Individuals, and their families, access, use and contribute their clinical information to understand and improve their health and collaborate with their providers.

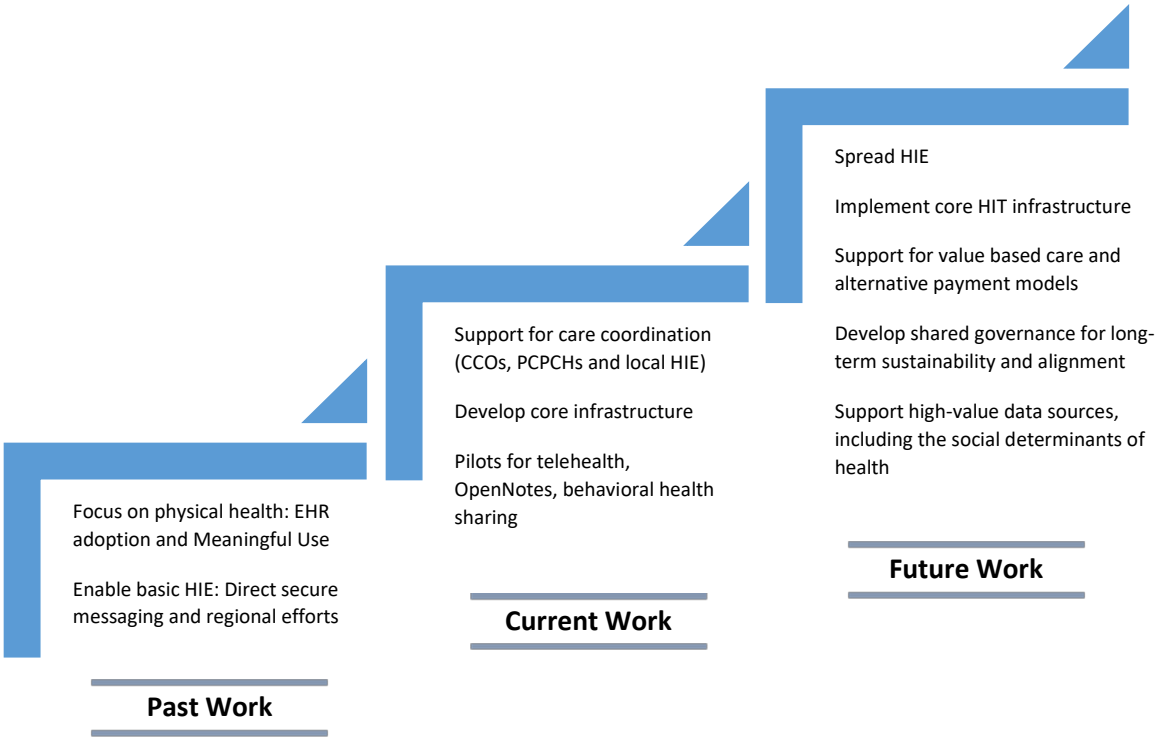
Oregon's health IT efforts are guided by overarching priorities of OHA and aligned with efforts of health system transformation. Health IT plays a critical role in several key initiatives, including expanding the coordinated care model, integrating physical, behavioral and oral health, and moving upstream to address the social determinants of health.

The vision of the coordinated care model is seamless care across providers and organizations. Thus, HIE is a key enabler for the coordinated care model, and there are significant opportunities to leverage health IT and HIE to reduce barriers and improve communication. To reap the full benefits of health IT, critical users need to be connected to meaningful HIE opportunities. Past work has focused on electronic health record (EHR) adoption and building the foundation for HIE and care coordination. Future work will involve ensuring that key providers and other critical care team members are connected to robust HIE.

Health IT is also critical to promoting the integration of physical, behavioral, and oral health. A key part of that work is improving Oregon's behavioral health system, and that improvement effort involves several health IT components. For instance, Oregon's Certified Community Behavioral Health Clinic Program (CCBHC) includes requirements for the use of health IT and the reporting of performance metrics. Oregon stakeholders recently convened the Behavioral Health Collaborative, which resulted in a series of recommendations on improving behavioral health information sharing and reducing barriers to data access.

Oregon's Health IT Progress and Future Work

CCOs and the overall health IT environment in Oregon has seen considerable progress since 2013. However, additional work to continue to advance health IT to close gaps remains.



Health IT Dimension	Progress	Gaps and work ahead
Baseline Capabilities (e.g., EHR adoption, Direct secure messaging)	Strong EHR adoption among physical health; Launched Direct secure messaging with some adoption and increasing use	Increase EHR adoption among behavioral health and dental providers. Many organizations without an EHR may benefit from Direct secure messaging. Pilots are focusing on long-term care and behavioral health opportunities.
EDIE and PreManage (hospital event notifications)	All Oregon hospitals participating and contributing data; significant adoption of PreManage among payers and CCOs as well as additional organizations	Not all users have adopted EDIE and PreManage to their workflows and operations; additional learning collaboratives and educational support are envisioned for the future. Increase adoption across provider types and settings.
HIE	Several regional HIE efforts launched and growing	Not all regions of the state are served by HIEs; HIE Onboarding Program will provide support to connect key Medicaid providers to HIEs with plans to connect HIEs as a network of networks.
Enabling Infrastructure (e.g., Provider Directory)	Provide Flat File of Direct secure message addresses. Progress on developing key infrastructure.	Implement key infrastructure, including statewide Provider Directory, Clinical Quality Metrics Registry, and Prescription Drug Monitoring HIE Gateway. Encourage health IT adoption in support of population management, value-based payments, and high-value data sources (e.g., social determinants of health). Ongoing assessment of additional opportunities and needs for shared enabling infrastructure. Working on development of a public-private governance body to guide future investments, including a network of networks.

Overview of CCO Health IT Efforts

In 2013, the Oregon Legislature approved $30 million in Health System Transformation Funds. The OHA Transformation Center awarded $27 million in Transformation Fund Grant Awards to help CCOs launch innovative projects aimed at improving integration and coordination of care

for Medicaid patients. Specifically, the Legislature directed the funds to be used for projects that would create services targeting specific populations or disease conditions, enhance the CCO's primary care home capacity, and invest in information technology and electronic medical records. Almost all of the CCOs invested a portion of their grant funds in health IT initiatives, including electronic health records (EHRs), health information sharing and exchange, data aggregation tools for population health, metrics collection, and telemedicine.

In general, all 16 CCOs have made an investment in health IT (either through Transformation Funds or otherwise) in order to facilitate healthcare transformation in their community. Nearly all CCOs are pursuing and/or implementing both health information exchange/care coordination tools and population management/data analytics tools.

Even with those similarities, each of the CCOs chose to invest in a different set of health IT tools. Through their implementation and use of health IT, CCOs reported early successes in achieving goals such as:

- Increased information exchange across providers to support care coordination.
- Making new data available to assist providers with identifying patients most in need of support/services and to help providers target their care effectively.
- Improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data.

In general, CCOs sought to understand which health IT and EHR resources were in place in their community and provider environments, identify which health IT capabilities were needed to support the CCO's efforts, and identify strategies to meet those needs including leveraging existing resources or bringing in new health IT tools to fill priority needs. Ultimately, the combination of different CCO community, organizational, geographic and provider contexts as well as the variation in EHR and existing health IT resources led to a number of differing approaches to health IT.

Changing Approaches and Next Phases for CCO's Health IT Efforts

Many CCOs are in the process of building upon their progress to date and are pursuing additional and/or improved health IT tools to add to (or replace) what they initially implemented:

- Connecting providers to health IT through integration with their EHR workflows
- Connecting clinics to real-time hospital event notifications via PreManage to access the Emergency Department Information Exchange (EDIE) (both emergency department and inpatient admission, discharge and transfer (ADT)) data and better manage their populations who are high utilizers of hospital services and support care coordination across the health care system around emergency and inpatient hospital events

- Moving from administrative/claims-based case management and analytics to incorporating and extracting clinical data from provider's EHRs
- Incorporating behavioral health information, long-term care and social services in order to increase care coordination across different provider types
- Working with providers and providing technical assistance to establish clinical data reporting
- Supporting providers in new ways by providing data and performance metrics/dashboards back to them
- Investing in new tools for patient engagement and telehealth

OHA's actions to support these efforts are outlined below.

CCO accountability for health information technology (STC 24c (1))

Each CCO is contractually obligated to meet standards in foundational areas of health IT. This includes facilitation of providers' adoption and meaningful use of certified EHR technology and HIE. CCOs should ensure that all providers on a care team are participating in statewide HIE, such as a regional HIE, hospital event notifications, and/or Direct secure messaging, that enables electronic sharing of information with providers in the CCO's network, and outside their organizational and systems' boundaries. Also, each CCO must currently have a health IT component in their contractual transformation plan that demonstrates, among other elements, how it will identify current capabilities, needs, and strategies to ensure adoption of certified EHR technology HIE, and health IT tools. For CCO providers who do not currently have this technology, there must be a plan in place for adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program and Medicare programs with Health IT components.

Adoption of Electronic Health Record Technology and Meaningful Use (STC 24c (2))

Through the Centers for Medicare & Medicaid Services EHR Incentive Programs, eligible Oregon providers and hospitals can receive federal incentive payments to adopt, implement or upgrade and meaningfully use certified EHR technology. Since the inception of the programs in 2011, 7,659 Oregon providers and 61 hospitals have received a total of $448.5 million in federal incentive payments ($296.2 million under the Medicare EHR Incentive Program and $152.3 million under the Medicaid EHR Incentive Program, as of December 31, 2016).

Minimum benchmarks based on federal targets for EHR adoption have been successfully surpassed by CCOs overall. The incentives for EHR adoption have transformed beyond paying for adoption; CCOs must demonstrate the advanced use of EHRs by reporting and meeting thresholds for clinical quality metrics and other EHR-based measures. As federal requirements advance, OHA's reporting requirements leverage that progress. For example, as of the 2016 reporting year, EHRs used in CCO reporting requirements must meet 2014 or 2015 Edition

certification standards. OHA in conjunction with the Metrics and Scoring committee will continue to monitor the CCOs' use of EHRs. If CCOs fall below the minimum threshold or standards, a plan will be implemented to move the CCO(s) to achieve at least the minimum threshold. This could be in the form of a corrective action plan, reinstating the EHR adoption metric, and/or technical assistance. See Attachment H Part III: Measurement Strategy for details on measures and benchmarks.

State Health IT Role and Activities (STC 24c (3 & 4))

In 2013, all 16 CCOs agreed to support OHA's plan to use the remaining $3 million of state Transformation Funds to leverage and secure significant federal matching funds for investing in statewide health IT infrastructure. These funds are being used to support OHA's vision of a statewide approach for achieving health IT-optimized health care. OHA-supported health IT infrastructure will connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

As we see the importance of supporting the coordinated care model and value-based care arrangements, OHA will continue to monitor and adapt to the environment. This includes exploring public/private partnerships and collaboratives with other organizations.

In 2015, Oregon passed legislation to align health IT efforts with health system transformation goals, formalize and support OHA's health IT efforts, improve OHA's ability to advance the necessary health IT to support CCOs and the spread of the coordinated care model. Oregon originally addressed health IT in HB2009 (2009) with the establishment of the Health IT Oversight Council (HITOC), setting forth a strategic, policy, and coordination role for OHA. HB2294 (2015) updated the health IT statute to account for changes since 2009 and has three major components:

1. Establishes the Oregon Health IT Program within OHA.
    - Grants OHA authority to provide optional health IT services to support health care statewide (e.g., beyond the Medicaid program)
    - Authorizes fees to cover the costs of operating OHA's health IT services. Fees would be charged to users of this program's service
2. Grants OHA flexibility in partnering with stakeholders and the ability to participate in partnerships or collaboratives that provide statewide health IT services. This is especially important where Oregon organizations are partnering to bring new statewide health IT services to Oregon, and allows OHA to participate and provide support, including:
    - Ability to vote on governance boards for such services, and
    - Ability to enter into agreements to support and provide funding for the appropriate Medicaid share of statewide health IT services.

3. Updates statute for Oregon's Health IT Oversight Council (HITOC)
    - Aligns HITOC under the Oregon Health Policy Board and solidifies its role in providing strategic and policy recommendations and oversight on the progress of Oregon health IT efforts.

Since HB2294 has been in effect OHA has established the new HITOC formally under the Policy Board with a revised charter and new membership. In 2017, HITOC completed an update to the three-year Health IT Strategic Business Plan[2] to focus and align efforts to advance health IT across the state. HITOC intends to make yearly updates to the three-year plan to account for the fast–changing landscape of healthcare transformation and associated health IT needs. Throughout 2017-2022, HITOC will also provide ongoing oversight to the Oregon Health IT Program and continue to monitor the environment and health IT efforts across the state.

In order to achieve the goals of a health IT-optimized health care system outlined above, the State will need to fill several roles:

The State will coordinate *and support community and organizational health IT efforts.*

- Recognizing that health IT efforts must be in place locally to achieve a vision of health IT-optimized health care, the State can support, facilitate, inform, convene and offer guidance to providers, communities and organizations engaged in health IT.
- OHA and HITOC will undertake significant policy development and strategic design work over the waiver period through 2022. Priority topics include behavioral health information sharing, health IT to support APMs, and data to support addressing social determinants of health.

[2] http://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/OHA%209920%20Health%20IT%20Final.pdf

HITOC Work Plan

	2017	2018-2020
Policy Topics	• Interoperability • Behavioral Health Information Sharing • Other Policy Board or HITOC-identified Topics	• Support for behavioral health information sharing • Patient access, consent, and specially protected information • Data sharing needs related to social determinants of health (SDoH) • New priorities as determined by OHPB and HITOC
Strategic Planning	• Complete update to strategic plan • Develop behavioral health HIT workplan for the Behavioral Health Collaborative	• Review and update strategic plan annually • Development or endorsement of strategies to support network of networks for HIE and HIT for Alternative Payment Methods (APMs) • Support HIT Commons and determine appropriate oversight and reporting roles
Oversight	• Oregon HIT Program (e.g. Provider Directory, Common Credentialing, Clinical Quality Metrics Registry, HIE Onboarding Program, etc.) • Behavioral Health Collaborative – HIT workplan • Advance data-driven measurement and milestones for HIT oversight	
HIT Environment	• Behavioral health scan	• Develop additional capacity for ongoing environmental scanning, with focus on new priorities (e.g., Long Term Services and Supports, SDoH, APMs, etc.)
Reporting	• Legislative Report in Summer 2017 • OHPB Report in Sept 2017	• Annual reports to legislature and OHPB • Explore opportunities to create dashboards to measure statewide progress
Federal Policy	• Federal Law/Policy Considerations (e.g. ACA, MACRA, 21st Century Cures Act, ONC initiatives, Meaningful Use, privacy and security requirements (42 CFR part 2, etc.))	

The State will align requirements and establish standards for participation in statewide health IT services.

- To ensure that health information can be seamlessly shared, aggregated, and used, the State is in a unique position to establish standards and align requirements around interoperability and privacy and security, relying on already established national standards where they exist.

The State will provide a set of health IT technology and services.

- New and existing state-level services connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

In particular, OHA's commitment to the CCOs in state-level health IT infrastructure includes the following:

- Statewide Direct secure messaging program, CareAccord, offers a standards-based, HIPAA-compliant, common method of health information exchange, leveraging new

requirements for certified EHRs and for hospital and providers seeking to meet meaningful use (funded, in part by CMS Medicaid Management Information System (MMIS) and CMMI State Innovation Model (SIM) funds).

- Bringing real-time hospital event notifications to all 60 Oregon hospitals through EDIE. All hospitals contribute ADT data (both emergency department and inpatient data) to EDIE. Reliance eHealth Collaborative HIE is receiving EDIE data for their members. Outside of the hospitals, CCOs, health plans, and provider clinics can subscribe to PreManage to access the EDIE data for their members/patients to better manage their populations who are high utilizers of hospital services and have complex care needs. PreManage supports care coordination across the health care system around emergency and inpatient hospital events (funded, in part by CMS MMIS and CMMI SIM funds).
    - OHA participates in the EDIE Utility, governed as a public/private partnership with hospitals, health plans, providers and CCOs participating in governance decisions and shared funding. At the core of the success of the EDIE Utility is the universal participation of Oregon's hospitals and emergency departments, the acceptance of a utility-wide data use agreement, and a shared funding model that draws support from Medicaid, hospitals, and insurers to provide EDIE to all Oregon hospitals.
    - There is continued PreManage adoption across provider types and settings. There are approximately 100 healthcare organizations in queue to come onto PreManage under the CCO subscriptions in 2018 and OHA will support the implementation of PreManage to Area Agency on Aging and Aging and People with Disabilities offices in all 16 DHS districts.
    - Fifteen CCOs currently have access to PreManage data and 13 of those CCOs have extended their subscriptions to key clinics in their networks. More than 200 primary care clinics, behavioral health organizations, dental care organizations, specialty care clinics, FQHCs, health plans, emergency services, and long-term services and supports systems have adopted PreManage. EDIE and/or PreManage are in use in every region of the state.
    - An evaluation of EDIE/PreManage links intentional workflows, including the creation of care guidelines, to successful ED utilization reduction. The evaluation also shows an 8% ED utilization reduction amongst Medicaid members since coordinated efforts using EDIE/PreManage began. (http://www.orhealthleadershipcouncil.org/wp-content/uploads/2017/09/EDIE-Evaluation-Report-Final-8-21-17-v.1.pdf). Focused regional community collaborations are being scheduled across the state to bring members of the care team (ED, primary care, behavioral health, long term services, etc.) together to determine roles and responsibilities for using EDIE/PreManage to support care

coordination. Training and sharing of best practices for workflows and care guidelines is planned in 2018/2019.

- Technical assistance is in progress to support approximately 1,400 Medicaid providers with the adoption and meaningful use of certified EHR technology as well as support providers in submitting their clinical quality metrics electronically from providers' EHRs to meet meaningful use and OHA's CCOs clinical quality metrics reporting requirements (funded, in part by CMS Health Information Technology for Economic and Clinical Health (HITECH) funds).
- Developing new health IT services to launch in 2018 to support efficient and effective care coordination, analytics, population management and health care operations, including:
  - A statewide Provider Directory, critical to supporting HIE, analytics and population management, accountability efforts, and operational efficiencies (funded, in part by CMS HITECH funds).
  - A Clinical Quality Metrics Registry (CQMR) to capture clinical quality measures (CQMs) from electronic health records (see Appendix C for CCO reporting requirements) (funded, in part by CMS HITECH and MMIS funds).
    - Consistent with OHA's goals for measure alignment, the CQMR is intended to decrease provider burdens and increase efficiencies by enabling a "report once" strategy. Initially, the CQMR will support CQM reporting for the Medicaid EHR Incentive Program and CCO incentives. Over time, it is intended to expand to serve additional programs, which could include the Merit-based Incentive Payment System (MIPS), CPC+, and other programs with aligned or overlapping measure sets.
    - The CQMR will support reporting in the Quality Reporting Document Architecture (QRDA) Category I format for patient-level data, as well as other formats. Although QRDA I is included in EHR certification standards and OHA sees advantages to moving to this reporting format, OHA anticipates challenges with provider readiness and the need for further technical assistance to support movement to reporting in this standard.
  - A Common Credentialing Program and database for the purpose of providing credentialing organizations centralized access to verified information necessary to credential or re-credential all health care practitioners in the State.
- Seek opportunities to support innovations. Past grant-funded initiatives have supported telehealth and patient access to full clinical notes, including:
  - Telehealth pilots in five communities (funded, in part by CMMI SIM funds).

- A telehealth resources and inventory website to link telehealth providers and purchasers (health plans, CCOs, etc.) to each other, through the Telehealth Alliance of Oregon (funded, in part by CMMI SIM funds).
- An Oregon effort to promote OpenNotes to health care providers with EHRs not currently configured for OpenNotes, which allows full clinician notes to be available through an EHR's patient portal (funded, in part by CMMI SIM funds).

- Identifying and addressing barriers to behavioral health information sharing and care coordination. This work includes a 2017 behavioral health IT environmental scan and survey to identify the health IT tools, opportunities and challenges faced by Oregon's behavioral health providers; as well as support through a 2015-2017 $2.2 million grant from the Office of the National Coordinator for Health Information Technology (ONC) to improve care coordination between behavioral and physical health care. Through the project, OHA's sub grantee, Reliance eHealth Collaborative (Reliance, formerly Jefferson Health Information Exchange), is focusing on consent management to enable coordination between primary care, behavioral health and emergency providers, by developing a common consent model that will be supported within the Reliance technology. In 2016, ONC awarded OHA and Reliance supplemental funds to expand multistate ADT notifications. The project supports the routing of EDIE ADT messages through Reliance to facilitate more actionable data across care teams, through encounter notifications and provider directory lookup, which improve patient outcomes and keep users within their workflows. OHA is a recipient of the ONC Advance Interoperable Health IT Systems to Support Health Information Exchange Cooperative Agreement program.

- Health IT also supports the shift from fee-for-service models of payment to alternative payment models that reward value and outcomes, which is crucial for health system transformation. These new payment models create requirements to track and report outcomes, and incentivize efforts to improve care coordination and health across populations. They also create an opportunity for aligned interests and shared need between health care payers and providers.
    - OHA is supporting care coordination, information exchange, and outcome reporting through strategies such as EDIE/PreManage, the HIE Onboarding Program, the Provider Directory, and the CQMR. Once these tools are fully implemented, they will support providers and CCOs in carrying out their work under the coordinated care model, as well as other value-based models, by giving them the ability to identify, share, and measure clinical data at the individual provider level. For example, OHA is exploring with other CPC+ payers the opportunity to leverage the CQMR for CPC+ clinical quality measure data collection to reduce reporting burdens on providers.
    - Current policy work at OHA is underway to develop a value-based payment roadmap and aligned strategies for primary care payment reform. As these policies are developed, OHA will work on developing additional support for the right health IT needed.

- To support care coordination and population health efforts, initiatives will also explore opportunities to leverage high-value data sources, such as public health registries, and non-clinical sources of data that can be useful in addressing the social determinants of health. At the same time, work is needed to ensure patient confidentiality and address issues around stigma and privacy. Past work has focused on expanding electronic access to the Prescription Drug Monitoring Program (PDMP) and Physician Orders for Life Sustaining Treatment (POLST) registries. CCOs do not access the PDMP or POLST electronically but do support their covered clinics in having PDMP and POLST directly integrated into their workflows as it bolsters prevention, chronic illness management and person-centered care – aims of the CCO model of care. Future work will look at expanded opportunities for exchange and access of similar high-value data, including electronic access to CCOs where appropriate.
    - Integration of PDMP data into health IT systems has been identified as a national best practice. Access to accurate and timely PDMP information at the point of care can help health care professionals make better-informed clinical decisions and improve patient care. Successful legislation was passed in 2016 to allow authorized practitioners or pharmacists and their delegates to access PDMP information through their health IT system and within their electronic workflow. The Oregon PDMP connected to health IT systems through a PDMP Gateway service in 2017. The PDMP Gateway is in the early adoption phase with the first integrations taking place with hospitals who have integrated EDIE into their EHRs. Two health systems with eleven hospitals have connected to the PDMP Gateway to allow PDMP data to flow within their EDIE notifications. Plans for a statewide PDMP Gateway subscription and statewide roll out are in development.
    - The CCOs model is designed to better coordinate services and focus on prevention and management of chronic conditions; PDMP data can provide a more complete medical profile on each patient including additional prescribers that they have been treated by and medication they have received. This information can be vital to coordinating care. With PDMP Gateway integration this tool is more accessible and more easily utilized.
    - Electronic access of POLST forms ensures patient orders are easily accessible across care settings and that processing times for POLST forms happen in a timely manner to ensure the most recent form is available. OHA awarded a grant to the Oregon POLST Registry in December 2016 to support EHR and health IT system integration with the registry. The goal was to enable electronic POLST form completion and bi-directional query by health systems, hospitals, and others to support patient care from their EHR or

health IT system. The upgrade has been completed to the electronic POLST (ePOLST) system and bidirectional data flow is now possible. Additionally, POLST forms will become available for EDIE users to view electronically within their workflow in 2018. The implementation of ePOLST has cut the number of paper submissions by more than half thus far. ePOLST availability for CCOs means member end-of-life wishes are known and executed in a way that respects the member. It also supports ease of access and integrated information for care providers. CCOs do not have access to ePOLST, but have supported their covered clinics in gaining access electronically.

New funding to Support Access **to Health Information Exchange**

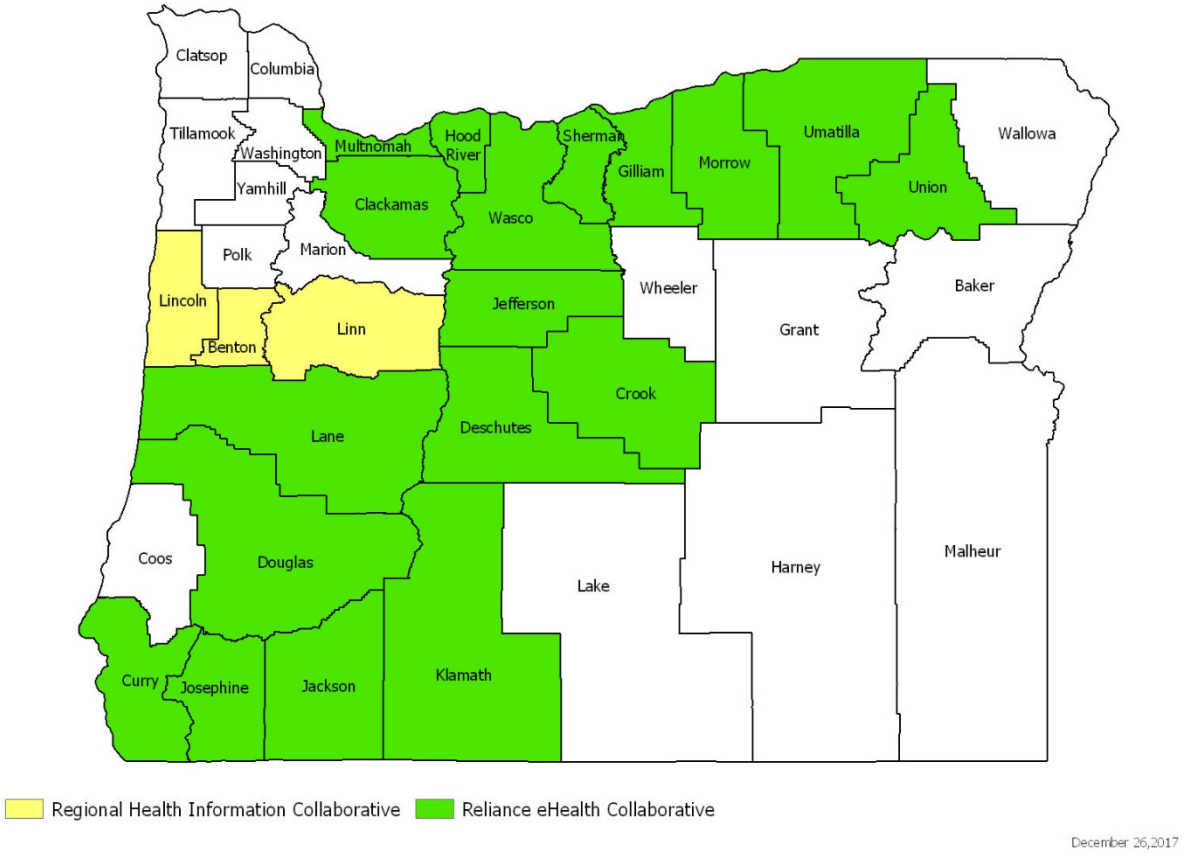
Oregon intends to leverage federal funding to support Oregon's Medicaid providers, including behavioral health, oral health, critical physical health, and social services, to connect to HIE entities. In early 2016, CMS issued guidance in the State Medicaid Director letter 16-003 about the availability of HITECH federal funding at the 90 percent matching rate for activities to promote HIE and encourage the adoption of EHR technology by Medicaid providers to enable eligible professionals to meet meaningful use requirements. Oregon intends to use these funds to increase Medicaid providers' ability to exchange health information by supporting the costs of an HIE entity (e.g., regional HIEs) to onboard providers, with or without an EHR.

The goals of the HIE Onboarding Program are:

- Accelerating HIE and filling gaps for critical Medicaid providers' ability to coordinate care through connecting to HIE entities
- Incentivizing cross-organizational HIE by supporting Oregon's HIE entities that make up its network of networks by funding onboarding for critical Medicaid providers
- Establishing and formalizing the Oregon HIE network of networks by ensuring HIE entities in Oregon are able to support HITOC's HIE objectives and OHA's Medicaid objectives by setting criteria that entities would need to meet to be eligible for funding

Oregon currently has several regional HIEs concentrated in the southern, central, and mid-valley areas of the state. The Program will leverage Oregon HIE entities' existing footprints, facilitate coordinated care across physical and non-physical health, and will prioritize different Medicaid provider types in different phases. The Program will require participating HIE entities to meet minimum criteria to be eligible for support. Criteria include, but are not limited to, robust privacy and security, use of standards-based or certified health IT, interoperability, participation in statewide HIE connectivity, participation in Oregon's state-level provider directory, reporting to OHA's clinical quality metrics registry and public health registries as appropriate, not engaging in practices that would result in health information blocking, and demonstration of a solid sustainability plan.

Regional Health information Exchanges in Oregon

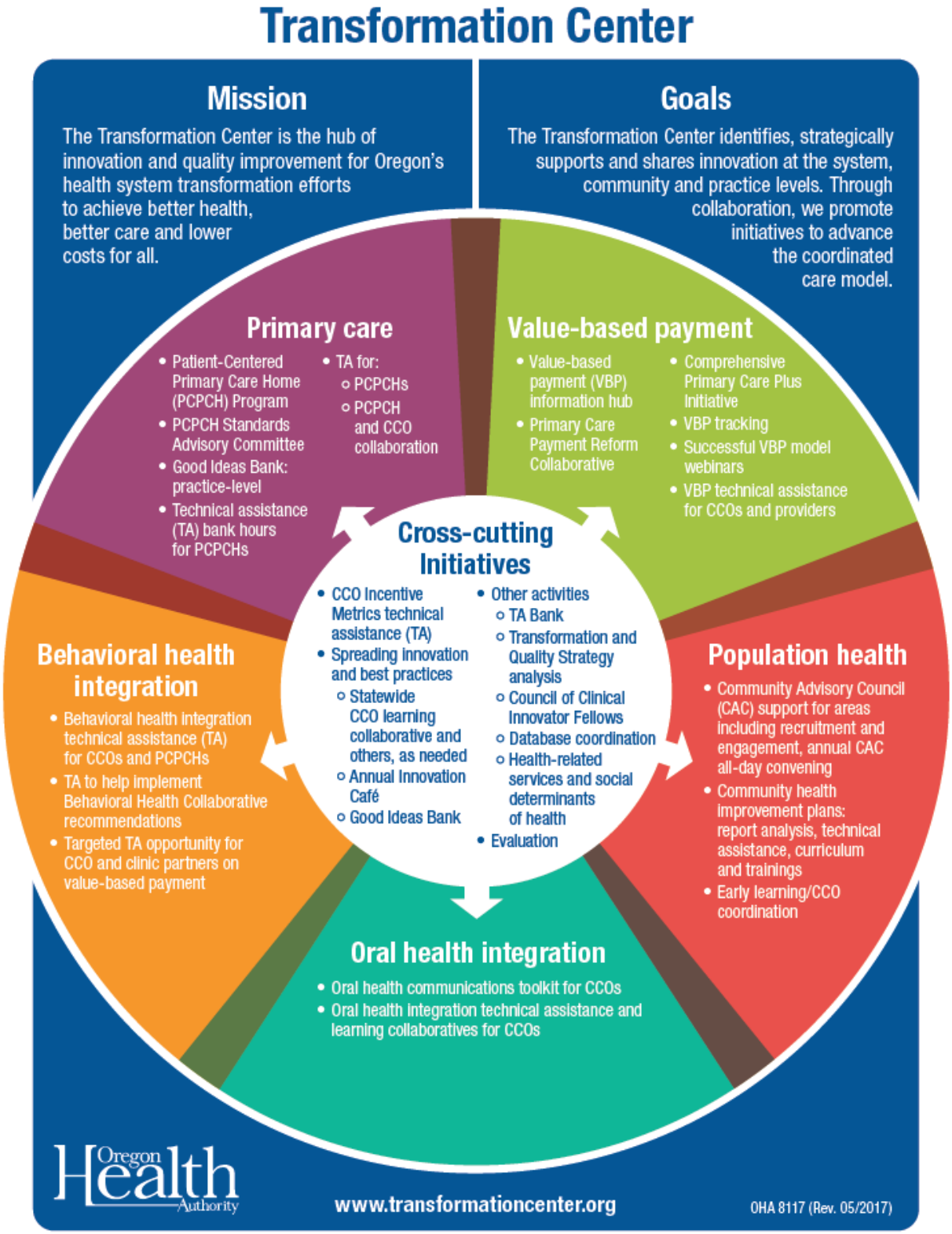


New Public/Private Partnership to Support Health IT Efforts

Building on the success of the EDIE Utility, OHA is working with stakeholders, including CCOs, hospitals, health systems, payers, and others, to launch a public-private partnership, HIT Commons, to advance health IT in Oregon. The new health IT governance effort will convene stakeholders, coordinate and standardize data sharing and trust framework agreements, leverage existing and future investments in health IT, and support the expansion of HIE efforts. Key goals include accelerating access to HIE across the state and enabling health system transformation efforts such as alternative payment models and population health.

For example, partnering across public and private sectors could accelerate the health IT vision of statewide HIE by coordinating across HIE efforts to ensure that a core set of patient data that is shared regardless of where a patient seeks care in Oregon. This type of partnership could also support the health IT components that support the metrics and data collection and use for alternative payment models such as CPC+.

Appendix A: Transformation Center



Part II: Quality Strategy

Monitoring the gains we've made

Introduction

To monitor how well Oregon's coordinated care model is achieving its goals of access, quality, and outcome improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have robust performance monitoring strategies and mechanisms to monitor and assess all Medicaid delivery systems (including Coordinated Care Organizations (CCOs) and Fee-For-Service (FFS)).

As required by CFR 438.330, Oregon assesses how well the CCOs and Managed Care Organizations are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees, and consumer satisfaction data described in Part III: Measurement Strategy. Oregon's evaluation plans, described in Attachment B, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries. Information on how Oregon will report to CMS on elements of the demonstration can be found in Attachment A.

Oregon has developed a comprehensive program to assess all aspects of the delivery system and the CCO and MCO activities to determine quality improvement and contract compliance. This section describes the components of that program.

Quality structure

The Oregon Health Authority is comprised of subject matter experts in evidence based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency wide committees who are responsible for oversight and planning. Underpinned across the quality and health transformation elements are health equity and social determinants of health with key contributions at the leadership committee level.

Oregon Health Authority (OHA) structure to support quality and access monitoring:

- Oregon Health Authority
  - Oregon Health Policy Board
  - OHA Quality Council
  - Managed Care and CCO Collaborative
  - Quality Management Program & Contract Compliance
- Health Delivery Systems
  - Quality and Health Outcomes Committee

- Health Evidence Review Committee

Accountability

In an effort to drive innovation, improve health outcomes and maintain compliance with regulatory agencies the Oregon Health Authority is managing the substantial work through clear lines of responsibilities. Aligning programmatic expertise and skills with the appropriate quality activity supports the necessary detail needed to move healthcare transformation forward. Specific delineation occurs for functions relating to quality and performance improvement, as well as quality assurance and compliance. Key attributes of accountability of this quality structure include, but are not limited to, the following:

- Oregon Health Authority
    a. Oregon Health Policy Board – develops strategic direction of health systems
    b. OHA Quality Council – monitors clinical quality performance, health transformation and quality improvement
    c. Managed Care and CCO Collaborative – monitors the client experience, through enrollment trends, complaints and grievances, appeals, and utilization trending
    d. Quality Management / Contract Compliance - monitors managed care organizations and CCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud, waste, abuse)

- Health Delivery System (partnership committees with health delivery system and OHA)
    a. Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation
    b. Health Evidence Review Committee – review and development of evidence based practices for all managed care entities (including FFS)

Methods and resources for monitoring

Across the Oregon Health Authority's quality programs, the agency utilizes multiple quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and LEAN principles are examples of proven methods of improvement. Ongoing use of these methods across the agency supports the transformation in the health care delivery system through train-the-trainer models with CCOs and contractual relationships with FFS. An additional resource for monitoring includes robust data systems to drive a data decision culture. Key agency data systems include, but are not limited to, the all payer all claims database, performance monitoring through measures reporting, and CCO data dashboards from claims reporting. See Attachment H, Part III: Measurement Strategy for more detailed description of data sources.

Framework for Quality

To monitor quality, the Oregon Health Authority will build upon the eight currently implemented focus areas across Oregon's health care delivery system. Continuing the progress in the focus areas, the Oregon Health Authority will intensify key focus areas, such as adding oral health to the existing primary care and behavioral health integration. Collaboratively working across the system, CCOs, MCOs, and the Oregon Health Authority will support the framework through quality improvement in these focus areas. Focus areas are detailed in the following "Improvement Strategies" section.

Continuing on the pathway to achieve the Triple Aim, the Oregon Health Authority recognizes the need for alignment across all health delivery systems for quality. Increased focus on alignment will include programs in Medicare, Medicaid (CCO and FFS systems), and federal improvement programs (e.g. Value Based Payment). Working with regional Quality Improvement Organizations (QIOs), OHA's External Quality Review Organization and health delivery systems (CCOs, MCOs), the Oregon Health Authority will look for opportunities to align state efforts with federal direction in quality and transformation activities. While maintaining the state's program integrity related to gains in health transformation, the Oregon Health Authority will develop strategic alignment for quality programs to increase organizations' efficiency, decrease burden on the health systems for reporting and communicate common-thread goals that will continue Oregon's work towards the triple aim of better health, better care and decreasing costs.

Improvement Strategies

As per STC 24b.ii, OHA will contractually require each CCO to address four of the quality improvement focus areas issues, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

Overview of 2012-2017 PIPs:

Under Oregon's 1115 2012-2017 demonstration waiver, CCOs developed performance improvement projects (PIPs) in a few key areas: high utilizers, maternal care, increased patient assignment within PCPCH medical homes, and diabetes care for individuals with serious and persistent mental illness. Development of effective coordination strategies across health systems, primary care, specialty care and hospital systems, for high utilizers and reducing re-hospitalizations is an ongoing effort. The PIPs initially focused on breaking down the silos of care and expanding care delivery to team based approaches. A few key lessons learned from adolescent well visits and maternal health have been helpful in providing for the patients social

determinants of health (food insecurity, stable transitions, supportive services); therefore, an additional focus area has been added for CCOs to test new models in the area of social determinants of health.

Advancing PIPs:

Moving forward, the PIP strategies are maturing into use of technology around care coordination and expanding into integrated practices. Allowing for the CCOs who have developed data monitoring systems, case management programs, and measurement alignment to develop initiatives in the space of social determinants of health will be key continuing to push health transformation. Additionally, lessons learned from the 2012-2017 demonstration for PIP implementation have led to the development of SMART (Specific, Measurable, Attainable, Relevant, Timely) objectives with a corresponding measurement for monitoring progress. Future technical assistance and monitoring will continue to focus on these quality improvement foundations.

PIP Focus Areas:

To move forward in testing and implementing improvement strategies, the CCOs will select three focus areas and one will be a focus study. One of the three required PIPs will focus on integrating primary care, oral and/or behavioral health, and will be conducted statewide. The quality improvement focus areas are:

1. Reducing preventable re-hospitalizations;
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs;
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers;
4. Integration of health: physical health, oral health and/or behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care;
7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care, and
8. Social Determinants of Health

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. PIP focus areas are subject to change as CCOs mature.

Quality Management Plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance. The newly developed Transformation and Quality Strategy will

incorporate all components of the Quality Assessment and Performance Improvement (QAPI) program. To ensure a robust quality program in accordance with best practice and CFR will be monitored with documentation of the activities and studies undertaken during both the certification process and regular External Quality Review (EQR) reviews. The QAPI will be incorporated into the CCO's Quality Strategy and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. See "Expectations of CCOs" section below for further details.

Performance Monitoring

Oregon has developed a comprehensive program to assess all aspects of the delivery system. This program involves routine analysis and monitoring of delivery system performance and consumer satisfaction data, comprehensive on-site operational reviews, and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews (described below).

Monitoring

On-site operational reviews

On-site reviews will be conducted periodically as a result of, gaps in performance, requested by CCO, or requested by the EQRO for example. Reviews will include, but not limited to, validating reports and data previously submitted by the CCO, an assessment of supporting documentation, and/or conducting a more in-depth review of the CCO's quality assurance activities. Reviews will also serve as an opportunity for in-person, one-on-one technical assistance in identified gap area. For example, a site visit relating to performance improvement projects will include a refresher in CCO deliverable, applicable state and federal requirements and provide technical assistance in root cause development and aim statement objectives. Furthermore, on-site review(s) supplements the state monitoring program of CCOs with direct and focused areas of improvement**.**

On-going focused reviews

Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through routine monitoring processes and grievance and appeal reporting. These reviews will also provide more detailed information on areas of particular interest to the state such as emergency department visits, behavioral health, utilization management, and data collection problems. Another example of a focused review is an on-going

review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

Appointment and availability studies

The purpose of these studies is to review managed care and FFS provider availability/ accessibility and to determine compliance with contractually defined performance standards. To conduct these studies, state and External Quality Review Organization (EQRO) staff attempt to schedule appointments under defined scenarios, such as a pregnant woman requesting an initial prenatal appointment.

Marketing and materials review

Managed care contractors are contractually required to submit all marketing materials, marketing plans, and certain member notices to the state for approval prior to use. This process ensures the accuracy of the information presented to members and potential members.

Quarterly and annual financial statements

In order to monitor fiscal solvency of plans, plans are contractually required to submit Quarterly and Annual Financial Statements of Operations.

Network Adequacy

Monitoring access to care includes, but is not limited to, review of access to networks of providers and provider access for members across the diverse regions of Oregon. Access standards will be developed in accordance with the recently approved 2016 CMS Medicaid and Children's Health Insurance Program (CHIP) rules. Monitoring will be through analysis that includes, but is not limited to, CCOs assessment of whether they are meeting State time and distance standards (Primary Care Provider and Patient Centered Primary Care Home), wait time and time to appointment standards (Oregon Administrative Rules), demonstrate with MOU and wraparound services plans that the CCO is aware of gaps in access and is actively coordinating with community partners to provide access to all elements of integrated care required in Oregon.

Credentialing

CCOs and MCO plans must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider's National Practitioner Data Bank profile. FFS providers are also enrolled through the state's Provider Enrollment Unit, which confirms that Medicaid, Medicare or other state agencies have not sanctioned providers. The Provider Enrollment Unit

also checks providers' National Practitioner Data Bank Profile. Additionally, all credentialed providers must verify regularly through the Office of Inspector General and SAMHSA for compliance with conflict of interest standards.

Policy requirements include standards on credentialing, privileging, conflict of interest compliance including time and interval of credentialing functions. Beginning in 2018, plans will be required to use the Oregon Common Credentialing Program's database to obtain verified practitioner credentialing information to the extent that it is available. CCOs must also work with OHA to assure proper credentialing of Mental Health Programs, associated providers and non-traditional health care workers. See Appendix B for a list of contractual elements and associated OARs.

Complaints and Grievances

On a quarterly basis, plans must submit a summary of all complaints registered during that quarter, along with a more detailed record of all complaints that have been unresolved for more than 45 days. A uniform report format has been developed to ensure that complaint data is consistent and comparable. OHA uses complaint data to identify developing trends that may indicate a problem in access, quality of care, and/or education. Complaint, grievance and appeals reports also identify FFS provider trends.

Improving upon the uniformed report will be the next step with administrative simplification through technology updates to the report, which will lead to deeper analysis for trend reporting. Analysis through the updated automated report will provide greater detail for health system (oral health, behavioral health, physical health) delineation of complaints origin and tracking of topic issues (e.g. non-emergency medical transportation) across the CCOs simpler. Potential changes also include developing systems for details regarding dual eligible client complaint tracking to ensure a smooth transition from passive enrollment.

Equity

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain disadvantaged communities. Some communities are less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider.

OHA utilizes several levers to improve health equity. The coordination of these levers and the monitoring and accountability are essential actions to have the greatest impact. Levers include, but not limited to, measurement monitoring and reporting across racial and ethnic disparities, health equity pay for performance incentive metric, equity components of the CCO

Transformation and Quality Strategy, and connections to the community health improvement plans and regional health equity coalitions.

Compliance

Accountability Team Reviews

The OHA accountability teams meet monthly to review contract compliance issues across all delivery systems in aggregate and quarterly to review performance metrics.

On an annual basis, OHA prepares a compendium of plan-specific descriptive data reflecting their performance metrics. This analysis includes information on trends in plan enrollment, provider network characteristics, performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies, and other on-site survey findings, focused clinical study findings, and financial data. Each of the data files helps prepare a profile for each plan, including a summary of plan strengths and weaknesses. These reports also provide a concise summary of critical quality performance data for each plan, as well as the EQRO's assessment of strengths and opportunities for improvement.

Each year, the state reassesses each plan's progress in addressing and improving identified problem areas. If any deficiencies are identified through the operational review, the plan will be issued a Statement of Deficiency (SOD), which specifically identifies areas of non-compliance. The plan will be required to submit a Plan of Correction (POC), which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up visits may be conducted as appropriate to assess the plan's progress in implementing its POC.

Fraud and Abuse

Fraud and Abuse

The plan must submit Complaints of Fraud or Abuse that are made to or identified by the plan which warrant preliminary investigation. The plan must also submit the following information on an ongoing basis for each confirmed case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees, or any other source:

- The name of the individual or entity that committed the fraud or abuse;
- The source that identified the fraud or abuse;
- The type of provider, entity, or organization that committed the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data or information as requested.

Concerns related to FFS provider networks are identified through ongoing Provider Services and Client Services reviews.

External Quality Review Organization (EQRO) Activities

OHA has contracted with an EQRO to support monitoring of quality in the CCO delivery system. In compliance with Federal regulations, the scope of work includes all mandatory activities: compliance reviews every three years, validating health plan PIPs; and performance measure validation including information system capability assessment (ISCA), and preparing an EQRO Technical Report for each Medicaid managed care plan.

The contract also ensures the ability to negotiate optional activities, including encounter data validation, the conduct of Focused Studies and/or PIPs, PM calculations described above and beyond what the state and/or plans calculate, and administration and/or validation of consumer and provider satisfaction surveys.

Technical Report

The technical report provides a feedback loop for ongoing quality strategy directions and development of any technical assistance training plans. In addition to the Statement of Deficiencies and resulting Plans of Correction, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

Enforcement

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance and reports for monitoring. If a plan cannot meet a reporting deadline, a request for an extension must be submitted in writing to the Division. The Division will reply in writing as well, within one week of receiving the request. Plans that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: (1) contact the Division within one week with an acceptable extension plan; or (2) submit the information within one week.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. If these efforts are not producing results, a corrective action plan may be jointly developed and the plan monitored for improvement. More aggressive enforcement options that OHA may apply include restricting enrollment, financial penalties and ultimately, non-renewal of contracts.

List of conditions that may result in sanctions

1. Fails substantially to provide Medically Appropriate services that the Contractor is required to provide, under law or under its Contract with OHA, to a Member covered under this Contract;
2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medical Assistance Program;
3. Acts to discriminate among Members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of Enrollment or refusal to reenroll a Member, except as permitted under the Medical Assistance Program, or any practice that would reasonably be expected to discourage Enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;
4. Misrepresents or falsifies any information that it furnishes to CMS or to the state, or its designees, including but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this Contract, encounter data or other information related to care of services provided to a Member;
5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;
6. Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210 and this Contract;
7. Fails to comply with the operational and financial reporting requirements specified in this Contract;
8. Fails to maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services under this Contract;
9. Fails to maintain an internal Quality Improvement program, or Fraud and Abuse Prevention program, or to provide timely reports and data required under Exhibit B, Part 1 through Part 9 and Exhibit L, of the model contract;
10. Fails to comply with Grievance and Appeal requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, and record keeping and reporting requirements;
11. Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services required under this Contract;
12. Fails to follow accounting principles or accounting standards or cost principles required by federal or state laws, rule or regulation, or this Contract;
13. Fails to make timely Claims payment to Providers or fails to provide timely approval of authorization requests;
14. Fails to disclose required ownership information or fails to supply requested information to OHA on Subcontractors and suppliers of goods and services;
15. Fails to submit accurate, complete, and truthful encounter data in the time and manner required by Exhibit B, Part 8, Section 7;

16. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information;
17. Fails to comply with a term or condition of this Contract, whether by default or breach of this Contract. Imposition of a sanction for default or breach of this Contract does not limit OHA's other available remedies;
18. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations;
19. Fails to submit accurate, complete and truthful pharmacy data in the time and manner required by Exhibit B, Part 8, Section 7; or
20. Violates any of the other applicable requirements of 42 USC §1396b(m) or 1396u-2 and any implementing regulations.

Expectations for CCOs

As Oregon's health transformation journey continues to meet the Triple Aim, how systems of care are delivered are becoming part of day-to-day functions. The ongoing performance management, while creating a culture of innovation, will be the foundation to move CCOs forward. Goals for coming years will include maintaining the gains in health transformation while increasing alignment of quality activities at the federal and state level, decreasing the burden of reporting and ensuring compliance with federal regulations will be achieved through the CCO Quality Strategy. Rather than CCOs submitting a Transformation Plan and a QAPI, OHA will be requiring CCOs to submit, on an annual basis, a CCO Quality and Transformation Strategy that will include elements of the QAPI, Transformation Plan, and an annual Work plan.

The CCO Quality and Transformation Strategy will reflect an analysis of quality and transformation activities of the full prior calendar year. This analysis will provide CCOs the necessary picture to further determine gaps in health delivery, health improvement and cost containment. As gaps are defined, CCOs will determine interventions in alignment with the CCO's strategic plan to improve the quality of members care for their region. When developing interventions, CCOs will consider areas of transformation for the development of activities. CCOs will define in their annual work plan the interventions, measures of success and accountability for implementation of the identified interventions. The contract requirements (deliverables) will be updated annually for clear lines of understanding of format, due date, and the accountable review structure at Oregon Health Authority.

CCOs will be notified by October 2017 of the necessary elements of the CCO Quality and Transformation Strategy.

Standards for Managed Care Contracts

As required by CFR 438.204(g), Oregon must establish standards for all managed care contracts regarding access to care, structure and operations, and quality measurement and improvement. Appendix B outlines each required component of the federal regulations and identifies the

section of the model coordinated care organization, dental care organization, fully capitated health plan, and provider service organization contracts, and/or Operational Protocol where this requirement is addressed.

Review of Quality Strategy

The OHA Quality Strategy shall be reviewed annually by OHA. The OHA Quality Strategy review and update will be completed by December of each year and submitted to CMS, upon significant changes, in the subsequent quarterly report update.

The OHA Quality Council shall have overall responsibility to guide the annual review and update of the Quality Strategy. The review and update shall include an opportunity for both internal and external stakeholders to provide input and comment on the Quality Strategy. Key stakeholders shall include, but are not limited to:

- Addictions and Mental Health Planning and Advisory Council*
- Medicaid Advisory Committee*
- Health Systems Division Executive Team
- Health Policy and Analytics Management Team
- OHA Executive Team
- CCO Medical Directors
- FFS Contractors
- CCO Quality Management Coordinators
- Local Government Advisory Committee*
- DHS Internal Stakeholders
- OHA Internal Stakeholders
- Health Equity Policy Committee*

* Committees including consumer representatives.

The Quality Strategy and subsequent updates will be posted online for a two-week public comment period before they are submitted to CMS for approval. Final versions will be posted on the OHA website.

Appendix B.: Contract Compliance

This table itemizes where the federal requirements of CFR 438.204(g) are addressed in the Medicaid model contracts.

Required Component	Contract Provision
438.206 - Availability of services • Delivery network, maintain and monitor a network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled. • Provide female enrollees direct access to women's health specialists. • Provide for a second opinion. • Provide out of network services when not available in network. • Demonstrate that providers are credentialed. • Furnishing of services, timely access, cultural competence.	Model Contract: • Exhibit B, Part 4, Section 3.a. • Exhibit B, Part 4, Section 2.m • Exhibit B, Part 4, Section 2.n. • Exhibit B, Part 4, Section 3.a. (6) • Exhibit B, Part 4, Section 3.b. • Exhibit B, Part 4, Sections 2.a. and 2.g.
438.207 - Assurances of adequate capacity and services • MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment. Submit the documentation in a format specified by the state at time of contracting and any time there is a significant change.	Model Contract • Exhibit B, Part 4, Section 3.b(1)
438.208 - Coordination and continuity of care • Each MCO must implement procedures to deliver primary care to and coordinate health care services to enrollees. • State must implement procedures to identify persons with special health care needs. Special health care needs are defined as:	Model Contract: • Exhibit B, Part 4, Section 2. • Exhibit B, Part 4, Section 2.f.

Required Component	Contract Provision
high health care needs, multiple chronic conditions, mental illness or substance use disorder and either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care. • MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions. • State must have a mechanism to allow persons identified with special health care needs to access specialty care directly, (standing referral).	
438.210 - Coverage and authorization of services • Service authorization process.	Model Contract: • Exhibit B, Part 2, Section 3.a.
438.214 - Provider selection • Plans must implement written policies and procedures for selection and retention of providers. • State must establish a uniform credentialing and recredentialing policy. Plan must follow a documented process for credentialing and recredentialing. • Cannot discriminate against providers that serve high risk populations. • Must exclude providers who have been excluded from participation in Federal health care programs.	Model Contract: • Exhibit B, Part 4, Section 3.b.
438.218 - Enrollee information • Plans must meet the requirements of 438.10	Model Contract: • Exhibit J

Required Component	Contract Provision
438.224 - Confidentiality • Plans must comply with state and federal confidentiality rules.	Model Contract: • Exhibit B, Part 4, Section 1.b.
438.226 - Enrollment and disenrollment • Plans must comply with the enrollment and disenrollment standards in 438.56.	Model Contract: • Exhibit B, Part 3, Section 6
438.228 - Grievance systems • Plans must comply with grievance system requirements in the Federal regulations.	Model Contract: • Exhibit B, Part 3, Section 5
438.230 - Subcontractual relationships and delegation • Plan is accountable for any functions or responsibilities that it delegates. • There is a written agreement that specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor's performance is inadequate.	Model Contract • Exhibit D, Section 18
438.236 - Practice guidelines • Plans must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically. • Guidelines must be disseminated. • Guidelines must be applied to coverage decisions.	Model Contract: • Exhibit B, Part 4, Section 6
438.240 - Quality assessment and performance improvement program • Each MCO and PIHP must have an ongoing improvement program. • The state must require that each MCO conduct performance measurement, have in effect mechanisms to detect both underutilization and overutilization, have in effect a mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Model Contract: • Exhibit B, Part 9

Required Component	Contract Provision
• Measure and report to the state its performance using standard performance measures required by the state. Submit data specified by the state to measure performance. • Performance improvement projects. Each plan must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the state the results of each project. • The state must review at least annually, the impact and effectiveness of the each program.	
438.242 - Health information systems • Each plan must have a system in place that collects, analyzes, integrates, and reports data and supports the plan's compliance with the quality requirements. • Collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system. • The plan should ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the state and CMS.	Model Contract: • Exhibit B, Part 7

Part III: Measurement Strategy

Framework for Measurement

Introduction

Since the July 2012 extension of the 1115 demonstration, Oregon has sought to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve the demonstration goals of reduced Medicaid spending growth, and improved health care quality, access, and outcomes. Oregon utilizes community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of Medicaid beneficiaries in communities, as well as an active commitment to data and measurement.

Oregon will accomplish the goals noted below through a variety of strategies and quality improvement activities, described in Attachment H: Part II, but also supported by a robust measurement strategy that will use financial incentives, multiple measure sets, and public transparency as mechanisms to drive improvement.

Through the 2017 extension, Oregon aims to accomplish several goals:

- Enhance Oregon's Medicaid delivery system transformation with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve;
- Increase the state's focus on encouraging CCOs to address social determinants of health and improve health equity across all low-income, vulnerable Oregonians to improve population health outcomes;
- Commit to an ongoing sustainable rate of growth and adopt a payment methodology and contracting protocol for CCOs that promotes increased investments in health-related services, advances the use of value-based payments; and
- Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

Oregon is intensifying its focus in key areas, including behavioral, physical health, and oral health integration. CCOs have made significant progress in linking behavioral, physical, and oral health but it will take additional time, effort, and coordination among different sectors (e.g., health care, corrections systems, counties, other agencies) to fully integrate health services. A preliminary evaluation of the integration of dental funding showed moderate reductions (<1%) in access to dental services. These results may be explained by the fact that oral health integration was implemented at the same time as Medicaid expansion; the preliminary result showing moderate reductions may be resolved by allowing additional time for CCOs to integrate dental care into the delivery system.[3] Due to professional silos, a

[3] Young, J., Kushner, J. McConnell, J. (2016). The Impact of Dental Integration in Oregon's Medicaid Program. Oregon Health and Science University, Center for Health System Effectiveness. Accessed at: goo.gl/JCPdgT.

delay in implementation, and increased difficulty in integrating oral health services, CCOs will require additional time and resources to fully integrate the delivery of oral health services. As outlined in Part I of Attachment H and in Attachment B, Oregon will engage in several key actions during the demonstration period to support models of care delivery that promote integration (e.g., additional oral health incentive measures, a suite of oral health communication materials for primary care providers and outreach workers, CCO oral health integration learning collaboratives and targeted technical assistance, Certified Community Behavioral Health Clinics, Behavioral Health Collaborative efforts).

As described in the goals above, Oregon also aims to increase focus on addressing social determinants of health for vulnerable Oregonians. Addressing social determinants of health will require the deployment of various strategies, including the use of health-related services, payment enhancements, and contracting strategies. OHA provided CCOs with clearer guidance regarding the use of health-related services, including a brief and is developing a supplementary FAQ document. Oregon is also taking steps to provide CCOs general guidance, recommendations, and direction for addressing social determinants of health. The state's Medicaid Advisory Committee is developing a framework for CCOs to address social determinants of health, including a standard definition, recommendations on the appropriate role for CCOs to take in this work, and a health-related services guide for a high priority area of SDOH. Through an enhanced rate setting methodology and new contracting strategies, Oregon will promote CCO and provider use of health-related services, including flexible services and community benefit initiatives aimed at addressing the social determinants of health. Oregon is also developing strategies to incentivize CCO investments in SDOH. For example, a subcommittee is developing food insecurity metric for consideration by the committee. Oregon will also improve access to health care services and care coordination for American Indians and Alaska Natives through the implementation of Attachment I. Finally, Oregon has added an eighth focus areas to the Transformation and Quality Strategy that will focus on addressing social determinants of health for CCO members.

In this demonstration period, Oregon will begin to passively enroll dual eligibles into a CCO, although members may choose to return to fee-for-service at any time. More than 55% of dual eligibles have voluntarily enrolled in a CCO. A preliminary internal analysis indicated that dual eligibles enrolled in a CCO had fewer hospitalizations and lower expenditures. A 2016 analysis found that CCO enrollment improved quality of care for dual eligibles to some degree, but the effects were small during the study period.[4] For some in this population there has been a lack of clarity about care delivery choices, and Oregon aims to improve care coordination and access to services for this population through CCO passive enrollment.

2017-2022 Measurement Strategy

Measurement and evaluation are necessary to determine whether Oregon's health system transformation efforts and goal of advancing the Triple Aim is met. This attachment describes Oregon's

[4] Kim, H., Charlesworth, C. (2016). Assessing the Effects of Coordinated Care Organizations on Dual-Eligibles in Oregon. Center for Health System Effectiveness, Oregon Health and Science University. Accessed at: goo.gl/bKsEZ2

robust measurement strategy, including continued monitoring of the quality of and access to care for Oregon's Medicaid population, as per STCs 39 and 41, the CCO incentive metrics program, data sources and validation, and commitments to transparent reporting. Most measurement activities are carried forward from the 2012-2017 measurement strategy, with minor updates to reflect current approaches and emerging areas of focus. Additional measurement through the Hospital Transformation Performance Program is described in Attachment J.

Oregon intends to measure quality of care, access to care, and health outcomes for individuals enrolled in CCOs, those receiving care through the Fee-For-Service (FFS) system, and for the Oregon Health Plan population as a whole. The Oregon Health Authority intends to continue quality and access monitoring to ensure members are not being harmed as a result of Oregon's continued health system transformation, and will use multiple other measure sets for both quality improvement and incentive purposes.

In addition to continuing to utilize measures from the CMS adult and child measure sets, and CAHPS surveys, Oregon's measures will reflect the increased state and national focus on measure alignment, and enhanced focus on population health and health outcomes.

The measurement strategy will continue to evolve to support the following priority areas:

1. Behavioral health and oral health integration;
2. Social determinants of health;
3. Public health priorities;
4. CCO collaboration and coordination with other systems, such as early learning hubs, hospitals, and the Department of Human Services (DHS);
5. Specific populations, including members with severe and persistent mental illness (SPMI) and dual eligibles; and
6. Populations experiencing disparities, including, but not limited to, inequities by race, ethnicity, language, gender, age, and geography.

OHA will continue its incentive program for CCOs, using the pay for performance lever to continue to drive focus and quality improvement efforts across the health system. The CCO program will continue to be guided by legislatively-established public committees, and changes to the program structure and specific measures are anticipated over time. See sections below for details on the CCO incentive program.

This measurement strategy will also better support CCO quality improvement efforts, with an overall goal to improve the health of members and improve administrative burdens on CCOs through the alignment of metrics, performance improvement projects, and transformation activities. See "Attachment H: Part II" for additional details on quality improvement efforts.

Committees

Oregon's robust measurement strategy includes several public committees, legislatively charged with selecting measures used in the CCO incentive programs, as well as providing oversight for measurement alignment. Committees include:

CCO Metrics and Scoring Committee

CCO Metrics and Scoring Committee

Established in 2012, the Metrics and Scoring Committee is charged with reviewing data and relevant literature to determine which measure will be included in the CCO incentive program each year. As per STC 38, the Committee also establishes the annual benchmarks and improvement targets that each CCO must meet in order to earn incentive payments. The Committee and their technical workgroup (described below) may also make recommendations to OHA regarding measure specifications or measure modification.

Beginning in 2017, the Metrics and Scoring Committee will become a subcommittee of the Health Plan Quality Metrics Committee (HPQM, see below), and will select incentive metrics for CCOs from the master measure set selected by the HPQM Committee. However, the HPQM Committee, when developing the master measure set, must take into account the recommendations of the Metrics & Scoring Committee.

Health Plan Quality Metrics Committee

Legislatively established in 2015, the 15-member Health Plan Quality Metrics Committee (HPQM Committee) is charged with working collaboratively with the Oregon Educators Benefit Board (OEBB), the Public Employees' Benefit Board (PEBB), the Oregon Health Authority, and the Department of Consumer and Business Services (DCBS) to adopt health outcome and quality measures that are focused on specific goals and provide value to the state, employers, insurers, health care providers, and consumers.

This Committee will convene in early 2017 and select an aligned set of health outcome and quality measures to be used for health benefit plans sold through the health insurance exchange, offered by PEBB and OEBB, and CCOs. State agencies and measurement programs are not required to adopt all of the measures selected by the Health Plan Quality Metrics Committee, but may not adopt any health outcome and quality measures that are different from the measures selected by the HPQM Committee.

The Committee is charged with prioritizing measures that:

- Utilize existing state and national health outcome and quality measures, including measures adopted by CMS, have been adopted or endorsed by other states or national organizations, and have a relevant state or national benchmark;
- Are not prone to random variations based on the size of the denominator;
- Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden;

- Can be meaningfully adopted for a minimum of three years;
- Use a common format in the collection of the data and facilitate the public reporting of the data; and
- Can be reported in a timely manner and without significant delay so that the most current and actionable data is available.

The HPQM Committee will take into consideration previous measure alignment efforts, including Oregon's HB 2118 Health Plan Quality Metrics Workgroup (2013), which identified 28 measures that are relevant for Oregonians enrolled in CCOs, Qualified Health Plans available through the exchange, and PEBB and OEBB's contracted health plans, the Institute of Medicine's Core Metrics for Health and Health Care Progress (2015) set of 15 standardized measures, and the Oregon Health Policy Board's Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics 92011). The Committee will also consider measure alignment efforts in other states, including Washington, Rhode Island, and several other SIM-funded states.

Technical Advisory Workgroups (TAG)

Technical Advisory Workgroups (TAG)

OHA also staffs monthly workgroup meetings for the CCO metrics program. These technical advisory group (TAG) meetings are public meetings, where all CCOs are invited to send representatives to participate in the discussion. TAG meetings focus on operationalizing selected measures, developing measure specifications, and making recommendations to the Metrics and Scoring Committee and OHA. Beginning in 2017, TAG meeting content will be more closely coordinated with the Transformation Center's technical assistance offerings and the Quality and Health Outcomes Committee agendas.

Measure Sets

In addition to the specific measure sets (described below) for quality and access monitoring and the CCO incentive measures, Oregon intends to explore developing, validating, and reporting on measures that support the following:

1. Quality improvement focus areas described in Attachment E
2. Population health and health outcomes
3. Integration
4. Behavioral health and substance use
5. Oral health and oral health integration
6. Social determents of health and health equity
7. Collaboration with other systems, particularly early learning and housing.

There are also several bodies of work that will inform Oregon's overall measurement strategy, including the CMS adult and child measure sets, the Child & Family Well-being Measures Workgroup, behavioral health mapping, and in-state and national measure alignment activities described above.

Oregon will continue to publicly report measures at the state and CCO level where appropriate, as per STC 33. See Transparency section below.

Performance Measures for Children and Adults in Medicaid/CHIP

Oregon intends to continue its commitment to reporting on the CMS Adult Medicaid Quality Measures and CHIPRA Measures where possible, and where appropriate, for the entire population.

As a participant in both the Adult Medicaid Quality Grant and the Children's Health Insurance Program Reauthorization Act Quality Demonstration Program, Oregon has developed a deep understanding of these measures, and has developed capacity to report and analyze the data to identify opportunities to improve health care for Medicaid beneficiaries. One finding from this work is that the two measure sets artificially segment the population, which can limit a population health focus. For example, the Ambulatory Care Emergency Department Utilization measure is only required as part of the Children's Core Set (for ages 0-19); Oregon has expanded this measure to monitor emergency department utilization in the adult population as well. Similarly, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure is currently only required in the Adult Core Set (for ages 18+), whereas the HEDIS specifications begin at age 13. Oregon intends to report Adult and CHIPRA measures for the entire population where possible, unless it is clinically appropriate to use the age-segmentation.

Many of these measures may be included in other measure sets described below.

Child & Family Well-being Measures Workgroup

The Child & Family Well-being (CFWB) Measures Workgroup was created by the Joint Early Learning Council / Oregon Health Policy Board Joint Policy Subcommittee, which focused on identifying opportunities for coordination and integration between health and early learning system transformation efforts. The CFWB Workgroup was convened to provide recommendations for shared, cross-sector measures for child and family well-being in Oregon.

The workgroup developed a 67-item child and family well-being measures library, as well as specific subsets of measures recommended for state level monitoring, and accountability measures that could be used as incentive or contract management measures with Coordinated Care Organizations and Early Learning Hubs. These measures, particularly the accountability measures, may be incorporated into future measure sets.

Behavioral Health Mapping

The Oregon Health Authority has convened a technical advisory committee to help develop a behavioral health system mapping tool that will assist OHA and partners to assess public resource and service needs, while tracking resource and service delivery.

The tool will enable the technical advisory committee to monitor and analyze system data to identify local areas with service gaps. Areas identified by the technical advisory committee may be appropriate for adoption into other monitoring or accountability measure sets.

In 2016, the Oregon Health Authority also convened a Behavioral Health Collaborative, focused on developing recommendations for improving Oregon's behavioral health system. These recommendations include discussion of behavioral health measurement and may inform monitoring or accountability measure sets moving forward.

Measure Alignment

There is growing interest in Oregon, and nationally, for measure alignment, and a developing understanding of measure fatigue. Both HB 2118 (2013) and SB 440 (2015), described above created public committees charged with developing an aligned set of measures for public payers, and in 2016, CMS partnered with America's Health Insurance Plans to develop seven sets of clinical quality measures to support multi-payer alignment. Additional work from the Institute of Medicine and others provide important frameworks that Oregon will likely be incorporating into future measure development and selection.

Oregon is cognizant of the changing state and national landscape for quality measurement, and the need for parsimonious, aligned measure sets for Medicaid and other public payers (where possible). These conversations will affect measure selection in coming years, and measures proposed in this initial measurement strategy will likely change over time to address local and national movement. However, throughout the 2017-2022 waiver period Oregon will ensure focus on selecting outcome measures and measures that reflect important aspects of health of Oregon Health Plan members, such as coordination of care for children in foster care.

Oregon is also particularly interested in ways in which the state level measure alignment conversation can overlap with CMS adult and child measures, and may be able to participate in future conversations determining which of the existing measures are essential to monitor state and national performance. For example, Oregon was selected for participation CMS' 1115 waiver technical advisory group focused on aligned measurement.

In addition, Oregon will monitor CMS and other national measure specifications to ensure implementation remains current and aligned. This includes updating measures to incorporate annual changes in HEDIS and CMS specifications, and potentially removing measures from measure sets described here if national measure stewards retire or significantly change measures.

Measure Development

Oregon is interested in a number of areas of measurement where national, standardized measures may not be available, or may need modification for Oregon's population or practice. Examples of this may include measures to address social determinants of health, such as developing a CCO-level measure for food insecurity screening, or housing, or transitioning existing claims-based measures to EHR-based measures, such as effective contraceptive use or alcohol and drug use screening (SBIRT).

As these measures are likely to be developmental and require testing before fully adopting them into the measurement framework, or incentive program(s), Oregon intends to establish a glide path for

measure development and adoption, similar to California's Medi-Cal 2020 demonstration plan for testing innovative measures.

Measures may be adopted as pay-for-reporting, or monitoring measures during the testing process, until they have been sufficiently vetted to be pay-for-performance metrics for CCOs, or incorporated into the quality and access measure set for ongoing reporting to CMS. Developmental measures may be utilized in other processes, such as performance improvement projects, where they can continue to be refined before being more formally adopted into pay-for-performance structures. The Metrics TAG workgroup described above will be a critical partner in developing and testing innovative measures.

Quality & Access Monitoring

Quality & Access Monitoring

This section lays out the details of the quality and access monitoring that will be conducted in each year of the demonstration that Oregon achieves its cost control goal to determine whether health system transformation has caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen.

Original Test (2012-2017)

Original Test (2012-2017)

In the previous demonstration period, Oregon's quality and access test consisted of two parts. In brief, part one of the quality and access test was a relatively simple comparison of program period quality and access to historical baseline levels of quality and access (2011). Part two was a more complex comparison of program period quality and access to a counterfactual level of quality and access that would exist had health system transformation not been undertaken. Part two of the test was only required if the state fails part one. Oregon fails the test for a given year if and only if it fails both part one and part two of the test. Failing the test would result in reductions in a portion of Designated State Health Program (DSHP) funding to the state, as described in the 2012 Standard Terms and Conditions.

Oregon has met part one of the quality and access test in each year of the 2012-2017 demonstration that has been reported to date.

Quality and Access Reporting (2017-2022)

As per STCs 39, 41, 49, and 70 OHA will collect and report on quality and access measures on a quarterly and annual basis. Quality and access measurement will be conducted in conjunction with third party contractor(s) who may calculate some of the measures, and/or validate OHA's calculation of the measures. This is similar to OHA's current approach for calculating and validating the CCO incentive measures and ensures iterative production and review of the measures for the most robust results. The table below highlights Oregon's current quality and access measures and additional metrics in development that could be incorporated during the 2017-2022 demonstration period.

Measure Inclusion/Exclusion

This approach relies on as broad a set of measures as possible, using measures for which data collection is already planned, because a broad set of measures encourage broad-based improvement and tends to increase the precision of the aggregate. CCO incentive measures are particularly attractive measures for quality and access monitoring, as the objectives of the CCOs should be aligned with those of the state as much as possible.

As measure sets are updated, new measures are developed, and measures are retired or adopted by the Health Plan Quality Metrics Committee and CCO Metrics and Scoring Committee, measures included for quality and access monitoring may shift. Oregon will keep the measure set the same to the extent possible, to ensure comparable results over time; however, allowing flexibility to remove measures if they are retired nationally, or to incorporate new measures that reflect care being provided in Oregon will be important.

Measures in development that might also be included for quality and access monitoring by 2018 include a revised measure of electronic health record adoption across CCO provider networks, an opioid prescribing related measure, and additional behavioral health and dental measures. Hospital measures may also be appropriate for inclusion, once the Hospital Transformation Performance Program sunsets in 2018 and any potential hospital incentive payments transition under CCO contracts, per STC 54.

In general, measures for which Oregon is already planning to collect data should be included for quality and access monitoring unless there is good reason to exclude the measure.

Good reasons to exclude a measure are:

1. No data are available for that measure in the baseline, or prior year within the demonstration for comparison;
2. Measure would contribute so much uncertainty that judgments about quality and access would be affected;
3. No benchmark is available;
4. Lack of consensus at the state level about the value of the measure.

Measures may also be retired from quality and access monitoring if they are retired from other measure sets, such as HEDIS, or dropped by the national measure steward, or retired as a pay-for-performance metric by the public committees. This ensures that Oregon's measures remain aligned and reduces measurement burden on health plans, hospitals, and providers who might otherwise be required to continue reporting on a measure for quality and access monitoring purposes that has otherwise been retired.

Reporting Timeframe

Oregon's quality and access reporting will take place on the same timeframes as the annual expenditure review.

Recurring Date	Deliverable	STC Reference
No later than October 1st	Annual Reports	Section XI, STC 69
Annually (included in annual report submission)	State Quality Strategy	Sections V and XI, STC 29 and 61

CCO Incentive Measure Program

Established in the 2012 waiver, and corresponding state legislation, the CCO incentive program is a mechanism for focusing CCO efforts and driving continuous quality improvement. Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. Oregon's strategy has been to annually increase the percentage of CCO payment at risk for performance, providing a meaningful incentive to achieve significant performance improvement and affect transformative change in care delivery.

To date, the CCO incentive metrics program has been a success. CCOs show improvements in a number of incentivized areas, including reductions in emergency department visits, and increases in developmental screening, screening for alcohol and other substance use, and enrollment in Patient-Centered Primary Care Homes (PCPCHs). CCOs have made important strides in developing cross-sector relationships and systems to also improve care, such as coordination with the Department of Human Services to ensure children in foster care receive needed health assessments.

Oregon has learned that "what gets measured, gets managed." Measures selected as incentive measures have been incredibly powerful in driving quality improvement efforts, and have demonstrated broad reach, as CCOs work with providers to make improvements that affect their entire panel, not just Medicaid beneficiaries. In addition, the CCO incentive measure set has been influential for other payers, who have aligned their measures with the CCO measures (e.g., the PEBB metrics are closely aligned with the CCO metrics). Even measures potentially in development as future incentive measures have the ability to change the conversation, such as recent work to develop a CCO-level measure of food insecurity screening.

To be assured of successful transformation in care quality, CCOs will typically subset and target between 3 to 5 incentive metrics for improvement in any calendar year. This is because of the major logistical effort required to transform patient care work procedures, electronic health record reporting and communication plans across hundreds of providers geographically spread across large distances within the state, as is the case for many CCOs. For this reason, no more than 17 to 18 measures are selected in a public process every year with a great deal of emphasis

on standardized specifications and definitions for the measures in order that each CCO is assured of reliable comparisons across CCOs. Each metric must satisfy at least two to three levers of the transformation plan or they are not included on the list. If the national benchmark is met or exceeded by many of the CCOs, that metric is removed from the incentive list and tracked as part of the state quality measures. The incentive process has become highly standardized as the years have progressed so that CCOs understand how improvement targets and national benchmarks are set by their Metrics and Scoring Committee. Because the incentive measurement program garners major attention and focus from CCOs, it is a very effective mechanism for health system transformation.

Support for Medicaid Theory of Change

In its 2012 demonstration waiver, Oregon articulated six levers (approaches) that served as a roadmap for health system transformation and moved OHP towards achieving the Triple Aim goals of: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.[5] The incentive measure program align with the six levers and help drive health system transformation and attainment of the Triple Aim. For example, percentage of members enrolled in a Patient-Centered Primary Care Home is one of the incentive metrics and tied to Lever 1. Some metrics are associated with multiple levers such as "Effective Use of Contraception" which is a unique state measure of best practices for women. It is tied to Lever 2 and Lever 6 as Oregon moves toward exploring best payment strategies for excellent care in this service category. Other metrics are meant to support integration of behavioral and oral health services into CCO care (Lever 3.) These include metrics such as depression screening, dental sealants and follow up after hospitalization for mental illness. The follow up after hospitalization metric also supports Lever 4 since it is meant to emphasize increased coordination across the spectrum of the delivery system. Assessments for children in DHS custody covers physical, oral and dental visits, Lever 3, but is also meant to address the social determinants of health in Lever 4 as well. Lever 5 calls out the health-related services that may be used to address social barriers or other access issues that impact health. These are typically discovered during developmental screening in the first 36 months of life and during adolescent well-care visits. In this manner, every incentive metric is connected to the six levers to promote transformation.

Measure Selection

See Appendix D for a measurement crosswalk that encompasses current incentive metrics and potential metrics to the OHA 1115 waiver levers and quality focus areas.

[5] Berwick, D., Nolan, T., and Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. Health Affairs: Vol. 27, no. 3. Accessed at: http://content.healthaffairs.org/content/27/3/759.abstract

Measure Selection

The CCO Metrics & Scoring Committee (described above), continues to select the annual incentive measures that will be tied to the quality pool, established in STC 36e.iii. See Appendix C below for additional information on the CCO quality pool.

While the list of incentivized quality metrics is typically less than 20 measures, they represent about one-third of the overall measures tracked closely. The Metrics and Scoring Committee selected approximately 18 (selected measures can vary from year to year) in order to focus on transformation activities for a targeted set of specific CCO activities. The Waiver also includes two other categories of metrics that are not incentivized but monitored closely. These important ancillary categories are the core measures and total nearly 60 metrics. When evidence of transformation is reflected by reaching the benchmark for a specific incentive metric across most of the CCOs, that metric is cycled off the incentive list. It then goes onto the monitored list of core tracking measures to ensure high quality performance continues over time.

Many of the incentive measures that have been selected to date overlap with other, national measure sets, ensuring that the incentive program is aligned with existing state and national quality measures. Selected incentive measures also align with Oregon's quality improvement focus areas, and as health system transformation continues to deepen into the next phase, the incentive measures will evolve.

The Metrics & Scoring Committee will select the 2018 incentive measures in the summer of 2017. The most current measure set is provided in the table below, as well as changes in the incentive measure set over time. Detailed measure specifications, technical documentation, and additional guidance are all published online.

To ensure continuous quality improvement, the Committee has developed robust measure selection and retirement criteria to help guide measure selection each year, and continues to pursue measures that will help drive health system transformation. Each year, the Committee will consider additional measures as potential incentive measures as priorities evolve and new measures are developed.

CCO incentive measures	**2013**	**2014**	**2015**	**2016**	**2017**
Adolescent well-care visits	x	x	x	x	X
Alcohol or other substance misuse screening (SBIRT)	x	x	x	x	[6]
Ambulatory care: emergency department visits (per 1,000 mm)	x	x	x	x	X

[6] The SBIRT measure has been removed from the 2017 measure set due to underlying challenges with coding for a claims-based measure. An EHR-based measure is in development and will be reinstated as part of the incentive measure set for a future measurement year.

CCO incentive measures	2013	2014	2015	2016	2017
CAHPS composite: access to care	x	x	x	x	X
CAHPS composite: satisfaction with care	x	x	x	x	X
Childhood immunization status				x	X
Cigarette smoking prevalence				x	X
Colorectal cancer screening	x	x	x	x	X
Controlling high blood pressure	x	x	x	x	X
Dental sealants			x	x	X
Depression screening and follow-up plan	x	x	x	x	X
Developmental screening (0-36 months)	x	x	x	x	X
Early elective delivery	x	x			
Diabetes: HbA1c poor control	x	x	x	x	X
Effective contraceptive use			x	x	X
Electronic health record adoption	x	x	x		
Follow-up after hospitalization for mental illness (FUH MI 7 day)	x	x	x	x	X
Follow-up for children prescribed ADHD medication	x	x			
Health assessments within 60 days for children in DHS custody	x	x	x	x	X
Patient-centered primary care home enrollment[7]	x	x	x	x	X
Timeliness of prenatal care	x	x	x	x	X

Benchmark Selection

Benchmark Selection

As per STC 38, the Metrics & Scoring Committee also establishes annual benchmarks and improvement targets for each of the incentive measures. CCOs must meet either the benchmark or improvement target to be eligible for receiving funds from the quality pool. The Committee will continue to review measures annually to ensure CCO performance is not stagnating. CCOs

[7] The current CCO incentive measure looks at the percent of CCO members who are assigned to a recognized patient-centered primary care home. As the PCPCH program standards are changing, the measure will need to be modified to reflect the new tiers.

will not be allowed to coast on early successes, or demonstrate improvement in just one area of transformation.

The Committee reviews CCO performance data, improvement over prior year's performance, distribution of the quality pool, and emerging areas of need to help determine the right combination of incentive measures and benchmarks to help improve quality, access, and outcomes for Medicaid beneficiaries. Incentive measures will be added in subsequent years, and it is likely that other measures will be retired from the set.

Current (2017) benchmarks and improvement targets are available online.

Future Priorities

The Committee is particularly interested in using the CCO incentive measure program structure to further health system transformation, by developing and adopting more transformational, and outcome-based measures, rather than traditional health care quality process measures, as well as exploring changes to the payment structure which would better support priority areas.

For example, the Committee has considered moving to a core and menu measure set, in which all CCOs would be incentivized for performance on the same core measures, but also have some flexibility to select additional incentive measures from a menu, based on local need and priority. The Committee will consider this, and other structural changes that best utilization the pay for performance lever, for future years of the program.

The Committee has also been exploring how to use the pay for performance structure to more directly incentivize CCOs to focus on health equity. After much discussion, the Committee has selected Emergency Department Utilization for Individuals Experiencing Severe and Persistent Mental Illness (SPMI) as an equity-focused incentive measure for the 2018 measurement year.

For-Service Measurement

As per STC 41, Oregon will also be reporting to CMS on the fee-for-service (FFS) population, primarily focused on quality and access, as well as services provided outside of the CCOs.

Oregon will primarily base this measurement and reporting on the *2016 Access Monitoring Review Plan*[8](AMRP) that was submitted to CMS in accordance with 42 CFR 447.203. The AMRP includes Oregon's strategy for monitoring FFS access to specified services for Oregon Health Plan members, to ensure sufficiency of access to care across several categories:

- Primary care services, including oral health access
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services, including labor and delivery

[8] https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/or-amrp-16.pdf

- Home health services

The *Access Monitoring Review Plan* establishes baselines for FFS member complaint rates and utilization rates, and then tracks these variables on a quarterly basis to determine if complaint rates increase above a threshold, or utilization rates decrease below a threshold. The threshold will trigger Oregon to research if there is an access issue for FFS members in the regions that crossed the threshold.

Additionally, as part of the *Secondary Monitoring Activities* within the plan, Oregon will complete an annual FFS Reimbursement Rate Study to determine how our FFS rates compare to CCOs and other regional healthcare payers.

Oregon will publicly report these measures for the FFS population as they are developed.

The AMRP may also include a review of quality and access metrics for FFS members that are aligned with the CCO incentive measures. Select measures may include, but are not limited to:

- Adolescent well care visits
- Child / adolescent access to primary care providers
- Well child visits
- Follow-up after hospitalization for mental illness
- Follow up care after prescription for ADHD medications
- Initiation and engagement for alcohol and other drug dependence treatment

CAHPS access to care questions and composites Other Secondary Monitoring Activities in the *Access Monitoring Review Plan* include the Physician Workforce Survey in regard to provider acceptance of Medicaid patients, ease of referral to services, and reasons for not accepting Medicaid members.

Data Sources and Validation

The Oregon Health Authority will be responsible for collecting data on all measures selected, although CCOs may be contractually required to submit data for specific measures according to specifications. Oregon will also work with contractors, including, but not limited to survey vendors and an external quality review organization to play a role in data collection and analysis where necessary. Oregon will also continue its robust measure validation process, for both the CCO incentive program and ongoing quality and access monitoring.

Data Sources

Oregon has developed many systems to collect data from plans and hospitals, and plans are required to have information systems capable of collecting, analyzing, and submitting required data and reports.

Data sources are described below. Data sources for specific measures are listed in the detailed specification sheets available online.

Administrative Data – All CCOs and FFS providers are required to submit encounters to the Medicaid Management Information System (MMIS) and the All Payer All Claims data system (APAC). MMIS and APAC data provide a source of comparative information and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, monitoring and developing quality and performance indicators, studying special populations and priority areas, and cost-effectiveness analysis.

Oregon follows all federal regulations regarding claims submission and processing.

In accordance with STC 36.e.i., Oregon also operates a monthly one-percent capitation rate withhold from CCOs to ensure the timely and accurate submission of administrative data.

Clinical Data/Chart Review – CCOs may be required to conduct annual chart review on defined samples of their member population to determine measure compliance. OHA provides guidance and collects the data for analysis.

Community Health Assessment – CCOs are contractually required to submit the community health needs assessment to OHA. See Appendix C for additional details.

Electronic Health Records – Oregon is building CCO and provider capacity to report on measures from their electronic health records. CCOs work with their provider network to develop and extract reports from their EHRs, where possible aligning with national standards for EHR certification and quality measure reporting. OHA will be launching a clinical quality metrics registry in 2018 which will enable electronic submission of EHR-based measures.[9]

Member Satisfaction Surveys – Oregon, in conjunction with its external quality review organization and external vendors, conducts statewide standardized surveys of patients' experience of care. These surveys allow for plan-to-plan comparisons. Plans are required to participate, as appropriate, in the performance of each survey. Survey results are shared with plans and reports are published on the OHA website, making them available to Medicaid beneficiaries to assist them in the process of selecting an appropriate plan.

Participating Provider Network Reports – Provider network reports are submitted by each plan and are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turnover.

Focused Clinical Studies – Focused clinical studies, conducted by the state and EQRO, usually involve medical record review, or surveys and focus groups. Plans and FFS providers are

[9] Oregon's Clinical Quality Metrics Registry website: http://www.oregon.gov/oha/OHIT/Pages/CQMR.aspx

required to participate in mutually agreed upon focused clinical studies. Results of focus studies are distributed to plans and reports are published on the department website.

Race/Ethnicity Data – In MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Ethnicity is currently defined as Hispanic/non-Hispanic. Oregon does not have data on multiple races. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

Oregon historically has collected data only on preferred household language, but is in the process of moving to collecting individual preferred language.

Validation

The Oregon Health Authority and the Department of Human Services have adopted rules establishing uniform standards and practices for the collection of data on race, ethnicity, preferred spoken or signed and preferred written language, and disability status.

The Oregon Health Authority may continue to contract with an independent third party for assistance in measure validation to ensure accuracy for the CCO incentive and quality and access measures. To date, OHA has contracted with the Oregon Health Care Quality Corporation (Quality Corp) and Providence Center for Outcomes Research and Education (CORE) for assistance in this area.

OHA currently engages in rigorous, multi-directional, and ongoing validation activities with two contractors, as well as with the 16 CCOs as part of the incentive program. OHA and contractors independently produce measures and compare results, leading to identification of discrepancies and code.

CCOs review data provided by OHA and compare to their own internal analysis, resulting in questions and corrections made if necessary. The CCO incentive metrics program has established periods for final review and validation of data, prior to closing out the measurement year and paying for performance, to ensure quality and accuracy of results.

Validation also occurs as part of the external quality review organization activities, including the ISCA. See Appendix B for additional details. Oregon intends to continue robust validation activities to ensure accurate measurement throughout the 2017-2022 period.

Data Analysis

OHA is responsible for conducting data analysis for the measurement strategy. Where possible measures will be aggregated by CCO, and analyzed for trends, issues, areas of concern and areas of innovative improvement. Data will also be analyzed by racial and ethnic groups, in addition to specific populations of interest (see below).

Where possible, measures will be analyzed and reported for the fee-for-service (FFS) population to align with the FFS Access Monitoring Plan (described above).

Data will be used to track program goals, address disparities, and drive quality improvement through the financial incentives, performance reporting, and rapid cycle feedback processes described in Appendix C. Data from selected measures will also be used to inform the evaluation questions described below.

Subpopulation Analysis

Where possible and appropriate, measures will be reported by race, ethnicity, language, disability, and where there is a diagnosis of serious and persistent mental illness (SPMI). Other subpopulations of interest include beneficiary language, individuals eligible for Medicare and Medicaid, and rural versus non-rural locations, as well as gender, and people with specific diagnoses or social complexity (e.g., chronic conditions, substance use, experiencing homelessness, etc).

Evaluation questions will also be explored for populations of focus. See the Evaluation Plan in Attachment B for additional details.

OHA will involve data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders as appropriate in defining additional subpopulations, and reviewing and interpreting any subpopulation analysis.

Reporting and Transparency

The Oregon Health Authority is committed to transparency in health system transformation efforts. Throughout the 2012-2017 demonstration period, Oregon has been improving its documentation and availability of publicly facing reports, as well as the user-friendliness of the reports. OHA will continue this emphasis throughout the 2017-2022 demonstration.

Public Reporting

Since 2013, Oregon has been providing regular public reports on statewide and CCO performance on a suite of metrics. In the interest of advancing transparency, and providing Oregon Health Plan members with information about quality and access of care to help them make informed choices, OHA will continue publishing these reports.

At minimum, data will be reported publicly on an annual basis, however a subset of information or measures may be reported more frequently to track patterns of utilization and highlight potential issues with performance. Measures will be reported by CCO, for specific populations, and in aggregate. Oregon will only publish data at aggregate levels that do not disclose information otherwise protected by law.

CCO Reporting

In addition to the ongoing public reporting described above, Oregon has also developed a monthly metrics dashboard for reporting interim results to CCOs. This dashboard allows OHA and CCOs to have an ongoing conversation about metrics, including understanding specifications, identifying potential issues with performance and areas for improvement, and allows CCOs to make course corrections as needed to meet benchmarks or improvement targets.

These dashboards will continue throughout the 2017-2022 demonstration. OHA will continue to explore options to make data more accessible to stakeholders, including data visualizations and potential interactive formats.

Appendix C: Quality Pool

Financial incentives are a key strategy for stimulating quality and for moving the health system from a capitated payment structure to value-based purchasing. It is expected that over time, savings accruing from the restructuring of the delivery systems and improved models of care will allow reductions in capitation rates and the growth of incentive payments that reward outcomes rather than volume of services.

This appendix describes the CCO incentive program quality pool structure and distribution methodology for the 2017–2022 demonstration period.

CCO Quality Pool Structure and Distribution

The Oregon Health Authority intends to continue its CCO incentive metrics program and quality pool, as established in 2012 and continued in the 2017 extension (STC 37.e.iii). Originally, Oregon's strategy was to annually increase the percentage of CCO payment at risk for performance, from 2 percent of the global budget in 2013 to 5 percent in 2017.[10]

When the quality pool was established, OHA believed that unless CCOs had a meaningful percentage of their payment at risk for performance, they would be unlikely to take the steps necessary to achieve significant performance improvement and effect the transformative changes in the delivery system.

Quality Pool Size

Looking forward through 2022, OHA intends to cap the CCO quality pool size at 5 percent of the global budget (or, 5 percent of the actual paid amounts to the CCO for a given calendar year). This will ensure that the annual at-risk amount is not so large as to threaten the financial viability of a CCO should it not perform well relative to the established benchmarks and improvement targets, while also being sufficiently large to prompt transformative changes and drive performance improvements.

Rate Setting Impact

In early 2017, OHA is undergoing a reevaluation of the incentive arrangement of the quality pool as it relates to financial reporting and rate development, and is recommending moving to a more traditional withhold arrangement under the 2017-2022 1115 Medicaid waiver demonstration for the quality pool program. OHA believes adjusting the quality pool to a withhold arrangement in the future will promote more timely payments for quality to participating providers and medical

[10] The quality pool is financed at a set percent of the aggregate value of the per member per month (PMPM) CCO budget, not including several specific payments (the prior year's quality pool payments, the federal Health Insurers Fee, Targeted Case Management, and Hospital Reimbursement Adjustment payments). Additional details about the annual quality pool composition are available in the "reference instructions" online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

expenses. This is still under discussion with CCOs and the final decision will be made my mid-2017. The quality pool operations will not change (i.e. payout timing, metrics, etc.); however, the quality pool expenses and revenue will be considered differently in the annual rate setting.

Quality Pool Distribution

As per STC 36.e.iii, disbursement of the CCO quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures (described above). Funds from the quality pool will be distributed on an annual basis, with the calendar year payment made by June 30 of the following year.

Quality pool award amounts will be determined through a two-stage process. In stage one, the maximum amount of dollars that a CCO is eligible for will be allocated based on performance on the incentive measures relative to the benchmarks and improvement targets established by the Metrics & Scoring Committee.

In stage two, any remaining quality pool funds that were not disbursed in stage one based on performance on the incentive measures (i.e., funds remaining if a CCO does not meet all benchmarks or improvement targets) will be distributed to CCOs that meet "challenge pool" criteria, as determined by the Metrics & Scoring Committee.

The Metrics & Scoring Committee will continue to examine the quality pool operation over time and annually re-evaluate the incentive measures, benchmarks and improvement targets, and challenge pool criteria.

The current stage one and two distribution mechanisms are described below; however these are under review with the Metrics & Scoring Committee and may be modified for future years, to better accommodate any structural changes (such as a core / menu measure set concept), and other priority areas, such as "must pass" measures. The quality pool distribution methodology is documented online and updated annually.[11]

Stage One Distribution

Distribution based on performance on all incentive measures

For most of the current CCO incentive measures, the portion of available quality pool funds that a CCO receives is based on the number of measures on which it achieves either an absolute benchmark or demonstrates improvement over its own prior year's performance (improvement target). The benchmarks are the same for all CCOs, regardless of geographic region and patient mix.

[11] Quality Pool Reference Instructions, available online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

CCO performance on these measures is treated on a pass/fail basis, and all measures are independent from one another. If the benchmark is met or the improvement target reached for a specific measure, the CCO receives all of the credit available for that measure, regardless of performance on other measures.

For the Patient-Centered Primary Care Home (PCPCH) enrollment measure, as long as it remains an incentive measure, performance is measured according to a tiered formula. The PCPCH enrollment formula has been updated for the 2017 measurement period to reflect new PCPCH certification standards:

$$\frac{(\text{\# of members in Tier 1}*1) + (\text{\# of members in Tier 2}*2) + (\text{\# in Tier 3}*3) + (\text{\# in Tier 4}*4) + (\text{\# in 5 STAR}*5)}{\text{total number of members enrolled in the CCO} * 5}$$

The results of the tiered formula are added to the number of measures on which a CCO meets the benchmark or the improvement target, for the CCO's total score.

For the 2013-2015 quality pool distribution, CCOs were required to meet three criteria to earn 100 percent of the quality pool funds for which they were eligible:

- Meet or exceed the benchmark or the improvement target on at least 75 percent of the incentive measures (i.e., 12 of 16); and
- Meet or exceed the benchmark or the improvement target for the Electronic Health Record (EHR) adoption measure as one of the required 75 percent measures above; and
- Score at least 0.60 (60%) on the PCPCH enrollment measure using the tired formula.

If CCOs did not meet the EHR adoption measure, or the PCPCH enrollment measure, the maximum payment they were eligible to receive was 90 percent.

For the 2016 and 2017 quality pool distribution, CCOs were required to meet two criteria to earn 100 percent of the quality pool funds for which they were eligible:

- Meet or exceed the benchmark or the improvement target on at least 75 percent of the incentive measures (i.e., 12 of 16); and
- Score at least 0.60 (60%) on the PCPCH enrollment measure using the tired formula.

The EHR adoption measure was retired from the measure set beginning in 2016, given strong CCO performance across the state.

Table 3: Current quality pool distribution (2016)

Number of benchmarks or improvement targets met	Percent of the quality pool payment for which the CCO is eligible
At least 13 and (at least 60% PCPCH enrollment)	100%

Number of benchmarks or improvement targets met	Percent of the quality pool payment for which the CCO is eligible
At least 13 and (less than 60% PCPCH enrollment)	90%
At least 11.6	80%
At least 10.6	70%
At least 8.6	60%
At least 6.6	50%
At least 4.6	40%
At least 3.6	30%
At least 2.6	20%
At least 1.6	10%
At least 0.6	5%
Fewer than 0.6	No quality pool payment

In future years of the CCO incentive metric program, the Metrics & Scoring Committee is considering moving to a core and menu set of measures, in which all CCOs would be held accountable for meeting benchmarks and improvement targets on the same measures (core set), but would also be able to select a specific number of measures from an approved list (menu set) based on their local priorities and need. As this will result in a consistent total number of incentive measures for all CCOs, the quality pool distribution during 2017–2022 will likely remain very similar to the tiered table above, but depending on the total number of measures across the core and menu sets, the specific number of measures in the tiers may shift.

The Committee may also choose to recommend that CCOs meet a higher percentage of all the measures to earn 100 percent of the quality pool funds for which they are eligible. For example, when the tiered distribution was originally established, there were 17 incentive measures (12 of 17 measures, plus PCPCH enrollment was roughly equivalent to meeting 75 percent of the measures to earn 100 percent of the funds). The Committee may choose to recommend CCOs must meet 90 or 100 percent of the measures to earn 100 percent of the funds.

These changes will be reflected in the annually updated Quality Pool Methodology documentation posted online and in quarterly reports to CMS.

Stage Two Distribution

Stage Two Distribution

Challenge Pool

In the second stage, remaining quality pool funds that have not been allocated to CCOs in stage one will become the 'challenge pool' – these funds will be distributed to CCOs that qualify based on the challenge pool criteria.

Historically, the challenge pool has been a subset of the incentive measures, those measures that the Committee believed were "most transformational." CCOs that performed well on those measures received both the stage one distribution, and any challenge pool dollars.[12]

Looking forward, the Committee is considering alternate ways to utilize the challenge pool, potentially selecting different measures, rather than a subset, to better incentivize areas of particular interest. These changes will be documented in the annually updated Quality Pool Methodology posted online and in quarterly reports to CMS.

During the second stage, all quality pool funds will be distributed; no quality pool funds will roll over into a subsequent year.

[12] Additional details about the challenge pool calculation and distribution to date are available in the "reference instructions" online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Section B: Expenditure Tracking for Trend Reduction Test

The following is a description of the elements within the expenditure workbook and the underlying assumptions regarding the calculation of costs as required by STC 44, 45, 46 and 47.

Description of Costs

Level 1: The per-member-per-month expenditure to the state to purchase identified global budget services for populations to be mandatorily enrolled in CCOs and voluntarily enrolled CCO populations.

- All capitated services, prospective global budget services, incentive payments, and FQHC/RHC wrap around payments are enumerated in this part of the expenditure-tracking sheet. At that point of inclusion in the global budget, the services will no longer be tracked separately.
- As specified by the STCs, expenditures for the mandatory CCO populations (children, non-disabled adults, disabled adults) are included in the Level 1 calculations and only expenditures for the voluntary dual eligibles who are actually enrolled in CCOs. Breast and cervical cancer treatment adults are included in the non-disabled adults category.
- This category includes all PPS rates or costs included in payments to CCOs regardless of when the RHC/FQHCs were established. In addition, wrap payments associated with RHC/FQHCs established prior July 1, 2011 are included in the two percent test. Wrap payments paid to RHC/FQHCs established on or after July 1, 2011, are not included in this category of expenditure, but will be included in Level 2. In addition, any incremental increases in wrap payments associated with a change in scope after July 1, 2011, are also not included in Level 1, but will be included in Level 2.

Level 2: The per-member-per-month total expenditure to the state to purchase services across all Medicaid service expenditures for populations that are mandatorily required to enroll in CCOs and voluntarily enrolled CCO populations regardless of whether the services are included in CCO global budgets.

- This level includes all CCO and non-CCO service expenditures for:
    1. All individuals in mandatory population groups, and
    2. Individuals in voluntary populations enrolled in a CCO.

- Expenditures associated with voluntary populations who are not enrolled in CCOs are not included in Level 1 or 2, including those for non-enrolled duals, individuals with third party coverage, and tribal members.

- Wrap payments for RHC/FQHCs established on or after July 1, 2011, as well as incremental increases in wrap payments for any RHC/FQHCs due to an increase in the scope of services will be included in this category of expenditure.

Description of Elements in the Work Book

- Tab 1: PMPM Target – includes target per member per month expenditures as developed using OHA expenditure information based on actual date of payment expenditure for 2011 as the base year. The chart creates spending targets by inflating expenditures forward using the agreed upon without transformation trend rate of 5.4 percent and the year by year reduction targets of one percent by the end of 2014 and two percent by the end of 2015, and thereafter. Expenditures are developed by using aggregate service expenditures from Tab 2, Expenditures Target, divided by caseload information in Tab 5, Caseload, to create PMPMs.
- Tab 2: Expenditure Targets – includes expenditure targets derived by multiplying trended target PMPMs from Tab 1 by Tab 5, Caseload.
- Tab 3: PMPM Actuals – includes actual PMPMs as available for each year of the demonstration calculated from total expenditure data for each year in Tab 4, Expenditure Actuals, and Tab 5, Caseload.
- Tab 4: Expenditure Actuals – includes actual aggregate expenditures derived from Tabs 6 through 10 as yearly data is available.
- Tab 5: Caseload – provides caseload by year and by population category (children, non-disabled adults, disabled adults, dual eligibles, and ACA) for calculation of PMPMs.
- Tabs 6-10: Yearly tabs that track actuals for each year of the demonstration by population category. These tabs form the basis for the PMPM summary sheets (Tabs 3 and 4) along with Tab 5, Caseload.

Per the 2012 waiver, expenditures from January 1-June 30, 2014 became the base against which SFY 2015 demonstration year (DY 13) expenditures were measured for the newly eligible population.

Expenditure Trend Review Workbook

Tab 1: PMPM Targets

	PMPM WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGET	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
	Without HST Baseline Growth (Per ST&Cs)	**5.40%**	**5.40%**	**5.40%**	**5.40%**	**5.40%**
	Without HST Baseline Growth PMPM	**$ 591**	**$ 623**	**$ 656**	**$ 692**	**$ 729**
	With HST Spending Reduction Growth Target	**3.40%**	**3.40%**	**3.40%**	**3.40%**	**3.40%**
Level 1: Global Budget	**Capitation**					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation PMPM					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget PMPM	**$ 580**	**$ 611**	**$ 644**	**$ 679**	**$ 715**
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative[2]					
	Hospital Presumptive Eligibilty					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation PMPM					

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 2: Expenditure Targets

	TOTAL EXPENDITURES WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGETS	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	**Capitation**					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget	$ -	$ -	$ -	$ -	$ -
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative[2]					
	Hospital Presumptive Eligibilty					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation	$ -	$ -	$ -	$ -	$ -

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 3: PMPM Actuals

	PMPM ACTUALS UNDER HEALTH SYSTEM TRANSFORMATION	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	**Capitation**					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation PMPM					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget PMPM					
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative[2]					
	Hospital Presumptive Eligibilty					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation PMPM					
	Total Expenditures PMPM					

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 4: Expenditure Actuals

	TOTAL ACTUAL EXPENDITURES UNDER HEALTH SYSTEM TRANSFORMATION	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	**Capitation**					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget					
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative[2]					
	Hospital Presumptive Eligibilty					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation					

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 5: Caseload

Caseload		TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
HSD Category	Eligibility Group					
Non-disabled adult	PCR					
Non-disabled adult	PWO					
Children	CMO 0-1					
Children	CMO 1-5					
Children	CMO 6-18					
Children	CMO 6-18 (100-133% FPL)					
Disabled/elderly[1]	AB/AD w/o Medicare					
Dual eligible[1]	AB/AD w/Medicare					
Disabled/elderly[1]	OAA w/o Medicare					
Dual eligible[1]	OAA w/Medicare					
Children	FC/SAC					
Non-disabled adult	BCCP					
ACA	Families ACA 19-44					
ACA	Families ACA 45-54					
ACA	Families ACA 55-65					
ACA	Adults/Couples ACA 19-44					
ACA	Adults/Couples ACA 45-54					
ACA	Adults/Couples ACA 55-65					
Children	CHIP 0-1					
Children	CHIP 1-5					
Children	CHIP 6-18					
Caseload Subtotal:		0	0	0	0	0
TPL Kids						
TPL Non-Disabled						
TPL Disabled						
TPL Duals						
TPL ACA						
Less Total TPL Caseload:		0	0	0	0	0
Less Duals Non-Enrollees:						
Total Caseload (Less TPL & Dual Non-Enrollees)		**0**	**0**	**0**	**0**	**0**
Footnote:						
[1]AB/AD w/o Medicare and AB/AD w/Medicare populations include disabled children.						

Tab 6: State Fiscal Year 2018

	State Fiscal Year 2018 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
	Total Caseload							
	Global Budget PMPM							
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative[2]							
	Hospital Presumptive Eligibilty							
	Health Insurer Fee (HIF)							
	Services Outside of Capitation + NOT Subject to Evaluation							

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 7: State Fiscal Year 2019

	State Fiscal Year 2019 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
	Total Caseload							
	Global Budget PMPM							
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative[2]							
	Hospital Presumptive Eligibilty							
	Health Insurer Fee (HIF)							
	Services Outside of Capitation + NOT Subject to Evaluation							

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 8: State Fiscal Year 2020

	State Fiscal Year 2020 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
	Total Caseload							
	Global Budget PMPM							
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative[2]							
	Hospital Presumptive Eligibilty							
	Health Insurer Fee (HIF)							
	Services Outside of Capitation + NOT Subject to Evaluation							

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 9: State Fiscal Year 2021

	State Fiscal Year 2021 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
	Total Caseload							
	Global Budget PMPM							
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative[2]							
	Hospital Presumptive Eligibilty							
	Health Insurer Fee (HIF)							
	Services Outside of Capitation + NOT Subject to Evaluation							

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Tab 10: State Fiscal Year 2022

	State Fiscal Year 2022 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
	Total Caseload							
	Global Budget PMPM							
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative[2]							
	Hospital Presumptive Eligibilty							
	Health Insurer Fee (HIF)							
	Services Outside of Capitation + NOT Subject to Evaluation							

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Appendix D: Measurement Crosswalk

1115 CMS Waiver
Measurement and Quality Crosswalk

Proposed quality and access test measures	2017 CCO incentive measure	Q&A measure (2012-2017)	Possible Q&A measure	Crossover to PIP focus (Attachment E)								1115 Waiver Levers					
				1	2	3	4	5	6	7	8	1	2	3	4	5	6
Adolescent well care visits	x	x			x			x		x		x	x			x	x
All-cause readmissions		x		x		x						x		x	x	x	
Ambulatory care: emergency department utilization	x	x		x		x						x	x	x			
Ambulatory care: avoidable emergency department utilization (Medi-Cal method)			x	x		x						x		x	x	x	x
Any dental service			x		x		x	x	x	x		x	x	x	x		
Assessments for children in DHS custody[1]	x		x				x	x		x		x	x	x	x	x	x
CAHPS: access to care (getting care quickly composite)	x	x		x	x	x	x	x	x	x		x	x		x	x	
CAHPS: medical assistance with smoking cessation		x		x	x	x	x	x	x	x		x		x	x	x	
CAHPS: satisfaction with care (customer care service composite)	x	x		x	x	x	x	x	x	x		x				x	x
CAHPS: access to dental care			x	x	x	x	x	x	x	x		x		x			
CAHPS: getting needed care composite			x	x	x	x	x	x	x	x		x			x		
CAHPS: how well doctors communicate composite			x	x	x	x	x	x	x	x		x			x		
CAHPS: overall ratings			x	x	x	x	x	x	x	x		x			x		
CAHPS: self-reported health status			x	x	x	x	x	x	x	x		x		x	x		
Child and adolescent access to primary care practitioners		x			x			x		x		x	x		x	x	
Childhood immunization status	x	x			x			x			x	x	x		x		
Cigarette Smoking Prevalence	x	x	x													x	x
Colorectal cancer screening	x	x			x			x				x	x		x		
Comprehensive diabetes care: HbA1c testing		x			x			x				x		x	x		

As of 1.16.2018

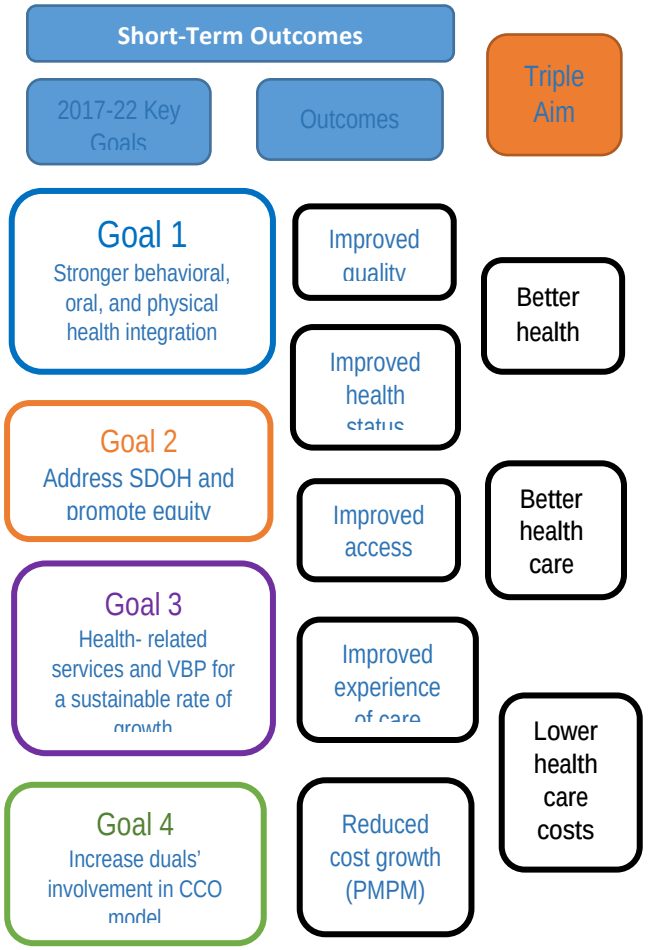
Page 1

1115 CMS Waiver
Measurement and Quality Crosswalk

Proposed quality and access test measures	2017 CCO incentive measure	Q&A measure (2012-2017)	Possible Q&A measure	Crossover to PIP focus (Attachment E)								1115 Waiver Levers					
Comprehensive diabetes care: HbA1c poor control	x	x			x			x				x	x	x	x		
Controlling high blood pressure	x	x			x			x				x	x		x	x	x
Dental sealants on permanent molars for children	x		x		x		x	x			x		x	x	x		
Depression screening and follow up plan	x	x			x		x	x		x		x	x	x	x		x
Developmental screening in the first 36 months of life	x	x			x			x		x	x	x	x	x	x		
Effective contraceptive use among women at risk of unintended pregnancy	x		x		x	x		x	x				x		x	x	x
Follow-up after hospitalization for mental illness	x	x		x	x	x	x	x		x	x	x		x	x	x	
Follow-up after ED visit for mental illness			x	x	x	x	x	x		x	x	x		x	x	x	x
Follow-up after ED visit for non-traumatic dental reasons			x	x	x	x	x					x		x	x	x	
Immunization for adolescents		x			x	x		x			x	x	x		x		
Patient-Centered Primary Care Home enrollment	x	x								x			x				
Timeliness of prenatal care: prenatal care	x	x							x			x	x		x	x	
Timeliness of prenatal care: postpartum care		x							x			x			x	x	
Topical fluoride varnish					x		x					x		x			
PQI 01: diabetes, short term complication admission rate		x			x		x					x			x	x	
PQI 05: COPD admission rate		x			x		x				x	x			x	x	
PQI 08: congestive heart failure admission rate		x			x		x				x	x			x	x	
PQI 15: adult asthma admission rate		x			x		x				x	x			x	x	
Well child visits in the first 15 months of life		x				x				x	x	x			x	x	

[1] Measure specifications changed in 2014 and now includes mental, physical, and dental health assessments.

Appendix E			
Inputs	**Activities**	**Outputs** CCO activities	Transformation Levers
Technology: • Business Objects • Regional HIE • EDIE PreManage • Webinars	Continue to support PCPCHs and CCBHCs; support tribal care coordination • Incentive payments • Quality pool • PCPCH tiers	Maximize use of PCPCHs; encourage use of EHRs & HIE participation; encourage patients to take an active role in their care	1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)
Staff: • OHA staff • Innovator agents • TA consultants • EQRO	Establish VBP roadmap & targets; provide technical assistance (TA); continue CCO quality pool (incentive metrics) • Bonus payments	Introduce new provider payment models; participate in models such as CPC+, achieve targets, performance measure reporting	**2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes**
Partners: • OHSU • Oregon Health Policy Board • Stakeholder committees • Technical Advisory Groups • Medicaid Advisory Committee	Establish single points of shared accountability; encourage oral health integration and access; related quality improvement projects • HIE platforms and onboard program • EDIE PreManage • Quality registry	Take steps to integrate & transform care (transformation plans), engage with community, do quality improvement projects, etc.	**3: Integrating physical, behavioral, and oral health care structurally and in the model of care**
	Process improvements and simplification; public health modernization • Webinars • Business objects	Consolidate care across silos; encourage efficient use of resources; develop CHA and CHP	4: Increased efficiency through administrative simplification and a more effective model of care
Money: • Global Budget • Quality Pool	Establish definitions, provide TA, tracking methods, & incentives for HRS	Design process for offering HRS, provide HRS where appropriate	**5: Use of health-related services to improve care delivery, enrollee health**
Federal and state rules and regulations	Provide support, TA, learning collaboratives and other convenings (e.g. Transformation Center); spread model to all dual eligibles	Transformation plans, quality improvement projects, serve duals	**6: Testing, accelerating and spreading effective innovations and best practices**



Measurement and improvement for health equity - RHEC, TQS Equity, performance measures reporting for metrics for health disparities, CAC