DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

December 24, 2013

Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301-1097

Dear Dr. Goldberg:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your November 4, 2013, amendment request to incorporate changes needed to conform with the Affordable Care Act and your November 13, 2013, request to extend the Tribal Health Facility Program to Oregon's section 1115 demonstration (11-W-00160/10), Oregon Health Plan. Approval of these demonstration amendments is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter through June 30, 2017, unless otherwise indicated.

The Special Terms and Conditions (STCs) include the following requested changes:

- Sunsets premium assistance and associated populations through the Family Health Insurance Assistance Program (FHIAP);
- Clarifies population that are covered under the Medicaid state plan, such as combining two populations that covered pregnant women at different income levels;
- Includes references to the Alternative Benefits Plan established in the Medicaid state plan to cover the newly eligible adults; and
- Extends the Tribal Health Facility Program originally slated to expire on December 31, 2013, through December 31, 2014.

The approval of the demonstration extension, including the waivers and the expenditure authority that are described in the enclosed list, is conditioned on the state's acceptance of the STCs within the proceeding 30 days from the date of this approval. The STCs will be effective, the date of the approval letter, unless otherwise specified.

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration. Your project officer is Ms. Terri Fraser. She is available to answer any questions concerning your section 1115 demonstration.

Ms. Fraser's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mailstop: S2-01-16
7500 Security Boulevard,
Baltimore, MD 21244-1850
Telephone: (410) 786-5573
Email: Terri.Fraser@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Carol Peverly, Associate Regional Administrator in our Seattle Regional Office. Ms. Peverly's contact information is as follows:

Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
2201 Sixth Avenue, MS RX-43
Seattle, WA 98121
Telephone: (206) 615-2515
Email: Carol.Peverly@cms.hhs.gov

If you have any questions regarding this correspondence, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at 410-786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

Cc: Carol Peverly, Associate Regional Administrator, Region X

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST AND EXPENDITURE AUTHORITY

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

All requirements expressed in Medicaid and Children's Health Insurance Program (CHIP) laws, regulations and policies apply to this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Such deviations from Medicaid requirements are limited in scope to expenditures related to the following populations affected by the demonstration:

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project. Under the authority of section 1115(a)(1) of the the Act, the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan beginning with the approval of this demonstration amendment through June 30, 2017. When the state amends its Medicaid state plan to include some or all of these populations after that date, the state will submit an amendment to the demonstration updating the populations that will be affected by the demonstration.

1. Statewideness/Uniformity — **Section 1902(a)(1)**
42 CFR 431.50

To enable the state to provide benefits through contracts with managed care entities that operate only in certain geographical areas of the state. (Applies to all Medicaid state plan populations listed in Attachment D.)

2. Amount, Duration and Scope of Services — **Section 1902(a)(10)(A)**
1902(a)(10)(B)
42 CFR 440.230-250

To enable the state to modify the Medicaid benefit package and to offer a different benefit package based on condition and treatments than would otherwise be required under the state plan to mandatory Medicaid populations for non-benchmark essential health benefits. (With the exception of children 0-1 years of age and pregnant women, applies to all Medicaid state populations listed in Attachment D.)

3. Retroactive Eligibility — **Section 1902(a)(34)**

To enable the state to not provide three months of retroactive coverage. (Applies to all Medicaid state populations, except 7 and 8, listed in Attachment D.)

4. Freedom of Choice **Section 1902(a)(23)(A) 42 CFR 431.51**

To enable the state to restrict freedom-of-choice of provider by offering benefits only through managed care entities (and other insurers) in a manner not authorized by section 1932 of the Social Security Act (the Act) because beneficiaries may not have a choice of managed care entities. This does not authorize restricting freedom of choice of family planning providers. (Applies to all Medicaid state plan populations listed in Attachment D.)

5. Disproportionate Share Hospital (DSH) Reimbursements **Section 1902(a)(13)(A)**

To the extent necessary to allow the state to not pay disproportionate share hospitals payments when hospital services are furnished to managed care enrollees. (Applies to all Medicaid state plan populations listed in Attachment D.)

6. Prepaid Ambulatory Health Plan Enrollment **Section 1902(a)(4) as implemented in 42 CFR 438.56(c)**

To enable managed care entities to permit enrollees eligible through Medicaid or the CHIP state plan, a period of only 30 days after enrollment to disenroll without cause, instead of 90 days. (Applies to all Medicaid state plan populations listed in Attachment D.)

Title XIX - Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) the Act, expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX state plan.

1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in an MCO.

2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.

3. Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.

5. Designated State Health Programs (DSHP). Subject to the conditions outlined in paragraph 53 and as described in section IX, a limited amount of expenditures for approved designated state health programs (DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. This expenditure authority will not be renewed or extended after June 30, 2017.

6. Uncompensated Care for Tribal Health Facility Program: Expenditures for supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority: 1) for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) for uncompensated care costs resulting from primary care services on the prioritized list that are provided to individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who have no Medicare, Medicaid, CHIP or other coverage. Beginning January 1, 2014, through December 31, 2014, the state shall only make supplemental payments to these facilities for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan

AWARDEE: Oregon Health Authority

I. PREFACE

The following are the special terms and conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115 (a) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to these STCs are the Oregon Health Authority (formerly Oregon Department of Human Services) (state) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These amended STCs are effective January 1, 2014, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The amended STCs are effective January 1, 2014, through June 30, 2017, unless otherwise specified.

The STCs have been arranged into the following areas:

I. Preface
II. Program Description, Objectives, Historical Context;
III. General Program Requirements;
IV. The Oregon Health Plan;
V. Delivery System Transformation;
VI. Capitation Rates and Performance Measures;
VII. Measurement of Quality of Care and Access to Care;
VIII. Calculating the Impact of Health Systems Transformation and Reductions in Designated State Health Program Funding;
IX. Designated State Health Programs;
X. Tribal Health Program for Uncompensated Care;
XI. General Reporting Requirements;
XII. General Financial Requirements for Title XIX;
XIII. Monitoring Budget Neutrality for the demonstration;
XIV. Evaluation of the demonstration; and
XV. Additional attachments have been included to provide supplementary information and guidance for specific STCs.
1. Attachment A: Quarterly Report Guidelines
2. Attachment B: Evaluation Guidelines
3. Attachment C: Glossary of Terms
4. Attachment D: Summary Chart of Demonstration Populations
5. Attachment E: Menu Set of Quality Improvement in Focus Areas
6. Attachment F: CCO Services Inventory

7. Attachment G: DSHP Claiming and Documentation Protocols
8. Attachment H: Calculating the Impact of Health Systems Transformation
9. Attachment I: Tribal Health Program for Uncompensated Care Claiming Protocol

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan (OHP) is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. OHP began in phases on February 1994. Phase I of the Medicaid demonstration Project started on February 1, 1994. Originally, the demonstration affected Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II added the aged, blind, disabled, and children in state custody/foster-care.

Objectives

Under the demonstration, Oregon strives to promote the objectives of title XIX by:

- Providing health care coverage for uninsured Oregonians;
- Providing a basic benefit package;
- Insuring broad participation by health care providers;
- Decreasing cost-shifting and charity care;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Making Medicaid available to people living in poverty regardless of age, disability or family status;
- Structuring benefits (what is covered), using a prioritized list of health care conditions and treatments.
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing the per capita costs of care for populations through such improvements.

Historical Context: Demonstration Extensions and Amendments

<u>1994 Initial Demonstration Approval</u>
CMS initially approved the Oregon Health Plan (OHP) section 1115 demonstration for a five-year period beginning February 1, 1994. Oregon sought to expand eligibility and manage costs by using managed care and a Prioritized List of Health Services. This list is updated every 2 (two) years, whereby services are added, deleted, or moved to a different ranking within the list.

<u>1998 Demonstration Extension</u>
The OHP was extended by CMS for a 3 (three) year period through 2001.

<u>2002 Demonstration Extension and Amendment</u>

CMS approved Oregon's application to extend and amend OHP to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration for 5 (five) years through 2007. With this approval, Oregon was able to expand the demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

2005 Demonstration Amendment

CMS approved a demonstration amendment that changed coverage under the demonstration which placed a new emphasis on preventive care and chronic disease management in the recognition that the utilization of these services can lead to a reduction in more expensive and often less effective treatments provided in the crises stages of a disease.

2007 Demonstration Extension

CMS revised the structure of the populations within the demonstrations to reflect updated law and CMS policy. Uninsured adults not eligible for Medicaid or CHIP were removed from the title XXI expansion populations and moved into title XIX expansion populations. In addition, title XXI targeted low-income children (TLIC) in Oregon from ages 0 through 5 years with incomes from 133 percent to 185 percent of the FPL and ages 6 through 18 with incomes from 100 percent up to 185 percent of FPL, were made eligible under the CHIP state plan regardless of whether the child opts for CHIP direct state plan coverage (OHP Plus) or premium assistance (Family Health Insurance Assistance Program/FHIAP). In addition, it was clarified that mandatory pregnant women and children 0 to 1 year of age receive full Medicaid state plan benefits, subject to necessary pre-authorizations.

2009 Demonstration Extension and Amendment

CMS approved an amendment to the demonstration that restructured and expanded coverage for children through the "Healthy Kids," initiative. Healthy Kids provides coverage through its various components for otherwise uninsured children through age 18 in the state with family incomes from 0 up to and including 300 percent of FPL. The state also provides access to coverage for children above 300 percent of FPL, but does not receive FFP for this population. Healthy Kids includes four different program components: 1) Existing CHIP direct coverage (OHP Plus), 2) premium assistance through FHIAP, 3) Child-only premium assistance administered by the Office of Private Health Partnerships (Healthy Kids ESI), and 4) A private insurance component (Healthy KidsConnect). Through Healthy Kids, children from 0 up to and including 200 percent of the FPL have the choice between title XXI CHIP direct coverage, premium assistance through FHIAP, or Healthy Kids ESI. Children from above 200 up to and including 300 percent of the FPL have the choice between Healthy Kids ESI or coverage under Healthy KidsConnect.

In addition, the last CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed the methodology for use of a 'reservation list" to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance program; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

2012 Demonstration Amendment

As reflected in these STCs, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and a reduction of other benefits (reflected in 13 lines of the Prioritized List of Health Services for FFY12-13). This amendment is effective January 1, 2012.

2012 Demonstration Extension and Amendment

In July 2012, CMS approved an amendment and extension related to Oregon's Health System Transformation

The amendment and extension of OHP seeks to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve a three-part aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The design and implementation of the Oregon demonstration will be driven locally; overall, the amended 1115 demonstration seeks to achieve two equally important and inter-related goals:

- **Goal 1: Medicaid Statewide Spending Growth Reduction.** The demonstration will bend the Medicaid cost curve to achieve a 2 percentage point reduction in Medicaid per capita trend by year 13 of the demonstration. Progress toward and ultimate achievement of this goal will be measured by reviewing the state and federal cost of purchasing care for individuals enrolled in Coordinated Care Organizations (CCOs).

- **Goal 2: Improving Statewide Care Quality and Access.** Oregon Medicaid beneficiaries will experience improved access to care and quality of care over the five-year program period of July 2012 – June 2017, compared to a baseline level of performance.

The demonstration authorizes expenditures on certain Designated State Health Programs (DSHP), and in order to align incentives and support progress, if demonstration goals are not realized after interventions have been pursued to reorient progress, CMS will reduce DSHP funding as described in Section VIII.

Oregon seeks to achieve these goals without any diminution of eligibility or benefits. Instead, the state will pursue several different approaches, or "levers" to drive savings and quality improvement:

- Lever 1: Improved care management experienced by beneficiaries in CCOs
- Lever 2: Administrative efficiencies in CCOs
- Lever 3: Integration of physical and behavioral health for beneficiaries in CCOs
- Lever 4: Improved care coordination experienced by beneficiaries aligned with patient-centered primary care homes (PCPCH)

- Lever 5: Use of flexible services

Oregon plans to realize these goals through better care management, increased provider and community accountability, payment reform, administrative efficiencies, use of flexible services, promoting the provision of services by nontraditional health workers, and expanding access through improvements to the state's health care workforce.

2013 Demonstration Amendment

In October 2013, CMS approved an amendment to add tribal health programs uncompensated primary care payments to the demonstration. The amendment allows the state to make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority: 1) for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) to pay for uncompensated care costs resulting from primary care services on the prioritized list provided to individuals not enrolled in Medicaid, Medicare, CHIP or other coverage who have incomes up to 133 percent of the Federal Poverty Level (FPL).

2014 Amendment

In December 2013, CMS approved amendments to align eligibility, populations, and benefits in the demonstration with provisions in the Affordable Care Act. The amendments reflect that the state has opted to expand Medicaid to adults under the Medicaid state plan, consolidates populations who will be covered under the Medicaid state plan, removes references to populations that will be covered by the title XXI CHIP state plan, and provides a uniform benefits package to all demonstration populations. Individuals who had previously been covered through the demonstration through either through OHP-Standard or premium assistance will be covered through an Alternative Benefits Plan or referred to the state-based exchange for coverage on the Marketplace.

Additionally, CMS has approved a one-year extension of uncompensated care payments to IHS or tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority. Beginning January 1, 2014, through December 31, 2014, the state shall only make supplemental payments to these facilities for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan).

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable

in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in federal law, regulation, or policy, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the date such state legislation becomes effective, or the date such legislation was required to be in effect under federal law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, reservation list, sources of non-federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in the these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Consistent with Oregon's community-focused health systems transformation approach, the state shall undertake a robust public process to ensure community engagement in the development and submission of amendments to the demonstration. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15, prior to submission of the requested amendment;

b. A data analysis which identifies the specific impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**

a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

b. Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:

i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special terms and conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR section 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a

revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

e. Post Award Forum: Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraphs 63 and 64 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 65.

10. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA)**
Upon implementation of the Affordable Care Act (ACA) expansion to adults with incomes at or below 133 percent of the FPL in January 2014, expenditure authority for many demonstration expansion populations will end. To the extent that the state seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP state plan, the state will, by April 1, 2013, submit proposed state plan amendments for any such populations. Concurrently, the state will submit proposed amendments to the demonstration to the extent that such populations will be subject to the demonstration. In addition, the state will submit by April 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

    a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the state must:

        i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

        ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these

individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the state identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b. Cost-sharing Transition: The Plan must include the state's process to come into compliance with all applicable federal cost-sharing requirements,

c. Transition Plan Implementation:

i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

In states with fly recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

17. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the state for premiums paid by beneficiaries shall not be used as a source of state match for FFP.

IV. THE OREGON HEALTH PLAN

18. **Overview of the Oregon Health Plan (OHP).** OHP provides health care coverage to low-income Oregonians through programs administered by the Division of Medical Assistance Programs (DMAP). Beginning January 1, 2014, all Medicaid state plan, mandatory and optional groups, will be covered by either OHP-Plus or the Alternative Benefits Plan approved in the Medicaid state plan.

    a. **ACA Implementation.** As set forth in paragraph 13 and upon implementation of the ACA expansion to adults with incomes under 133 percent of the FPL on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII); benefits; and cost sharing will revert to the Medicaid state plan and comply with Medicaid regulatory and subregulatory guidance. Benefits under the Oregon Health Plan demonstration will include the provision of Essential Health Benefits identified in the Medicaid/CHIP state plan.

    b. **OHP Populations.** The state will provide health care coverage through the OHP programs defined within these special terms and conditions (STCs)to the Medicaid mandatory and optional groups under the Oregon state plans, as well as demonstration expansion groups as defined in the "**Summary Chart of Demonstration Populations"** (Attachment D).

    c. **Applicability of Medicaid Laws and Regulations.** All requirements expressed in Medicaid laws, regulations and policies apply to all the populations affected by this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration

    d. **Summary of OHP Benefit Structure.** The Oregon Health Plan demonstration has two components, two offered directly through public sector programs (OHP Plus and the

Alternative Benefits Plan). Most beneficiaries under the public sector programs receive services through managed/coordinated care delivery systems.

Mandatory and optional Medicaid state plan eligibles receive the OHP Plus benefit (populations 1, 3, 5, 6, 7, 8 and 21 in Attachment D).

i. All mandatory and optional Medicaid state Plan eligible children younger than 21 years old are entitled to elect to receive direct Medicaid coverage outside of OHP including all state plan and EPSDT covered services (populations 3, 5, 6 7, and 8 in Attachment D).

ii. The following Medicaid services and expenditures are not affected by the OHP demonstration, and are available as otherwise provided under the state plan:

1. Mental Health Facility – DSH Adjustment Payments;
2. Long Term Care Services;

   a. Nursing Facility Services
   b. Home- and Community-Based Services
   c. Community Supported Living Services
   d. Programs of All-Inclusive Care Elderly

3. ICF/MR Services;
4. Medicare Premium Payments;

e. **Prioritized List of Health Services.** One of the distinguishing features of the OHP demonstration is that OHP benefits are based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services.

i. **Oversight**

1. **The Health Evidence Review Commission (HERC) -** The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Office for Oregon Health Policy and Research. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse. The Health Evidence Review Commission performs a biennial review of the Prioritized List and will amend the List as required.

ii. **Modifications to the Prioritized List**. Modifications to the Prioritized List require federal approval through submission of an amendment, as described in paragraph 7 in order to ensure the Prioritized List is comprehensive enough to

provide Medicaid beneficiaries with an appropriate benefit package. A current version of the prioritized list of health services is maintained by the state of Oregon at the following website: http://www.oregon.gov/OHA/OHPR/HERC/Current-Prioritized-List.shtml. During the demonstration period and as specified below the state will not reduce benefits.

iii. **Ordering of the Prioritized List.** The Prioritized List is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g. common colds); (b) are primarily cosmetic in nature (e.g. benign skin lesions); or (c) have no effective treatments available (e.g. metastatic cancers).

iv. **Updating the Prioritized List**. The Commission is charged with updating the list for every biennial legislative session. The Oregon State Legislature determines how much of the list to cover (subject to federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.

v. **Non-covered Condition and Treatment Pairs**. In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

The state must adopt policies that will ensure that before denying coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the prioritized list of health services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, providers will be instructed to provide the specified treatment. The state shall provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

f. **Funding Line for the "2012-2013" Prioritized List of Health Services.**

i. Beginning January 1, 2012, the 2012-2013 Prioritized List of Health Services contains 692 lines. Lines 1-498 are funded to provide the OHP Plus and Standard benefit packages.

ii. The 2012-2013 Prioritized List will stay in effect until September 30, 2014 to allow time for a transition from the ICD-9 code system to the new, more extensive ICD-10 codes, which is currently underway.

iii. Beginning October 1, 2014, the 2014-2015 Prioritized List of Health Services will go into effect and will change the line number, structure and composition as a result of the biennial review and the conversion to ICD-10-CM. The state will maintain the funding line at the same position relative to the 2012-2013 List (currently between Chronic Sinusitis and Keratoconjunctivitis and Corneal Neovascularization) on the 2014-2015 List and for the remainder of the demonstration.

g. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

i. The state will maintain the cutoff point for coverage at the same position on the List relative to the 2012-2013 List for the remainder of the demonstration as noted above in subparagraph (g). For a legislatively directed line change to increase benefit coverage or a legislatively approved biennial list with substantive updating of benefits due to new evidence, an amendment request (in compliance with paragraph 7) will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in Section XIII.

ii. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.

iii. For a change to the list not defined above that meets the terms of paragraph 6, an amendment request.

h. **Non Traditional Health Workers (NTHW).** NTHWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and doulas. NTHWs may serve individuals currently enrolled in Managed Care Entities (MCEs), and/or through the state's FFS delivery system.

i. **Patient Centered Primary Care Homes (PCPCH):** The state includes PCPCH services in the OHP Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether

they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement and obtaining agreement to participate. The state will work with CCOs to provide the enrollee with notice that s/he has been enrolled in a PCPCH. In addition this notice will provide the participant with information informing them of their right to opt out.

19. **Oregon Health Plan Plus (OHP Plus)**

a. **Eligibility -** The Medicaid state plan, mandatory, optional and expansion groups (populations 1, 3, 5, 6, 7, 8, and 21 in Attachment D) are served in the component known as OHP Plus.

b. **Eligibility Redeterminations.** Medicaid state plan, mandatory and optional groups (populations 1, 3, 5, 6, 7, 8, and 21 in Attachment D) enrolled in the OHP Plus program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for any OHP program. Any enrollee may apply for any OHP program at any time for any reason. The state will determine eligibility and enroll individuals in programs for which they are found eligible.

c. Benefits. The OHP Plus benefit package is the Prioritized List of Heath Care Services through the line on the list funded by the Oregon State Legislature as of January 1, 2012, except as specified in ii and iii below.

i. The benefits table in paragraph 19(d) provides a high-level summary of the services funded and covered on the prioritized list.

ii. Notwithstanding the prioritized list, benefits for Mandatory pregnant women and children 0 up to 1 year of age (populations 1 and 3, in Attachment D respectively) include the entire Medicaid state plan Services Benefit Package, subject to necessary pre-authorization for services not in the prioritized list.

iii. Notwithstanding the prioritized list, benefits for individuals under age 21years of age include Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).

c. **High Level Summary forOHP Plus.**

COVERED SERVICES	OHP PLUS[1]
Acupuncture	✓
Chemical Dependency Services	✓

[1] No benefit limitations apply to children under the age of 21 with Medicaid or CHIP direct coverage.

Dental	Limited**
Emergency/urgent hospital services	✓
Hearing aids and hearing aid exams	✓
Home Health	✓
Hospice Care	✓
Hospital Care	✓
Immunizations	✓
Labor and Delivery	✓
Laboratory and X-ray	✓
Medical Equipment and Supplies	✓
Medical Transportation	✓
Mental Health Services	✓
Physical, Occupational, & Speech Therapies	✓
Physician Services	✓
Prescription Drugs	✓ *
Private Duty Nursing	✓
Vision	Limited***

* For individuals with Medicare Part D, the OHP Plus benefit package does not cover drugs covered by Medicare Part D.
** Limited Dental coverage as described in the state plan
***Limited Vision coverage as described in the state plan

d. **Cost Sharing under OHP Plus**

i. For OHP Plus, individuals may be liable for nominal copayments. No copayment liability will be imposed on pregnant women or children under the age of 19.
ii. The approved copayments are included in the Title XIX state plan.
iii. Oregon uses the state plan amendment process to make changes to its OHP Plus copayment policies.

e. **Disenrollment from OHP Plus.** Enrollees in OHP Plus may be disenrolled if they:

i. Exceed income limits allowed for the program at redetermination;
ii. Exceed resource limits allowed for the program at redetermination;
iii. Voluntarily withdraw from the program;
iv. No longer reside in the State of Oregon;
v. Become incarcerated or are institutionalized in an IMD;
vi. Are no longer pregnant;
vii. No longer have a qualifying disability; or
viii. Are no longer living.

20. **Alternative Benefits Plan**

a. The mandatory state plan group, new adult group (Population 23 in Attachment D), will receive a benefits package provided through the state's approved alternative benefit plan (ABP) in the Medicaid state plan.

b. Benefits in the ABP that are determined essential health benefits provided through the state plan are subject to utilization management and medical necessity determination according to the prioritized list and equal or exceed each of the base benchmark benefits duplicated, which define the floor of coverage for an ABP.

c. Benefits in the ABP that are determined to be other 1937 covered benefits that are not essential health benefits provided through the state plan are subject to utilization management and medical necessity determination according to the prioritized list in the same manner as other populations in the waiver.

21. **Breast and Cervical Cancer Treatment Program (BCCTP)**

a. The Breast and Cervical Cancer Treatment Program (BCCTP), formerly known as BCCM, provides medical assistance to women under the age of 65 who have been screened and diagnosed through the Breast and Cervical Cancer Treatment Program (BCCTP) and found to need treatment for breast or cervical cancer, or specific precancerous conditions, and are receiving such treatment. Such individuals are uninsured or underinsured with respect to necessary treatment.

b. Women determined to be eligible for BCCTP (population 21 in Attachment D) will be enrolled on the Oregon Health Plan for the duration of their treatment.

c. BCCTP Presumptive Eligibility

   i. Any licensed health care provider qualified to diagnose cancer or pre-cancerous conditions can determine presumptive eligibility under the BCCTP
   ii. Presumptive eligibility provides immediate, temporary coverage for women who appear to meet basic eligibility criteria.
   iii. Presumptive coverage lasts approximately a month before full determination of coverage through OHP.

d. Eligible individuals remain eligible for a period of 12 months. At the end of the 12 months:

   i. A redetermination application is sent to the client;
   ii. The client's provider verifies if patient still requires treatment and submits verification to OHP;
   iii. If the client still needs treatment, coverage is extended for additional year;
   iv. Not have creditable health insurance to cover her treatment; and
   v. Be in need of treatment for breast or cervical cancer, including qualifying precancerous conditions.

V. DELIVERY SYSTEM TRANFORMATION

Description of the pre-Health System Transformation Managed Care Delivery System

22. **Pre-Health System Transformation Delivery Systems for OHP Plus and OHP Standard.** The majority of health care services under OHP Plus and OHP Standard are provided through a managed care delivery system. The managed care entities (MCEs) coordinate health care systems, including pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and comprehensive or targeted management of health services. The managed care services have been delivered through the entities in Table 1. Once the health system transformation has been fully implemented the current managed care providers will be replaced by the Coordinated Care Organizations.

Table 1. Existing Care Delivery Systems

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Fully Capitated Health Plan (FCHP) (a managed care entity)	An organization contracted to provide physical health services and chemical dependency treatment services, including inpatient hospitalization. Oregon contracts with FCHPs throughout the state to provide health care services to Oregon Health Plan members.	FCHP contract ends if the FCHP reorganizes as a CCO in a particular service area.	No new FCHP contracts after July 1, 2014.
Physician Care Organization (PCOs) (a managed care entity)	An organization contracted to provide physical health services, excluding payment for inpatient hospitalization.	The two PCO contracts will end if they join a CCO in the PCO service areas.	No new PCO contracts after July 1, 2014.
Mental Health Organizations (MHOs) – (a managed care entity)	An organization contracted to provide outpatient and acute inpatient mental health services. Mental Health services are provided by stand-alone organizations that specialize in such services and are paid on a capitated rate basis	MHO contract ends if the MHO reorganizes as, or joins, a CCO in a particular service area. MHOs will continue to serve enrollees currently FFS for physical health care until 11/1/12. After that date, MHO contracts will end.	No new MHO contracts after July 1, 2014.

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Dental Care Organizations (DCOs) – (a managed care entity)	An organization contracted to provide dental services, including preventive care, restoration of fillings, and repair of dentures. Dental services are contracted on a stand-alone basis through a DCO and are paid on a capitated rate basis to provide services to OHP members	CCOs will contract with DCOs in the CCO service area, but DCOs must be integrated into CCOs by July 1, 2014.	CCO/DCO contracts will be executed by July 1, 2014.
Primary Care Manager (PCM)	A physician or other OHP approved medical provider responsible for providing primary care and maintaining the continuity of care, supervising and coordinating care to patients, initiating referrals to consultants and specialist care. PCMs are not under contract with a managed care organization; they provide health care services through a FFS system, and receive a nominal management fee on a per member per month basis. Compensation to PCMs for direct services is non-risk based and in accordance with the state plan.	Some PCMs will continue to exist for the small FFS population remaining. The state will be working with PCMs to meet PCPCH requirements.	Ongoing and parallel to CCO timelines.
Fee-For-Service/ Open Card	The OHP participants may also receive services through the fee-for-services delivery system. The OHP participant that receives service through FFS may be served through a PCPCH.	FFS open card will be maintained only for small number of exempted or excluded populations or those outside CCO service areas.	Ongoing
Patient Centered Primary Care Homes (PCPCH)	The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support	The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a	Ongoing Transition over 3-5 years as more PCPCHs become

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
	services, and referral to community and social support services.	CCO or served through the FFS delivery system.	certified

Health System Transformation Transition

23. The state will transform its delivery system through a shift to the delivery of care from current specialized MCEs to Coordinated Care Organizations (CCOs) beginning in August 2012. Initially, CCOs will be required to provide both medical and behavioral health services (formerly provided under different MCEs). Dental services must be merged into the CCO by July 2014. The state's contracting with the CCO will result in the phase out of new Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), and Mental Health Organization (MHO) contracts by July 1, 2014 and CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. The CCOs initially will be phased into the delivery system over four monthly cycles (or "waves") beginning in August 2012 and ending in November 2012.

    a. Transition of OHP Populations to CCOs

        i. Existing enrollees of an MCE that has transitioned to a CCO will be given a 30 day notice and transitioned (rolled over) to the new CCO when certification and contracting is complete. This roll over will include currently enrolled tribal members and dual eligibles, who will be able to opt-out if they wish. Existing members who are receiving services from out-of-area or non-participating providers will be moved to a CCO when their MCE transitions. For these members, the CCO will be expected to cover out-of-network or non-participating provider services authorized by the member's care team, Medical Director of the MCO or the Medical Director of the Division of Medical Assistance Programs, for a transitional period until the CCO establishes a relationship with the member and is able to develop a medically appropriate care plan.

            1. An MCO transitioning to become a CCO in any of the four initial contracting waves will retain its existing enrollees and those enrollees will be transitioned (rolled over) to the new CCO when certification and contracting is complete.

            2. For an MCO not transitioning to become a CCO in any one of the four waves, enrollment of existing members will continue in the plan until the member chooses another plan as described below, or until the OHA determines on a case-by-case basis that members should be transitioned to other plans serving the geographic area.

ii. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.

1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.

2. All existing MCEs from Table 1 in paragraph 22 will be closed to new enrollment once sufficient capacity is determined to exist in the CCO(s) serving the area. If CCOs do not have sufficient capacity, new members may be enrolled only in MCOs on the path to becoming a CCO in one of the four waves until capacity in those plans is reached, then can be enrolled in any remaining MCOs.

iii. Individuals who are currently in FFS for physical health, other than dual eligibles and tribal members, will receive a 30 day notice and be required to enroll in CCOs by November 1, 2012 where sufficient capacity exists, and will be given their choice of plan.

1. Members not choosing a plan will be auto-assigned to a plan through an auto-enrollment process.

2. For members who are enrolled in an MHO for mental health services but otherwise receive physical health services through fee for service, if a CCO becomes operational in their area prior to November 1st, their mental health coverage will be through that CCO until they are enrolled in a CCO for both physical and mental health services in November.

iv. Tribal members and dually eligible individuals are both populations that must make an affirmative voluntary choice for CCO (and existing MCE) enrollment (i.e., cannot be auto-enrolled).

v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.

vi. OHA is planning member transition strategies for FFS members with special considerations:

1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:

- Care management requirements based on the beneficiary's

medical condition
- Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations
- Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services)
- Availability of medically appropriate medications under the CCO formulary
- Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team

2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.

Description of Delivery System Transformation

24. **Definition and Role of Coordinated Care Organizations**. CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the state. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR Part 438 unless a requirement has been specifically identified in the waiver authorities for this demonstration. CCOs will provide a governance structure to align the specialized MCE services under one managed care organization. CCOs will partner with OHA to further the state's implementation of PCPCH and utilization of Non-Traditional Health Workers (NTHWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

a. **CCO Criteria**. The CCOs are required to meet the following criteria:

i. **Governance and Organizational Relationships.**

1. Governance. Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see 2 below); and at least two members from the community at large to ensure that the organizations decision making is consistent with the community members' values.

2. Community Advisory Council (CAC). The CCOs are required to convene a CAC that include representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be ongoing bodies and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.

3. Clinical Advisory Panel. The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.

4. Partnerships. The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees and with county health departments and other publicly funded providers for certain point-of-contact services.

5. Community Health Needs Assessment. Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The state encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

b. **CCO quality and access measurement.** CCOs will be accountable for metrics for quality and access as described in Section VII and Attachment E, including measures to track progress in the quality improvement focus areas, measures to track quality broadly, and measures to track access. Specific measures, timeframes, and CCO reporting requirements will be determined by the state and approved by CMS during the supplemental 120-day planning period.

i. **Menu-set of CCO quality improvement focus areas.** OHA will ensure that each CCO will commit to improving care in at least 4 of the following 7 focus areas, which have the significant potential for achieving the demonstration's goals of improving the patient experience of care, improving population health, and reducing per capita Medicaid expenditure trend. Three of these four projects may serve as a CCO's Performance Improvement Projects in accordance with 42 CFR 438.358 and 438.240. Attachment E provides further details on each of these focus areas. The state and CCOs may add to this menu of focus areas but should review Attachment E and provide a similar level of detail for anything not on the list below. The state will incorporate the PIP requirements into its CCO/MCE contracts within 120 days of the approval of the demonstration

1. Reducing preventable rehospitalizations.
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, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by "super-utilizers".
4. Integrating primary care and 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 model of care throughout the CCO network.

c. **Health Information Technology (Health IT).** The CCOs are directed to use HIT to link services and core providers across the continuum of care to the greatest extent possible. The CCOs are expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

i. Health IT:

1. CCOs must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the state's health information exchanges. If providers 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.

2. In order for CCOs to fully realize years 2-3 performance incentives, the state must require that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The related incentives must take into account the costs incurred in order to facilitate adoption and meaningful use of EHRs, as well as the existing incentives available to eligible providers.

3. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. The state must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

4. All requirements must also align with Oregon's state Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

d. **Innovator Agents and Learning Collaboratives**. State shall utilize innovator agents to act as a single point of contact between the CCO and the Oregon Health Authority. Innovator agents will be assigned to each contracted CCO by January 15, 2013. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the demonstration's goals of improving quality and access while managing costs, within 120 days from the approval of the demonstration amendment the state will:

i. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.

ii. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as

underperforming (as described above), the state will plan and execute intensified innovator/learning collaborative interventions.

iii. The information in (a) and (b) above will be incorporated into the CCO contracts by amendment.

25. **Alternate Delivery System**. The FFS delivery system applicable to some demonstration populations will continue under the health system transformation.

26. **Patient Rights and Responsibilities, Engagement and Choice.** The CCO is responsible for ensuring that its enrollee receives integrated person-centered care and services designed to provide choice, independence and dignity.

27. **Compliance with Managed Care Requirements.** The state must meet the requirements of 42 CFR Part 438 unless a requirement of part 438 has been identified in the waiver authorities for this demonstration.

28. **Managed Care Enrollment, Disenrollment, Opt Out and Transitions**

a. **Mandatory Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive benefits pursuant to Sections – IV and V of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to 12 months. The Table below illustrates the mandatory and affirmative choice (i.e., "opt-in") populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given[2]
1, 3, 5, 6, 7, and 8	Individuals of the identified populations other than those footnoted. [3]	Mandatory; current FFS enrollees not transitioned for physical health until November 2012	Other CCO if available; MCO if no CCO in area; FFS with cause
21	Breast and Cervical Cancer Treatment Program	Not enrolled until November 2012, then Mandatory	Other CCO if available; MCO if no CCO in area; FFS with

[2] See (b) below for more information on disenrollment/plan change options and timelines.

[3] Exceptions include individuals who are: dually eligible for Medicare and Medicaid, American Indian or Alaska Native who are permitted to enroll, but not mandatorily enrolled. Current MCO enrollees will be rolled over to a CCO in November 2012, others may opt in. FFS populations who require special consideration (e.g., HIV/AIDs) will be transitioned in November 2012, after receiving individualized transition planning.

Population	Description	In/Out of CCOs	Disenrollment Options Given[2]
	Income: Up to 250% FPL Resource Limit: None		cause
23	New eligible adults	Mandatory	Other CCO, if available; MCO if no CCO in the area; FFS with cause
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
1-11, 21	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid state plan	Individuals who are receiving non-OHP Medicare (QMB, SLMB, QI)	Out	N/A
Medicaid state plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A
Medicaid state plan	Individuals who are Transplant Rx only	Out	N/A

b. **Disenrollment.** The information in the table is applicable to all managed care enrollees.

Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR Part 438.
Eligibility redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

29. **Network Adequacy and Access Requirements.** The state must ensure that any MCE and CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and

services, considering the urgency of the service. Detailed standards for various levels of care (e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the state's quality strategy required by 42 CFR 438.204.

30. **Required Notice for Change in CCO Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The state must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

31. **Contingency Planning.** In the event that a CCO contract is amended to significantly reduce its service area or the contract is terminated, the state will implement contingency planning in consultation with CMS to assure enrollee continuity of care.

32. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10(f)(4), 42 CFR 438.6(i) and 42 CFR 431.20, the state may allow the use of electronic methods for the beneficiary and provider communications as required by:

    - 42 CFR 438.10(b) – Special rule for mandatory enrollment states – timeframes for providing information;
    - 42 CFR 438.10(e) - Information for potential enrollees;
    - 42 CFR 438.10(f)(2), (3) and (6) - Right of enrollee to request and obtain information;
    - 42 CFR 438.10 (g)(2) and (3) – Other plan information, including PIPs;
    - 42 CFR 438.10(h)(2) and (3) - For PAHPs only - Other plan information, including PIPs;
    - 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
    - 42 CFR 438.102(b)(1)(ii) – state policies on excluded services.

    a. The state may allow the use of such electronic communications only if:

        i. The recipient has requested or approved electronic transmittal;
        ii. The identical information is available in written form upon request;
        iii. The information does not constitute a direct beneficiary notice related to an adverse action or any portion of the grievance, appeals, hearings or any other beneficiary rights or beneficiary protection process; and
        iv. Language and alternative format accommodations are available.
        v. Please note: All HIPAA requirements apply with respect to personal health information.

33. **Transparency/Public Reporting.**

a. The state must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).

b. The state shall publish data regarding CCOs' performance on state-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the state's progress toward achieving the two primary goals of this demonstration.

34. **State Oversight of the CCOs.** The state Agency must have in effect procedures for monitoring the CCO operations, including, at a minimum operations related to the following: recipient enrollment and disenrollment; processing of grievance and appeals; violations subject to immediate sanctions, as set forth in sub part I of 42 CFR 438; violations of the conditions for FFP, as set forth in subpart J; and all other provisions of the contract.

VI. CAPITATION RATES AND PERFORMANCE MEASURES

35. **Principles for Payment Methods that Support the Three-Part Aim.** The state will employ the following concepts in its payment methods to CCOs:

a. The state will transition to a payment system that rewards health outcomes improvement and not volume of services.

b. The state will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services. The global budget will be phased in, but will eventually consist of two parts: 1) a capitated per member per month (PMPM) payment; and 2) a separate PMPM payment for services not included under the capitation rate.

Until January 2013, the global budget will include only capitated services (i.e., the first part above). After January 2013, the state will begin including additional services to the global budget (see Attachment F). These services may be included in the capitated portion of the global budget or in the separate PMPM payment methodology. The methodology for inclusion of additional services in the global budget will be mutually agreed upon by the state and CMS and phased in over the course of the demonstration. The state and CMS will finalize the methodology for inclusion of additional services within 120 days of this agreement.

No payment will be made for CCO enrollees to FCHPs, MHOs and, if dental services are included in the CCO benefit package, DCOs.

i. Attachment F provides a proposed schedule of inclusion of additional services into the CCO global budgets. Initial CCOs approved August through December 2012 will be at risk for Lines 1-8 through a PMPM

global budget. The state intends to add service lines 9-22 to CCO global budgets over the course the demonstration. While the intent is to include as many services as possible within the PMPM payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding these services to the global budget. Until services are added to the global budget either through the PMPM or another methodology, CCOs are not at risk for services other than 1-8 in Attachment F. If the state wishes to add any services included in lines 23-38 in Attachment F, the state will work with CMS to determine the most appropriate methodology for inclusion of the additional services within the CCO global budgets and amend the Section 1115 waiver if necessary.

c. The CCO contract language will require the CCOs to consider alternative non-state plan services (the constellation of these services includes services known as "in-lieu of services," "substitute services," "flexible services," and "non-encounterable services" and hereafter referred to as "flexible services" in order to capture the array of potential services). CCOs are always at liberty to offer any *additional* health-related services at their discretion, as allowed under 42 CFR 438.6(e). Since enrollees may need additional services that are not substitutes for state plan services, which could ultimately improve the enrollee's health, the CCOs should use this option as necessary.

   i. The contract must not require specific, discrete service substitutions, but may require that the principle of "flexible services" (i.e., that CCOs look for more cost-effective services to replace or supplant the need for state plan services, as appropriate) be applied under the following circumstances:

      1. An enrollee's request to have a state plan service rather than a flexible service must be honored when medically necessary.

      2. All flexible services will be health related however the CCO will have broad flexibility in creating the array of services to improve care delivery and enrollee health. The state will report on the non-state plan services provided through the CCO contracts, including the effectiveness of the services in deterring higher cost care.

      3. Flexible services will be accounted for in the administrative expenses part of the capitation rate. Although flexible service will not be included in the medical expenses portion of the capitation rate, utilization assumptions may be applied.

   ii. The CCO contracts may levy performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. I.e., the more creative the CCOs are with flexible service delivery, health outcomes will improve and growth in per capita expenditures will decrease.

1. As CCOs provide health care services that are more cost-effective than state plan services (which is what the capitation rate is based on), the capitation per capita growth rate should gradually decrease over the waiver period. The state will offset the decrease in capitation per capita rate growth with additional incentives outside of the capitation rate.

2. Over time, the per capita expenditure trend should be lower through decreased use of unnecessary and costly services. This will happen when: 1) Decreased utilization of unnecessary and costly services; 2) Financial reward of CCOs and their contracted providers for quality improvement, not volume of services; and 3) the health status of enrollees improves through coordination of care.

3. Success will be measured by and incentives paid based upon: 1) decreased rate of per capita Medicaid expenditure growth; 2) increased patient satisfaction with, and involvement in, care planning and quality of care; and 3) overall population health improvement.

d. In each year, the state and CCOs must track discrete services whether it is a state plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate.

36. **Structure.** Capitation rates and incentives for the Coordinated Care Organizations (CCOs) for each demonstration year (DY) will be structured as follows:

a. Demonstration Year 11:

i. Capitation rates. There will be no major changes in the currently approved rate-setting methodology for DY11.

ii. Incentives and Withholds. There will be no incentive payments made to CCOs or amount withheld from the CCOs.

iii. Special performance Standards. The state will apply special performance standards of timely and accurate data reporting in the first year.

b. Demonstration Years 12 through 15:

i. Capitation Rate Withhold. The first quarter of DY 12 will include a 1-percent capitation rate withhold that will be returned to CCOs successful in DY 11 performance metrics which reward timely and accurate data reporting A CCO that successfully meets the performance metrics of timely and accurate data reporting in DY 11 will receive the full capitation rate in this quarter. A CCO that does not meet the DY 11 performance metrics will not have the withhold restored, resulting in a 1-percent rate reduction. The state will determine the parameters for the special performance standards of timely and accurate data reporting within 120 days of this agreement.

ii. The state will have an additional 120 days after the agreement is in effect to address the details of DYs 12-15 so long as it is within the following parameters and subject to CMS approval:

1. Bonus Incentive Pool. The state will establish a separate bonus/incentive pool outside of the capitation rates (i.e., in addition to any capitation rate withholds). Incentives must be designed to reduce costs and improve health care outcomes. When developing the bonus pool, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing.

a. The state will alert the CCOs that the bonus incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole bonus incentive pool amount will be at risk. The state will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark, and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance. Within 120 days of the demonstration approval, the state will submit and CMS will approve the specific requirements. The state will amend its CCO contracts to incorporate the changes immediately following the 120-day period.

2. CCO Provider Agreements. Incentives must be correlatively reflected in the CCO/provider agreements to insure that the incentives are passed through to providers to reflect the arrangement with the state-CCO contract.

iii. Each subsequent DY rates and incentives will be set in the DY preceding the implementation in order to apply program experience as the program matures (e.g., DY 13 rates and incentives will be set in DY 12). The state will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

VII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

37. **Overview.** Improving access and quality is a key component of the state health system transformation and measurement is necessary to determine whether the demonstration's goal of advancing the triple aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required.

38. **Metrics and Scoring Committee.** The state's strategy for a robust measurement includes the newly established Metrics and Scoring Committee. The Committee will review data and

the relevant literature, determine which measures will be included in the CCO incentive program, and establish the performance benchmarks and targets to be used in this incentive program. The Committee will endorse/develop specifications for each measure. In future years, the Committee will review earlier decisions and make adjustments as needed. A transitional Metrics and Scoring Committee recommended a set of metrics for the first program year, which were described in CCO RFA contracts. Going forward, the permanent Metrics and Scoring Committee will recommend metrics that will be used to determine financial incentives for CCOs.

39. **Additional Quality Measures and Reporting at the CCO Level.** CMS developed an additional list of requirements for the Metrics and Scoring Committee that should be incorporated into the measurement planning and financial incentive determinations. This should not supplant the work of this committee, but rather provide some strategic direction to reach the two goals of this demonstration. The CCOs will be required to collect and validate data and report to the state on the metrics listed in this section, which may be revised or added to overtime as the demonstration matures, but these metrics will remain constant for the first 2 years of the demonstration. CMS also encourages the CCOs to report on the core set of performance measures for children and adults in Medicaid and CHIP.

    a. **Metrics to track quality improvement focus areas:** Pursuant to paragraph 24.b.i), the state and CMS will ensure the collection and validation of measures to track progress in the quality improvement focus areas. (See Attachment E)

    b. **Core set of quality improvement measures**. The initial core measures will track the following:

        i. Member/patient experience of care (CAHPS tool or similar);
        ii. Health and functional status among CCO enrollees;
        iii. Rate of tobacco use among CCO enrollees;
        iv. Obesity rate among CCO enrollees
        v. Outpatient and emergency department utilization;
        vi. Potentially avoidable emergency department visits;
        vii. Ambulatory care sensitive hospital admissions;
        viii. Medication reconciliation post discharge;
        ix. All-cause readmissions;
        x. Alcohol misuse-screening, brief intervention, and referral for treatment;
        xi. Initiation & engagement in alcohol and drug treatment;
        xii. Mental health assessment for children in DHS custody;
        xiii. Follow-up after hospitalization for mental illness;
        xiv. Effective contraceptive use among women who do not desire pregnancy;
        xv. Low birth weight;
        xvi. Developmental screening by 36 months; and
        xvii. Difference in these metrics between race and ethnicity categories;

    c. **Access improvement measures based on CCO data.** The state and CMS will identify and agree to additional access measures by 120 days after the approval of this demonstration planning period. CCOs will ensure the collection and validation of the

measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.

i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
ii. Percentage of adults with any outpatient visit.
iii. Percentage of adults with a chronic disease w/any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.
v. Percentage of children with at least one dental visit.
vi. Fraction of physicians (by specialty) 'participating' in the Medicaid program.
vii. Change in the number of physicians (by specialty) participating in Medicaid
viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
ix. Percentage of CCO enrollees with access to a PCPCH.

d. **Access improvement measures based on state survey data.** The state will identify and CMS will approve additional access measures, particularly measures based on survey data, by 120 days after the approval of this demonstration planning period. Additional survey-based measures could include:

i. Percent of beneficiaries with a usual source of care.
ii. Percent of beneficiaries with a preventive visit in past year.
iii. Percent of beneficiaries with a dental visit in past year.
iv. Percent of beneficiaries with any unmet needs.
v. Percent of beneficiaries delaying/deferring care due to cost.
vi. Percent of beneficiaries delaying/deferring care due to lack of available provider.
vii. Percent of beneficiaries delaying/deferring care due to provider office being. closed at time of illness.
viii. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

40. **Utilization of new services.** The state and CCOs must track discrete services whether it is a state plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement.

41. **Quality and Access Data Reporting from the State to CMS.** In accordance with paragraph 5164, "Monitoring to Assure Progress in Meeting demonstration Goals," the state will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the state will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the

CCOs. Within 120 days of the demonstration approval, the state will submit and CMS will approve a reporting format.

42. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**

    a. **Statewide quality, access, and expenditure monitoring and analysis.** The state, working with the CCO Innovator agents, shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The state must report to CMS any CCO issues impacting the CCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights

    b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the state shall intervene promptly within 30 days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to focused learning collaboratives and/or innovator agents, targeting underlying issues affecting outcomes, performance, access and cost.

    c. **Additional actions taken if goals are not achieved**. If the interventions undertaken pursuant to paragraph 42.b do not result in improved performance in identified areas of concern within 90 days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the state placing the CCO on a corrective action plan. The state must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the learning collaboratives and peer-support to the extent practicable.

43. **EQRO.** The state is required to meet all requirements found in 42 CFR 438, subpart E. The state will need to amend its current EQRO contract to require the reporting of outcomes information in the annual technical report related to performance measures and performance improvement projects. The state should generally have available its final EQR Technical Reports to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)]. In the first year of the transition to the CCO system and to a modified EQRO contract, CMS will use the quality and access data from the quarterly reports as identified in paragraph 41 to satisfy regulatory requirements.

44. **State Quality Strategy**. In accordance with CMS regulations, the state is required to submit a written strategy for assessing and improving the quality of managed care service offered by all managed care entities. This written strategy (also referred to as the "quality strategy") must meet all of the requirements found in 42 CFR 438, subpart D. Before implementing a final, approved quality strategy, the state is required to submit a draft quality strategy to CMS for approval within 120 days of the approval date of the demonstration. The state will submit a revised strategy to CMS within 60 days, whenever significant changes are made. The state will submit annual reports to CMS on the implementation and success of the strategy, by means of the annual EQRO technical report or a separate annual report that assesses the implementation and effectiveness of the quality strategy.

VIII. CALCULATING THE IMPACT OF HEALTH SYSTEMS TRANSFORMATION AND REDUCTIONS IN DESIGNATED STATE HEALTH PROGRAM FUNDING

This section establishes the parameters by which the state and CMS will annually measure the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved. Data specified in this section shall be reported on a quarterly and annual basis as specified in paragraph 64.

There are three levels of baseline and actual expenditures that the state must calculate and provide to CMS that will be measured and monitored annually under this demonstration. These levels are:

- 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,
- 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, and
- Level 3: The per member per month total expenditure to the state to *provide* care under Health System Transformation in Oregon.

45. The following section summarizes the specific populations, expenditures, and other variables that will be included in calculations of each of the expenditure levels described above.

    a. **<u>Level 1: Global Budget Expenditures</u>**.
    These expenditures are for services identified in Attachment F for all individuals enrolled in eligibility categories that are required to enroll in CCOs (mandatory populations) and for individuals that voluntarily enroll in CCOs that are in non-mandatory enrollment populations (voluntary populations). Expenditures would also include any incentive payments, shared savings payments made to CCOs as well as wrap-around or supplemental payments for services identified in the global budget and

provided to these populations. This expenditure level is the level against which the health care cost trend targets and the associated funding consequences described in paragraph 53 will be based.

b. **Level 2: Medicaid Program Service Expenditures**

These expenditures are for all Medicaid services provided to all individuals enrolled in mandatory eligibility categories as well as those individuals enrolled in voluntary populations who voluntarily enroll in CCOs. This expenditure level includes all payments described in level 1 plus all other Medicaid payments for services provided under the demonstration or the state plan to individuals described in level 1 during a demonstration year. These additional expenditures would include services such as long term care services that are not included in the global budget service package but are provided to individuals described in level 1.

c. **Level 3: Medicaid Program Costs for Health System Transformation**

This expenditure measure will capture total costs to support Health System Transformation (HST) and will include all costs in level 1 plus all costs that the state incurs for supporting HST including activities such as learning collaboratives, innovation agents, and other activities performed or contracted by the state to implement and operate HST.

46. **Calculating Baseline Expenditures.** The baseline expenditures to the state without Health Systems Transformation of these services will be developed using expenditure information from 2011 for the full calendar year. The costs will be developed for each level of spending for each eligibility group. These baseline costs will be transformed into aggregate per member per month costs based on total member months in 2011. The groups are:

Population	**Enrollment**
Children	Mandatory
Non-disabled Adults	Mandatory
Disabled Adults	Mandatory
Dual Eligibles	Voluntary

The baseline PMPMs for each level will be developed as follows:

a. Level 1: The actual baseline PMPM will include all costs for global budget services plus all wrap-around payments for all populations whose enrollment is mandatory or voluntary (as defined in Table 2 in paragraph 28). The base costs for global budget services will be divided by the total applicable member months to create an aggregate PMPM.

The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the state and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

b. Level 2: The actual baseline PMPM will include all level 1 costs plus all other Medicaid service expenditures attributable to 2011 for all individuals in both mandatory and voluntary populations. The total base costs for global budget services will be divided by the total applicable member months.

   The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the state and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

c. Level 3: The actual baseline PMPM will include all level 1 costs by eligibility group and for the base year, should not differ from Level 1 expenditures as the additional costs in this category is expenditures supporting health system transformation.

The baseline PMPM in Level 1 will be the without Health System Transformation (HST) costs. The trend rate applied to the aggregate PMPM, which is based on the President's Budget estimates of the national rate of growth in Medicaid expenditures on a per member per month basis, is 5.4% for each year in the demonstration. If within the 120 day period following approval of the demonstration, the state provides analysis and data demonstrating that Oregon's trend differs substantially from this national average, and the Chief Actuary of CMS determines the difference to be valid and calculated reasonably and in accordance with general actuarial standards of practice, CMS will adjust this trend rate.

The PMPM calculation will be performed for each level (1, 2, and 3) described above in the aggregate.

47. **Calculating Actual Expenditures under Health System Transformation.** This measurement is based on actual DY expenditures for services and supports under HST. Actual HST PMPM expenditures will be calculated as follows:

    a. Level 1: The actual HST expenditure PMPM will include all costs for global budget services plus all wrap-around payments.

       For the mandatory populations, costs for global budget services will be included regardless of whether the CCO directly provided the services or not and whether or not individuals were enrolled in a CCO.

       For voluntary populations, the costs for global budget services will be included regardless of whether the CCO directly provided the services or not. Expenditures and member months for individuals in the voluntary group will be included in this calculation only if they were enrolled in a CCO.

       The state will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory populations and voluntary populations if they were enrolled in a CCO.

b. Level 2: The actual HST PMPM will include all Level 1 costs plus all other Medicaid service expenditures during the DY. For the mandatory populations, the total level costs will include both global budget services and all other Medicaid services provided to individuals in the mandatory eligibility groups.

For voluntary populations, costs will include all Level 1 costs plus all other Medicaid service expenditures during the DY only for individuals actually voluntarily enrolled in CCOs. Individuals in the voluntary group will contribute their expenditures only if they were enrolled in a CCO.

The state will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory and voluntary populations.

c. Level 3: The HST PMPM will include all Level 1 costs by eligibility group and all costs incurred by the state for expenditures to support HST. The costs will include activities such as learning collaboratives, innovator agents, the quality and access metrics committee, and other administrative support the state may provide to facilitate the implementation and operation of CCOs and HST. The state will submit and CMS will approve within 120 days after the date of approval of the demonstration the activities and costs that will be included in the HST support expenditure category.

For mandatory and voluntary populations, the HST calculation will include Level 1 aggregate expenditures plus aggregate, identified HST support expenditures divided by total Level 1 mandatory and voluntary member months.

48. **Calculation of Trend Reduction Targets:** The state must beginning immediately following DY 12 to annually demonstrate the savings achieved under HST using the without HST PMPM and the HST PMPM for Level 1 expenditures each DY. The savings requirements and penalties are described in paragraph 53.
The PMPM savings percentages will be reported for each eligibility group and in the aggregate, although the savings reduction requirement will be applied only to the aggregate with and without HST expenditures. The aggregate HST PMPM must be below:

a. the 5.4% without HST trend rate by 1 percentage point in DY 12 (i.e. aggregate PMPM expenditures in DY 12 must be no more than a 4.4% increase over DY 11 aggregate without HST PMPM expenditures).

b. the 5.4% without HST trend rate by 2 percentage points in DY 13, 14 and 15 (i.e. aggregate PMPM expenditures in DY 13 must be no more than a 3.4% increase over DY 12 aggregate without HST PMPM expenditures).

49. **Return on Investment.** Annually, CMS will analyze the total return on investment in HST. The state must provide information (as part of the reporting requirements in paragraph 64) on total new federal funds claimed as DSHP as well as federal funds claimed using state funds repurposed as a result of DSHP relative to health savings achieved under the health transformation process. Elements in the analysis will include:

a. New federal funds drawn as match against DSHP programs.
b. New federal funds drawn as a result of DSHP. Under the state's proposal, this includes all federal funds drawn associated with state funds redirected from DSHP except DY1 rate stabilization.
c. Savings identified in the total cost of purchasing care in level 3 as described above (the total investment in HST).

50. **Evaluating Impact on Medicare and Medicaid Expenditures for Dual Eligibles.** In addition to expenditure estimates in paragraphs 46, 47, and 48, CMS and the state will examine total expenditures on individuals who are dually eligible for Medicaid and Medicare who are enrolled in CCOs.

51. **Measurement of Quality and Access Under the Demonstration.** The state will also monitor and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 64. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.
Within 120 days of approval of the demonstration, the state will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's Medicaid population as a whole. The state's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). state quality and access reporting will take place on the same timeframes as the state's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

52. **Deliverables to be Negotiated Within 120 Days Post Approval:** Within 120 days of approval of the demonstration, CMS and the state will:

a. Finalize the benefit package for the global payment Level 1 analysis during the demonstration period (Attachment F).
b. Finalize the parameters of the total cost of care for levels 2 and 3 by identifying all payments and costs subject to inclusion in the costs of care calculation.
c. Finalize the annual per capita amount for the baseline period.
d. Finalize safe harbor language to limit risk to the state for increases in FQHC wrap-around payments for reasons that are not within the state's control for the purposes of Level 1 calculations. Valid reasons would include an increase in FQHCs in the state relative to the base year or changes in scope of service that actually effect the PPS rate.
e. Finalize a methodology for the treatment of long term care services and supports (LTSS) expenditures.

f. Finalize the return on investment formula template and the per capita reporting templates.
g. Finalize the calculation of cost shifting using Medicaid uncompensated care (shortfall) using DSH audit information.
h. Finalize the timing of and reporting format of the annual expenditure and savings calculations.
i. A plan for specific quality and access measures that the state and CMS will use to monitor access and quality during the demonstration, as well as methods for such measurement and reporting timeframes.
j. CMS will review, discuss with the state, and approve all of the above deliverables within 30 days after the 120 day period.

53. **Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets**

This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. **Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates**. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 48, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Table 3: Per Capita Expenditure Growth Reduction Targets and Associated DSHP Expenditure Authority Reductions for Failure to Meet Targets

Demonstration Year	**Per Capita Expenditure Growth Reduction Target** (measure following DY close)	**Reduction in DSHP Expenditure Authority** (reduce succeeding DY's DSHP expenditure authority)
DY11	NA	NA
DY12	1 percentage point	$54 million
DY13	2 percentage points	$68 million
DY14	2 percentage points	$68 million
DY15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the state in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the state has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. **Earn Back Option.** For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:

   i. If the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year *and* significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.
   ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.
   iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

IX. DESIGNATED STATE HEALTH PROGRAMS

54. **Designated State Health Programs (DSHP).** To support the goals of health system transformation, the state may claim FFP for the following state programs subject to the annual limits and restrictions described below through June 30, 2017, unless otherwise specified. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment G. Subject to approval by the federal Office of Management and Budget, these expenditures can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of paragraph 53.

55. **Aggregate DSHP Annual Limits –** Expenditure authority for DSHP is limited to $704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by year as follows:

Table 4: Aggregate DSHP Annual Limits

Demonstration Year	Time Period	Annual Limit on FFP
DY 11	07/1/12-06/30/13	$230 M
DY 12	07/1/13-06/30/14	$230 M
DY 13	07/1/14-06/30/15	$108 M

DY 14	07/1/15-06/30/16	$ 68 M
DY 15	07/1/16-06/30/17	$ 68 M

56. **Restrictions on DSHP Programs.** Approved Designated State Health Programs for which FFP can be claimed are outlined below subject to the following funding limits by the four categories listed below. Prior to claiming funding for these programs, the state will submit and CMS will approve a DSHP claiming protocol. The state is not eligible to receive FFP until the protocol is approved. Upon CMS approval of the claiming protocol, state is eligible to receive FFP for the approved DSHP program expenditures beginning July 5, 2012.

Table 5. Limits on Allowable Designated State Health Programs

Expenditures by Type of Designated State Health Programs:	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**Total**
Oregon Medical Insurance Program	93	93	0	0	0	186
Workforce Training	69	69	40	0	0	178
Gero-Neuro	8	8	8	8	8	40
Other CMS Approved*	60	60	60	60	60	300
Total	**230**	**230**	**108**	**68**	**68**	**704**

*See Table 6 for all approved programs.

a. **Oregon Medical Insurance Program.** The state may claim FFP for expenditures related to the Oregon Medical Insurance Program only for DYs 11 and 12.

b. **Workforce Training.** To promote improved access and quality of care for Medicaid beneficiaries in the state by supporting the development of the health care workforce in the state and to the extent that such education promotes the rate of Medicaid participation among Oregon providers, the state may claim FFP for health workforce training programs and related supports at Oregon Health and Science University (OHSU), Oregon University System (OUS), and community colleges as follows; Blue Mountain, Clatsop, Linn Benton, Rogue, Umpqua, Central Oregon, Columbia Gorge, Mt Hood, Southwestern, Chemeketa, Klamath, Oregon Coast, Tillamook Bay, Clackamas, Lane, Portland, Treasure Valley. The state may only claim FFP for workforce training DSHP programs in DYs 11-13. The annual limit the state may claim FFP for workforce training programs is limited to direct and indirect costs and shall not exceed $69 million in each of DYs 11 and 12 and $40 million in DY 13.

i. **Loan Repayment:** To ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the

State shall commit to funding a primary care provider loan repayment program, with the following conditions:
By July 1, 2013, the state shall establish an annual funding level of $2,000,000 to provide assistance to providers who make written commitments to serving Medicaid populations in rural and underserved areas. If the state is unable to establish funding for this program at the amount specified in this term, the state's Workforce Development state designated health program expenditure authority must be reduced. The DSHP Workforce Development funding must be reduced by 25 percent of the difference between the $2,000,000 and the amount that the state is able to reinstate for the loan repayment program for Demonstration Years 12 and 13.

ii. **Training for Community Health Workers:** The state, through its Community Colleges, shall establish Community Health Worker curriculum that meets the core training elements established by the Oregon Health Policy Board. The state shall train 300 additional Community Health Workers by December 2015.

iii. **Increased Workforce/Provider Capacity.** The state must track the number of Medicaid primary care providers (including nurse practitioners, etc.). The state must submit to CMS within 180 days of the date of the demonstration amendment approval letter, a report detailing the number and types of primary care providers that are currently seeing Medicaid beneficiaries in the state of Oregon. In addition, the state must track where the graduates of these Educational Institutions are working and whether they become Medicaid providers beginning with DY 12 Quarterly and Annual Reports.

c. **Gero-Neuro.** The state may not begin claiming FFP for the Gero-Neuro program until the state begins the process to recertify the facility as an IMD meeting the inpatient hospital requirements as set forth in 42 CFR section 440.140 which include by reference requirements for the hospital conditions of participation at 42 CFR 482. Medicaid and CHIP citizenship rules apply as a condition for receiving FFP.

d. **Other CMS Approved DSHP.** For DYs 11-15, the state may claim FFP for expenditures related to state health programs specified in the "other" category of Table 6 in paragraph 57, subject to a 4.2% reduction on an annual basis. To the extent that the state identifies other programs in this category that support the health care needs of low-income, uninsured Oregonians, the state may submit to CMS for review and approval additional program expenditures for which expenditure authority may be provided. In the event of a shortfall in the "other" category, CMS will consider additional expenditures for OMIP if the state is able to document such expenditures. Additionally, subject to the aggregate annual DSHP limit, the state may exceed the amounts listed in Table 5 for the "other" category only in the event there is a shortfall in the remaining categories. The state must notify CMS in advance of the anticipated shortfall amount by category and the amount of funds to be redirected to either "OMIP" or "other" category. Upon approval, the state may only prospectively claim additional expenditures over the individual limits for OMIP and the "other" category. The state must not exceed the annual aggregate limit. For any additional OMIP or other expenditures, the state must

obtain prior CMS approval for the methodology used to claim any such additional expenditures, subject to the aggregate limit described in Table 5. Once all relevant approvals are obtained, CMS and the State will update the DSHP claiming protocol (Attachment G).

57. **Specified Designated State Health Programs (DSHP).** The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and limits described in section XIII of the STCs.

Table 6.

DSHP
OTHER
Non-Residential Adult (AMH1)
Child and Adolescent (AMH1)
Regional Acute Psychiatric Inpatient (AMH1)
Residential Treatment for Youth (AMH2)
Adult Foster Care (AMH2)
Older/Disabled Adult (AMH2)
Special Projects
Community Crisis
Support Employment (AMH1)
Homeless (AMH1)
Residential Treatment (AMH2)
Non-Residential Adult (Designated)
A & D-Special Projects (AMH3)
A & D Residential Treatment - Adult (AMH4)
Continuum of Care (AMH5)
System of Care (CAF1)
Community Based Sexual Assault (CAF2)
Community Based Domestic Violence (CAF3)
Family Based Services (CAF5)
Foster Care Prevention (CAF6)
Enhanced Supervision (CAF8)
Nursing Assessments (CAF11)
Other Medical (CAF13)
IV-E Waiver (Demo Project for Parenting, mentoring, enhanced supervision)
Personal Care (CAF17)
Oregon Project Independence
SE #150 Family Support (SPD3)
SE #151 Children Long-Term Support (SPD4)
Licensing Fee
General Microbiology

Virology
Chlamydia (PHD4)
Other Test Fees (PHD5)
State Support for Public Health (PHD6)
(Newborn screening OF is used for match for the MCH block grant) (PHD11)
Prescription Drug Monitoring Program (PHD7)
HIV Community Services (PHD8)
General Funds - HST (PHD9)
Sexually Transmitted Diseases
Mental Health Treatment
Drug and Alcohol
Formerly Medically Needy (Organ Transplant) Clients
Workforce Training To Promote Medicaid Provider Participation
Undergraduate and graduate health professions education
OMIP
State Hospitals (OSH and BMRC)
Gero-Neuro

X. TRIBAL HEALTH FACILITY PAYMENT PROGRAM FOR UNCOMPENSATED CARE

Through a tribal health program for uncompensated care, the state shall make supplemental payments to IHS and tribal health facilities operating under ISDEAA 638 authority: 1) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) for uncompensated care costs of primary care services on the prioritized list provided to individuals who have no Medicare, Medicaid, CHIP or other coverage, with incomes up to 133 percent of the Federal Poverty Level (FPL). Beginning January 1, 2014, through December 31, 2014, the state shall only make supplemental payments to these facilities for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan).

58. **Payments to IHS and tribal health facilities.** The state is authorized under expenditure authority of this demonstration to make payments to (IHS) and tribal health facilities subject to the following conditions:

    a. Individuals receiving care at these facilities would continue to receive acute care hospital and specialty care services as they do now through the IHS contract health service referral system. These services are not included for payment under this section.

b. Services will continue to be provided in these tribal health facilities to non-IHS beneficiaries according to the eligibility policy currently set by the IHS or tribal health authorities in accordance with the Indian Health Care Improvement Act.

c. Payment will be based on the approved methodology set forth in Attachment I, Tribal Health Facility Payment Program Claiming Protocol.

d. These payments will expire after December 31, 2014.

XI. GENERAL REPORTING REQUIREMENTS

Effective January 1, 2014, reporting requirements will change to reflect the new eligibility and benefits structure. The state will submit timely requests for amendment of the demonstration, consistent with the Transition Plan required by demonstration paragraph 13, in order to implement the reporting requirement changes by January 1, 2014.

59. **General Financial Requirements.** The state shall comply with all general financial requirements under Title XIX set forth in these STCs.

60. **Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request, including revised budget and allotment neutrality spreadsheets consistent with these STCs.

61. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR Section 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

62. **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, CCO/MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, CCO/MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

63. **Quarterly Progress Reports.** The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter. CMS will provide the format for these reports in consultation with the state. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the OHP demonstration; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative activities, litigation status and other operational issues;

c. Action plans for addressing any policy, administrative, or budget issues identified;

d. Quarterly enrollment reports required under paragraphs 68 and 71; and

e. Evaluation activities and interim findings.

f. FHIAP Reporting inclusive of:

i. **Premium Costs (member share and state subsidy):** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

ii. **Subsidy Costs:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iii. **Enrollee Premium Contributions:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iv. **Employer Contributions:** By subsidy level, with a weighted overall average.

v. **Overall Premium Cost:** For individual and group, with a weighted overall average.

vi. **Overall Subsidy Cost:** For individual and group, with a weighted overall average.

64. **Monitoring To Assure Progress in Meeting Demonstration Goals:** The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the state's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of demonstration goals.

a. **Interim Reporting Format.** The state and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;
ii. Quality Improvement Metrics: Section VII;
iii. Access to Care measures: Section VII;

b. **Timeframe for Reporting.** The state will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.

c. **Data Sources:**
   i. Goal 1:
      1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with state);
      2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;
      3. Total Medicaid service spending per beneficiary; and
      4. CCO provider spending per beneficiary.

   ii. Goal 2:
      1. Benchmarked metrics tied to incentive payments, including patient experience surveys;
      2. Data from the all payer-all claims database;
      3. Process Improvement Projects (PIPs);
         a. EQRO studies;
         b. Complaints and grievances;
         c. Health risk assessment data;
         d. Public health data;
         e. Health risk assessment data;
         f. Meaningful use attestation data;
         g. State CCO monitoring reports; and
         h. Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the duals demonstration.

d. **Final Annual Report:** The state shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The state will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.

e. **Penalty for Late Reporting:**

   i. If the state fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The state may upon such notice provide CMS with information that documents reasons that that a reduction is

unwarranted. In the event of an emergency, such as a natural disaster, that prevents the state from reporting timely, the state can request an exception to these timeframes and penalties.

Percentage withheld of quarterly demonstration administrative funding	Days late
.2	15-30
.4	30-40
.8	41-50
1	51+

65. **Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration covering Medicaid. The draft report is also to include, at a minimum, the following:

    a. **FHIAP activity**: the names of all participating private individual insurance plans and carriers; any changes in participating individual insurance plans and carriers; the number of OHP eligible participants enrolled with each individual insurance plan or carrier; and the amount of premium subsidies paid each individual insurance plan and carrier.

    b. **Premium Assistance Evaluation Related to Cost Effectiveness.** Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the state's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The state provides limited wrap around services.

        i. The state will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:

            1. FHIAP's (populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies); to

            2. OHA direct coverage (populations 1 through 11 in Attachment D) overall pm/pm costs.

        ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in populations 12, 14, 16, 17, and 18 in Attachment D are based on maximum plan out of pocket costs (excluding premium share) to:

1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.[4]

iii. OPHP will monitor program expenditures for HK ESI (population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.

iv. OPHP will report average aggregate cost sharing for HK ESI plans (population 20 in Attachment D) based on maximum plan out of pocket costs (excluding premium share).

v. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

c. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its FHIAP children in the demonstration. DY 12 will be the last year that the state will include the reporting requirements for FHIAP and title XXI.

66. **Beneficiary Survey.** The state shall conduct surveys, at least every other year, of OHP enrollees and providers that assess the following information: enrollee health status; satisfaction with provider communication; and access to routine and specialty care. The surveys will be designed to allow analyses based on CCOs/MCOs and benefit plans. The state will also monitor and report on disenrollment requests and the reasons for the requests.

67. **Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act, and as specified in Section XIV of these STCs.

68. **Enrollment Reporting.**

a. Through the end of the second quarter of FY 2014, each quarter the state will provide CMS with an enrollment report for the title XXI FHIAP population, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30-days after the end of each quarter. The data will be reported for the same groups, categories and in the same manner as the state reports enrollment data for CHIP state plan population as described in Section 457.740 of the CHIP Final Regulation. SEDS reporting is required for any title XXI-funded population, including populations, and is also required for title XIX Medicaid child enrollment.

[4] OHP Plus applies co-pays on an extremely limited basis: none for children, pregnant women, OAA and AB/AD clients with long-term care services, and only limited co-payments for other groups. Thus, they are not likely to provide a fair comparison with FHIAP and ESI cost sharing.

b. Enrollment reporting in the Quarterly and Annual Reports is required by Eligibility Group (EG) and Type for the title XIX and XXI state Plan and populations.

c. Quarterly Enrollment Reports. Within 60-days of the end of the quarter, the state shall provide CMS with an enrollment report by population showing the end of quarter actual and unduplicated enrollment. The state shall also report on the percent change in each category from the previous quarter and from the same quarter of the previous year. The state shall also report the number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

XII. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

69. **Title XIX Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under section 1115 authority and subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIII of these Terms and Conditions.

70. **Reporting Title XIX Demonstration Expenditures.** The following describes the reporting of title XIX expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures**. In order to track expenditures under this demonstration, Oregon must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual.

i. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver.

ii. Year 1 (DY 1) is defined as the year beginning October 1, 2002, and ending September 30, 2003. DY 2 and subsequent DYs are defined accordingly, through DY 9. DY 10 is defined as beginning November 1, 2011 and ending June 30, 2012. Beginning with DY 11, the Year is defined as beginning July 1, 2012 and ending June 30, 2013. DY 12 and subsequent DYs are defined accordingly. To simplify reporting, expenditures from the original Oregon Health Plan demonstration (11-W-00046/0) paid on or after October 1, 2002, shall be considered expenditures under OHP 2, and must not be reported on any Form CMS-64.9 Waiver or 64.9P Waiver for the original Oregon Health Plan demonstration.

iii. Up to and including the July-September 2008, QER, demonstration expenditures are to be reported on Forms CMS-64.9 Waiver and 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) in which payments were made for services.

iv. At the end of the demonstration, expenditures for which payment was made after the last day of the demonstration, but were for services or coverage provided during the demonstration period, are subject to the budget neutrality expenditure limit. These expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the demonstration project number assigned by CMS, with a project number extension equal to the DY number of the last year of the demonstration plus one. For example, if the last year of the demonstration is DY 8, the Forms CMS-64.9 Waiver and/or 64.9 P Waiver discussed here will bear the project number extension 09. The use of the last DY plus one as a project number extension is a reporting convention only, and does not imply any extension of the budget neutrality expenditure limit beyond the last DY.

v. All title XIX service expenditures that are not demonstration expenditures should be reported on the appropriate Forms CMS-64.9 Waiver/64.9P Waiver for another demonstration or waiver, if applicable, or on Forms CMS-64.9 Base/64.9P Base.

b. **Premium and Cost-Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the Eligibility Groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost-settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver schedules, and allocated to forms named for the different EGs described in (e) below, as appropriate. In the calculation of expenditures subject to the budget neutrality

expenditure limit, pharmacy rebate collections applicable to populations shall be offset against expenditures.

e. **Use of Waiver Forms.** The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

   i. "Current": Base 1 EG expenditures;
   ii. "New": Expansion EG expenditures;
   iii. "SSI": Base 2 EG expenditures.
   iv. DSHP Expenditures
   v. CCO Expenditures
   vi. Indian Health Service or tribal health facility expenditures

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to (1) all title XIX expenditures with dates of service between November 1, 2002 and the end of the OHP2 demonstration on behalf of individuals who are enrolled in this demonstration, net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse) and (2) expenditures with dates of service during the original Oregon Health Plan demonstration that are reported as OHP2 expenditures under paragraph 70.a.ii) above. However, certain Title XIX expenditures, as identified in paragraph 18.d.ii), are not subject to the budget neutrality expenditure limit. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit. Nevertheless, the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10 P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) for which the costs were expended.

h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the later 2-year period, the state must continue to separately identify net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 Waiver forms, in order to account for these expenditures properly to determine budget neutrality.

i. **Review of Past Expenditure Reporting and Corrective Action.** The state will conduct a review of title XIX expenditures reported on Form CMS-64 during the approval period for the OHP demonstration to ensure that expenditures subject to the budget neutrality expenditure limit have been reported appropriately, according to the instructions contained in this paragraph. The review will seek to verify that all demonstration expenditures have been reported on Forms CMS-64.9 Waiver, as required by the STCs, and not on any other CMS-64 form, and that no non-demonstration expenditures have been reported on Forms CMS-64.9 Waiver for the demonstration. The review will also ascertain whether demonstration expenditures have been reported under the correct DY. By the end of the second month following the date of approval of this extension, the state will submit a draft plan to the Project Officer for conducting the review, and for taking action to correct past reporting, subject to CMS approval. All corrective actions must be completed by October 31, 2009. At a minimum, the corrective action must result in the expenditures pertaining to the DY ending September 30, 2003 being identified as DY 01 expenditures, and correspondingly for subsequent DY. The state completed this corrective action on November 30, 2009.

71. **Reporting Member Months:** The following describes the reporting of member months for demonstration eligibles from October 1, 2002, forward:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 63 of these STCs, the actual number of eligible member months for all Medicaid and demonstration Member-Month Reporting Groups (MMRGs) defined in the table below. The state must submit a statement accompanying the quarterly report, which certifies the member-month totals are accurate to the best of the state's knowledge. These member month totals should include only persons for whose expenditures the state is receiving matching funds at the Title XIX FMAP rate. The state must also ensure that member-months reported as FHIAP member-months are also not simultaneously reported as direct coverage member-months. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

MMRG	Included Populations	Limitations
Base 1 - Direct Coverage		
AFDC	6	
PLM-A Pregnant Women	1	
PLM Children	3	
BCC Population	21	
Newly eligible adults	23	
Base II Direct Coverage		
OAA	7 (aged only), 8 (aged only)	
Blind/Disabled	7 (blind/disabled only), 8 (blind/disabled only)	
Foster Children	5	

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

72. **Standard Medicaid Funding Process.** The Standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

73. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section entitled "Monitoring Budget Neutrality For The demonstration" of these STCS.

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

    c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

    d. Tribal Health Program for Uncompensated Care to IHS and tribal health facility.

74. **Sources of Non-federal share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

75. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in paragraph 70.

76. **Risk.** Oregon shall be at risk for the per capita cost (as determined by the method described below in this Section) for "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and "Expansion - Parents or Medicaid" population (as defined in paragraph 71(a) reporting of Member Months) enrollees under this budget neutrality agreement, but not for the number of such enrollees. By providing FFP for all "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and Expansion - Parents or Medicaid" enrollees, Oregon shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Oregon at risk for the per capita costs for these enrollees, CMS assures that the fderal demonstration expenditures will reflect Oregon's estimates of savings from managed care, CCO implementation the priority list. Oregon will be at full risk for both enrollment and per capita cost for "Expansion – Childless Adults/Other" eligibles (as defined in paragraph 71(a)). Effective with the implementation of the ACA, these Expansion populations will become mandatory, and Oregon will no longer be at full risk for either enrollment or per capita cost.

77. **Budget Neutrality Ceiling.** The following describes the calculation of the yearly targets mentioned in paragraph 75. This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP through the end of the approval period.

a. The Base 1 Subtotal is calculated by multiplying the actual number of member-months for each "Base 1" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

b. The Expansion Upper Limit is equal to the total number of Base 1 member months times the Oregon Ratio, which is equal to 46.86 percent.

c. Between October 2002, and October 2007, the following rules will govern calculation of the Expansion subtotal.

   i. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is less than the Expansion Upper Limit, then the Expansion Subtotal is calculated by multiplying the actual number of member-months for each Expansion MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

   ii. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is more than the Expansion Upper Limit, the Expansion MMRG totals are adjusted downward by multiplying them by the ratio calculated by dividing the Expansion Upper Limit by the actual total number of Expansion member-months. The adjusted member-month totals are then used in place of the unadjusted totals to calculate the Expansion Subtotal, following (c) above.

d. Beginning November 2007, and thereafter, the Expansion subtotal will be calculated by multiplying the actual number of member-months for each "Expansion - Parents or Medicaid" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together. The Oregon Ratio calculation will no longer be used after October 31, 2007.

e. The Base 2 Subtotal is calculated by multiplying the actual number of member-months for each Base 2 MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

f. The annual limit is calculated as the sum of the Base 1 Subtotal, Expansion Subtotal, and Base 2 Subtotal. The cumulative budget neutrality expenditure limit is equal to the sum of the annual limits over the entire period of the demonstration.

g. The following table gives the projected PMPM costs for the calculations described above.

   i. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
AFDC	$420.74	6.2%	$446.83	$474.53	$504.08
PLM-A Pregnant Women	$1,605.08	6.1%	$1,702.99	$1,806.87	$1,917.16
PLM Children	$613.21	6.2%	$651.23	$691.61	$ 734.70

Individuals receiving treatment under the Breast and Cervical Cancer Medical (BCCTP) program		6.2%	$		$2504.78

ii. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Expansion Parents to 100% FPL	$326.31	6.1%	$346.21	$367.33	$391.86
FHIAP (Medicaid)	$294.48	6.2%	$312.74	$332.13	$352.72

iii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Old Age Assistance	$546.17	5.0%	$573.48	$602.15	$658.53
Blind/Disabled	$1,750.67	5.8%	$1,852.21	$1,959.64	$2179.61
Foster Children	$735.95	6.2%	$781.58	$830.04	$887.03

The following table gives the projected PMPM costs for demonstration years 12 through 15. For DY 12 (July 1, 2013 to June 30, 2014) a blended per member per month was created to account for 4 months of state historical rate and 8 months of 2013 President's budget trend rate.

a. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM 7/1/14-6/30/15	DY 14 PMPM 7/1/15-6/30/16	DY 15 PMPM 7/1/16-6/30/17
AFDC	$529.80	4.5%	$553.83	$578.95	$605.22
PLM-A Pregnant Women	$2018.86	4.9%	$2117.88	$2221.76	$2330.74
PLM Children	$768.80	3.8%	$798.32	$828.98	$860.81
BCCTP	$2631.69	4.5%	$2750.12	$2873.87	$3003.20

i. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Expansion Parents to 100% FPL	$658.53	4.9%			
FHIAP (Medicaid)	$352.72	4.9%			

ii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Old Age Assistance	$721.39	4.1%	$786.23	$855.19	$928.47
Blind/Disabled	$2419.85	5.1%	$2673.57	$2946.88	$3241.11

Foster Children	$934.56	3.8%	$977.06	$1021.43	$1067.77

Beginning 1/1/2014 MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
New mandatory adults	$522.00	7%	$559.88	$600.50	$644.07

78. **Future Adjustments to the Budget Neutrality Expenditure Limit.**

    a. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under OHP. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903 (w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

    b. Should the state submit a state plan amendment to expand coverage, the state must submit written notification to the Project Officer, including a proposal for how the new or expanded eligibility group will be incorporated into the budget neutrality test for OHP.

79. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the composite federal share. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process through an alternative mutually agreed to method.

80. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds shall be returned to CMS.

    a. To perform the budget neutrality test, actual cumulative FFP received by the state on OHP demonstration expenditures are compared to the federal share of the cumulative OHP budget neutrality expenditure limit. The federal Share of the cumulative budget neutrality expenditure limit is equal to the cumulative budget neutrality expenditure limit calculated above (on a total computable basis) times the composite federal share,

which is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by total computable demonstration expenditures for the same period. Actual expenditures are those reported on Form CMS-64, as described in paragraph 70 above. The state may include budget neutrality savings from the original Oregon Health Plan demonstration (11-W-00046/0) in its application of the budget neutrality test for OHP.

b. Should the demonstration be terminated prior to the end of the approval period (see paragraphs 9, 10, and 12, the budget neutrality test (including calculation of the Composite federal share) will be based on the period in which the demonstration was active.

c. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite federal share may be used.

d. Interim Checks/Corrective Action Plan. If the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
DY 9	Cumulative budget neutrality cap plus:	0.25 percent
DY 10	Cumulative budget neutrality cap plus:	0.25 percent
DY 11	Cumulative budget neutrality cap plus:	0 percent
DY 12	Cumulative budget neutrality cap plus:	0.25 percent
DY 13	Cumulative budget neutrality cap plus:	0.25 percent
DY 14	Cumulative budget neutrality cap plus:	0.25 percent
DY 15	Cumulative budget neutrality cap plus:	0 percent

XIV. EVALUATION OF THE DEMONSTRATION

81. **Evaluation Design.** In the 120 days following the date of approval of this demonstration, the state shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the state will consider the Evaluation Guidance in Attachment B. The evaluation will include:

a. A discussion of the demonstration hypotheses that will be tested, focusing on key areas of the state's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional demonstration outcome measures;
b. An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.
c. Any other information pertinent to the state's evaluative or formative research via the demonstration operations.

d. Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;
e. The draft plan shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation; and
f. Any other information pertinent to the state's evaluative or formative research via the demonstration operations
g. An independent interim evaluation of the uncompensated care payments provided to IHS and 638 tribal health facilities as described in 58and Attachment I. The evaluation must test the following specific hypotheses related to the uncompensated care payments:

   i. What is the effect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?
   ii. Are the affected facilities able to maintain and/or increase their current staffing levels?

   Methods by which the state can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

h. The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 (Extension of the Demonstration) and paragraph 82 (Interim Evaluation Reports) should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

   i. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.
   ii. Evaluation of Medicaid denial and termination reasons.
   iii. Evaluation of average application processing times and timeliness.
   iv. Evaluation of reasons for disenrollment and internal churn.
   v. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

82. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of Section 1115 (a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

83. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

84. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

Attachment A - Quarterly Report Guidelines

(updated December 18, 2012)

As written within these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. In particular, the reporting elements may change to take advantage of new reporting via automated data systems that will support the transmission of data through data portals and other electronic reporting channels.

A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided in Appendix D.

REPORT FORMAT

I. Introduction

A. Letter from the State Medicaid Director – overview of the report

B. Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

C. State Contact(s):

1. Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise concerning quarterly reports.

II. Title

Title Line One – Oregon Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 11 (7/1/2012 – 6/30/2013)

Federal Fiscal Quarter: 4/2012 (7/2012 – 9/2012)

III. Events affecting health care delivery during the current quarter

Table 1 – Overview of significant events across the state affecting health care delivery during the current quarter

Table 1 is a statewide overview of the effect, or impact, of changes – positive, negative or with neutral effect – happening in the current quarter that are noteworthy because they reflect trends, major policy modifications or planned or unforeseen occurrences that affect:

- **The demonstration goals** of better health, better care, and lower costs as reflected in measures of efficiency, value and health outcomes;
- **A substantial portion of the delivery system**; or
- **A substantial portion of beneficiaries**.

Each category identifies data sources and whether there is a documented impact on the delivery system or beneficiaries. This table also shows interventions, or actions, the state may take or require to remedy, sustain or improve an outcome, as appropriate.

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
A. Enrollment progress	Quarterly enrollment reports – Appendix A				
B. Benefits	Provider and member transmittals – online at: http://www.dhs.state.or.us/policy/healthplan/transmit/main.htm				
C. CCO Complaints and Grievances	Monthly/quarterly CCO logs submitted to OHA and presented with detail in Table 2				
D. Quality of care – CCO	CCO and Innovator agent reporting to OHA as reported in Table 3 and Appendix F				
D. Quality of care – MCO	MCO reporting to OHA as reported in QI monitoring reports				
D. Quality of care – FFS	OHA FFS reporting				

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
E. Access	CCO and Innovator agent reporting to OHA as reported in Appendix F				
F. Provider Workforce	OHA surveys, summarized in Table 4				
G. CCO networks	CCO and Innovator agent reporting to OHA as summarized in Table 5 and Appendix F				

Detail on impacts or interventions

C. Table 2 – Complaints and grievances – statewide report -- all categories of CCO complaints and grievances for the current quarter

See www.oregon.gov for quarterly reports of complaints and grievances for individual CCOs.

NOTE: Oregon defines a grievance as any written or verbal complaint by an enrollee or consumer, or the enrollee's representative, regarding the enrollee's quality and access of care, individual or system abuse or neglect, issues related to the health plan's compliance with the Medicaid Program rules, billing complaints related to rights and limitations as provided by 42 CFR §438 and complaints related to eligibility and/or enrollment.

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
ELIGIBILITY AND ENROLLMENT					
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.					
b) Plan unresponsive, not available or difficult to contact for appointment or information.					
c) Provider's office too far away, not convenient					
d) Unable to schedule appointment in a timely manner.					
e) Provider's office closed					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
to new patients.					
f) Referral or 2nd opinion denied/refused by provider.					
g) Unable to be seen in a timely manner for urgent/ emergent care					
h) Provider not available to give necessary care					
i) Eligibility issues					
j) Client fired by provider					
INTERACTION WITH PROVIDER OR PLAN					
a) Provider rude or inappropriate comments or behavior					
b) Plan rude or inappropriate comments or behavior					
c) Provider explanation/instruction inadequate/incomplete					
d) Plan explanation/instruction inadequate/incomplete					
e) Wait too long in office before receiving care					
f) Member dignity is not respected					
g) Provider's office or/and provider exhibits language					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
or cultural barriers or lack of cultural sensitivity.					
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity					
i) Lack of coordination among providers					
CONSUMER RIGHTS					
a) Provider's office has a physical barrier					
b) Abuse, physical, mental, psychological					
c) Concern over confidentiality					
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.					
e) No choice of clinician					
f) Fraud and abuse					
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)					
h) Plan bias barrier (age, race, religion, sexual rientation, mental/physical health					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
status)					
i) Differential treatment for Medicaid clients					
j) Lack of adequate or understandable NOA					
k) Not informed of consumer rights					
l) Complaint and appeal process not explained					
m) Denied member access to medical records					
CLINICAL CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.					
b) Testing/assessment insufficient, inadequate or omitted					
c) Medical record documentation issue					
d) Concern about prescriber or medication or medication management issues					
e) Unsanitary environment or equipment					
f) Lack of appropriate individualized setting in treatment					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
QUALITY OF SERVICE					
b) Delay, quality of materials and supplies (DME) or dental					
c) Lack of access to ENCC for intensive care coordination or case management services					
d) Benefits not covered (Right click on drop down for selection)					
CLIENT BILLING ISSUES					
a) Co-pays					
b) Premiums					
c) Billing OHP clients without a signed Agreement to Pay					

Trends related to Grievances and Complaints, to include:

- Rate of complaints and grievances per enrollee
- Rate of complaints and grievances per enrollee using services
- Trends across quarters, including year to date total complaints and grievances with percentages

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

NOTE: Appeals and Contested Case Hearings are based on "actions" or denials, limited authorization, reduction, termination or suspension of services; or when payment is denied for a service that has been provided or a CCO has failed to act within specified timeframes.

	CCO Appeals		Overturned at plan level		Decisions Pending		Contested Case Hearings from CCO Appeals		Overturned at hearing		Decisions Pending	
Category	#	Range	#	Range	#	Range	#	Range	#	Range	#	Range
a) Denial or limited authorization of a requested service												
b) Single PHP service area, denial to obtain services outside the PHP panel												
c) Termination, suspension or reduction of previously authorized covered services												
d) Failure to act within the timeframes provided in § 438.408(b)												
e) Failure to provide services in a timely manner, as defined by the State												

f) Denial of payment for a service rendered												
TOTALS												

Trends (Narrative):

Interventions (Narrative):

D. Table 3 – Summary – Implementation of 1% withhold

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

Metric	Amount(s)	Quarterly	Annually
Encounter data analysis - **Spending in top 25 services by eligibility group and by CCO** - **To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well**		X	X

E. Table 4 – Statewide Workforce development – Non-Traditional Health Workers (NTHW)

	Total Number Certified Statewide* (current quarter & cumulative)	Number of approved training programs (current quarter & cumulative)
Community Health Workers		
Personal Health Navigators		
Peer wellness specialists		
Other NTHW		

* Statewide NTHW registry anticipated to launch in fall of 2013. Quarterly reporting would be reasonable after that point.

Narrative detail on regional distribution of certified NTHWs and NTHW training programs; news about relevant recruitment efforts or challenges

Health professional graduates participating in Medicaid

Tracking method and reporting format in development. Current assumptions are that:

- Tracking and reporting will begin July 2013, per STC 57(b)(iii) and will continue through the period for which FFP is claimed.
- Tracking will include graduates of each health professional training program for which FFP is claimed, within Oregon Health & Science University, the Oregon University System, and select Community Colleges.
- Tracking and reporting will be done by program/professional type (e.g. reporting will distinguish between physicians, nurses, dentists, physical therapists, and so on) and by practitioner specialty to the extent possible.
- These data will be presented in a detailed annual report. Updates will be provided quarterly, as available.

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

Type of Change	Specific change	Effect on delivery system	Effect on members	Number of CCOs affected	Number of CCO members affected
Approval and contracting with new plans					
Changes in CCO/MCO networks					
Rate certifications					
Enrollment/disen-rollment					
CCO/MCO contract compliance					
Relevant financial performance					
Other					

G. Table 6 – Transformation center

Innovator Agents – Summary of promising practices statewide during current quarter

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
Innovator agent training				
Learning Collaborative activities				
Assisting and supporting CCOs with Transformation Plans				
Assist CCOs with target areas of local focus for improvement				
Communications with OHA				
Communications with other Innovator Agents				
Community Advisory Committee activities				
Rapid-cycle Stakeholder feedback to identify and solve barriers; to assist with adapting innovations; to simplify and/or improve rate of adoption and to increase stakeholder engagement				
Data base implementation – Tracking of CCO				

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
questions, issues and resolutions in order to identify systemic issues				
Information sharing with public				
Other				

G. Table 7 – Innovator Agents – – Measures of effectiveness

Measure	Data published for current quarter? Type?	Web link to Innovator Agent quality data
1. Surveys rating IA performance		
2. Data elements (questions, meetings, events) tracked		
3. Innovations adopted		
4. Progress in adopting innovations *		
5. Progress in making improvement based on innovations *		
6. CCO transformation plan implementation		
7. Learning Collaborative effectiveness		
8. Performance on Metrics and Scoring Committee metrics		

* These items will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

H. Legislative activities during current quarter

I. Litigation status

J. 2 percent trend data are reported in Appendix D: This table shows expenditures, including services inside and outside capitation rates for all populations served by CCOs, as well as administrative expenditures and indicates progress in meeting spending growth reduction targets.

K. DSHP terms and status are reported in Appendix E: This table shows new federal funds drawn as match against DSHP programs; new federal funds drawn as a result of DSHP and savings identified in the total cost of purchasing care (as described in STC 48).

IV. Status of Corrective Action Plans (CAP) that address any policy, administrative, or budget issues identified by CMS, the State, or a regulatory entity that impacts the demonstration.

Table 8 – Status of Corrective Action Plans (CAP)

Entity (CCO or MCO)	Purpose and type of CAP	Start date of CAP	Action sought	Progress during current quarter	End date of CAP	Comments

V. Evaluation activities and interim findings

Primarily narrative section focusing on the levers that are expected to drive quality improvement and cost trend reduction under the waiver, and results available to date regarding progress toward demonstration goals.

Reporting and discussion will include both OHA and CCO actions and may make reference to data presented in other sections of the quarterly report or in other documents (e.g. Section III of quarterly report, 2% trend reporting etc.)

Table 9 – Evaluation activities and interim findings

Lever	Report and Discussion
Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient- centered primary care homes (PCPCH)	*Discussion to include any rapid-cycle improvement activities planned as a result of findings, and reports on previous improvement efforts.*
Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes	
Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of	

Lever	Report and Discussion
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 Transformation Center	

Discussion of progress to date on waiver goals: reducing per-member cost growth, and improving quality, access, member experience and health outcomes.

VI. Public Forums – For any public forums held during the quarter**,** include public comment and summary report

VII. Transition Plan, Related to Implementation of the Affordable Care Act (ACA) – Effective 4-1-13 and ongoing, submit state's transition plan on 4-1-13, report and update on changes to or implementation of the plan quarterly, as necessary. The plan will include how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible.

VIII. Appendices

A. Quarterly enrollment reports that report:

1. SEDS
2. State reported enrollment tables
3. Actual and unduplicated enrollment, showing:
   a) The percent change in each category from the previous quarter and from the same quarter of the previous year
   b) The number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

B. Complaints and Grievance reports by sub-categories

C. Neutrality reports:

1. Budget monitoring spreadsheet
2. CHIP allotment neutrality monitoring spreadsheet
3. Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

D. Two percent trend reduction tracking

E. DSHP tracking

F. Oregon Measures Matrix for Quarterly Reporting

IX. Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

The state may also add additional program headings as applicable.

Appendix F: Oregon Measures Matrix

NOTE: Measures with an asterisk (*) are those that are reported quarterly. All others are reported annually.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
Improving behavioral and physical health coordina-tion	*Alcohol or other substance misuse (SBIRT)	√	√			√	MN method** Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplishe d 44% initial screen after 2 years of focused, evidence-based intervention).	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based intervention).			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from predecessor	TBD			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
									organization.				
	*Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available by April 2013.	90% (Note: Benchmark based on Metrics & Scoring Committee consensus).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	90%			
	*Follow-up care for children prescribed ADHD meds	√			√	√	Oregon Medicaid baseline 2011: Initiation:	Medicaid 2012 NCQA National 90th percentile: Initiation:	Individual CCO baselines will be determined with 2011	Medicaid NCQA National 90th percentile:			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	(NQF 0108)						50% C&M: 57%	51% C&M: 63%	data from predecessor organization.	Initiation: 51% C&M: 63%			
Improving perinatal and maternity care	*Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 89%			
	*Prenatal and postpartum care: postpartum			√		√	TBD (baseline data available in	2012 National Medicaid benchmark 75th	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	care rate (NQF 1517)						Feb 2013)	percentile: 90th percentile: 74.7%					
	*PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could also use the 16% rate publically available	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could also use the	5% or below.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
							from Joint Commission - Diane Waldo)		16% rate publically available from Joint Commission - Diane Waldo)				
Reducing preventable re-hospitaliza-tions	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			
	*Ambulatory	√	√		√	√	TBD (baseline	TBD	MN method	2011 National Medicaid 90th			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	Care: Outpatient and ED utilization						data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	percentile (ED utilization): 44.4/1,000mm			
	*All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a			
Ensuring appropriate care is delivered in appropriate	*Ambulatory Care: Outpatient and	√	√		√	√	TBD (baseline data available in	TBD 2011 National Medicaid 90th	MN method with 3% floor. Individual CCO	2011 National Medicaid 90th percentile (ED utilization):			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
settings	ED utilization						Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	percentile (ED utilization): 44.1 / 1,000 mm	baselines will be determined with 2011 data from predecessor organization.	44.4/1,000mm			
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5 year period based on trends in Medicare and Commercial data).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor	2012 National commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile:			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
									organization.	61.34 (Based on Metrics & Scoring Committee consensus)			
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	*Developmen-tal screening in the first 36 months of life (NQF 1448)	√	√		√	√	Oregon baseline: 19.6% using admin data only.	50% (Metrics & Scoring Committee consensus)	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	50% (Metrics & Scoring Committee consensus)			
	*Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								77.3%					
	*Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile: 56.9%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 75th percentile: 56.9%			
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								90th percentile: 27.5%					
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a			
	Appropriate testing for children with pharyngitis (NQF 0002)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								90th percentile: 83.9%					
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed or recommen	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
							ded medication s with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)						
Deploying care teams to improve care and reduce	*Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013)	TBD 2011 National Medicaid 90th percentile	MN method with 3% floor. Individual CCO baselines will	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
preventable of unnecessarily costly utilization by super users							ED utilization baseline (2011): 56 / 1,000 mm	(ED utilization): 44.1 / 1,000 mm	be determined with 2011 data from predecessor organization.				
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%			
	*Comprehen-sive diabetes care: LDL-C			√		√	TBD (baseline data	2012 National Medicaid	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
coordinating a broad set of resources, including CHW.	Screening (NQF 0063)						available in Feb 2013)	benchmark 75th percentile: 90th percentile: 83.5%					
	*Comprehen-sive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 91.1%	n/a	n/a			
	Diabetes: HbA1c Poor Control (NQF	√				√	TBD (baseline data	Pick percentile	MN method. Individual	Pick percentile NCQA National			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	0059)						available in Feb 2013)	NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile: 28% 75th percentile: 34%			
	*PQI 01: Diabetes, short term complication admission rate (NQF 0272)		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
	*PQI 05:		√	√		√	416.9	10% reduction	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	Chronic obstructive pulmonary disease admission (NQF 0275)						(2011)	from baseline Benchmark set based on Oregon's data (2002-2011)					
	*PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
	*PQI 15: Adult asthma admission rate		√	√		√	178.7 (2011)	10% reduction from baseline	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	(NQF 0283)							Benchmark set based on Oregon's data (2002-2011)					
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	**Access to Care** OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentil	**Access to Care** OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%			
	CAHPS 4.0H (child version including Medicaid and children with	√	√		√	√							

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	chronic conditions supplemental items).							e: 90.31% National average: 86.97%					
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 72.7%	n/a	n/a			
	*Cervical cancer			√		√	TBD (baseline data	2012 National Medicaid	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	screening (NQF 0032)						available in Feb 2013)	benchmark 75th percentile: 90th percentile: 78.5%					
	*Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a			
	Provider Access Questions from the Physician Workforce Survey:					√	In 2009: 52.4% of Oregon's physicians accepted	TBD	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	1) To what extent is your primary practice accepting new Medicaid/ OHP patients? (include: completely closed, open with limitations, and no limitations) . 2) Do you						new Medicaid patients without limitations; 29.7% accepted with some limitations; and 17.9% were completely closed. 84% of physicians have Medicaid patients. The						

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	currently have Medicaid/ OHP patients under your care? 3) What is the current payer mix at your primary practice?						statewide payer mix for Medicaid is 15%.						
	Screening for depression and follow up plan (see above)												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	*SBIRT (see above)												
	*Mental and physical health assessment for children in DHS custody (see above)												
	*Follow-up care for children on ADHD medication (see above)												
	*Timeliness of												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	prenatal care (see above)												
	Colorectal cancer screening (see above)												
	PCPCH enrollment (see above)												
	*Developmen-tal screening by 36 months (see above)												
	*Adolescent well child visits (see above)												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
Meaningful Use	EHR adoption (Meaningful Use 3 question composite)	√				√	TBD (Baseline data available in April 2013)	TBD	TBD (Baseline data available in April 2013)	TBD			

* These measures are reported quarterly

**The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Attachment B – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS requires states with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; states, federal government, and individuals benefit from state conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to state and federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should states have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and
    - Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
    - Hypothesis or research questions to be investigated;
    - Goals, such as:
        - Increase Access
        - Impact of title XXI cost sharing waiver for children in premium assistance
        - Cost Effectiveness
        - Improve Care Coordination
        - Increase Family Satisfaction and Stability
    - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
    - The type of research design(s) to be included -
        - Pre/Post Methodology
        - Quasi-Experimental
        - Experimental
    - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
    - Enrollment and outreach records;
    - Medicaid claims data;
    - Vital statistics data;
    - Provide record reviews;
    - School record reviews; and
    - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
    - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
    - How findings will be incorporated into outreach, enrollment and education activities;
    - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
    - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the state and/or relevance to nuances of the demonstration intervention.

ATTACHMENT C
Glossary of Terms Related to title XIX and XXI funded Children

Effective with the implementation of the ACA, changes to the demonstration will require revision of the Glossary.

Exhibit 1: Glossary of Terms Related to title XIX and XXI funded Children

- **Healthy Kids*:*** Created by House Bill 2116 during Oregon's 2009 Legislative Session, *Healthy Kids* provides coverage for all uninsured children up to age 19 in the state. The plan offers comprehensive health care coverage that includes dental, vision, mental health and physical health care. The objective of *Healthy Kids* is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. *Healthy Kids* includes three different program components:

    1. Existing CHIP and Medicaid direct coverage (OHP Plus);

    2. Premium assistance administered by the Office of Private Health Partnerships (family coverage under FHIAP for children up to and including 200 percent of FPL, and Healthy Kids ESI child only premium assistance for kids up to and including 300 percent of FPL;

    3. A private insurance component, Healthy KidsConnect, which is provided under the CHIP state plan.

  The federal government will provide match for children up to and including 300 percent of the FPL. The state will also permit uninsured children above 300 percent of the FPL to purchase the plan under Healthy KidsConnect without state or federal match.

- **Family Health Insurance Assistance Program (FHIAP) for Families Enrolled in ESI or Individual Market:** The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA) administers FHIAP. The premium assistance program provides subsidies to help families and individuals pay for health insurance offered either through employer-sponsored insurance (ESI) or private health insurance carriers. Coverage provided by the insurance plans must meet or exceed the FHIAP benchmark criteria, which is approved at a level actuarially equivalent to federally mandated Medicaid benefits.

As of January 1, 2014: 1) Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP or Healthy Kids ESI components of this demonstration rather than enroll in the Medicaid or CHIP state plan, and 2) Parents and childless adults enrolled in FHIAP with income from 0 up to 133 percent of the FPL, will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP state plans. Individuals currently receiving premium assistance who, based on an initial screening evaluation, do not appear to be eligible under

the approved Medicaid or CHIP state plans will be afforded a full eligibility determination prior to termination. Individuals denied continued benefits will be offered the opportunity to have their information electronically transmitted to the state Affordable Insurance Exchange (Exchange) to be treated as an application for coverage and benefits through the Exchange.

- **Premium Assistance for children and families with incomes from zero up to and including 200 percent of FPL:** Subsidies are available to children in this income category through FHIAP or Healthy Kids ESI. Children determined eligible by DHS or OHA are referred to OPHP for enrollment and subsidy payment or go directly to OPHP and on the FHIAP reservation list. FHIAP pays premium subsidies ranging from 50 to 95 percent for adults. Both FHIAP and Healthy Kids ESI pay100 percent of the premium for children in this income group. Individuals (adults and children) who enroll in this program are subject to all other cost sharing provisions of the insurance plan. The children in this income group have the option of enrolling in FHIAP, Healthy Kids ESI, or CHIP direct coverage (OHP Plus), and children who choose FHIAP or Healthy Kids ESI can move back to state plan direct coverage at any time.

- **Healthy Kids ESI/Child Only Premium Assistance and Healthy KidsConnect for children in families with incomes above 200 up to and including 300 percent of FPL who have access to ESI:** Subsidies are available to children in this income category through ESI or the state's private insurance option, Healthy KidsConnect. Children in families with incomes above 200 percent FPL are not eligible for CHIP direct coverage (OHP Plus). Sliding scale subsidies are available for children who are able to enroll in the family's ESI.
    - Families with incomes above 200 up to and including 250 percent of FPL will receive state subsidies equaling about 90 percent of the child's monthly premium.
    - Families with incomes above 250 up to and including 300 percent of the FPL will receive state subsidies equaling about 80 percent of the child's monthly premium.
    - All other cost-sharing is subject to the cost of the employer plan.

- **Healthy KidsConnect:** This is a CHIP state plan direct coverage option provided under the state's separate child health program. Sliding scale subsidies are available to children who enroll in state-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP direct coverage (OHP Plus) benefit package.

- Families with incomes above 200 percent up to and including 250 percent of FPL will receive state subsidies equaling about 90 percent of the child's monthly premium; and
- Families with incomes above 250 percent up to and including 300 percent of the FPL will receive state subsidies equaling about 80 percent of the child's monthly premium.
- Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.

- **Oregon Health Plan (OHP) Plus:** OHP Plus is a CHIP state plan direct coverage option provided under the state's separate child health program. The state provides Secretary-approved coverage that is the same as coverage offered under the state's Medicaid program. The state's benefit package is based on the OHP Prioritized List of Health Services, which is a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration for its entire Medicaid population. Medically necessary services are defined in the Prioritized List. The benefit package includes mandatory services for children, including well-baby and well-child visits, immunizations and dental services. There are no premiums, co-payments, or deductibles for children in direct coverage.

- **FHIAP Reservation List:** Oregon uses reservation lists to manage enrollment in the premium assistance program. Only FHIAP-eligible families with income from 0 up to and including 200 percent of the FPL are subject to the reservation list.

  As of January 1, 2014 the FHIAP reservation list will no longer be applicable. Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP component of this demonstration rather than enroll in the Medicaid or CHIP state plan, and parents and childless adults enrolled in FHIAP with income below 133 percent of the FPL will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP state plans.

  - **The individual reservation list** is for applicants who do not have access to ESI.
    - Once approved, individuals may select an individual health plan from a list of approved FHIAP insurers.
    - Only plans that meet FHIAP's benchmark are offered to individual members.

  - **The group reservation list** is for applicants who have access to ESI.
    - ESI plans must meet FHIAP's benchmark.

Attachment D - Summary Chart of Populations Affected by or Eligible Under the Demonstration

ACA Implementation. As set forth in paragraph 13 and upon implementation of the ACA on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII) of the Act and the collapsing of certain eligibility groups will revert to the Medicaid state plan.

I. Mandatory Medicaid Populations*							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
1	Pregnant Women	Title XIX	Title XIX state planstate plan and section 1115	Effective through December 31, 2013: 0% up to 133% FPL Effective January 1, 2014: 0% up to 185% FPL	None	OHP Plus	Base 1
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL** Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus	Base 1
4	Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	Effective through December 31, 2013: 0% up to 100% FPL Effective January 1, 2014: this	None	OHP Plus	Base 1

				population will be combined with population 3			
5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus	Base 2
6	Medicaid mandatory section 1931 low0income families. (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX	Title XIX state plan and Section 1115	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus	Base 2
21	Uninsured or underinsured women under the age of 65	Title XIX	Title XIX	0% up to 250% FPL	None	Limited – case-by-case basis	Base 1
23	Low-Income Expansion Adults	Title XIX	Title XIX	0% up to 133% FPL	None	ABP	Base 2

II. Optional Medicaid Populations* **							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
8	Aged, Blind, & Disabled	Title XIX	Section 1115 and Title XIX state plan	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus	Base 2

2	Pregnant Women	Title XIX	Section 1115 and Title XIX state plan	Effective through December 31, 2014: From 133% up to 185% FPL Beginning January 1, 2014, this group will be covered through population 1	None	OHP Plus	Base 1

**Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the state also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by federal regulations, since the state has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL.
***Optional Medicaid (OHP Plus) populations have the option of choosing FHIAP, in which case they would be in Population 14.
**** Unborn population is precluded from receiving the following services: abortion, death with dignity, sterilization, hospice services and postpartum services beyond the global rate

Attachment E: Menu Set of Quality Improvement in Focus Areas

The measures in bold would be the core measures for each focus area and would be required of any CCO selecting that focus area.[5] The purpose for these focus areas is to reduce costly, inappropriate, and unnecessary care where possible without decreasing the quality of care. The state may wish to add to this menu to account for how they will measure access and quality for individuals receiving care FFS—this should include populations receiving costly long term care and supportive services.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
1) Reducing rehospitalizations	**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 rehospitalizations and/or incentives for low rates (must remove the financial incentive to rehospitalize through incentives and penalties), care transition programs. Also see "super-utilizers" interventions
2) Addressing discrete 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	These will vary depending on issue identified, but could include disease specific measures such as Diabetes Care measure, pediatric asthma hospitalization	Ideally these would include a wide range of activities by multiple entities such as pediatric community based asthma initiatives, enhanced by coordinated public health interventions to target tobacco cessation. Clinical diabetes care initiatives can dovetail with public health interventions such as outreach programs and community based obesity reduction programs
Reducing utilization by "super-utilizers"	Cost of care measures (total cost of care per patient over	Community-based outreach programs to better address

[5] The rest of the measurement strategy will be determined later but sample additional measures are included for discussion purposes.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	specific time period), and the **readmissions measures mentioned above, rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; and outpatient and ED utilization**	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 superutilizers. Oregon's proposal includes pieces of these, including community health workers to help beneficiaries navigate the system and access resources; coordination with long-term care case workers and providers for individuals receiving long-term care and/or developmental disabilities supports and services; CCO efforts to integrate information flow across providers. It is critical these services are appropriately targeted
Integrating primary care and 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 health assessment for children in DHS custody, mean cost for outpatient mental health and medications per patient; mean cost for inpatient	Global budget and single point of accountability for behavioral and physical 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

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	mental health and substance abuse care per patient	
Ensuring appropriate care is delivered in appropriate settings	**Rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization,** Hospital readmissions (across age groups); Plan all-cause readmissions, primary care access measures	Narcotics registries, programs to address "super-utilizers", targeted case management for frequent ED users, connect vulnerable patients with appropriate behavioral health and social services
Improving perinatal and maternity care	**Early elective delivery before 39 weeks**, 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
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, BMI recorded (and appropriate counseling), drug-to-drug and drug allergy checks, and maintain active	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 EHR adoption and meaningful use; PCMH participation incentives; shared incentives across primary, specialty, long-term, and acute care; improved access (e.g., after-hours physician availability, 24/7 access to an NP or doctor); PHRs; open-access scheduling and sick hours.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	medication list (including allergies)	

Attachment F: CCO Services Inventory
(updated January 1, 2014)

This attachment provides the schedule for inclusion of new services into CCO global budgets and reflects OHA's planning as of December 2012. Oregon will notify CMS if contract amendment schedule is revised.

Pursuant to STC 36b, the inclusion of additional services in the global budget will be mutually agreed upon by the state and CMS and phased in over the course of the demonstration. Oregon will submit proposed changes to the Regional Office as part of draft CCO contracts or contract amendments at least 45 days in advance of their effective date. Services outlined in Attachment F will generally be included in CCO global budgets as capitated services. For any services not paid as capitation, the state will identify the rate (referencing the state plan methodology or describing the rate methodology to CMS) and the rates will be subject to CMS review and approval.

				Per Capita Trend Monitoring					**Per Capita Trend Monitoring**	
	Program Area	**Program/Service/Function**	August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
1	Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	X						Yes	Yes
2	Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities)	X						Yes	Yes
3	Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	X						Yes	Yes
4	Mental Health	Children's Statewide Wraparound Projects	X						Yes	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
5	Mental Health	Exceptional Needs Care Coordinators	X						Yes	Yes
6	Mental Health	Non-forensic intensive treatment services for children(Inpatient Psychiatric Facility Services for Individuals Under age 21)	X						Yes	Yes
7	Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	X						Yes	Yes
8	Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	X						Yes	Yes
9	Mental Health	Supported Employment and Assertive Community Treatment		X					Yes	Yes
10	Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating	X				Yes	Yes
11	Addictions	Youth residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X				Yes	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
12	Addictions	Adult residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X				Yes	Yes
13	Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating			X		Yes	Yes
14	Targeted Case Management	HIV/AIDS Targeted Case Management					X		Yes	Yes
15	Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon					X		Yes	Yes
16	Maternity Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)		Optional where currently operating	X				Yes	Yes
17	Transportation	Non-Emergent Medical Transportation			X Pilot	X Partial Phase-in	X Complete		Yes	Yes
18	Mental Health	Adult Residential Mental Health Services					X		Yes	Yes
19	Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						X	Yes	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
20	Dental	OHP dental coverage	Optional	Optional	Optional		X		Yes	Yes
21	Mental Health	Young Adults in Transition Mental Health Residential			X				Yes	Yes
22	Mental Health	Personal Care 20 Client Employed Provider						X	Yes	Yes
23	Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)						X	No	Yes
24	Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)						X	No	Yes
25	Long Term Care	Long term care institutional and community supports						X	No	Yes
26	Mental Health	State Hospital Care - Forensic						X	No	Yes
27	Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations				X			No	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
28	Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)						X	No	Yes
29	Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB						X	No	Yes
30	Mental Health	OHP-covered mental health drugs						X	No	Yes
31	Other	Hospital Leverages: GME, Pro-Share, and UMG						X	No	Yes
32	Other	FQHC Full-Cost Settlements						X	No	Yes
33	Other	A & B Hospital Facilities Settlements						X	No	Yes
34	Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)						X	No	Yes

	Program Area	Program/Service/Function		Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014	July 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
35	Targeted Case Management	Child Welfare Youth (Targeted Case Management)						X	No	Yes
36	Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)						X	No	Yes
37	Targeted Case Management	Tribal Targeted Case Management						X	No	Yes
38	Other	DSH						X	No	Yes
		Note: All services are state plan services with the overlay of the Section 1915(b) waiver for transportation and the Section 1115 demonstration that includes application of the Prioritized List of Health Services.								

Attachment G

Reimbursement and Claiming Protocol for Oregon Designated State Health Programs
Determination of Allowable DSHP Costs Per Waivers 21-W-00013/10 and 11-W-00160/10

Acronyms:

A & D – Alcohol and Drug
APD – Adults and People with Disabilities (formerly SPD)
AMH – Addictions & Mental Health
CAF – Children, Adults, and Families
CPMS – Client Process Monitoring System
DMAP – Division of Medical Assistance Programs
DSHP – Designated State Health Programs
eXPRS – Express Payment and Reporting System
OSPHL – Oregon State Public Health Lab
OMIP – Oregon Medical Insurance Pool
PHD – Public Health Division
SFMA – Statewide Financial Management System
SPD – Seniors and People with Disabilities

To support the goals of health system transformation, the state may claim federal Financial Participation (FFP) for the following state programs subject to the annual limits and restrictions described in the Standard Terms and Conditions (STCs) # 55 -58 of Oregon's Health Transformation Waivers 21-W-00013/10 and 11-W-00160/10 through June 30, 2017. This attachment contains the protocol for such determination of cost.

Office of Management and Budget (OMB) Circular A-87 (2 CFR Part 225), Cost Principles for state, Local and Indian Tribal Governments, section C.4. requires federal grants be provided net of any applicable credits. The state is required to offset all revenues received relating to eligible expenditures identified under this attachment.

For purposes of this protocol, CMS will recognize as allowable costs under this demonstration the total amounts expended by the state without reduction to FFP to reflect revenues in the form of premiums and tuition paid by program enrollees that might be otherwise treated as applicable credits. This exception is only available for approved expenditures associated with the Oregon Medical Insurance Pool through June 30, 2014, and for approved education expenditures associated with for Workforce Training at the State of Oregon's public colleges and universities through June 30, 2015.

All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval. CMS may review at any time the sources of the non-federal share of funding for the emonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding. For purposes of expenditures claimed under this protocol, the state cannot utilize provider-related donations as a source of the non-federal share.

Below are descriptions of each DSHP program that was approved under waivers 21-W-00013/10 and 11-W-00160/10. The following programs have been arranged based on program groups.

PROGRAM GROUP: AMH—Addictions and Mental Health

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the AMH non-contract program group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the tate in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure.

For each program in this group that involves contractual services, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual services delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the AMH Contractual Services Program Group is R-Base.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the AMH R-Base data base system (R-Base), a contract database subsidiary system for accounting data to the SMFA accounting system, the official 'book-of-record' for the state. The R-Base system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state Funds only will be so identified. Coding tables in R-Base are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. Data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

<u>Program: Mental Health (MH) Non-Residential Adult Services</u>

- **Brief Description:** MH services delivered to persons diagnosed with serious mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. The following services are provided via this program:

  - Vocational and social services
  - Medication and medication monitoring
  - Counseling for emotional support
  - Individual/family and group counseling and therapy
  - Support to locate and obtain housing
  - Coordination of care services

  Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Adults 18 years or older with serious mental illness who do not qualify for Medicaid.

<u>Program: MH Children and Adolescent</u>

- **Brief Description:** Mental health services for children and adolescents with primary mental, emotional or behavioral conditions. The following services are provided via this program:

  - Provision of screening
  - Assessment and Level of Service Intensity
  - Referral and care coordination services
  - Skills training

- Crisis planning
- Respite care
- In-home support.

Services may be delivered, as appropriate, in a clinic, home, school or other settings familiar and comfortable for the individual receiving such services. Other settings may be aftercare/daycare, county case manager office, mental health clinic, and primary care clinic.

Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Individuals under age 18 who have primary mental, emotional or behavioral conditions and are not eligible for Medicaid.

Program: MH Regional Acute Psychiatric Inpatient

- **Brief Description:** Stabilize, control or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the individual to a less restrictive environment. The following services are provided via this program:

  - Ancillary services such as regional coordination and enhancements to County, Community Mental Health Program (CMHP) ; treatment plan development that include identification of goals, strengths, target behaviors, methods for change; coordination of care, evidence-based interventions with families, advocates, representatives of community agencies; and medication management; individual and group therapy that addresses issues identified in the treatment plan.
  - Services that serve to expedite the movement (including secure transportation) of individuals into and out of facilities where inpatient psychiatric services are delivered and to divert persons from acute care services, collaboration with families, parenting support, crisis planning, skills training for client and family members, continuum of care plan to move client to less restrictive settings.

- **Eligible Populations:** Individuals in need of inpatient psychiatric services who are uninsured and/or indigent and are not eligible for Medicaid. These are individuals who suffer from an acute mental illness, or other mental or emotional disturbance posing a danger to the health and safety of the individual or others.

Program: MH Residential Treatment for Youth

- **Brief Description:** Services for individuals needing continued long-term services to avoid hospitalization. The following treatment services are provided via this program:

  - Medication and Medication monitoring supervision)
  - Vocational and social services
  - Individual and family group counseling
  - Counseling emotional support
  - Coordination of care services
  - Services delivered on a 24-hour basis.

Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Residential Treatment for Youth: Young adults through age 25 who are eligible, under ongoing review of the jurisdiction of the Juvenile Psychiatric Review Board or in the Youth and Young Adult in Transition Program, with mental or emotional disorders who

have been hospitalized or are at immediate risk of hospitalization, who need continuing services to avoid hospitalization or who are a danger to themselves or others or who otherwise require long-term care to remain in the community. These individuals are not eligible for Medicaid.

Program: MH Adult Foster Care

- **Brief Description:** This program includes continuing services, including ongoing supervision, which are provided to adults to avoid higher level services or hospitalization. The following services are provided via this program:
    - Clinical assessment
    - Develop individual plan of care that addresses clients MH diagnosis
    - In-home case management
    - Counseling (individual and family group)
    - Coordination of care services
    - Skill training
    - Transition support to move to the next step to independent living.
    - These services are delivered in family home or facility.

- **Eligible Population:** Adults 18 years old or older who are in need of continuing services to avoid hospitalization, or who have been hospitalized, or who pose a danger to the health and safety of themselves or others, and who are unable to live by themselves without supervision. These individuals are not eligible for Medicaid.

Program: MH Older and Disabled Adults

- **Brief Description:** This program includes specialized geriatric mental health services delivered to older and disabled adults with mental illness. The following services are provided via this program:
    - MH services
    - Medication management
    - Follow-up services.
    - Medical condition follow-up (many of these clients have ongoing medical conditions).
    - Coordination of care

- **Eligible Populations:** Older and disabled adults with mental illness needing mental health services. These individuals are not eligible for Medicaid.

Program: MH Special Projects

- **Brief Description:** These are projects that provide enhanced services, services to enable service delivery expansion, peer delivered services, and, educational and employment support services. The following services are provided via this program:
    - Peer delivered services (PDS): is the social, emotional and instrumental support offered or provided by persons with a mental health condition, to others who share a similar mental health condition in order to bring about a desired social or personal change. This overall service includes an array of agency or community-based services and supports provided by peers and peer support specialists.

Included is assistance for people with Serious Mental Illness (SEMI) to meet their education and/or recovery goals and/or become gainfully employed through the education and training acquired during postsecondary education.
    - Skill training
    - Counseling for emotional support
    - Community integration
    - Crisis support

- **Eligible Population:** Adults and Children with mental illness in unique condition situations who need special mental health services. These individuals are not eligible for Medicaid.

Program: MH Community Crisis

- **Brief Description:** This program provides immediate MH crisis intervention (24/7) and assessment; triage and intervention services (psychological treatment services and crisis counseling services) delivered to individuals experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. This program also includes the following psych services which can be rendered at a hospital or a non-hospital facility. Services are of limited duration and are intended to stabilize the individual and prevent further serious deterioration in the individual's mental status or mental health condition.

- **Eligible Population:** Adults and Children in a crisis situation who are not eligible for Medicaid.

Program: MH Support Employment

- **Brief Description:** This program includes the following services which are delivered to individuals to enable them to obtain and maintain employment:

    - Supervision and job training
    - On-the-job visitation
    - Consultation with the employer
    - Job coaching
    - Counseling
    - Skills training
    - Transportation
    - Transitional employment services: On-the-job skills development for the next level—to obtain a better job, job counseling.

- **Eligible Population:** Individuals 18 years or older with chronic mental illness needing to obtain and maintain employment. These individuals receive non-residential adult services and need evidence-based supported employment services. These individuals are not eligible for Medicaid.

Program: MH & Alcohol and Drug (A & D) Homeless

- **Brief Description:** This program provides transitional services to a supported environment, i.e., treatments services, housing/living environments that maintain and reinforce the client's recovery efforts. This program provides a broad range of transition services that include:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation and rehabilitation services
- Community MH services, A&D treatment services
- Staff training
- Case management services
- supportive and supervisory services in residential settings
- Referrals for primary health services
- Job training
- Educational services
- relevant housing assistance services (locating and securing housing)

Room and board is not considered in the amounts that will be claimed for this program

- **Eligible Population:** Individuals with serious mental illness that may have co-occurring substance abuse use disorders and who are homeless or at risk of being homeless. These individuals are not eligible for Medicaid.

Program: MH Residential Treatment for Adults

- **Brief Description:** This program includes crisis stabilization and intervention services, including:

  - Behavior management
  - Daily living activity coordination
  - Crisis stabilization services
  - Crisis intervention services
  - Residential treatment services determined upon individualized assessment of treatment needs and development of plan of care
  - Management of personal money and expenses
  - Supervision of daily living activities
  - Life skills training
  - Administration and supervision of medication
  - Provision or arrangement of transportation
  - Management of behavior
  - Diet management.

- Services are delivered on a 24-hour basis to individuals who need continuing services to remain in the community and to avoid higher levels of services or hospitalization or who are a danger to themselves or others or who otherwise require continuing care to remain in the community.

  Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Adults 18 years or older who are determined unable to live independently without supervised intervention, training or support, and who do not qualify for Medicaid.

Program: MH Non-Residential, Designated

- **Brief Description:** These individuals in this program have low frequency, high intensity needs above the standard non-residential structure. Services include:

    - Vocational and social services
    - Support to obtain and maintain housing (locating and securing housing)
    - Medication and medication monitoring
    - Emotional support
    - Individual, family and group counseling and therapy
    - Case management services

- **Eligible Population:** Adults 18 years old or older, who are uninsured needing mental health services delivered to designated persons (adults) diagnosed with serious, chronic mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. These individuals are not eligible for Medicaid.

Program: A & D Special Projects

- **Brief Description: This program includes the following** treatment enhancement activities:

    - Early screening and assessment for alcohol and drug problems
    - Facilitation of collaboration between schools and partner agencies in developing and maintaining screening and referral processes
    - Outreach
    - Case management

- **Eligible Population:** Youth at high risk of problems with alcohol and drugs and their families. These are Non-Oregon Health Plan individuals or may pay for services not provided by OHP. This program is specifically designed for families at risk of Temporary Assistance for Needy Families (TANF) involvement or in the TANF program.

Program: A & D Residential Treatment, Adults

- **Brief Description:** This service is to support, stabilize and rehabilitate individuals and to permit them to return to independent community living. Services provide a structured environment for an individual on a 24-hour basis consistent with chemical dependency placement, continued stay and discharge criteria Level III-services (twenty-four hour supervision is needed using a structured 7-day-a-week therapeutic environment to achieve rehabilitation). The services within this program address the needs of diverse population groups within the community. This program helps people stabilize physically and mentally so they are able to transition to a lower level of care including self-directed recovery management.

- **Eligible Population:** Individuals 18 years of age or older who are unable to live independently in the community and cannot maintain even a short period of abstinence and are in need of 24-hour supervision, treatment and care. These individuals are for non-OHP eligible and must be indigent status with income at 100 percent or lower of the federal Poverty Level (FPL). These individuals are not eligible for Medicaid.

Program: A & D Continuum of Care

- **Brief Description:** This program provides outpatient substance abuse disorder treatment including medication-assisted treatment (primarily methadone). This program also includes non-hospital detoxification, case management and wrap around services such as:

    - Peer mentoring
    - Child care
    - Transportation
    - Relapse prevention
    - Healthy eating and wellness counseling
    - Connection to social support groups

    Services build upon resilience, assisting individuals to make healthier lifestyle choices and to promote recovery from substance use disorders. Services consist of case management, clinical care and continuing care delivered when therapeutically necessary and consistent with the developmental and clinical needs of the individual, Level I (Outpatient), Level II (Intensive Outpatient), Level III (Non-medical Detoxification, and Intensive Treatment and Recovery Services).

- **Eligible Population:** Services delivered to youth and adults with substance use disorders. These are individuals who are indigent with no OHP or insurance coverage. These individual are not eligible for Medicaid.

PROGRAM GROUP: Children, Adults and Families (CAF)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the CAF program group is Oregon Kids System (OR-KIDS).
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the OR-KIDS, an interface sub-system for accounting data to the state accounting system official 'book-of-record' SFMA. The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the OR-KIDS system as they are then authorized for service payments to providers providing the designated client care services. The system checks the client eligibility status then matches to the appropriate fund source based on the client eligibility status. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state funds only will be so identified. Only those services funded with state funds only are allowable for DSHP match. Coding tables in OR-KIDS, are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: System of Care

- **Brief Description:** This program consists of purchased services provided to meet the individualized needs of children and parents involved with Child Welfare. This program is only applicable to services not rendered by any other state program. The following services are provided via this program:
  - Wrap-around planning services
  - Healthcare services for uninsured parents

- **Eligible Population:** Children and families being served by Child Welfare where caseworkers have identified needs for supports and services unmet by any other state resource.

Program: Community Based Sexual Assault

- **Brief Description:** This program consists of contracted services for Sexual Assault Counselors to provide counseling and support services to victims of sexual assault.
- **Eligible Population:** Victims of sexual assault who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Community-based Domestic Violence

- **Brief Description:** This program consists of contracted services for Domestic Violence Advocates to provide support and treatment services to victims of Domestic Violence.
- **Eligible Population:** Victims of domestic violence brought to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Family Based Services

- **Brief Description:** This program consists of services to provide in-home safety and reunification services. As a result of this program, families remain together while safety supervision and parenting support/coaching are provided. Services include:
    - Parent training
    - Therapeutic support
    - Supportive remedial day care.
- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Foster Care Prevention

- **Brief Description:** This program consists of Child Welfare services for families with children at risk of out-of-home placement. The following services are provided via this program:
    - Therapeutic supports
    - In-home case management
    - Counselling
    - Referrals to families to help them transform their lives.
- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Enhanced Supervision

- **Brief Description: This program consists of** one-on-one supervision services to children in out-of-home care to assure their safety or the safety of those around them. These are children that have emotional, behavioral or medical issues. This program involves assessment services to identify services needed, and the supervision of the process by which the client receives those services.

- **Eligible Population:** Children placed in out-of-home care due to allegations of abuse and/or neglect requiring additional supervision to assure safety.

Program: Nursing Assessments

- **Brief Description:** This program involves Individualized assessments provided by a Registered Nurse to determine the need for Personal Care services to be provided to a child in an out-of-home care setting.
- El**igible Population:** Children placed in out-of-home care that may have medical needs requiring ongoing care in a home setting.

Program: Other Medical

- **Brief Description:** This program consists of contracted services for assessments and evaluations deemed necessary for the comprehensive and coordinated care planning needed for children and families involved with Child Welfare.
- **Eligible Population:** Parents and children who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: IV-E Waiver Demonstration Project

- **Brief Description:** This program consists of additional supports in the form of Peer Mentoring or Relationship Based Visitation for parents and children being served by Child Welfare. These supports are in addition to traditional child welfare programs that provide services for prevention and reunification (of families). Traditional services and community supports include mental health counseling, parenting training, and assistance navigating the process (e.g., court processes) for victims of domestic violence.
- **Eligible Population:** Parents and children served by Child Welfare, not receiving Medicaid or services via any other federal program.

Program: Personal Care:

- **Brief Description:** This program consists of the provision of medical services including skilled services delegated by a Registered Nurse under Oregon's Nurse Practice Act, identified in an individual care plan and provided to eligible children in a family foster care setting. Services provided in this program can include: medication supervision and monitoring assistance, assistance with activities of daily living, specific medical procedures (e.g. trachea support), and incontinence management procedures.
- **Eligible Population:** Children served by Child Welfare that must be in out-of-home care due to allegations of abuse and/or neglect, and have medical needs requiring an individualized care plan approved by the state.

PROGRAM GROUP: Adults and People with Disabilities (APD) (formerly SPD—Seniors and People with Disabilities)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> > **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-systems for the APD (formerly SPD) Program Group are the House Keeper System for Oregon Project Independence, and the CPMS and eXPRS interface sub-systems for Family Support and the Children's Long-Term Support programs.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The tate further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- **House Keeper System :** The process of the determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients, and entry of the data into the House Keeper system as they are then authorized for service payments to providers providing the designated client care services. In the Housekeeper system, the status identifies the client for Oregon Project Independence (OPI) services and the system generates provider payments. The system assigns SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) that identify the clients' services and related costs attributable for DSHP. Payment data is interfaced to the state SFMA system from which payment (expense) reports are produced. The accounting reports pull data directly from the SFMA system, and/or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **eXPRS System:** Payment source data is from the eXPRS system, an interface sub-system for accounting data to the SFMA accounting system, the 'book-of-record' for the state. The eXPRS system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state funds only will be so identified. Coding tables in eXPRS are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **CPMS System:** The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the CPMS system. A report is pulled from CPMS source data and reconciled on a quarterly basis with the payment as authorized by the eXPRS System and paid by SFMA. Only those services funded with state funds only are allowable for DSHP match.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Project Independence (OPI)

- **Brief Description:** OPI provides in-home services to seniors who require the same level of care as people in nursing homes, but who do not qualify for Medicaid. Services can be received in their own homes, and include personal assistance, nursing tasks and help with housekeeping. Services may also include help with activities of daily living, memory and confusion, mobility and transfers, housekeeping and laundry, meal preparation or delivery, shopping and transportation, medical equipment, assistance with medications.

- **Eligible Population:** Eligibility for OPI is age (60 years of age or older or under 60 with a diagnosis of Alzheimer or related dementia) and a Client Assessment & Planning System assessment evidencing a service priority level (SPL) of 1-18. These services are provided statewide through Area Agencies on Aging local offices. Clients with net incomes between 100 percent and 200 percent of federal Poverty Level (FPL) are expected to pay a fee toward their service, based on a sliding fee schedule. Families with net incomes above 200 percent FPL pay the full hourly rate of the service provided.

Program: Family Support

- **Brief Description:** Services are provided for eligible children with developmental disabilities, in their parents' or relatives' home. Through this program, families determine what they need most. Families have the flexibility to choose services and providers. Families and service coordinators work to develop a plan revolving around the child and family needs. In some cases, a family may access family support for a brief time while other families may need an on-going family support plan. The program strives to help children and families remain independent, healthy and safe. The service coordinator and family work to identify all available resources from the family and community. These might include people, support-groups, public and private programs, private insurance, and many other resources. Services include assistance in determining needed supports, respite care, purchase of adaptive equipment; services are proactive, and are intended to help prevent families from going into crisis.

- **Eligible Population:** Families who have children with developmental disabilities. It is a capped program ($1,200 per eligible child per year) with a current caseload of approximately 500. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and have tried to get access to funds to cover their needs prior to submitting request for Family Support. These individuals are not eligible for Medicaid.

Program: Children Long-Term Support

- **Brief Description:** This program provides supports to a child with a developmental disability at risk of out-of-home placement (foster care, residential, etc.). Children are assessed for level of service by the local Community Developmental Disability Program Service Coordinator. With the family, the Service Coordinator assists in plan development that identifies supports needed for the child to stay in the home. Supports include:

  - In-Home Supports
  - Respite
  - Behavior Consultation
  - Family Training
  - Environmental Adaptations
  - Specialized Medical Equipment and Supplies.

- **Eligible Population:** Families who have children with developmental disabilities who are at risk for out of home placement. This is a capped program with a current caseload of approximately 180. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and meet a crisis criteria of risk of out of home placement. These individuals are not eligible for Medicaid.

PROGRAM GROUP: Public Health Division (PHD)

- **Funding Sources:** State General Funds, Other Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Public Health Division Program Group is the Oregon Statewide Payroll (OSPS) system.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service that is eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with state funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All PHD expenditures are processed directly in the SFMA system.

- **Payroll System**: Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses

(OPE) directly to the PHD programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination is entered to ensure their time is properly allocated to DSHP. Coding tables in OSPS are accessed that assign an SFMA coding structure and are interfaced to SFMA system.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

Program: PHD Licensing Fee (Health Care Regulation and Quality-HCRQI)

- **Brief Description:** The Health Care Regulatory & Quality Improvement Section (HCRQI) is statutorily mandated to regulate, inspect, license and provide certification approval for the following entities and individuals: Ambulatory Surgical Centers, Birthing Centers, Dialysis Facilities, Hemodialysis Technicians, Home Health Agencies, Hospice Agencies, Hospitals, In-Home Care Agencies, Special Inpatient Care Facilities, Trauma Hospital designations.
  HCQRI is responsible for the entire licensure and certification processes for each of the above-listed individuals or entities. HCRQI also provides licensing information to the public and other agencies. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

- **Eligibility:** HCRQI does not provide direct care to Oregonians so there are no eligibility criteria. However, the ultimate beneficiaries are Oregonians who are able to find access to safe, high-quality and patient-centered health care because of HCRQI's efforts. All Oregonians benefit from having a wide access to health care. The program ensures that the health care will be safe, of high quality, and meet or exceeds and federal standards.

Program: PHD, Oregon State Public Health Lab (OSPHL) General Microbiology Testing Program

- **Brief Description:** The OSPHL General Microbiology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitters. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: PHD OSPHL Virology/Immunology Testing Program

- **Brief Description:** The OSPHL Virology/Immunology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitter. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: State Support for Public Health

- **Brief Description:** This program consists of services rendered by Local Public Health Departments (LPHA) to operate a Communicable Disease control program This program includes the following components: (i) epidemiological investigations that report, monitor and control Communicable Disease, (ii) diagnostic and consultative Communicable Disease services, (iii) early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases, (iv) appropriate immunizations for human and animal target populations to control and reduce the incidence of Communicable Diseases, and (v) collection and analysis of Communicable Disease and other health hazard data for program planning and management. LPHAs must operate its Communicable Disease program in accordance with the Coalition of Local Health Officials (CLHO) Standards for Communicable Disease Control and the requirements and standards for the Control of communicable disease set forth in Oregon Revised Statutes (ORS) Chapters 431, 432, 433 and 437 and Oregon Administrative Rule (OAR) Chapter 333, Divisions 12, 17, 18, 19 and 24, as such statutes and rules may be amended from time to time. As part of its Communicable Disease control program, LPHAs must, within its service area, investigate the outbreak of Communicable Diseases, institute appropriate Communicable Disease control measures, and submit to the Oregon Health Authority as prescribed in the Oregon Health Authority Communicable Disease Investigative Guidelines.

- **Eligibility:** All Oregonians benefit from the communicable disease control program provided to Local Health Departments. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: PHD Laboratory Northwest Regional Newborn Screening (NBS) Program

- **Brief Description:** The Northwest Regional Newborn Screening Program conducts screening of all newborn infants to prevent mental retardation and premature death in children through early detection and treatment of congenital disorders by: screening and testing for selected diseases and conditions; serving as the regional center for newborn screening; contracting for the medical consultation needed for the initial clinical follow-up; and maintaining a data base of all screened infants for use in follow-up, tracking, and monitoring disease incidence. Oregon designates practitioners as being responsible for specimen collection. The definition of "practitioner" includes physicians, nurses, and midwives who deliver or care for infants in hospitals, birth centers or homes. Also, parents are responsible to ensure that their infants are tested.

- **Eligibility:** Newborn screening activity is not divided among specific eligibility groups within Oregon newborn infants. It is a population-based service applicable to all newborn infants in the state. Oregon statutes require that every infant be tested. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees and driven by volume or amount of tests received by the Lab for which they receive test fee revenues.

Program: Prescription Drug Monitoring Programs (PDMP)

- **Brief Description:** Oregon-licensed pharmacies are required to report to the Oregon Health Authority PDMP system all Schedule II – IV controlled substances dispensed to patients. The system must be accessible by healthcare providers and pharmacists 24/7. The intent behind the PDMP is to help improve patient management particularly among pain patients. Health improvements include pain care, addictions treatment and reduced overdose.

- **Eligibility:** Services are provided to any Oregonian who requests a copy of their own patient record. Services are provided to any authorized PDMP system user that can include any Oregon-licensed healthcare provider who prescribes controlled substances or any Oregon-licensed pharmacist who dispenses controlled substances. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: HIV Community Services

- **Brief Description:** The HIV program provides case management and support services (case managed, treatment and support plan) for people already tested and living with an HIV diagnosis.

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: General Funds – HIV, Sexually Transmitted Disease, Tuberculosis (HST)

- **Brief Description:** The HST program works with local health authorities and community based organizations to provide guidance on the delivery of services to the populations impacted by HIV, STD, and TB. This program is administered by local health authorities that primarily screen, treat or control the transmission of those diseases. As well, this program provides support administration, prevention, TB case management and medications for STD's and TB

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable STD's TB or HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: Sexually Transmitted Disease

- **Brief Description:** The program provides Clinician Training for the clinician workforce in Oregon. The training is a two-day didactic training designed for clinicians. Training is intended to provide an update on HIV, HPV, Cervicitis, Chlamydia, Gonorrhea, Syphilis and other STD's.

- **Eligibility:** Clinicians workforce in Oregon to provide training on reducing and detecting STD's.

PROGRAM GROUP: Oregon Youth Authority (OYA)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the OYA Program Group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services. The Waiver approval for DSHP included mental health and A & D treatment services funded through state funds only. The Protocol identifies the allowable state fund only funding stream(s) for these DSHP allowable services and expenditures for non-Medicaid eligible youth. The youth receiving and benefiting from these services (mental health and A & D) may be placed in the custody of the OYA, but are not incarcerated in a close custody setting. DSHP does not allow nor include expenditures for services

rendered to youth in a close custody setting, in other words, for incarcerated youth. Expenditures for which DSHP is claimed are community based, delivered in the youth's place of residence or in a licensed professional provider's office or clinic. Youth are living at home or in an out-of-home non-secure placement (not a residential treatment facility), where youth are free to leave the premise. The youth are not incarcerated, not associated with the prison system, not in secure facilities operated by OYA and are not in the physical custody of OYA. The youth may be in the custody of OYA, e.g. adjudicated youth served by county probation or diversion programs, are not Medicaid eligible, and are receiving mental health and A & D treatment funded by state funds only.

- Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with state Funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OYA contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the R*STARS accounting database. Code and expenditures will be displayed.

Program: Alcohol & Drug Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Alcohol and drug abuse treatment provided to youth in community settings occurs through community service contracts for non-Medicaid eligible youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: alcohol and drug abuse treatment services in the community include: assessment, group treatment, individual treatment, individual care coordination, recovery, maintenance and relapse prevention.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for alcohol and drug treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

Program: Mental Health Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Mental health services provided to youth in community settings occurs through community service contracts for non-Medicaid eligible

youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: mental health treatment services in the community include: assessment of mental health needs, psychotropic medication management, group treatment, individual treatment, individual care coordination, crisis intervention and family therapy.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for mental health treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

85.

PROGRAM GROUP: DMAP – Division of Medical Assistance Programs

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 - Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the DMAP Program Group is MMIS.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. Thes further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the MMIS data base system that contains the requirements (i.e., edits) for processing claims for this population. MMIS is a subsidiary system for accounting data to the state SFMA accounting system, the 'book-of-record' for the state. From client and related payment data entered in MMIS, payments to providers are produced. The payment/expenditure data is interfaced to SFMA from which provider payments and expense reports are produced that identify the relevant category in which the DSHP allowable expenditure is incurred. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly. The SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) identifies the program, funding, and client are entered with the MMIS data. The coding is mapped to specific service tables that include each service funding source, thereby isolating the claims and associated payments for this population. The coding generated by the MMIS interfaces to SFMA. For this program, those services that match to state Funds only, will be allowable for FFP. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Formerly Medically Needy (Organ Transplant) Clients

- **Brief Description:** The program provides limited drug coverage for individuals receiving post-transplant services, formerly eligible for the Medically Needy program, which ended in 2003. Oregon Administrative Rule (OAR) 461-13-120-1195, chapter 461 filed with the Secretary of State, 9-30-2011, defines the population and covered services. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds and limited to 22 identified individuals.

- **Eligible Population:** This program provides services for 22 identified individuals receiving post-transplant services who were participating in the formerly Medically Needy program, as of January 31, 2003.

PROGRAM GROUP: Workforce Development and Education

- **Funding Sources:** State General Funds, Tuition and Fees

Expenditures for DSHP allowable Workforce Development Training expenditures are defined in the Waiver agreement, as those incurred by universities, colleges, and community colleges in the course of workforce training of health professionals in fields likely to benefit Medicaid beneficiaries. Source data elements are used to support the expenditures and payments of DSHP allowable Workforce Development Training and for the certification of DSHP allowable expenditures. The source data elements are:

- **Audited Financial Statements**
- **Invoices**
- **Payroll data**
- **Funding Source (ensures restriction to state only funds through the accounting elements and structure)**

Each university/college entity uses an integrated accounting system. Though they are not all the same system, they accumulate, process, and employ coding structures in similar formats for reporting and audit processes. These systems are the 'book of record' for each entity. They are complete systems with modules devoted to accounting, purchasing, accounts payable, fixed assets, grants, and budget development. The charts of accounts structures have these primary coding structure elements: Fund, Organization, Account, and Program. Transactions in the systems require these coding structures to store, process, and report out expenditures for all programs, including DSHP. The coding structure elements are hierarchical and roll up from lower data entry levels to higher summary levels. The DSHP expenditures roll into the regular monthly and annual final statements. Typically these types of expenses are tracked at a lower level of the accounting system coding structure and while they are not visually displayed in annual financial reports, they are included in the respective Instruction line displays in the financial statements.

For each Workforce Development Training program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #57(b). The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – Original source data is identified where data from the source documents is reviewed, and approved for coding and entry into the appropriate financial accounting sub-system for each Workforce Development Training program (e.g., accounts payable, payroll-personnel).

Step 2 – The financial data accumulation begins with initial entry into source data systems for the following:

- Invoices received for services and set up in the accounting system accounts payable module: invoices reviewed, services received verified, payment amounts approved, specific coding verified for programs and unique projects (e.g., DSHP - Instruction)

- Employee data set-up in the payroll system: Personnel payment data, pay rates, default cost center to be charged, etc.. Specific coding identified for additional programs/projects to where employee work time should be charged. Time sheet data, for time and effort recording, including proper employee and supervisory verifications/authorizations.

Step 3 – Source data systems access internal data and coding tables, and based on entry data, assigns to expenses the accounting coding element structures (i.e., codes: Fund, Organization, Account, Mission, Object). ***See Table 1,*** below.

TABLE 1 – Coding Elements

Oregon Health Sciences University

- *Fund code:* University General Fund 0151
- *Organization code:* Identifies the Schools: Medicine 54000-54999, Nursing 58000-58999, Dentistry 60000-69999.
- *Mission code:* Non-Sponsored Instruction & Training 11; Student Admin and Services
- *Object code:* Functional description of expenditures, Wages 5100-5199; Supplies 5300-5399; Cost of goods 5400-5499; Purchased services 5500-5599

A combination of the above codes identifies DSHP allowable expenses.

Oregon University System

- *Fund code:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Department of Community Colleges and Workforce Development

- *Fund Type:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code/Account Type:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Step 4 – Source data systems compile data during the system scheduled maintenance runs for interface to the financial accounting system, the 'book-of-record', source for all financial audits (e.g. general; A-133; other audits).

Step 5 – Accounting system processes are compiled, interfaced data configured according to the system processing design and the internally established chart of accounts. It matches the coded expense data to the internal chart of accounts (See ***Table 3 – OUS Example*** below). At period end close, the Overhead Cost Allocation module is run, charging indirect cost expenses (e.g. Administration and General (A & G)) to revenue producing cost centers, based on standard, approved cost allocation principles **(See *Table 2 – Cost Allocation***, below**)**. Closed period end financial data is downloaded to a database system (e.g., a financial services 'datamart') that can be queried using specific general ledger established accounting coding elements to pull out DSHP expenditure data (see ***Table 1 –Coding Elements above***).

TABLE 2 – Cost Allocation

DSHP approved program expenditures can include direct charged costs as well as indirect costs (i.e., a cost necessary for the functioning of the organization as a whole, but which cannot be directly assigned to one service or product, and therefore must be allocated). Very similar to the Medicare cost finding principles, cost allocation is a process, to identify common costs (e.g., A & G—executive staff, accounting, legal, human resources, etc.) to the courses of health care

professionals in fields likely to benefit Medicaid recipients. The entity can determine those costs that can be accurately direct charged, or charge them to an allocation cost center for charging via the allocation process. --Medicare Reimbursement Manual form 2552-10, 40-93

Step 6 – Report queries are run against the financial services datamart using the coding element structures unique to the DSHP program/project. (***See Table 1***, ***Coding Elements above***)

Step 7 – Expense Reports for DSHP expenditures are run after the accounting period end close. Accounting period close may be monthly, quarterly or annually.

Step 8 – Certification of Public Expenditures (CPE) form, certifying allowable DSHP expenditures per STCs #55 – 58 are represented in the expense reporting, will be sign by the appropriate and authorized college or university authority and provided to the State.

If an expenditure made under DSHP Workforce Training Program Group is found, in a future audit or financial review requiring corrective action, the prior period transaction(s) will be reconciled in the current DSHP claiming period using CMS 64 established guidelines. The CMS 64 reporting will reflect this reconciliation.

Accounting System, DSHP Expense Report Crosswalk to Financial Statements: DSHP Workforce Training expenditures, processed through the respective accounts payable and/or payroll systems are coded with organization department and instruction program coding elements (described in the preceding individual protocol narratives) that will identify DHSP allowable expenditures, per STCs # 55-58.

DSHP expenditures are a small subset of the overall individual operation of each university, college and community college. Expenditures to be claimed as DSHP, per STCs #55-58, are included in the annual year end audited statements as specific amounts at a lower level than displayed on the Instruction report line. These expenditures can be audited down to individual transactions for which original source documents can be pulled. Table 3 below illustrates this process.

Agreements will be in place between OHA and workforce entities to include allowance for audit by OHA of DSHP allowed expenditures. DSHP Expense Reports will be certified, and the amounts on the DSHP expense reports can be directly tied to the individual university, college and community college audited financial statements.

The total computable amount to be claimed to the federal government begins with the amount recorded for Instruction within the university, college or community college's audited financial statement. The financial statements may include the amount applicable to Instruction for one institution, or multiple institutions, depending on the structure of the university/college system.

In support of the total computable amount to be claimed under DSHP, supporting documentation will include the university's/college's expenditure report/account detail. The expenditure report classifies expenditures (as detailed in Table 1 – Coding Elements) by code, including fund code, organizational code, mission code and object or program code. The organization and fund type level codes will be primarily used to distinguish between aggregate expenditures applicable to Instructions and expenditures applicable to Instruction eligible under DSHP, per STCs #55-58.

Categorical Examples of Workforce Development Training DSHP allowable programs
School of Medicine
School of Nursing
School of Dentistry
Clinical Laboratory Science
Radiologic Technology/Diagnostic Imaging

Respiratory Care
Clinical Care
Medical Assistant
Dental Assistant/Dental Hygienist
EMT/Paramedic
Nursing Education/Certified Nursing Assistant
Pharmacy Technician

The examples above are not intended to be an exhaustive list of each course offered by the individual college or university. Rather, they an example by category of the type of DSHP allowable graduate and undergraduate workforce training programs available at the colleges and universities.

Upon receipt of the specific college and university expenditure report, OHA will verify the expenses reported are for health-care and health-care related fields of education and training. The specific listing of the DSHP allowable health-care and health-care related course offerings will be made available to OHA by each college or university, and will become a part of the DSHP report to CMS Region X for purposes of claiming via the CMS 64 Report. By keeping the specific list(s) apart from, yet referenced herein Attachment G, as a college or university changes, adds or deletes a DSHP allowable course, it would not be necessary to amend Attachment G.

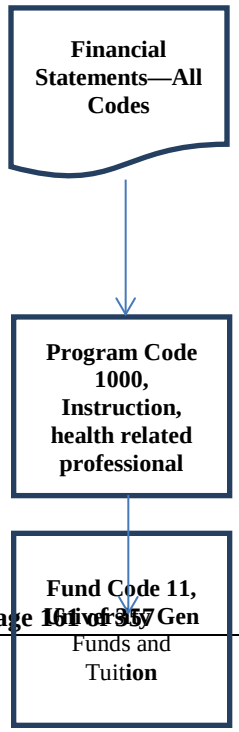
Verification of the DSHP allowable course may be accomplished in a three-fold manner using the 1) published course offering/calendar of the college or university; 2) through enrollment information, and; 3) through the college and university expenditure reports.

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for Workforce Training will be computed without taking into account program revenues from tuition. However, to the extent the above universities and colleges receive funds that are directly used to support Workforce Training applicable offsets will be made to the amount claimed to the federal government as an allowable DSHP expenditure per the above referenced STCs.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the Workforce entities accounting systems databases. Codes and expenditures will be displayed

Table 3 – OUS Example

Highest Level -- Financial Statements: Includes all accounting data codes. To reconcile to financial statements, the report query would not restrict to specific codes; all would be pulled.
Program Codes: Report query, restrict codes to program code 1000 for Instruction Courses of health care professionals in fields likely to benefit Medicaid recipients.
Funds: Further restrict report query to fund code 11, university general funds (incl tuition).



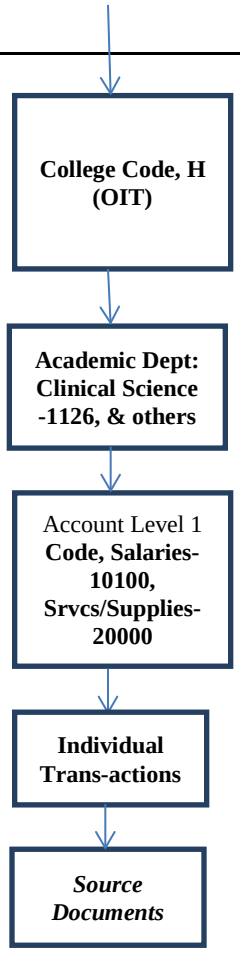
College Codes: Further restrict report query to college code H for OIT

Organization Codes: Further restrict report query to academic codes, 1126 & others.

Functional Codes: Further restrict report query to account level one codes for personnel, materials & supplies, etc.

Lowest Level -- Transactions: Further restrict to the lowest level Transactions that identify vendor/payee and personnel/ staff payee.

Documents Level **--** Based on the transaction list pulled (i.e., showing the amounts entered, vendor, other identifying data; payroll time & effort data) supporting documents can be pulled.



PROGRAM GROUP: Oregon Medical Insurance Pool (OMIP)

- **Funding Sources:** State General Funds

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for the Oregon Medical Insurance Program will be made without considerations for high risk pool healthcare premiums.

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the OMIP Program Group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OMIP contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Medical Insurance Pool

- **Brief Description:** The Oregon Medical Insurance Pool (OMIP), administered by the state Office of Private Health Partnerships (OPHP), is the high-risk health insurance pool for the state established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions. OMIP also enables continuance of insurance coverage for those who exhaust COBRA benefits and have no other options. The funding for OMIP comes from two sources. Premiums paid by enrollees currently cover about 52% of program costs. Statutory requirements for establishing premiums limit them to no more than 125% of average market premiums for comparable benefits. The remaining 48% of the costs are funded from assessments the OMIP Board charges the licensed Oregon commercial health insurers on a per covered life basis.
-
- **Eligibility:** Enrollees must be residents of Oregon when they enroll and, once enrolled, they must demonstrate that they have lived in Oregon for at least 180 days during each benefit year. It does have a six-month pre-existing condition waiting period for which enrollees can get credits if they have had prior comparable coverage. To be eligible for portability coverage, they must not have access to a commercial portability insurance plan.

PROGRAM GROUP: Oregon State Hospital (Gero-Neuro)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Oregon State Hospital Program Group is the Oregon Statewide Payroll (OSPS) system.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All Hospital expenditures are processed directly within the SFMA system.
- **Payroll System:** Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses (OPE) directly to the various Hospital programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination can be entered to ensure their time is properly allocated to DSHP.
    - The Hospital is accounted for as an enterprise fund where all costs for the program are recorded as one fund source. However, any resources from insurances (e.g., Medicaid, Medicare, Private pay) are identified to the various wards and are subtracted to record the State Only Fund expenditures that are allowable under the DSHP Waiver amendment. Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Coding and expenditures will be displayed.
-

Program: Gero-Neuro Wards at the Oregon State Hospital (MH, Psychiatric)

- **Brief Description:** This program is for patients who require a hospital level of care for dementia, organic brain injury or mental illness. Patients in this program require physically secure, 24-hour care that is not available through community programs. These patients often have significant medical issues. Some are either civilly committed or voluntarily committed by

a guardian because they are a danger to themselves or others, or are unable to provide for their own health and safety needs. Some patients who require significant medical care come through the criminal court system. Those admitted under criminal commitments are excluded, are not approved for DSHP federal Funds Claiming. The program's goal is for everyone to return to a community-care setting. From the day of admission, the treatment team works with the patient toward this goal. The program uses the following treatments:

- Sensory and behavioral therapy
- Recreation
- Coping and problem-solving skills learned through group and individual therapy in the treatment mall setting.

- Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.

- **Eligibility:** Elderly persons with a mental health diagnosis that requires hospital level of care, or all ages with special needs due to related neurological impairment. Inpatient services are available to older adults who have major psychiatric disorders and adults older than 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive community care nursing home system environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical-surgical hospital.

Attachment H: Calculating the Impact of Health Systems Transformation
(updated December 18, 2012)

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State of Oregon

Attachment H: Calculating the Impact of Health Systems Transformation -

Oregon's Accountability Plan and Expenditure Trend Review

Attachment H: Calculating the Impact of Health Systems Transformation

Table of Contents

Executive Summary

Section A - Oregon Accountability Plan

Part I: Quality Strategy

I. Introduction 179

II. Improvement Strategies 181

III. Oregon's Goals 195

- A. Lower Costs 195
- B. Better Care: Quality of Care 198
- C. Better Care: Access to Care 201
- D. Better Care: Experience of Care 203
- E. Better Health 204

IV. Assessment 208

- Performance Monitoring 208
- Data Sources 210
- Credentialing 211
- Health Information Technology 211

V. Contract Compliance 213

- Standards for Managed Care Contracts 213
- Delivery Services Performance Monitoring 213
- Enforcement 215

VI. Review of Quality Strategy 215

VII. Achievements and Opportunities 216

Appendix 1.A: Coordinated Care Organization Service Area Density 217

Appendix 1.B: Theory of Action Model 218

Appendix 1.C: Quality Pool Structure 219
Appendix 1.D: Innovator Agent Plan 228
Appendix 1.E: Contract Compliance 232
Appendix 1.F: List of Conditions that can result in Sanctions 236

Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluation

Preface 240
Oregon Special Terms and Conditions 52, 54, 64, 86 and 88 240
Introduction 246
Statewide Quality and Access Test 249
Evaluation 256
Evaluation Objectives 256
Contextual Considerations 257
Research Questions, Data Sources, and Analytic Approach 260
Table 1 – Formative Evaluation 261
Table 2 – Summative Assessment 265
Timeline 271

Part III: Oregon's Measurement Strategy

Introduction 273
OHA Measurement Framework 273
Incentive Measures 274
Ensuring Continuous Quality Improvement 275
Data Collection 276
Measurement Year 276
Data Analysis 277
Data Reporting 277
Appendix 3.A: Measure Sets by Population and Domain 279
Appendix 3.B: Oregon Measures Matrix 283
Appendix 3.C: CCO Incentive Measure Specifications 301

Appendix 3.D: Rationale for Incentive Measures 324

Appendix 3.E: Measures for Consideration in Demonstration Year 3 333

Section B - Draft Expenditure Trend Review

Description of Costs 326
Treatment of Populations within the Workbook 329
Description of Elements in the Workbook 332
Expenditure Trend Review Workbook 333

Executive Summary

Oregon has a long history of choosing innovative means of managing its Medicaid program. Yet, Oregon has faced a number of challenges in recent years familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and government (both state and federal); cost growth that far outpaces the state's general fund revenue; and a system focused on volume, not value. For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical.

Instead of responding to these challenges with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon chose a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon developed a coordinated care model for this transformation built on the three-part aim of better health, better care and lower costs. In alignment with that aim, the two overarching goals of Oregon's 2012-2017 demonstration are to reduce the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

This document contains Oregon's Accountability Plan, a multi-pronged strategy to achieve the three-part aim and methodology for the two percent trend reduction test. The document represents a shift toward a new model of care encouraging continuous learning and transformation, increased transparency, and clear expectations and incentives for improvement along with a significant investment in measurement, analytics, and evaluation.

Attachment H is divided into two sections: Oregon's Accountability Plan (Section A) and the Expenditure Trend Review (Section B).

Section A: Oregon's Accountability Plan is divided into three parts:

Part I: Coordinated Care Organization Quality Strategy

Part I of the Accountability Plan (pages 9-66) contains Oregon's Coordinated Care Organization (CCO) quality strategy, which describes the process by which the CCOs will work towards the three-part aim. The CCOs will be held accountable for spending through a comprehensive capitated per-member-per-month payment (PMPM). Under this capitated arrangement, beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures.

CCOs will also be rewarded for improving quality. At the start of the demonstration, two percent of the PMPM budget will form a quality incentive pool and will be available to CCOs that achieve specific quality goals. The percent assigned to this pool will increase over the course of the demonstration, subject to approval from CMS where necessary. By holding CCOs responsible for spending as well as quality, and by shifting incentives towards outcomes over time, the CCO model will increasingly reward value and outcomes rather than utilization.

A key part of the strategy is changing the way care is delivered in key focus areas. Each focus area was chosen because of prior evidence suggesting that improvement in these areas can achieve the three-part aim. Each CCO will address four of seven quality improvement areas:

- Reducing preventable re-hospitalizations;
- 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 federal and state programs;

- Deploying care teams to improve care and reduce preventable, unnecessary and costly utilization by frequent utilizers;
- Integrating primary care and behavioral health;
- Ensuring appropriate care is delivered in appropriate settings;
- Improving perinatal and maternity care; and
- Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness.

The state will support CCO efforts with a wide array of resources and supports:

- **The Oregon Transformation Center:** Once launched in 2013, the Oregon Transformation Center will act as the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state. The center will provide support mechanisms that include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a range of topics including health equity. A patient-centered primary care home (PCPCH) technical assistance institute, that is already operational, will coordinate with the Oregon Transformation Center's learning collaboratives once launched.
- **Innovator agents:** Innovator agents will be assigned to each CCO. They will be a single, constant point of contact between the CCO and OHA and will help champion and share innovation ideas in support of transformation, within either the CCOs or the state agency. The state's innovator agent plan is included in this master document.
- **Non-Traditional Healthcare Workers:** These workers include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems
- **Patient-Centered Primary Care Homes:** The adoption of patient-centered primary care homes (PCPCH) is integral to transforming the health system. The primary care home model of care is defined by Oregon's statewide PCPCH standards and measures. These measures call for a patient-and-family-centered approach to all aspects of care, wellness and prevention. This includes culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner.

- **Evidence-based clinical decision tools:** Disseminated through the Oregon Transformation Center, these tools, based on extensive research and expertise on treatment effectiveness in achieving meaningful clinical outcomes, will provide guidance to providers and CCO clinical advisory panels in delivering clinically and cost-effective care.

- **Transparency:** Quarterly public reporting on a wide range of quality, access, and beneficiary experience measures, via CCO dashboards, will synthesize performance data to make it clear and understandable to all stakeholders, most importantly Medicaid beneficiaries.

- **Timely feedback:** Feedback will be presented to CCOs about progress, opportunities, and areas for improvement through a robust measurement strategy and analytics infrastructure.

Part II: Statewide Quality and Access Tests and Evaluations

Part II of the document (pages 67-97) provides information about statewide activities to support and incent quality and access, including an annual statewide test of quality and access required by CMS to assure that the demonstration's cost control goal is not being achieved at the expense of quality. The tests are structured to encourage improvement in quality, but if quality and access significantly diminish, a Designated State Health Programs (DSHP) penalty specified in the demonstration special terms and conditions (STCs) will apply. Part II of the Accountability Plan also includes demonstration evaluation plans to support continuous quality improvement as well as a summative evaluation as required by the STCs.

The goal for these tests and evaluations is to create a new paradigm of accountability between CMS and the state. The key elements of this are:

- **Structured access and quality test:** Not only is the state required to meet the expenditure test outlined in Section B of this document, but in years where it meets that test, it is also required to meet a structured access and quality test to ensure that cost containment goals are not achieved at the expense of access or quality. The quality and access test consists of two parts: a relatively simple initial comparison of annual performance on a broad set of metrics against a baseline; and a more complex analysis of the associated between transformation activities and performance on access on quality, to be conducted only if the state fails part one of the test.

- **Formative, midpoint, and summative impact evaluations:** Building on the measurement strategy described in the first part of this document, the state will track and report regularly on OHA and CCO actions, the "levers" for health system transformation described in the STCs, and progress toward the goals of the three-part aim. The formative evaluation will provide timely and actionable feedback to CCOs, the state, and CMS. The midpoint and summative evaluations will be conducted by external, independent contractors and will employ more sophisticated analytic methods in order to determine whether changes in quality and outcomes resulted from the state's transformation activities.

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. The expansions and delivery reforms under this demonstration are intended in part to bridge the transition to implementation of the ACA, making monitoring the changes in 2014 an essential part of the state's efforts. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the quality and access tests will apply no differently in 2014 than in other demonstration years, except that the midpoint assessment is designed to provide analytical insight into progress as of 2014.

Part III: Measurement Strategy

Part III of the document (pages 98-170) describes the measurement strategies to support both CCO level quality activities in Part I as well as statewide quality activities in Part II.

Performance for all of these metrics will be made transparent, and will be reported by race, ethnicity and language to the extent possible, to ensure improved outcomes for all communities. CCO level dashboards will also be created to assist in rapid cycle improvement.

Metric groups:

- **Oregon CCO Incentive Measures:** The state's Metrics and Scoring Committee is responsible for identifying and adopting metrics for a program that establishes CCO financial incentives for improved outcomes. The Committee has identified an initial set of 17 metrics.
- **Oregon Demonstration Core Performance Measures:** Oregon's 1115 demonstration also includes ten additional measures that represent a broad snapshot of the Medicaid program.
- **CMS Adult Core Set for Medicaid**: These are the core set of measures recommended by an expert panel and established by CMS to track quality of care for the adult Medicaid population.
- **CMS Child Core Set for Medicaid and the Children's Health Insurance Program**: These are the core set of measures established by CMS for the pediatric population, also recommended by an expert panel. Both core sets will be part of the reporting format to the extent feasible, even as the sets evolve.

There is considerable overlap among these metric groups. The CCO incentive measures will determine the disbursement of the CCO-level quality pool and will serve as a strong incentive for quality improvement. The other measure sets, to the degree they are not included in the incentive measures, will serve as a broad snapshot of the Medicaid program in order to ensure that there is no degradation in some areas as the CCOs focus on the quality improvement areas represented by the incentive measures.

The statewide tests for quality and access that can trigger DSHP penalties include a very broad set of measures from all of these metric groups.

Section B: Expenditure Trend Review (pages 168- 188)

The expenditure trend review provides the methodology and template for measuring the required two-percentage point reduction in the rate of growth of Oregon Health Plan per capita expenditures. The test consists of three levels that capture growth in: 1) CCO global budget services; 2) total Medicaid expenditures for CCO enrollees; and 3) new administrative costs that may accrue to Medicaid in order to provide care under health system transformation in Oregon.

Along with submitting the expenditure trend review data quarterly, the state has agree to conduct an exploratory stakeholder process regarding opportunities, barriers, and strategies to integrate long term care into CCO global budgets. The state will also augment the expenditure review test reporting in March of each year with trends on hospital uncompensated care in the state for monitoring purposes.

Conclusion

The overall purpose of this demonstration is to help support fundamental changes in the delivery system. These changes can in turn help not only achieve the three-part aim, but also to prepare the state for the transition to 2014 when more of its population will be enrolled in CCOs.

Oregon's Accountability Plan and Expenditure Trend Review memorialize agreements negotiated between the state and CMS to ensure robust monitoring of the state's innovative health system transformation activities. Through regular reporting and rapid cycle improvement activities, both CMS and Oregon hope to learn lessons that can be applied to other payers and perhaps in other states.

Part I

Coordinated Care Organization (CCO)

Quality Strategy for the Oregon Health Plan 2012

CCO Quality Strategy Table of Contents

I. Introduction 179

II. Improvement Strategies 181

III. Oregon's Goals 195

A. Lower Costs 195

B. Better Care: Quality of Care 198

C. Better Care: Access to Care 201

D.Better Care: Experience of Care 203

E. Better Health 204

IV. Assessment 208

Performance Monitoring 208

Data Sources 210

Credentialing 211

Health Information Technology 211

V. Contract Compliance 213

Standards for Managed Care Contracts 213

Delivery Services Performance Monitoring 213

Enforcement 215

VI. Review of Quality Strategy 215

VII. Achievements and Opportunities 216

Appendix 1.A: Coordinated Care Organization Service Area Density 217

Appendix 1.B: Theory of Action Model 218

Appendix 1.C: Quality Pool Structure 219

Appendix 1.D: Innovator Agent Plan 228

Appendix 1.E: Contract Compliance 232

Appendix 1.F: List of Conditions that can result in Sanctions 236

I. Introduction

Oregon has a long history of choosing innovative means of managing its Medicaid program. Almost all of the state's Medicaid population is in managed care, and most of its long-term care program is in-home and community based services. When faced with the need to curb costs, the state developed the Prioritized List of Health Care Services to ensure that there was a rational, open process for selecting services to be covered based on their impact on population health. Even with this history as background, Oregon has faced a number of challenges in recent years familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and for the state and federal government; cost growth that far outpaces the growth in state general fund revenue and personal income; and a system focused on volume, not value.

For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical. Nationally, it is estimated that about 30 percent of care provided is either unnecessary or does not lead to patient health. For racial and ethnic minorities, access to care and health status are worse than for the general population. For example, 35 percent of minority women in Oregon have no regular care provider, compared to 18 percent for Caucasian women, and the life expectancy for African Americans and American Indians/Alaska Natives in Oregon is two years less than for Caucasians. People of color disproportionately represent one in four covered lives in the Medicaid population. Native Americans have lower utilization rates of preventive services for children (birth through 10 years old), when compared to Caucasians, Latinos, and Asian Americans. African Americans and Native Americans have high rates of ambulatory care sensitive condition hospitalizations than Caucasians, Latinos and Asian Americans. Oregon's Action Plan for Health issues a call for action to address racial and ethnic health disparities. Addressing these disparities will go a long way toward improving Oregon's health system.

Instead of responding to trends over the last several years with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon has chosen a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon has developed a coordinated care model for this transformation that is built on the three-part aim of better health, better care and lower costs, and is being implemented in Oregon's Medicaid program through Coordinated Care Organizations (CCOs).

The coordinated care model was the logical next step for Oregon's health reform efforts that began in 1994 with the creation of the Oregon Health Plan (OHP). The coordinated care model grew out of recognition that the services people need are not integrated, leading to poorer health and higher costs. Physical health, mental health, substance abuse, and oral health, services are fragmented and are insufficiently tailored to meet the diverse needs of Oregon's

population. There is a sense of urgency in the state to rein in these costs or they will continue to overwhelm state, business and personal budgets.

Coordinated Care Organizations are community-based organizations governed by a partnership among those sharing in financial risk, providers of care, and community members. CCOs are and will be the single point of accountability for the health quality and outcomes for their members. They have the flexibility, within model parameters, to institute their own payment and delivery reforms that achieve the best possible outcomes for their membership.

Oregon's first eight Coordinated Care Organizations were certified to begin enrolling new members as of August 1, 2012. As of December 2012, there are 15 CCOs extending across every county in the state and approximately 90 percent of the Medicaid enrollees *(See attached map in Appendix 1.A)*.

As in the past, Oregon will continue to develop and maintain a quality strategy to assess and improve the quality of CCO services and to ensure compliance with standards. Section A, Part 1 of this Accountability Plan (the current section) satisfies both STC 45 and 42 CFR Part 438, subpart D requirement for a state quality strategy. Oregon will continue its robust monitoring of system performance and will continue to assure that standards of access, program operation, and quality are met. Although many oversight mechanisms used today will continue in the future, the transition from managed physical and mental health care to CCOs has greater implications for quality assurance and performance improvement focus areas than for methods of oversight.

CCO accountability measures and related incentives will be core elements of the state's quality strategy. These measures will allow the Oregon Health Authority (OHA) to set clear expectations for care delivery and health systems transformation and to monitor CCOs' performance against those expectations. OHA will institute a system of progressive shared accountability that maximizes the opportunity to succeed but also protects the public interest.

OHA will perform periodic reviews of the quality strategy to determine the need for revision and to assure CCOs are in contract compliance and have committed adequate resources to perform internal monitoring and ongoing quality improvement activities.

II. Improvement Strategies

To meet the goals of the three-part aim, Oregon's coordinated care model and FFS delivery systems 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 will take in the form of the stimuli and supports described below, 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 alternative payment methodologies 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

OHA will employ a variety of stimuli to promote the action of the levers and supports to enhance their effectiveness. *See the theory-of-action visual in Appendix 1.B for more details on the interaction between these levers and supports.*

STIMULI

Contractual requirements

One of the hallmarks of Oregon's health system transformation is local governance and flexibility, which requires a unique approach to a quality strategy in that it must recognize that each organization is unique in its approach to a model of care that meets the three-part aim. To that end, the state has included in its contracts a requirement that each CCO submit a draft transformation plan for approval by OHA by January 15, 2013. These plans must incorporate all

the contractual requirements of transformation, including milestones and benchmarks in each of the following areas:

- The model of care that the CCO will adopt;
- Their strategies for integrating behavioral, physical and oral health;
- The use of flexible services;
- How they will coordinate care;
- How they will adopt alternative payment methodologies for compensating providers;
- How they will work with diverse community partners and their Community Advisory Council;
- How they will reduce health disparities and advance health equity for culturally and socially diverse communities;
- How they will employ non-traditional healthcare workers and health care interpreters; and
- How they will address four of the seven focus areas in the STCs, three of which will be addressed as performance improvement products (PIPs). See below for a detailed discussion.

OHA will negotiate the content of the transformation plans with the CCOs and the final plans will become part of the CCO contracts as addenda. *See also section V of the Quality Strategy for further discussion of contract compliance and the repercussions for CCOs of non-compliance*.

Global budgets for CCOs (STC 36b)

CCO global budgets integrate previously separated funding streams – physical, mental and, beginning in 2013, oral health – and represent the total cost of care for all services a CCO is responsible. CCOs are held accountable for managing the total array of services, either through a capitated per-member-per-month (PMPM) payment or though payment for outcomes. In addition to reducing administrative overhead and promoting administrative simplification by combining the infrastructure and function of previously separate organizations, global budgets require coordination of care across all services and promote accountability. By shifting some services away from capitation and toward payment for outcomes (subject to CMS approval where necessary), Oregon is moving toward a system that increasingly pays for value rather than utilization.

This global budget is neither a per-capita cap nor a global cap. Beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures. Per person spending trends will be measured to assure the demonstration is on track to save state and federal funds, but do not in any way serve as a cap on federal funding for medical assistance provided to Oregon's Medicaid beneficiaries.

Transparency

Beginning in January 2013, data supporting measures of cost, quality, access, experience of care, and health status will be collected by OHA over all delivery settings and populations. These measures include the core performance measures listed in the Oregon demonstration; others will be drawn from the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measures, the Medicaid adult core set, and a set of measures specifically addressing the needs of the severely and persistently mentally ill (SPMI) population. (*See Oregon's Measurement Strategy in Part III for the complete listing of metrics*). Data to track these measures will also be collected by race, ethnicity and language, to ensure improved outcomes for all communities. These measures will be reported publicly beginning June 2014 and will be updated either quarterly or annually depending on the measure. In addition, CCO dashboards will be created that will synthesize performance data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries.

Financial Incentives

A legislatively mandated stakeholder group, the Metrics and Scoring Committee, identifies metrics for financial incentives and makes recommendations to OHA about the design of the incentive structure. Incentive payments linked to metrics recommended by the Committee will form the basis of a fully-at-risk quality pool. The quality pool is a bridge strategy to move CCO payments from utilization to value. Over time, the proportion of a CCO's global budget based on capitation is expected to decrease as the proportion based on incentives tied to improvements in outcomes and efficiency increases, with prior CMS approval as needed.

The Oregon Metrics and Scoring Committee has worked with national experts to create the appropriate metrics and incentives that are aligned with the state's Medicaid quality strategy. Beginning July 2014, incentives will be linked to each CCO's performance on quality, cost and access measures as well as electronic health record adoption. In addition, in order to maximize the potential for achieving quality goals, CCOs will be required to align their provider incentives with the quality pool incentives; that requirement is reflected in CCO contracts. Timelines and milestones for implementation of alternative payment methodologies that further align CCOs and their providers with health system transformation objectives are addressed as part of CCO

transformation plans (drafts due January 15, 2013). *See Oregon's Measurement Strategy in Part III and the Quality Pool Structure in Appendix 1.C for a fuller description of financial incentives*.

One Percent Administrative Withhold

In accordance with STC 37b.i., OHA will withhold one percent of capitation revenue from CCOs in each year of the demonstration in order to ensure timely and accurate data submission. CCOs will forfeit up to the full one percent if they do not meet Oregon's standards for timely and accurate submission of encounter data. The specific contractual requirements are reflected in Oregon's January 2013 CCO contract amendments.

Quality Improvement Focus Areas

As required by contract and STC 25b.i., each CCO must address four of the quality improvement focus area 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 problem identified,
- Implement the action plan,
- Study its effects, and
- Refine the intervention.

Three of the focus areas will be conducted as performance improvement projects (PIPs). In Demonstration Year 11 (DY11), one of the three required PIPs will focus on integrating primary care and 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. Integrating primary care and behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care; and

7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. Finally, Attachment E of the demonstration's STCs outlines example measures that would be required of any CCO selecting specific focus areas.

SUPPORTS

The Oregon Health Transformation Center

In 2008 the Oregon Health Fund Board recognized the need for an infrastructure to stimulate system innovation and improvement. The Oregon Health Policy Board directed OHA in creating "Oregon's Action Plan for Health" to provide necessary supports for success of the model of coordinated care. As an important support, Oregon is forming a Transformation Center in the winter of 2013 to support the rapid learning and improvement necessary to implement the coordinated care model and to make any required mid-course corrections quickly. In Oregon's vision, the Oregon Transformation Center is the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state.

The activities of the Transformation Center will be aimed at creating the optimal conditions for the rapid spread of the key elements of the coordinated care model. Everett Roger's Diffusion of Innovation theory suggests that there are eight critical components in the successful spread of innovation.[6] In accordance with this work, the Transformation Center will conduct activities aimed at identifying or achieving:

- **Change leaders:** respected individuals who can serve as key messengers for the innovations;
- **Active learning networks:** peer-to-peer networks, collaboratives and other communication channels that enable stakeholders (CCOs and other payers, their providers, communities and consumers) to engage in learning and sharing information about the innovations;
- **Relative advantage:** stakeholders believe that the innovations are an improvement over current practice and their benefits outweigh the risks;

[6]Everett M. Rogers, *Diffusion of Innovations*, Fifth Edition 2003, Free Press, New York

- **Compatibility:** stakeholders understand how the innovations fit in with their current system and community needs;
- **Simplicity:** innovations are as easy as possible to implement;
- **Trialability:** stakeholders are able to try out an innovation with minimal investment before moving to full implementation;
- **Observability:** stakeholders see demonstrated evidence that an innovation works; and
- **Reinvention:** stakeholders can appropriately adapt innovations to serve local community needs.

The specific tools and support mechanisms to be provided by the Transformation Center include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a variety of topics including advancing health equity. Timely data and targeted analytic tools are among the most important supports that the Transformation Center will provide. In order to make sustainable progress towards integrating and coordinating care, CCOs and other health system partners will need better tools and stronger incentives to improve performance.

In cooperation with OHA's Office of Health Analytics, the Transformation Center will provide, both through Innovator Agents (described below) and directly to CCOs:

- Timely, reliable information and analysis to improve the targeting and delivery of services and to improve health equity;
- Data to drive accountability mechanisms, such as alternative payment methodologies aligned with performance measures and health outcomes; and
- Clear communication of analyses of performance, progress, and opportunities for improvement to help develop consensus around priorities and improve decision-making.

See Part III for descriptions of data sources and measurement details.

Learning Collaboratives

The Oregon Health Authority will establish a CCO learning collaborative as required by STC 25d within the Transformation Center, the purpose of which is to promote innovations and activities that will contribute to the objectives of health system transformation and accountability for achievement of the three-part aim of better health, better health care and

lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. In addition to learning collaborative areas of focus to be defined by OHA, CCO learning collaborative members will work together to decide upon additional focus area(s) of the collaborative and work with OHA to develop appropriate performance measures.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract. Also established by contract is a requirement 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.

Innovator Agents

STC 25d. and Senate Bill 1580 require OHA to provide CCOs with "innovator agents" who will act as a single point of contact between the CCO and OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation's three-part aim: better health, better care, lower cost. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight. (*See section V for additional details on contract monitoring and oversight*).

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication and allowing streamlined reporting, reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports.
- Assist the CCO in managing and using data to accelerate quality improvement.

- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The innovator agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other innovator agents, CCOs, community stakeholders and/or OHA.

Innovator agent performance will be assessed annually through a "360" review process that includes input from the Community Advisory Councils, CCO management, OHA partners and other relevant stakeholders.

For more details on innovator agents and the Transformation Center, see the innovator agent plan, Appendix 1.D.

Community Advisory Councils (STC 25a)

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 council must:

- Include representatives of the community and of each county government served by the coordinated care organization, 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 coordinated care organization; and
- Annually publishing a report on the progress of the community health improvement plan.

Community Advisory Council members will be surveyed annually to assess their satisfaction with the level and quality of their engagement with the functions of the CCO board.

Community Health Assessments and Community Health Improvement Plan (STC 25a)
Community health assessments and the resulting community health improvement plan are required annually of each CCO. 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.

Non-Traditional Healthcare Workers (STC 18j)
Non-Traditional Healthcare Workers (NTHW) include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems, including reaching fee-for-service members. NTHWs take health care beyond the four walls of clinics and hospitals, out into homes and the community, supporting healthcare transformation in a variety of ways.

By focusing on culturally sensitive and linguistically appropriate approaches, NTHWs support adherence to treatment and care plans, coordinate care and support system navigation and transitions, promote chronic disease self-management, and foster community-based prevention. In order to build a health care workforce for the future, Oregon will:

- Establish systems for certifying NTHWs and certify 300 new community health workers by December 2015;
- Establish infrastructure to accelerate the certification of health care interpreters and certify 100 interpreters by June 2016; and
- Establish a curriculum within the Transformation Center learning collaboratives that supports best practices in using this new workforce to improve access and outcomes.

Patient-Centered Primary Care Home (PCPCH) Adoption (STC 18k, 25, 40c.viii, ix)

The Patient-Centered Primary Care Home (PCPCH) is integral to health systems transformation, and is defined by Oregon's statewide PCPCH standards and measures[7], developed through a public process to advance the three-part aim. These PCPCH standards call for a focus on patient-and-family-centered approach to all aspects of care, wellness and prevention, culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner. PCPCHs are available for both CCO and FFS members alike.

Practices are recognized to meet the criteria for one of three tiers, with tier one being the basic level, tier two an intermediate level, and tier three a more advanced level of practice. There is a crosswalk so that practices that are NCQA-certified medical homes can use that as a portion of their requirement for designation. Health plans and other payers can then use the tiers to determine payment to incent and support the model.

Through a state plan amendment, OHA is currently providing tiered payments to recognized clinics for care to Medicaid enrollees with specific chronic diseases using federal funding through the Affordable Care Act's Section 2703. Several private payers are also paying an incentive payment to certified clinics based on the Oregon PCPCH standards, including those in partnership with the state and Medicare through the Centers for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care Initiative to 70 Oregon clinics.

House Bill 3650 (the enabling legislation for health system transformation) calls for CCOs to provide access to services through PCPCHs to the greatest extent possible. Through its contracts with CCOs, Oregon will encourage CCOs to use alternative payment methodologies that support PCPCH functions. Oregon will assess the implementation of PCPCHs through the

[7]See:http://www.oregon.gov/oha/OHPR/pages/HEALTHREFORM/PCPCH/standards.aspx

statewide PCPCH recognition process, CCO performance monitoring, and by assessing the percentage spent on primary care services and numbers of enrollees attributed to PCPCHs over time.

CCOs will demonstrate how they will use PCPCH capacity to:

- Partner with and/or implement a network of PCPCHs to the maximum extent feasible;
- Require other contracting health and services providers to communicate and coordinate care with PCPCHs in a timely manner using HIT/HIE technologies;
- Incent and monitor for comprehensive transitional care;
- Assure that beneficiaries receive integrated, person-centered care and are fully informed partners in transitioning to this new model of care;
- Assure that beneficiaries are informed about access to non-traditional providers as they are available through the CCO. Non-traditional providers may include personal health navigators, peer wellness specialists, and community health workers; and
- Assure that the primary care team provides culturally and linguistically appropriate assistance to beneficiaries in accessing needed services.

To further support the development of PCPCH capacity in Oregon, with funding from the Northwest Health Foundation and the Health Resources and Services Administration (HRSA) State Health Access Program, OHA awarded a $1.3 million contract to the Oregon Health Care Quality Corporation (Quality Corp) to establish a public-private partnership focused on supporting primary care transformation. The PCPCH Institute will provide technical assistance to Oregon clinics looking to improve care and gain recognition as patient-centered primary care homes.

Quality Corp will facilitate a collaborative and open process to establish the PCPCH Institute, beginning with the appointment of an expert oversight panel. The panel will include practicing providers with PCPCH knowledge and experience, experts in PCPCH learning techniques, behavioral health experts, public and private health system representatives, Independent Physicians Association representatives, and OHA staff. The Institute will invite proposals from interested technical assistance providers and organizations and the expert panel will oversee the selection process.

Once organizations are selected for providing specific services, a broad array of technical assistance will dramatically expand the quality and capacity of resources available to primary care clinics in Oregon including:

- The PCPCH learning collaborative

- A comprehensive, interactive learning system website
- Online learning modules and webinars
- Practice facilitation or "coaching" services
- Quality improvement training via a train-the-trainer model.

The Oregon Health Authority, Northwest Health Foundation, and Quality Corp will also be working to sustain the PCPCH Institute as an ongoing vehicle to support the patient-centered care model that will result in significant improvements in health care quality and outcomes in Oregon.

The Public Health Division (PHD) and the Office for Oregon Health Policy and Research are collaborating on the implementation and oversight for the PCPCH Program evaluation site visits in order to maintain the integrity and outcomes of the Program. PHD will train site evaluators that will conduct site visits in order to assist PCPCHs in identifying areas of strength and improvement.

In addition to these supports, the quality pool for CCOs will include an incentive for member enrollment in PCPCHs. *See Part III and Appendix 1.C for more details on Oregon's Measurement Strategy and Quality Pool Structure.*

Health Information Technology (HIT) is another tool that will support transformation; see the discussion of HIT initiatives at the end of Section IV, under the heading Health Information Technology.

Coordination with Other State Agencies

Public Health Division

Many of the factors that lead to chronic disease and disability, including unhealthy behaviors, 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 systemic barriers and root causes of poor health outcomes as well as corresponding risk factors such as tobacco use, poor nutrition and physical inactivity. Oregon's healthcare transformation initiative specifically delineates expectations that CCOs will address these root causes through the community needs assessment, community health improvement plan, the Community Advisory Council and collaboration with state and local public health agencies and community partners.

Through the Transformation Center, the state's Public Health Division will work with local health departments to collaborate in developing training and technical assistance for CCOs that

includes webinars, group training, individual coaching, and sharing of best practices, related to health promotion and disease prevention. This would include topics such as:

- The development and implementation of evidence-based cessation services, including benefits, referral systems, tobacco use as a vital sign, and integrating cessation support into electronic health records.
- The development of tobacco-free campus/worksite policies.
- The development of nutrition standards for hospital campuses, worksites and health care settings.
- USPSTF clinical preventive services recommendations for colorectal, breast, and cervical cancer screening, with specific emphasis on the importance of evidence-based colorectal cancer screening.
- The development and implementation of evidence-based chronic disease self-management programs, including referrals through electronic health records.

OHA will also be establishing a prevention policy committee that spans its operating divisions, including mental health, Medicaid, and public health to ensure that the OHA's policies support prevention in healthcare settings, extend prevention linkages between healthcare settings and communities, and integrate a variety of programmatic and professional approaches. This policy committee will consider issues related to supporting the CCOs, including operational policy issues and payment policy issues to support the three-part aim through prevention, and will review and make recommendations upon the request of the OHA Director. Issues the committee might consider include facilitating payment mechanisms for evidence-based chronic disease self-management programs such as Living Well with Chronic Conditions that are known to reduce the burden and costs associated with chronic diseases.

Office of Equity and Inclusion (OEI)

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.

Through the Transformation Center, the Office of Equity and Inclusion (OEI) will assist in developing a curriculum for CCOs and Medicaid providers that will include webinars, group training, individual coaching, information sharing, and technical assistance related to health equity. This would include topics such as:

- Language access services such as interpretation, translation, signage, web sites.
- Job descriptions, training, recruitment and retention of community health workers and other non-traditional health workers.
- Diversifying the health care workforce.
- Diversity and inclusion best practices.
- Diversifying community advisory boards.
- Including equity and diversity in CCO community health assessments and improvement plans.
- Cultural competence continuing education for all staff.
- Race, ethnicity, and language data collection, analysis, and reporting for quality improvement, and
- Community outreach and partnership with trusted culturally competent community and faith based organizations.

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. 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. OHA is coordinating with the ELC to ensure that a broad view of early learning is adopted, one that 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 ELC and OHA are seeking shared opportunities for coordination of services, workforce training, data sharing, quality measurement, and accountability for child outcomes.

Oregon Patient Safety Commission

OHA will partner with the Patient Safety Commission to make the Commission's Breakthrough Series Collaboratives available to CCOs, and to bring learnings from the work of the commission to improving patient safety throughout the Medicaid population.

III. Oregon's Goals

Oregon is engaged in multiple efforts to achieve the three-part aim. Through specific objectives, ideal behaviors, supportive stimuli, and through an infrastructure of learning systems to support rapid cycle improvement, the state can achieve lower costs, improve quality of care and improve the patient experience.

A. Lower Costs

In the past two decades, Oregon's health care expenditures have been increasing exponentially. It is one of the sectors of Oregon's economy with the highest growth rate, averaging 7.6 percent annually. Medicaid served 14 percent of the Oregon population in 2010. Its expenditures, at $3.3 billion, represented 12 percent of the total healthcare spending in 2010, and per capita Medicaid expenditures were $6,049.[8]

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as $10 billion in the FY 2017-2019 biennium with more than 900,000 individuals enrolled in the program. This figure includes approximately over 200,000 newly eligible under federal health reform expansion provisions that take effect in 2014.

With healthcare costs increasing unsustainably, a key goal of healthcare transformation in Oregon is to reduce the growth in statewide PMPM Medicaid spending by one percentage

[8]Sources: Population counts: Portland State University; 2010 expenditures by payer type from 1990-2004 National Health Expenditure (NHE) Data, Center for Medicare & Medicaid Services (CMS).

point in demonstration year two and by two percentage points over demonstration years three, four, and five.

Specific objectives:

1. Decrease trend rate by two percentage points as evidenced by total cost PMPM.
2. Meet or exceed 90th percentile national Medicaid benchmark for ED visit rates.
3. Meet or exceed national Medicaid benchmark for all cause readmissions

LOWER COST			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	Align provider financial incentives to achieve the Three-part aim Take meaningful action to reduce administrative waste Be creative with deploying flexible services Be creative with deploying caregivers directly when appropriate	Global budget creates incentive to coordinate care and eliminate redundant organizational structures Transparency: o Avoidable ED visits o ED utilization o PQI o Re-admissions to hospital o % of service dollars for enabling services for SPMI populations o Length of stay in various care settings for SPMI population Incentives: o Follow-up after hospitalization for mental illness o EHR adoption	• Analytic support: quarterly analysis of: o PQI o Avoidable ED visits o Expenditures per CCO o High utilizers • Innovator agents work with CCO to use results of analysis to determine most efficacious interventions in rapid cycle improvement (RCI) • Innovator agents recommend and provide information regarding best practices, innovative models, to address issues in RCI, e.g.: o Financial models, including alternative payment methodologies o Financial tools, such as groupers o Models for administrative simplification

LOWER COST			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
		o ED utilization Contract requirements for: • Flexible services • NTHWs • APMs	• Transformation center provides TA and tools related to the "starter set" of promising alternative payment models (APMs) including: o Bundled payments o Risk and gain sharing arrangements o Global payments o Service agreements aligning primary and specialty care incentives
Providers:	• Coordinate care with other providers • Coordinate care with community resources and services • Offer after-hours help and alternatives to the emergency department • Avoid duplicative and unnecessary services	Alternative payment methodologies Flexible services	• PCPCH adoption • Case managers and NTHWs • Support with community health solutions • Innovator agents work with CCO to share data analyses with PCPs • Transformation Center supports innovative strategies such as community health workers to address needs of high utilizers; use of flexible services

B. Better Care: Quality of Care

An in-depth examination of Oregon managed care organizations' (MCOs) historical performance on a number of measures of quality of care reveals significant areas where performance should improve to equal the national Medicaid average. In other measures, Oregon performs at the national average. In either case, it is important to maintain the level of quality and strive to improve it. Thus, Oregon set objectives to meet or exceed national Medicaid averages where they are available, focusing on areas that are closely aligned with the overall goals of health system transformation. For some measures, an Oregon baseline has not yet been calculated, but it is believed that the measure is critically important to evaluating the quality of care provided.

Specific objectives:

1. Improve developmental screening by 36 months to align with Oregon Early Learning Council objectives (no national baseline available).

2. Meet or exceed the 75th percentile of the national Medicaid average on HEDIS timeliness of prenatal care visits, 69.4%, using administrative data only.

3. Meet or exceed the March of Dimes goal of <5% rate of elective deliveries before 39 weeks. Establish baseline in DY11.

4. Meet or exceed the 75th percentile national Medicaid benchmarks for diabetes care (HbA1C poor control). Pay for measurement and reporting in DY12 and DY13, pay for performance beginning in DY14. Access to the challenge pool will be based on pay for performance beginning in DY13.

5. Meet or exceed the 75th percentile national Medicaid average for controlling hypertension (HEDIS). Establish baseline in DY11. Pay for measurement and reporting in DY12 and DY13; pay for performance in DY14. Access to the challenge pool based on pay for performance beginning in DY13.

6. Maintain or improve colorectal cancer screening. Set target at 49% (based on improvement across Oregon's Medicaid plans since 2002).

7. Improve substance abuse screening (SBIRT): Establish baseline in DY11 and set benchmark for DY12.

8. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.

9. Maintain or improve to meet or exceed the 90th percentile of the national Medicaid average for follow up after hospitalization for mental illness.

10. Improve mental health and physical health assessment in children in DHS custody. Establish baseline in DY11 and set benchmark for DY12.

11. Improve screening for clinical depression and follow up plan. Establish baseline in DY11 and set benchmark for DY12. Pay for measurement and reporting in DY12 and DY13, pay for performance beginning in DY14. Access to the challenge pool based on pay for performance beginning in DY13.

12. Meet or exceed the 90th percentile national Medicaid benchmarks for follow up care for children on ADHD medication

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to improve care coordination, including behavioral health • Encourage providers to exceed benchmarks for meaningful use and participate in HIE • Engage meaningfully with community, including culturally and linguistically diverse communities, to address its health needs • Encourage members to take an active role in their care	Global budgets provide stimulus for integrating and coordinating care Financial incentives: • Screening for addiction, brief intervention and referral to treatment (SBIRT) • Follow up after hospitalization for mental illness • Diabetes control • Colorectal cancer screening • Hypertension control • Elective delivery before 39 weeks • Timeliness of prenatal care visits • Developmental screening by 36 months • Mental health and physical health	• Learning collaboratives that target areas of concern • Provide TA as needed on PIPs • Innovator agents champion and share ideas • Transformation Center supports analysis of data by race, ethnicity and language to assure equitable quality of care • Support and encourage employment of NTHWs through registry of workers, establishment of certification criteria, and partnerships with community colleges • Transformation Center shares best practices, evidence-based interventions, and care models across communities • Public health supports through evidence-based interventions to improve population health

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
		assessment for children in DHS custody • EHR adoption Transparency: Quality measures will be tracked and posted on the OHA website. See Part III for the complete listing. Contract requirements for: • Focus areas (PIPs) • Community needs assessment • Community Advisory Council • Transformation plan	• Work with Oregon Patient Safety Commission to bring information about best practices and evidence-based interventions to improve patient safety to CCOs
Providers:	• Strive for tier 3 PCPCH status • Coordinate care with other providers • Coordinate care with community resources and services • Help patients navigate the healthcare system • Encourage patients activation • Show respect to patients and families • Adhere to clinical guidelines • Use data to ensure timely follow up, prevention, and	• Incentives for PCPCH status • Incentives for EHR adoption • Payment methodologies that incentivize performance	• Community support through public health • Utilization of NTHWs • Transformation Center and Innovator agents share best practices and resources • Feedback on performance measures

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
	interventions • Increase healthcare workforce diversity, including non-traditional health care workers • Access cultural competency continuing education		

C. Better Care: Access to Care

Oregon exceeds national Medicaid benchmarks in some measures of access, particularly for access to primary care and ambulatory care visits. For Consumer Assessment of Healthcare Providers and Services (CAHPS) measures, Oregon is often just below national Medicaid CAHPS measures of access. For adolescent well care visits, Oregon is below national Medicaid average and our goal is to improve it to meet that standard.

Specific objectives:

1. 100% of beneficiaries will have access to a certified PCPCH.
2. 75% of PCPCH sites will be certified as tier 3.
3. Meet or exceed the AHRQ national in patient sample rates for primary care sensitive admissions (PQI).
4. Rates for avoidable ED visits will meet or exceed (i.e., be lower than) national Medicaid averages.
5. Dental visits for children (after 2014) will meet or exceed national Medicaid averages.
6. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.

ACCESS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to meet level 3 PCPCH certification • Care about and take action to increase access • Encourage use of NTHWs • Support culturally and linguistically specific outreach and engagement to promote access • Support availability and use of culturally and linguistically appropriate materials	Transparency: Access measures will be tracked and reported on the OHA website. See Part III for additional details. Contractual requirements for: • Transformation plan must incorporate model of care that addresses access issues • Community needs assessment must address access • Community Advisory Council provides ongoing feedback on access to CCO Financial incentives: • CAHPS survey questions about access • ED utilization • Access to PCPCH • Adolescent well visits	• Support for NTHW, who help increase access by helping members navigate the healthcare system and advocating for them as needed • Data analytic support on measures of access • Innovator agents bring resources on best practices and innovations to increase access • Learning collaboratives focus on improving access • Support from Office of Equity and Inclusion to promote culturally competent care that is welcoming to all and increases access
Providers:	• Offer after-hours help and alternatives to the emergency room • Help patients navigate the healthcare system • Diversify the workforce	PCPCH financial incentives	• Learning collaboratives • NTHWs and HCIs

D. Better Care: Experience of Care

Patient-centeredness is the key component of the care Oregon aspires to provide to Medicaid beneficiaries. By encouraging feedback from patients about their experience of care, OHA learns how to make significant improvements in the quality of the care provided and build a model of care that meets their needs. In Oregon, CAHPS scores for patient experience of care measures for individuals are slightly lower than the national Medicaid average for adult members reporting getting needed care and positive communication with a doctor, but slightly higher for getting care quickly.

Specific goal:
Meet or exceed the 75th percentile of the national average for Medicaid CAHPS (for both adults and children) experience of care tools for specified composite measures that focus on areas critical to Oregon's goals for health system transformation:

- Access to care composite, for both children and adults

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
CCOs:	• Adopt value-based purchasing • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care	Transparency: OHA will post on its website: • CAHPS survey results • Performance metrics by race and ethnicity. Financial incentives: CAHPS survey questions are included in quality pool metrics: ▪ Composite: Health plan's customer service gave information or help you needed ▪ Composite: Getting care quickly Contract requirements include quarterly reporting of grievances and appeals by CCOs (*see section IV)*	• Data from CAHPS and other surveys used to identify learning needs • Innovator agents : o support improvement with learning collaboratives, peer-to-peer learning o Collaborate with the OHA Ombudsman to monitor emerging trends in complaints and appeals assigned CCOs. o Provide feedback to assigned CCOs and identify needs for peer-to-peer and learning collaboratives to address problems as they arise. • Community Advisory Council monitors patient experience and works with CCO to improve in identified areas • Office of Equity and Inclusion

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
			supports provision of culturally competent care which will improve the patient experience
Providers:	• Help patients navigate the healthcare system • Are accessible • Put patients first • Encourage patients to play an active role in their care • Show respect to patients and their families	Value-based purchasing and provider incentives encourage providers to address needs of patients	• Community support through public health • NTHWs support members in navigating healthcare system and getting needed services • Best practices and sharing of resources (e.g. Quit Line)

E. Better Health

The ultimate test of the effectiveness of a healthcare system is the health of the people who use it. While pursuing the goals of lower cost and better experience of care, it must be assured that at the very least health and healthcare are not degraded, and aim to improve them.

To improve population health and lower costs, Coordinated Care Organizations must address the increasing burden of chronic diseases. Chronic diseases account for 75 cents of every health care dollar spent. Eighty percent of health care resources are spent on 20 percent of members,[9] most of whom have multiple chronic conditions that are complex to manage. Chronic diseases that remain undetected untreated and poorly managed result in increased hospitalizations, costly medical interventions, lower productivity and, most importantly, lower quality of life for Oregonians.

Health status: Oregon's baseline data for Medicaid, taken from the 2011 Medicaid Adult CAHPS survey, reveals health status responses that are below national averages as well as health status of Oregon's general population as reported on the 2010 BRFSS:

[9] Agency for Healthcare Research and Quality

	Oregon CAHPS (Medicaid)	National Average CAHPS (Medicaid)	Oregon BRFSS Adult General Population
Excellent	7%	11%	19%
Very good	16%	22%	33%
Good	33%	32%	30%
Fair	29%	24%	13%
Poor	14%	10%	5%

Obesity: Oregon's 2010 BRFSS data reveal an adult Medicaid obesity rate of 38.3 percent, compared to 27.7 percent of the general population in Oregon. *(Note: the Medicaid data are not age adjusted, while the general population data are)*.

Tobacco: The current adult Medicaid rate of tobacco use is 31 percent (CAHPS 2011), compared to 23 percent in the general population in Oregon (BRFSS 2010). Oregon Medicaid is below the national average of 37 percent (Medicaid CAHPS), but tobacco use is a major driver of long-term health risks.

Specific objectives:

1. Reduce the proportion of beneficiaries who report their health status to be poor to 10 percent by 2017**.** Oregon will initially assess health status through the use of the CAHPS survey. It is expected that health status will be evaluated through a self-assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

2. Obesity as calculated from self-reported height and weight will not exceed 41 percent over course of the demonstration. Oregon will initially assess obesity through the use of the CAHPS survey. It is expected that a self-assessment tool will be available as part of a new online enrollment system projected to come on line in 2014. Enrollees will be asked to state their height and weight, from which a BMI can be calculated.

3. Decrease tobacco use in the Medicaid population to 25 percent over the course of the demonstration. Oregon will initially assess tobacco use through the use of the CAHPS survey. It is expected that tobacco use status will be determined through a self-assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

4. Reduce ethnic and racial disparities over the course of the demonstration. Establish baseline in first year of the demonstration. Use enrollment data, which identifies race, ethnicity, and foster child status to compare these groups for health status, obesity and

tobacco use. In the first year of the demonstration, develop strategy to identify disabled and Serious and Persistent Mental Illness (SPMI) populations, and establish baseline for disparities among all groups.

HEALTH STATUS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Care about and take actions to guarantee strong member outcomes • Use value-based purchasing to improve outcomes • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care • Focus on health equity	Contract requirements: • CCOs must perform a community health assessment in the first year • CCO's transformation plan must reflect the community health assessment • Community Advisory Council (CAC) will guide the development of the community health assessment, connect the CCO with the community, and hold it accountable to improving the health of beneficiaries enrolled Financial incentives for PCPCH adoption Transparency: publish health outcomes data by CCO on the OHA website. Relevant performance measures include: • Health and functional status among CCO enrollees;	The Transformation Center will provide data and analytic support to CCOs for race/ethnicity composition of their population and inequities in performance metrics and the community health assessment Innovator agents work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work, champion and share ideas. Office of Equity and Inclusion will support CCOs in designing culturally appropriate strategies to improve health

		• Rate of tobacco use among CCO enrollees; • Obesity rate among CCO enrollees • Reduction of disparities: differences in these metrics among race and ethnicity categories Community Advisory Council Community Needs Assessment PCPCH incentives	
Providers:	• Encourage patients to play an active role in their care	PCPCH incentives	• The Public Health Division will work with local health departments to support the implementation of evidence-based community interventions • Support for the employment of NTHWs through a registry of workers, establishment of certification criteria, and partnerships with community colleges

IV. Assessment

To monitor how well Oregon's coordinated care model is achieving its goals of access and quality improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have a robust measurement and reporting strategy and mechanisms to monitor and assess all Medicaid delivery systems (including Coordinated Care Organizations and Fee-for-Service). Full details on how the Oregon Health Authority will measure quality of and access to care for the Oregon Health Plan population are available in Part III: Oregon's Measurement Strategy. The format for the state's required quarterly reporting to CMS on quality, access, and many other elements of the demonstration can be found in STC Attachment A, Quarterly Report Guidelines. This section describes Oregon's assessment program, available data sources, requirements for credentialing, and an overview of health information technology.

Performance Monitoring

As required by CFR 438.202(d), the state assesses how well the Coordinated Care Organizations 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. Oregon's evaluation plans, described in Part II, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries.

In addition, OHA monitors plans activities on an ongoing or periodic basis for the level of contract compliance. Assessment program components are described below:

On-site operational reviews – Operational reviews are conducted on a regular basis. These reviews are designed to supplement other state monitoring activities by focusing on those aspects of CCO performance that cannot be fully monitored from reported data or documentation. These reviews focus on validating reports and data previously submitted by the CCO through a series of review techniques that include an assessment of supporting documentation and conducting a more in-depth review of the CCO's quality assurance activities.

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 the 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 reviews – 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.

Complaint, grievance and appeals reports – 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.

Fraud and abuse reports – 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 committee 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.

Data Sources

Oregon assesses the quality and appropriateness of care through the collection and analysis of data from many sources. The state has developed many systems to collect data from plans and plans are required to have information systems capable of collecting, analyzing, and submitting the required data and reports. Data sources include:

Administrative Data – All CCOs, managed care plans, 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.

In the MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Ethnicity is currently defined as Hispanic/non-Hispanic. Oregon does not have data on multiple races. Oregon only has data on preferred household language, not language spoken by an individual client.

Community Health Assessment – CCOs are contractually required to submit the community health needs assessment to OHA. For additional detail on the community health assessment, see section II, above.

Enrollment Data – Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

As the state moves to an online enrollment system in 2014, data collection on race, ethnicity, and language will be improved and additional data will be collected through this system, including tobacco use status and body mass index (BMI). All enrollment data is shared with the plans.

Member Satisfaction Surveys – Oregon, in conjunction with its external quality review agent (EQRO), conducts statewide-standardized surveys of patients' experience of care (satisfaction). These surveys allow for plan-to-plan comparisons. Plans are required to participate, as appropriate, in the performance of such surveys. Plans whose results are meaningfully and statistically below acceptable thresholds may be required to develop a corrective action plan that the state will review and monitor. The results of the surveys are made available to

Medicaid beneficiaries to assist them in the processes of selecting an appropriate plan. Survey results are shared with plans and reports are published on the OHA website.

Participating provider network reports – Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turn over.

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 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.

Credentialing

Managed care 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.

CCOs must also work with OHA through the Addictions and Mental Health Division and Public Health Division to assure proper credentialing of Mental Health Programs, associated providers and non-traditional health care workers. *See Appendix 1.E for a list of contractual elements and associated OARs.*

Health Information Technology

Adoption of Electronic Health Record Technology and Meaningful Use (STC 25c)

The Medicaid Electronic Health Record (EHR) Incentive Program provides incentives to certain providers who adopt and demonstrate meaningful use of certified electronic records. The program began in 2011 and concludes in 2021. Initial participation by eligible professionals (EPs) may begin any time until 2016. Oregon requires that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The Metrics and Scoring Committee is developing measures and benchmarks that will demonstrate CCO commitment to exceed the federal standards for EHR adoption. *See Part III for details on measures and benchmarks.*

Information Sharing

Health information exchange activities are critical for central elements of this demonstration, including reporting of quality metrics, progress with meaningful use of electronic health

records, meaningful care coordination, and real-time data assessments. CMS has made funds available, at state request, for the Medicaid portions of the health information exchange infrastructure. These funds could help support the HIE provisions outlined in STC 25(c).

The Health Information Technology Oversight Council (HITOC), created legislatively in HB 2009, has guided the development of Health Information Exchange (HIE) work in Oregon. HIE is not a single technical solution, but rather includes any solutions that allow health information to be made available to the provider at the right time and in the right place to meet patient needs. For Oregon's first phase of HIE, HITOC selected the standards for secure, HIPAA-compliant electronic messaging developed by the Direct Project through the Office of the National Coordinator for Health Information Technology (ONC). Using these standards, statewide Direct Secure Messaging was developed through the Oregon Office of Health Information Technology (OHIT) and launched in May 2012 under the brand CareAccord™. OHIT is tracking the number of Direct addresses in use and number of Direct messages being sent through CareAccord™ as one way to measure growth in information exchange.

Direct Secure Messaging is not the totality of HIE, and currently Oregon is in the process of gathering stakeholder input from within the state, from CCOs, from patient groups, and others to determine the right path for the development of further HIE services.

Recommended measures start with those that ONC has published in a program information notice (PIN) for HIE which established that states report the following measures annually:

- Percent of pharmacies participating in e-prescribing
- Percent of clinical laboratories sending lab results electronically and in structured format
- Percent of providers and hospitals sharing patient care summaries electronically
- Percent of state health programs within the Oregon Department of Health electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results

In addition, each CCO is contractually obligated to meet standards in foundational areas of health IT. This includes facilitation of providers' adoption and meaningful use of EHRs and ensuring that every provider either is registered with a statewide or local Direct-enabled health information service provider (HISP), or is a member of a health information organization (HIO) that enables electronic sharing of information with other providers in the CCO's network. Also, each CCO must develop a transformation plan that demonstrates, among other elements, how it will develop EHRs, HIE and meaningful use. The Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) are also investigating the inclusion of measures for HIE in future contracts.

These developments in EHR adoption and HIE support better collection of timely, actionable data to enable quality measurement and improvement.

Trailblazer State Project

The HIT Trailblazer Project is a new technical assistance award from ONC and supported by the National Academy for State Health Policy (NASHP) for a small number of states that are leading the nation in health system transformation. An action plan will be developed by March 2013 for the technical infrastructure for statewide quality reporting and feedback. Part of the assistance that the federal partners will be providing Oregon is an understanding of the federal vision for quality measures and how those can be aligned with the state measures to reduce the burden on providers for reporting while providing metrics that are meaningful to Oregon's specific implementation of health system transformation.

V. Contract Compliance

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 1.E 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.

Delivery System Performance Monitoring

Oregon has developed a comprehensive program to assess all aspects of the delivery system. As described in section IV, above, 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.

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 described in section IV above.

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.

External Quality Review Organization Activities

OHA has contracted with Acumentra Health to serve as its external quality review organization (EQRO). In compliance with federal regulations, the scope of work includes all mandatory activities: compliance reviews every three years, validating health plan Performance Improvement Projects; 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.

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. These Quality Management Plans (QMPs) are reviewed, along

with documentation of the activities and studies undertaken as part of the QMP during both the certification process and ongoing EQRO reviews.

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. A list of conditions that may result in sanctions can be found in Appendix 1.F.

VI. Review of CCO Quality Strategy

The Quality Strategy shall be reviewed annually by OHA. This annual review and update will begin each August and shall be completed by December of each year. The Quality Strategy update will be provided to CMS in December of each year upon significant changes.

The OHA Quality Committee 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:

- AMH Planning and Management Advisory Council (PAMAC)*
- Medicaid Advisory Committee*
- DMAP/AMH Executive Team
- OHP Medical Directors
- OHP Contractors

- OHP Quality Management Coordinators
- Local Government Advisory Committee*
- DHS 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.

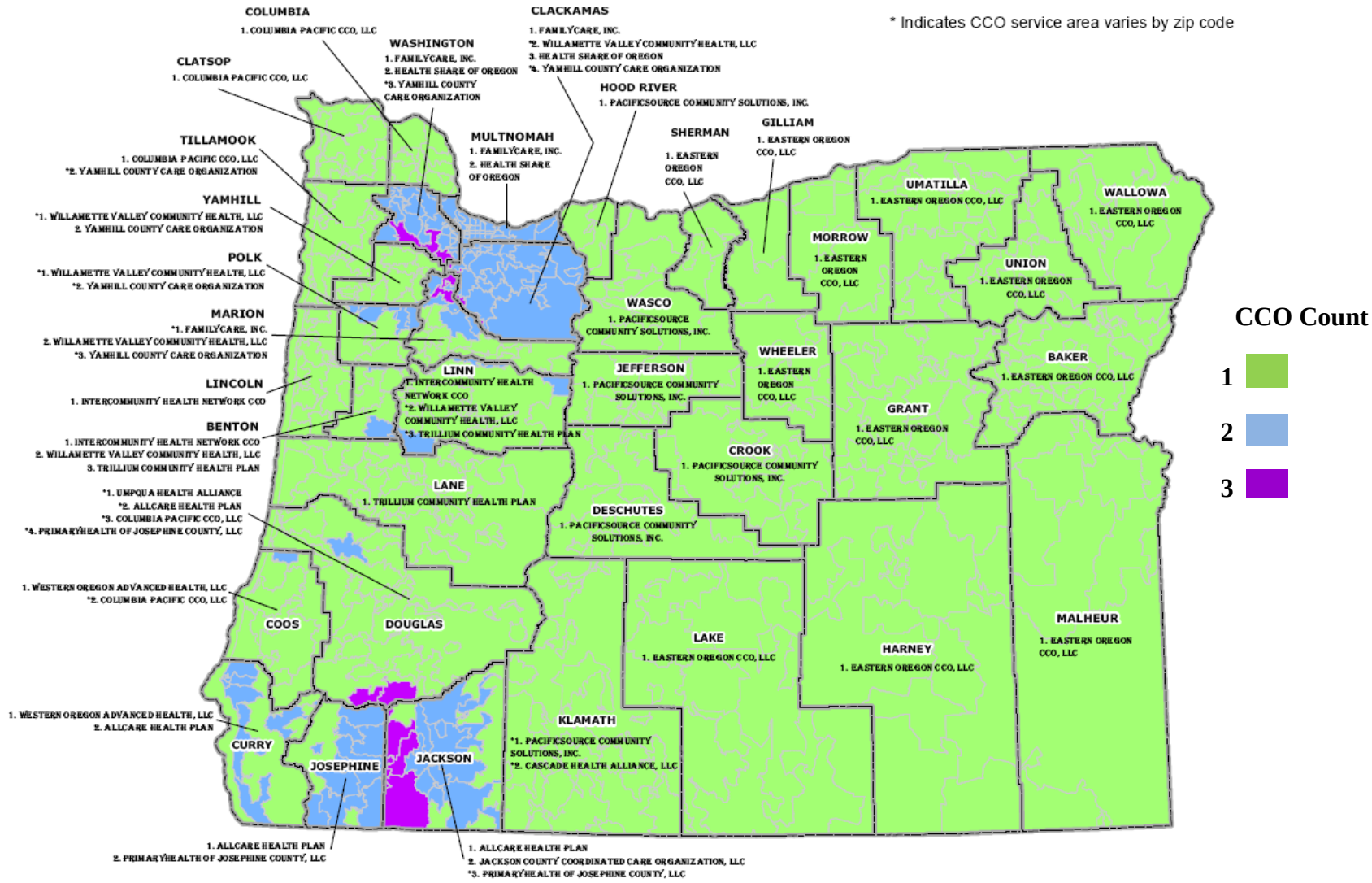
VII. Achievements and Opportunities

Passage of House Bill 2009 and HB 3650 are important achievements for the state and present a significant opportunity for Oregon to expand work already in progress to improve population health and increase access to high quality, efficient, and cost effective health care.

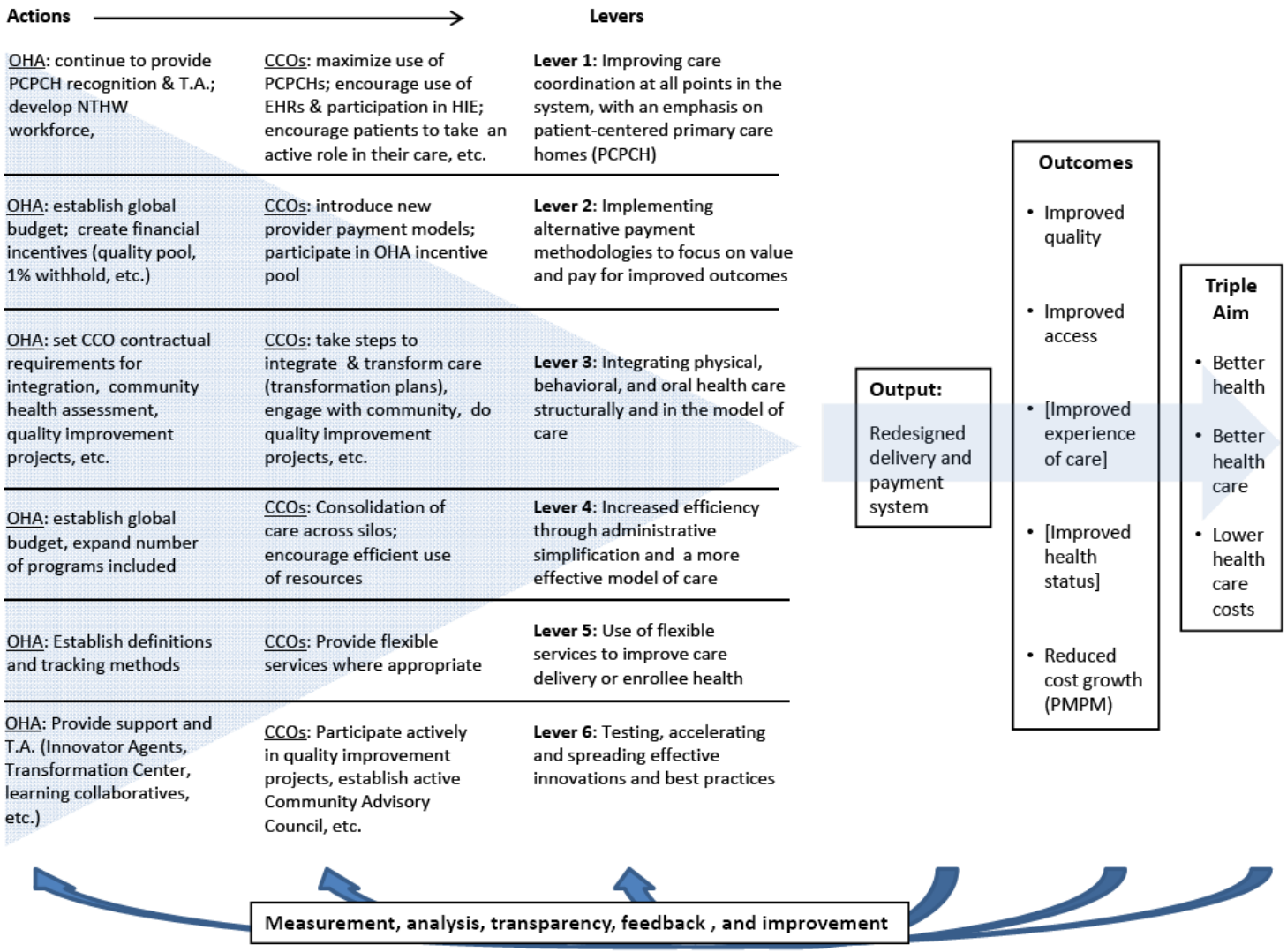
Oregon has a strong foundation for future health system transformation based upon the 20-year history of the Oregon Health Plan, and the extensive knowledge and experience developed during that time, including the unique use in Oregon of the Prioritized List of Health Services under the Health Services Resource Commission.

With the creation of the Oregon Health Authority consolidating all state health agencies in Oregon, there is further opportunity for increased focus and support for the Quality Strategy, including alignment with other quality and health improvement initiatives.

Appendix 1.A: Coordinated Care Organization Service Area Density



Appendix 1.B: Theory of Action Model



Appendix 1.C: Quality Pool Structure (STC 37b.ii)

Introduction

Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. By establishing a quality incentive pool as required by STC 37b.ii, the state is taking the first step in this process. It is expected that over time, savings accruing from the restructuring of 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.

OHA's Strategy for Annually Setting the Amount of CCO Payment at Risk for Performance

OHA's strategy is to annually increase the percentage of CCO payment at risk for performance over the term of the demonstration. OHA believes that unless CCOs have a meaningful percentage of their payment at risk for performance, they are unlikely to take the steps necessary to achieve significant performance improvement and affect transformative change in care delivery. OHA also believes that it must be careful to not make the at-risk amount so large as to threaten the financial viability of a CCO should it not perform well relative to the contractual targets.

Because performance-based contracting is new to both OHA and CCOs, OHA anticipates the need to annually assess the experience, with CCO and Metrics and Scoring Committee input, and then determine both a) changes to the quality incentive pool methodology, and b) the desired level of CCO financial risk for the next contract year.

OHA recognizes that while a substantive incentive payment will provide meaningful motivation for CCOs, research has shown that fear of loss is a greater motivator than is the potential for gain.[10] For this reason, OHA intends to increase the at-risk amount by a percentage point each year of the demonstration—meaning poor performance could result in a loss of margin–although not a loss so large as to threaten the CCO's stability.

OHA's Planned Approach for Defining the At-Risk Amount for the DY12 Contract Year

OHA plans to finance the Quality Pool for the demonstration year 12 (DY12) contract year at two percent of the aggregate value of the per member per month (PMPM) CCO budget. Specifically, OHA will make disbursement of these funds contingent on measurement and

[10]Kahneman, D. and Tversky, A. "Choices, Values, and Frames." American Psychologist39 (4): 341–350 (1984) and Kahneman, D., Knetsch, J., & Thaler, R. "Experimental Test of the endowment effect and the Coase Theorem" *Journal of Political Economy* 98(6), 1325-1348 (1990).

reporting activities for three specific measures: diabetes control, hypertension control and depression screening and CCO performance relative to both absolute (benchmark) targets and improvement targets on the remaining measures.

Using OHA's planned methodology, there will be two rounds of funding distributions. In Round One, each CCO will have a maximum amount of Round One dollars from the incentive pool for which it is eligible in any particular contract year. This pre-determined amount will be calculated by multiplying a common PMPM value by the CCOs' beneficiary average monthly member count for the contract year. Seventy-five percent of the "pay for measurement and reporting" funds (for the three pay for measurement metrics only) will be disbursed upon OHA's acceptance of a technology plan for collecting and reporting the three specified measures, with an end of year adjustment if the monthly average monthly member count differs from that used at the time of disbursement of the "pay for measurement and reporting" funds. The remaining twenty-five percent of the "pay for measurement and reporting" funds will be dispersed upon the CCO's reporting of the three measures. OHA plans, however, to set a floor such that regardless of enrollment, each CCO shall be eligible to earn at least $1 million dollars, assuming maximal performance, through the incentive pool. OHA has adopted this strategy in order to ensure that small CCOs have sufficient grounds for making necessary investments in quality improvement.

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs in a second round of funding distribution called the "challenge" round. The challenge funds will be distributed to those CCOs that meet the performance (or measurement) targets on a subset of four incentive measures described in this document as "challenge measures." A complete description of the challenge measures and the distribution of challenge funds are provided below.

CCOs will only be rewarded for attaining performance (or measurement) targets ***or*** improving performance; there will be no penalties assessed related to performance in DY12.

OHA believes this strategy is appropriate for the first year for the following reasons:

- CCOs will view an incentive pool equivalent to the aggregate size of the rate increase to be sizeable, particularly given the large rate cuts experienced previously by the predecessor MCOs. The CCOs will be motivated to achieve this potential reward.
- This approach has been used by commercial health plans with providers with positive results.[11]

[11]Richard Weisblatt, Harvard Pilgrim Health Care, personal communications, March 8, 2011 and October 24, 2012.

- Use of a challenge pool will allow CCOs to give special attention to those aspects of performance that are most important to OHA for DY12.
- The CCOs have never been measured or been held accountable for performance relative to many of the adopted measures. Neither OHA nor the CCOs can be absolutely certain regarding the feasibility of CCO target attainment. As CCOs develop experience with the measures and with implementing efforts to generate improvement to attain targets, they will be better prepared to accept higher levels of risk.

For the above reasons, a first-year approach that offers a meaningful incentive appears appropriate as OHA and the CCOs transition to a new method of contracting and doing business.

Timeline for Distribution of Funding in DY12

The incentive funds will be distributed on an annual basis. The incentive period will run for one calendar year (January – December 2013); there will be an additional three-month period following the incentive period to account for the time lag to obtain complete claims data and conduct any needed chart reviews, with the incentive payments to be made by June 2014.

The baseline measurement year for each of the incentive metrics will be 2011 and will be derived from combining the predecessor organizations (MCO + MHO) metrics in each service area. In areas where there is no predecessor MCO, the statewide average will be applied.[12]

The first measurement year and reporting period for the incentive measures will be 2013. Results will be available in early 2014, in time for the first quality pool distribution in the second quarter of 2014. The year two data measurement and reporting period for incentive measures will be 2014. Using this timeline, the final incentive payments of the demonstration program will not be paid until several months after the end of the demonstration period.

Process for Distributing Incentive Pool Dollars in Round One

The Metrics and Scoring Committee has selected an initial set of 17 measures, listed below. OHA will be collecting baseline data for these measures and conducting some statistical testing to determine if the selected measures and performance targets are feasible. Any revisions to the measure set will be made in coordination with the Metrics and Scoring Committee.

Measures selected by the Oregon Metrics and Scoring Committee as of Oct. 22, 2012 and negotiated with CMS as of December 12, 2012:

[12] Most CCOs have predecessor MCO organizations. In every case, they have structurally and organizationally restructured to adopt the CCO business model as well as the coordinated care model.

Prevention

1. Developmental Screening in the first 36 months of life (NQF 1448)
2. Assessment of Children in DHS Custody within 60 days (mental health and physical health)
3. Adolescent Well Care Visits
4. Colorectal Cancer Screening

Access and Patient Satisfaction and Access

5. Rate of Patient-Centered Primary Care Home enrollment (*Challenge Measure*)
6. CAHPs composite "Getting Care Quickly" (adult and child)
7. CAHPs composite "Health Plan Satisfaction" (adult and child)

Chronic Illness Management

8. Diabetes Control: HbA1c >9% (*Challenge Measure*) (NQF 0057)
9. Controlling High Blood Pressure (BP less than 140/90) (NQF 0018)

Behavioral Health

10. Screening for Clinical Depression and Follow-up Plan (*Challenge Measure*)
11. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT) (*Challenge Measure*)
12. Follow up for children prescribed ADHD medications (NQF 0108)
13. Follow-up after Hospitalization for Mental Illness (NQF 0576)

Maternal Care

14. Timeliness of Prenatal Care (NQF 1517)
15. Reducing Elective Delivery Before 39 weeks (NQF 0469)

Overuse

16. Ambulatory Care: Outpatient and Emergency Department Utilization

EHR Adoption and Use

17. Rate of EHR adoption and Meaningful Use among eligible Medicaid and Medicare providers.

In order to access the incentive pool, CCOs will be measured against a specified benchmark for each measure. CCOs that don't meet the benchmark for a given measure will be assessed against an improvement from baseline target. The benchmark and improvement targets for each measure are described in detail in Part III. The target levels of performance and

improvement are the same for all CCOs, regardless of geographic region and patient mix. All of these measures are independent from one another such that a CCO can receive an incentive payment if performance on a specific measure warrants it, regardless of overall performance.

All of the measures are valued equivalently in the algorithm. For all measures except for the Patient-Centered Primary Care Home (PCPCH) measure, performance is treated on a pass/fail basis. For example, if the benchmark is met or minimum improvement level achieved, the CCO receives all of the credit available for that measure. If neither target is met, the CCO does not receive any credit for the measure.

For the PCPCH measure, performance is measured according to the following formula known as the "tiered formula." This formula multiplies the number of members enrolled in each tier (1, 2 and 3) with the level of the tier (if 100 people are enrolled in tier 3, multiply 100 by 3), adds the totals and divides by the total number of members enrolled in the CCO multiplied by 3. The goal is to have all members enrolled in a tier 3 PCPCH so the result of the tiered formula provides a sense of where the CCO is relative to the goal. The formula is below.

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

For the three "pay for measurement and reporting" metrics in DY12, CCOs will hav e the opportunity to earn seventy-five percent of the quality pool funds tied to these metrics (e.g. 3/17ths of the quality pool) upon OHA's approval of a technology plan for electronic collection and reporting of the three specified measures. CCOs must submit their technology lan by February 1, 2014. Requirements for the technology plan are under development in collaboration with the Office of Health Information Technology and the Technical Advisory Workgroup (TAG) of the Metrics & Scoring Committee.

OHA will conduct an end of year adjustment if the monthly average member count differs from that used at the time of disbursement of these funds. The remaining twenty-five percent of the quality pool funds tied to these three metrics will be disbursed upon CCO submission of "proof of concept" data for these three metrics by May 31, 2014. In DY12, the proof of concept data submission must comprise at least 10 percent of the CCO enrollees. If CCOs are unable to demonstrate "proof of concept" data, they will not be eligible to receive the remaining twenty-five percent fo the quality pools tied to these three measures and the remaining funds will be re-distributed through the challenge pool (described below).

For DY13, OHA will apply the same approach for the three "pay for measurement and reporting metrics" for Round One, with updated requirements for the DY13 technology plan and more robust data reporting expectations, to be developed in collaboration with the Office of Health Information Technology and the Technical Advisory Workgroup (TAG) of the Metrics and Scoring Committee.

Once OHA has calculated how much incentive funding each CCO is eligible to receive and determined each CCO's level of performance against the measure targets and reporting requirements, then it will calculate the amount of the incentive funds each CCO will receive based on its level of performance.

For the three "pay for measurement and reporting" metrics, OHA will hold out 3/17ths of the total quality pool and distribute these funds based on the technology plan and "proof of concept" data criteria described above the DY12 and DY13. Funds left over if CCOS do not meet the technology plan and "proof of concept" criteria will be included in the challenge pool. In DY14 and after, the three "pay for measurement and reporting" metrics will become pay for performance metrcis with benchmark and improvement targets. A statewide baseline will be collected for DY12 and DY13 by OHA using a sampling strategy and chart review.

For the remaining fourteen measures, there are ten performance tiers ranging from 10 percetn to 100 percent of the remaining quality pool funds. As the CCOs meet more benchmarks or improvement on these fourteen measures, they receive a higher payment. If the CCO attains the benchmark or the improvement target on at least seventy-five percent of the remaining measures (10.6 measures) and met or exceeded the benchmark or improvement target for the EHR measure, then the CCO will receive 100 percent of the remaining incentive funds.

If the EHR measure is not met, then the maximum incentive payment that the CCO can receive is equivalent to the second tier of incentive payment. If the CCO gets fewer than 1 measures, then the CCO does not receive any of the remaining incentive funds. A detailed definition of the tiering methodology is provided in Table 1 below.

Table 1: Example of Initial Round Quality Pool Distribution

Tier	Percent of targets met (benchmark or improvement)	Number of targets met (benchmark or improvement)	Percent of total incentive payment for which the CCO is eligible
1	74.12-100% (with EHR)	At least 10.6 (with EHR)	100%

2	68.57%	At least 9.6 (does not require EHR)	90%
3	61.43%	At least 8.6	80%
4	54.29%	At least 7.6	70%
5	47.14%	At least 6.6	60%
6	40%	At least 5.6	50%
7	32.86%	At least 4.6	40%
8	24.71%	At least 3.6	30%
9	18.57%	At least 2.6	20%
10	11.42%	At least 1.6	10%
Nothing	Less than 7.14%	Fewer than 1	No incentive payment

Process for Distributing Incentive Pool Dollars in the Challenge Round

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs that met the benchmark or improvement target for one or more of the following measures:

1. Rate of Patient-Centered Primary Care Home Enrollment (PCPCH)
2. Screening for Clinical Depression and Follow-up Plan (Depression)
3. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT)
4. Diabetes Control: HbA1c > 9%

In the challenge round, OHA will determine the aggregate number of instances in which a CCO achieves either the benchmark or improvement target for each of the four challenge measures (Diabetes Control, Depression, PCPCH, SBIRT). For the two "pay for measurement and reporting metrics, CCO achieve the target in DY12 if they report the "proof of concept: data. In DY13 and after, access to the challenge pool for these two measures will be "pay for performance." Since the PCPCH measure does not have a benchmark, OHA will assume that all of the CCOs achieved the target. OHA will then calculate the base amount for achieving the target on this measure by dividing the challenge pool funds into equal portion equivalent to the total number of challenge targets met (e.g. if all 16 CCOs met a PCPCH target, 5 CCOs met an SBIRT target, 6 met a Depression target, and 3 met a Diabetes Control target, then the incentive fund would be divided into 30 equal portions (the "base payment").

For the Diabetes, Depression, and SBIRT measures, OHA will calculate the payments for each CCO that achieved a target on each challenge measure by adjusting the "base payment" described above based on the CCO's enrollment relative to the mean for those CCOs that met a specific challenge measure's target. This calculation will be performed separately for each of the three measures. An example of this calculation is detailed in Table 2 below.

Table 2. Example of Challenge Fund Distribution for Standard Measures (Diabetes, depression, SBIRT)

CCO Name	Base Payment	Member Months (MM)	CCO's ratio of MMs to total MM	Adjusted Challenge Fund Payment
CCO A	$ 1,666.67	29,588	1.459	1,666.67*1.459= $ 2,432.26
CCO B	$ 1,666.67	23,343	1.151	1,666.67*1.151= $ 1,918.90
CCO C	$ 1,666.67	22,788	1.124	1,666.67*1.124= $ 1,873.27
CCO D	$ 1,666.67	18,014	0.889	1,666.67*.889= $ 1,480.83
CCO E	$ 1,666.67	16,394	0.808	1,666.67*.808= $ 1,347.66
CCO F	$ 1,666.67	11,521	0.568	1,666.67*.568= $ 947.08
	$10,000 (Total pool for measure #1)	121,648 (Total MM)		$ 10,000 (total)
		20274.67 (Mean MM)		

For the PCPCH measure, the funding will be distributed to the CCOs based on a combination of results of the tiered formula and overall enrollment. For each CCO, OHA will multiply the result of the tiered formula with the total number of member months for the CCO to get an adjusted number of member months. OHA will then multiply this adjusted enrollment with an adjustment factor (the adjusted member months relative to the mean) and multiply that by the "base payment" described above to determine the total incentive payment amount for PCPCH. An example of this calculation is detailed in Table 3 below.

Table 3: Example of Challenge Fund Distribution for PCPCH

	Base Payment	Result of Tiered formula	Member Months	Adjusted Member Months	Adjusted Member Months Relative to the Mean	Adjusted challenge fund payment (PCPCH)

CCO A	$ 1,666.67	0.4 *	29,588	=11,835.2	0.969	$ 1,666.67*.969= $ 1,615.21
CCO B	$ 1,666.67	0.5 *	23,343	=11,671.5	0.956	$ 1,666.67*.956= $ 1,592.87
CCO C	$ 1,666.67	0.6 *	22,788	=13,672.8	1.120	$ 1,666.67*1.120= $ 1,866.00
CCO D	$ 1,666.67	0.7 *	18,014	=12,609.8	1.033	$ 1,666.67*1.033= $ 1,720.92
CCO E	$ 1,666.67	0.8 *	16,394	=13,115.2	1.074	$ 1,666.67*1.074= $ 1,789.90
CCO F	$ 1,666.67	0.9 *	11,521	=10,368.9	0.849	$ 1,666.67*.849= $ 1,415.10
	$10,000 (Total pool for PCPCH measure)			73,273 (Total adjusted member months)		$ 10,000.00 (total)
				12,212 (mean adjusted member months)		

Appendix 1.D: Innovator Agent Plan

Innovator agents and Learning Collaboratives

Learning Collaboratives (STC 25d)

The Oregon Health Authority will establish a CCO learning collaborative, the purpose of which is to promote innovations and activities that will contribute to the goals of health system transformation and accountability for achievement of the three-part aim of better health, better health care and lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. CCO learning collaborative members will work together to decide upon the area(s) of focus of the collaborative and work with OHA to develop appropriate performance measures. OHA reserves the right to select some of the learning collaborative topics.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract as will a requirement that when a CCO is identified by OHA as underperforming in access, quality or cost against metrics established by the OHA Metrics and Scoring Committee, the CCO will be required to participate in an intensified innovator/learning collaborative intervention.

Role of the Innovator agents (STC 25d)

Senate Bill 1580 requires OHA to provide CCOs with "Innovator agents" who will act as a single point of contact between the CCO and the OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation's three-part aim of better health, better care and lower cost.

The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability for achieving the three-part aim. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight.

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication; allowing streamlined reporting and reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports
- Assist the CCO in managing and using data to accelerate quality improvement.
- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other Innovator agents, CCOs, Community Stakeholders and/or OHA.

Tasks to be performed by innovator agents:

- Complete OHA innovator agent training (training will be developed in consultation with national experts and based on other national models, such as the CMMI Innovation Advisory program training).
- Assist and support the CCOs in developing and implementing their transformation plans.
- Assist the CCO with gathering and interpreting data to target areas of local focus for improvement.
- Gather input on CCO performance from other state agency staff working directly with the CCO, primarily the Quality Improvement Coordinator and Health Plan Coordinator.
- Communicate at least every other week with all other innovator agents (and meet in person at least once each quarter) to discuss ideas, projects and creative innovation planned or undertaken by their assigned CCO.
- Attend Community Advisory Committee meetings and provide input into Community Health Assessment process.
- Participate in innovator agent learning collaborative; Participate and/or convene in other learning collaboratives as appropriate (CCOs, providers, etc.).
- Ensure rapid-cycle stakeholder feedback to identify and solve barriers; to assist with adapting innovations to simplify and/or improve rate of adoption; and to increase stakeholder engagement.

- Track questions / issues from CCOs and the answers/resolution, establishing a database not only to serve as the basis for a FAQ and information sharing among innovator agents, but also to identify potential systemic issues.
- Participate in information sharing through an interactive website, sharing documents, communicate, collaborate, and developing resources to share with the team.

Innovator Agent Reporting Requirements:

- Monthly reports on CCO progress toward the implementation of the CCO's transformation plan.
- Monthly reports about CCO progress toward achieving "ideal behaviors".
- Quarterly reports on promising practices and/or innovations occurring within the CCO.

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.
- Secure website with a database into which the Innovator Agent will log all CCO/ Community Stakeholder questions and answers.
- Not less than once every calendar quarter, 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.

Measures of Effectiveness

The success and effectiveness of innovator agents will be measured in a variety of ways, but initially will focus on measures of the IAs level of engagement with the CCO and the community it serves as well as shared accountability for CCO outcomes, including:

- Survey rating innovator agent's performance to be completed by CCO leadership, Community Advisory Council members, and other relevant stakeholders.
- Number of questions answered (tracked in online database as outlined above) and number of meetings/ events an innovator agent has in the community.
- Number and success of innovations adopted by a CCO.
- Rate at which CCOs test new ideas and improve.
- Successful implementation of CCO's transformation plan, the measures for which will be developed upon completion of the CCO's transformation plan.
- The measures used to gauge the effectiveness of learning collaboratives (number of meetings, level of engagement, etc.) may also be used to measure efficacy of innovator agents.
- CCO performance on metrics as identified by the Metrics and Scoring Committee: improved access and quality, decreased per capita costs.

Appendix 1.E: Contract Compliance

The following 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, Subsection 3.a. • Exhibit G,1.b. • Exhibit B, Part 4, Subsection 2.m. • Exhibit B, Part 4, Subsection 3.a. (6) • Exhibit B, Part 4, subsection 3.b.(1) • Exhibit B, Part 4, subsection 3.a.(1)
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 3.a.(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	Model Contract: • Exhibit B, Part 4, 2.i. • Exhibit B, Part 4, 2.e.

Required Component	Contract Provision
with special health care needs. Special health care needs are defined as: 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 M, subsection 7
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, 3.b.
438.218 - Enrollee information • Plans must meet the requirements of 438.10	Model Contract: • Exhibit N
438.224 - Confidentiality • Plans must comply with state and federal confidentiality rules.	Model Contract: • Ex. B, Part 4, Section 5.b.(3)

Required Component	Contract Provision
438.226 - Enrollment and disenrollment • Plans must comply with the enrollment and disenrollment standards in 438.56.	Model Contract: • Ex. B, part 3, subsection 6
438.228 - Grievance systems • Plans must comply with grievance system requirements in the federal regulations.	Model Contract: • Ex. B, part 3, subsection 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: • Ex. M, subsection 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. • 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.	Model Contract: • Ex. B, Part 9

Required Component	Contract Provision
• 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

Appendix 1.F: List of Conditions that can 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.

Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluations

Evaluation Design and Quality and Access Tests

Table of Contents

Preface 240

Oregon Special Terms and Conditions 52, 54, 64, 86,and 88 240

Introduction 246

Demonstration Overview 247

Statewide Quality and Access Test 249

Evaluation 256

Evaluation Objectives 256

Contextual Considerations 257

Research Questions, Data Sources, and Analytic Approach 260

Table 1 – Formative Evaluation 261

Table 2 – Summative Assessment 265

Timeline 271

Preface

The prior part of this document describes the Oregon quality improvement strategy, and primarily addresses the interactions between the state and the CCOs as part of this demonstration.

Part II describes the efforts to monitor and assess quality and access at a statewide level to ensure that statewide quality and access are improving over the course of the demonstration.

The relevant special terms and conditions relating to evaluation, monitoring, and statewide tests are listed below.

Oregon Special Terms and Conditions 52, 54, 64, 86, and 88

Oregon's special terms and conditions (STCs) for the Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115(a) Medicaid demonstration extension ("demonstration"), contain the following provisions related to monitoring quality and access (STC 52) and standards of quality and access, including the standard that must be met for purposes of DSHP expenditure authority (STC 54):

52. ***Measurement of Quality and Access Under the Demonstration***. The state will also monitor *and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 64. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.*

Within 120 days of approval of the demonstration, the state will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's Medicaid population as a whole. The state's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). state quality and access reporting will take place on the same timeframes as the state's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

54. ***Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets.*** *This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration*

goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 49, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Demonstration Year	**Per Capita Expenditure Growth Reduction Target** (measure following DY close)	**Reduction in DSHP Expenditure Authority** (reduce succeeding DY's DSHP expenditure authority)
DY 11	NA	NA
DY 12	1 percentage point	$54 million
DY 13	2 percentage points	$68 million
DY 14	2 percentage points	$68 million
DY 15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the state in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the state has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. Earn Back Option. For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:

> *i. If the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year and significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.*

ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.

iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

Quarterly reporting requirements are outlined in STC 64 and are an integral part of monitoring the demonstration:

64. Monitoring To Assure Progress in Meeting Demonstration Goals: *The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the State's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of demonstration goals.*

a. ***Interim Reporting Format.*** *The state and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:*

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;

ii. Quality Improvement Metrics: Section VII;

iii. Access to Care measures: Section VII;

b. ***Timeframe for Reporting.*** *The state will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.*

c. ***Data Sources:***

i. Goal 1:

1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with state);

2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;

3. Total Medicaid service spending per beneficiary; and

4. *CCO provider spending per beneficiary.*

ii. *Goal 2:*

1. *Benchmarked metrics tied to incentive payments, including patient experience surveys;*

2. *Data from the all payer-all claims database;*

3. *Process Improvement Projects (PIPs);*

    a. *EQRO studies;*
    b. *Complaints and grievances;*
    c. *Health risk assessment data;*
    d. *Public health data;*
    e. *Health risk assessment data;*
    f. *Meaningful use attestation data;*
    g. *State CCO monitoring reports; and*
    h. *Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the Duals Demonstration.*

d. ***Final Annual Report:*** *The state shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The state will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.*

e. ***Penalty for Late Reporting:***

i. *If the state fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The state may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that prevents the state from reporting timely, the state can request an exception to these timeframes and penalties.*

Percentage withheld of quarterly demonstration administrative funding	***Days late***
.2	*15-30*
.4	*30-40*
.8	*41-50*
1	*51+*

The STCs also include the following language specific to Evaluation Design and Final Evaluation Design and Implementation:

86. ***Evaluation Design.*** *In the 120 days following the date of approval of this demonstration, the state shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the state will consider the Evaluation Guidance in Attachment B. The evaluation will include:*

a. *A discussion of the demonstration hypothesis that will be tested, focusing on key areas of the State's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional demonstration outcome measures;*

b. *An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.*

c. *Any other information pertinent to the State's evaluative or formative research via the demonstration operations.*

d. *Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;*

e. The draft plan shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation; and

f. Any other information pertinent to the State's evaluative or formative research via the demonstration operations.

88. ***Final Evaluation Design and Implementation.*** *CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the state shall submit its final design within 60 days after receipt of CMS comments. The state shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 after the expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after the receipt of CMS comments.*

Introduction

The statewide assessments of quality and access serve multiple functions for the demonstration.

First, the assessments help CMS determine the impact of the demonstration on quality and access, consistent with STCs 52 and 54. The state must pass these "tests" in order to avoid financial penalties as per STC 54. The first section of this Part II describes how these "tests" will function.

The second section of this Part II describes three types of evaluations. Each evaluation examines a specific set of questions. Although the analyses may be similar with regard to method, the demonstration evaluation is distinct from the quality and access “tests” associated with designated state health program (DSHP) expenditure authority under STC 54. The results of demonstration evaluation activities—including the midpoint assessment—have no bearing on the state’s DSHP authority.

Quarterly reports, as described here and as required by STC 64, will provide frequent feedback in order to inform ongoing operations. Elements of the quarterly reports are part of the "formative evaluations." These formative evaluations are intended to provide frequent feedback in order to ensure that course corrections are made, and that the results from those course corrections are understood in a timely fashion so as to continue the feedback cycle.

At the midpoint of the demonstration, a broader effort to learn from the demonstration will be conducted, called here the "midpoint assessment." This type of statewide assessment will provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

Finally, the state will conduct a "summative evaluation," which is required by STC 86 and 88 and is intended to summarize the experiences to ensure that this innovative demonstration is fully analyzed to determine whether it has been successful in achieving the stated goals.

As with the prior section, the measurement strategy is more fully described in Part III of this overall document.

Demonstration Overview

Demonstration Context

Health care costs are increasingly unaffordable. Despite the success of the Oregon Health Plan (OHP), which Oregon estimates has saved the state and federal government an estimated $16 billion since its inception in 1994, the growth in Medicaid expenditures in Oregon far outpaces the growth in General Fund revenue. And while health plan performance is generally strong, the growth in expenditures has not been matched by improvement in health outcomes. There are still significant opportunities to enhance access to care, improve care delivery, and advance health outcomes at the community level.

The structure of separate managed care organizations, mental health organizations and dental care organizations limits Oregon's ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. OHP clients face a sometimes dizzying array of plans and rules and the current payment system provides little incentive for the prevention or disease management actions that can improve health and lower costs.

Demonstration Goals

The July 2012 amendment and extension of Oregon's 1115 demonstration seeks 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 and access. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The current demonstration aims to accomplish two equally important and inter-related goals: reducing the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

These two goals form **the hypotheses to be tested as part of this demonstration**:

I. Oregon will reduce the growth in statewide PMPM Medicaid spending by 1 percentage point in demonstration year two and by 2 percentage points in demonstration years three and beyond; and

II. Over the course of the demonstration, Oregon will achieve control of PMPM cost growth while improving access to and quality of care for Oregon's Medicaid

beneficiaries.

Reflecting the state's commitment to the three-part aim, Oregon also proposes to evaluate the impact of Medicaid transformation on beneficiary experience of care and health outcomes.

Medicaid Transformation, Theory of Change

The Coordinated Care model, as implemented in Medicaid through Coordinated Care Organizations (CCOs), begins to address the health system shortcomings described above using several different approaches, or levers, to drive savings and quality improvement:

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on patient- centered primary care homes (PCPCHs)
- Lever 2: Implementing alternative payment methodologies 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 through administrative simplification and a more effective model of care
- Lever 5: Implementation of flexible services to improve care delivery or enrollee health
- Lever 6: Testing, accelerating and spreading effective innovations and best practices

These levers are described in more detail in Part I: Oregon's Quality Strategy, above, and are aligned with Oregon's quality improvement focus areas.

The OHA and CCO actions (including "ideal" behaviors) that power those levers are shown above in Appendix 1.B: theory of action model.

OHA and the CCOs will work toward improvement in specific focus areas (as outlined in Attachment E and elsewhere in this document) that can result in achievement of the three-part aim.

Statewide Quality and Access Test

Overview

The following section lays out the details of a "quality and access test" (the test), which will be applied each program year that the state achieves its cost control goal to determine whether Oregon's Health System Transformation (HST) has caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen. "Failing" the test results in reductions in a portion of DSHP funding to the state, as described in STC paragraph 54.

The quality and access test consists of two "parts," both described in detail below and in satisfaction of STCs 52 and 54. In brief, part 1 of the quality and access test is a relatively simple comparison of program period quality and access to historical baseline levels of quality and access; part 2 is a more complex comparison of program period quality and access to a counterfactual level of quality and access that would exist had HST not been undertaken. Part 2 of the quality and access test is required only if the state fails part 1, and Oregon fails the test for that year if and only if it fails both part 1 and part 2.

Seeking to balance the need for accurate and complete information against timeliness, CMS and the state have negotiated a streamlined reporting structure to monitor the goals of the demonstration while meeting the analytic requirements specified in STC 52 on an annual basis. This document memorializes CMS and the state's agreement to an annual test to assess whether unadjusted metrics for quality and access under the demonstration have stayed constant or, in later years, have improved. For the first two years, this first order test is passed if the score for the quality or access metrics remains constant or improves as compared to the historical baseline. After that, the first order test is passed only if the quality and access test shows improvement. If the State does not pass the first order test in any year to which it is applied, the state will undertake, and submit to CMS, a more detailed counterfactual analysis (as prescribed by STC 52 and conducted by an independent, third party evaluator) to determine whether quality and access have significantly diminished in a manner attributable to the state's efforts under the demonstration. If this counterfactual analysis indicates a significant diminishment in quality and access under the demonstration in a given year (or is not completed according to the timeframes specified below), CMS will apply the five percent DSHP reduction to the FFP claimed in the year immediately following the year for which the

determination was made as specified in STC 54. As described, after two demonstration years, Oregon will also undertake a robust midpoint analysis that will provide more detailed information about achievement of the demonstration's goals.

If the state has met its per capita expenditure growth target in any year, as described in Attachment H, Section B, but fails to achieve its quality and access goal as determined by the analysis conducted pursuant to STCs 52 and 54, beginning at the end of DY 12, the STCs give CMS the authority to prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year. Recognizing that data lags will prevent CMS from determining Oregon's satisfaction of yearly demonstration goals until several months after the close of the demonstration year, the prospective reduction will be applied at the beginning of the next succeeding demonstration year, as follows:

- Oregon may begin each new demonstration year claiming DSHP up to the full amount authorized in that year but will be at risk for a penalty of five percent of that year's DSHP allotment should CMS subsequently verify through the required reporting that, in the demonstration year in question, Oregon achieved a cost trend reduction at the expense of quality and access, or that the analyses were not submitted in accordance with the STCs.

- Once CMS has made such a determination and informed OHA of the rationale and the amount of expenditure reduction which it is subject to, Oregon must refund the funds identified as the agreed upon DSHP expenditure reduction in the quarter following the CMS determination.

- If the state does not voluntarily refund these funds, CMS may exercise the option of taking a deferral or disallowance for the amount.

Part 1 Quality and Access Test

A single "aggregate" indicator will be constructed using a number of "component" quality and access measures. A test result will be generated based on the difference between performance on this aggregate indicator in the current period (using the most recent full demonstration year) and a baseline period (calendar year 2011).

Component Measures

Oregon and CMS determined the component measures that will be used to construct the single quality and access aggregate indicator.

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 encourages broad-based improvement and tends to increase the precision of the aggregate. Measures included in the CCO incentive measure set are particularly attractive candidates, as the objectives of CCOs should be aligned with those of the state as much as possible. In general, measures for which the state is already planning to collect data should be included in the aggregate unless there is good reason to exclude that measure. Good reasons to exclude a measure are: no data are available for that measure in the baseline period; that measure would contribute so much uncertainty to the aggregate that judgments about the aggregate would be affected; it is not possible to establish a functional benchmark for the measure; or there is a lack of consensus at the state level about the value of the measure. For the three CCO incentive "pay for measurement and reporting" metrics where CCOs qualify for the incentive pool in DY12 and DY13 by obtaining OHA approval of the a technology/measurement plan and reporting "proof of concept" data, the state will report the measure a the statewide level by conducting chart review.

The component measures to be used in constructing the quality and access aggregate measure, as well as baseline and benchmark information for as many measures as possible are indicated on the *Oregon Measures Matrix* in Part III, below.

Aggregation of Component Measure Results

Because component measures may be in different units, on different scales, for different populations, and at different levels of performance compared to an ideal target, each component measure will be "translated" to a common scale, reflecting the fraction of the performance gap between baseline and ideal performance closed since the start of Medicaid system transformation. The algorithm for generating these translated measure values is as follows:

1. For each measure, Oregon and CMS will agree to a "target" level of performance, reflecting the best possible performance that Oregon would be able to achieve as a high performing program. Where possible, these targets are aligned with the CCO incentive benchmarks.

2. For each measure, where possible, the baseline (calendar year 2011 as described above) level of performance will be calculated.

3. For each measure, for each program period, the translated level of performance for the measure will be calculated as the difference between current and baseline performance divided by the difference between target and baseline performance. (Note that this

formula applies whether or not the component measure has improved or worsened over time compared to a baseline.)

4. The translated value for each component measure takes the form of a percentage.

For each of the quality and access subtests, the aggregate measure is then constructed by taking the average of the component measures' translated values and rounding to the nearest first decimal place, i.e., to the nearest tenth of a percentage.

Metrics may be modified over time in the manner described in Part III of this document, regarding Oregon's Measurement Strategy.

Definition of Passing

Subject to CMS review and approval of reported findings and calculations, Oregon will be considered to have passed part one of the quality and access test for the DSHP performance periods of DYs 12 and 13 if the aggregate measure value for this test, rounded to the nearest tenth of a percentage, is greater than or equal to zero percent. In subsequent years (DYs 14 and 15), Oregon will be considered to pass a subtest only if the aggregate measure value, rounded to the nearest tenth of a percentage, is strictly greater than 0.

Timing and Deadlines

The statewide quality and access test applies only in years when the state meets its target for cost growth reduction. The first target is a one percentage point reduction for DY 12 (July 2013 – June 2014), so, allowing for data lag, the earliest point at which the test might be performed would be 6 months after the end of the end of the demonstration year in question, or early 2015. To align with quarterly reporting deadlines, the state will report test data and results to CMS in February 2015. However, the state will also calculate and report the aggregate measure to CMS in late fall 2013 on a practice basis only, using as much DY 11 performance data as is available at the time. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a report to CMS by the August following the end of the demonstration year in question (see Timeline).

The quality and access test for any year in which Oregon has met the cost growth reduction target will be based on measurements from the most recent full demonstration year, as follows:

DSHP Quality and Access Test Data Periods

DY 12 (7/1/13-6/30/14)
DY 13 (7/1/14-6/30/15)
DY 14 (7/1/15-6/30/16)
DY 15 (7/1/16-6/30/17)

2014

As described above, the period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the part 1 quality and access test will not be any different for 2014 in order to reflect the expectation that the demonstration will continue to provide high quality care and to preserve the simplicity of the part 1 quality and access test approach. Nevertheless, it would not be surprising if part 2 of the quality and access test were to be necessary for this year and the part 2 quality and access methodologies should specifically account for the particular circumstances in this year.

Subpopulation Subtests

Due to potential technical challenges, and the increased risk of false-negative test results associated with a substantial increase in the number of comparisons, CMS will not require Oregon to demonstrate any minimum level of quality and access performance for beneficiary subpopulations as part of part one quality and access test.

However, these analyses should be included in evaluation analyses, and performance of metrics for subpopulations should be made transparent in a similar fashion to the core performance metrics. See Part III: Oregon's Measurement Strategy below for additional details about planned subpopulation analysis and public reporting.

Part 2 Quality and Access Test

As described above, if Oregon fails to pass part one of the quality and access test, a more complex analysis will be undertaken to determine whether the performance decline compared to baseline was attributable to the state's transformation efforts. Methodologically, part 2 of the quality and access test will largely follow the rigorous independent analysis of the association between state transformation activities and changes in access and quality (controlling for external forces) that is described under Midpoint Assessment. (There is one exception: part two of the quality and access test will not include any subgroup specific analysis.) Practically, however, the part 2 test and any evaluation activities differ in both cause and consequence:

- Part 2 of the quality and access test is only triggered if the state does not pass part one of the test for a particular year. Formative, midpoint and summative evaluations will occur as planned, regardless of the state's performance related to cost growth reduction targets or part one of the test.

- Evaluation activities have no bearing on DSHP expenditure authority. In other words, if part 1 of the quality and access test is passed in a particular year, the state passes the test for that year and incurs none of the DSHP penalties described in STC 54, even if a concurrent rigorous analysis may be occurring as part of a formative, midpoint, or summative evaluation.

Definition of Passing

Oregon will be deemed to have passed the part 2 quality and access test if access and quality have not significantly diminished relative to changes in a comparison group or counterfactual scenario across the same time period. Thus, Oregon will pass as long as the difference between CCO members and the comparison group does not significantly change to the detriment of CCO members.

Responsibilities of Oregon

Oregon will issue a Request for Proposal for and contract with an independent evaluator or evaluators, which will be responsible for performing the part one and, if necessary, part two analyses in all required years. The state will convene a review group consisting of key state partners and independent scientific experts with appropriate expertise to review and score all proposals. The evaluator's responsibilities will include:

- Develop a detailed methodology for the execution of each part of the test, in advance of their use;

- For each required program year, review the relevant raw data, verify its accuracy, and, if necessary, clean the data;

- Produce the part one quality and access test —and, if necessary—part two quality and access test results described above.

- Deliver a package to CMS and Oregon containing (1) the cleaned datasets; (2) the detailed methodology; and (3) any results produced, by the required deadlines

Allowing for data lag, the state will submit the part one of the quality and access test to CMS in the February following the end of each demonstration year in which the test applies (see Timeline below). Failure to submit the required data also will result in application of the DSHP withhold specified in STC 54, as well as invoke the penalties for late reporting that are

described in STC 64. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a report to CMS by the August following the end of the demonstration year in question (see Timeline).

Responsibilities of CMS

CMS will fully review the data, methods, and results produced for each year's test to ensure that calculations were made appropriately. Upon such a determination, CMS will notify the state that the DSHP penalty authorized by STC 54 shall not apply. If the state fails the test, the DSHP penalty described earlier will apply.

Evaluation

This section contains four parts: evaluation objectives; contextual considerations; research questions, data sources, and analytic approaches; and plan development.

Evaluation Objectives

This evaluation has three objectives:

(1) To perform a formative evaluation of Medicaid transformation that seeks to provide timely and actionable feedback on the initiative's progress, in terms of both outcomes and implementation activities. The formative evaluation will track and report regularly on OHA and CCO actions, progress toward achieving a health care system characterized by the key transformation levers; and progress toward achieving the primary goals of Medicaid transformation.

(2) To perform a midpoint assessment of Oregon's Medicaid transformation to provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

(3) To perform a summative assessment of Oregon's Medicaid transformation describing changes in Medicaid per capita expenditure trend and quality and access outcomes, as well as other outcomes of interest, and to identify the changes in outcomes resulting from transformation activities.

Note that there will be some overlap in the research questions, data sources, and measures used to fulfill these three objectives. In particular, early and medium-term results for certain questions will be addressed in a midpoint assessment in the third year of the demonstration, but may also be addressed in a formative or summative evaluation.

Contextual Considerations

Analytic challenges

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act will take effect. Expansion of Medicaid eligibility is expected to extend additional benefits to some adults already enrolled in the demonstration and bring more than 200,000 new individuals into the program and on to CCOs' membership rolls. These individuals, many of whom will have been uninsured previously, may need and utilize Medicaid services differently than the previously eligible group. In addition, all other large scale reforms—the individual mandate, guaranteed issue, tax subsidies for coverage through the Exchange etc.—are likely to have a significant impact on the capacity of the delivery system. The expansions and delivery reforms under this demonstration are intended to help bridge the transition to this new challenge, and so monitoring the changes in 2014 is an essential part of the efforts. The transitions in 2014 do create a few inter-related analytic challenges for assessing the impact of Oregon's Medicaid transformation, most notably:

- How to account for any effect the needs and experiences of the newly eligible group might have on aggregate trends of quality, access, and cost for Medicaid populations over the 5 years of the demonstration;
- How to account for any effect that the delivery system's response to health care reforms outside of Medicaid may have on measures of access, quality, and cost for Medicaid populations;
- How to isolate the impact of Oregon's Medicaid transformation activities from contemporaneous trends in quality, access, and cost.

Oregon will contract for independent analysis that includes a triangulated approach to addressing these analytic challenges including tracking outcomes for the expansion population separately, development of a sound comparison group, and in-depth or complex mixed methods analyses. On some questions, it will also be useful to compare Medicaid enrollees to those with other sources of coverage (via the state's All-Payer All-Claims data system or population surveys such as BRFSS), although there are likely to be some spill-over effects given that almost 85 percent of Oregon's health care providers serve Medicaid clients. A difference-in-differences design may also be helpful as part of this triangulated approach to compare changes over time among Medicaid CCO enrollees to an appropriate comparison population, at the mid- and end-points of the demonstration period. Together, these should provide a reasonable picture of the success of Oregon's Medicaid transformation against its stated goals.

External evaluations

Oregon has an active and engaged health services research community and a history of sophisticated, policy-relevant research on the Oregon Health Plan including the landmark Oregon Health Study (OHS). The Oregon Health Research & Evaluation Collaborative (OHREC) serves as a point of collaboration and connection between state staff researchers from a variety of organizations. Two OHREC-affiliated research projects have already received funding from a mix of foundation, government, scientific, and philanthropic sources:

- The Robert Wood Johnson Foundation-funded SHARE grant is a mixed-methods study building on the OHS to assess what CCOs in Oregon actually do, how they impact health care access, use, quality, costs, and health outcomes, and how each CCO's outcomes are associated with its individual design. The partners in the study are the Office for Oregon Health Policy and Research in the Oregon Health Authority, Portland State University, Oregon Health & Sciences University and the Center for Outcomes Research at Providence Health System.

- An NIH-funded economic study focuses on the impact of spending reductions implemented through the CCO global budgets and the financial integration of behavioral specialty care and primary health care. The study includes cross-state comparisons, and also includes a qualitative component. This study is being conducted by researchers at Oregon Health & Sciences University, Portland State University, and the University of Colorado Denver.

Other proposals are currently under review at different funding agencies.

The state will use results from these and future independent evaluations to supplement its own demonstration evaluation work and provide independent analysis on the demonstration hypotheses. In addition to taking advantage of related research, Oregon intends to issue a request for proposals (RFP) and to contract directly with independent evaluators for two products: a midpoint assessment of quality and access (described in more detail shortly); and a summative evaluation at the end of the demonstration that will address the major research questions described under Summative Assessment below, synthesizing and summarizing findings from earlier evaluation and research.

The demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. Among the characteristics of rigor that will be met for the midpoint and summative evaluations are use of best available data; controls for and reporting of the limitations of data and their effects on results and the generalizability of results. Treatment and control or comparison groups will be

used, except (in the common circumstance) where randomization is difficult, in which case appropriate methods will be used to account and control for confounding variables. The evaluation design and interpretation of findings will include triangulation of various analyses, wherein conclusions are informed by all results with full explanation of the analytic limitations and differences.

An independent third party, selected by some means other than sole source contracting, following applicable state procurement, selection and contracting procedures, will conduct the midpoint and summative evaluations. The third party selected for the evaluation shall be screened to assure independence and freedom from conflict of interest. The assurance of such independence will be a required condition by the state in awarding the evaluation effort to a third party.

STC 88 requires that the state will provide to CMS within 120 days after expiration of the demonstration a draft summative evaluation report. Recognizing data lags and complexity of the analyses that comprise the midpoint and summative evaluations, we have agreed that CMS will not hold the state to be out of compliance with the timing requirements of STC 88 if the state provides to CMS its draft summative evaluation report within 180 days after the end of demonstration Year 15. In addition, CMS will not hold the state to be out of compliance for the draft midpoint analysis if submitted to CMS 180 days after the close of the initial review period, July 1, 2012 through June 30, 2014.

For both reports, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the state or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the contractor.

Draft reports related to the midpoint and summative evaluations will not be routinely released except as required by state and federal law. Until the later of the following two dates – July 1, 2019 (two years after the end of the demonstration) or 12 months from the date that the final reports for these evaluations are provided to CMS, CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the contractor or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

In light of the flexibility that CMS has offered in enforcing these evaluation deadlines, Oregon has agreed that in each demonstration year, when draft and final midpoint and summative evaluation reports are due, it will reduce claimed DSHP expenditures by one half of one percent (0.5) for the year to follow if any of these reports are not provided or are found by CMS to be unacceptable because they do not represent adequate rigor and independence and do not adequately implement the final evaluation design. The claimed expenditures withheld by CMS would be authorized only if revised reports are provided and found by CMS to be acceptable within a year of their original due dates under STC 88. The penalties related to quarterly and annual reporting submission deadlines, as specified in STC 64(e), continue to apply as specified in the STCs.

Research Questions, Data Sources, and Analytic Approach

Formative Evaluation

The formative evaluation will track and report regularly on: (1) OHA actions; (2) CCO actions; (3) progress on the "levers" intended to drive savings and quality improvement; and (4) progress toward achieving the primary demonstration goals. (See the Quarterly Report Guidelines—Attachment A of the STCs—for details on who information from the formative evaluation will inform the state's quarterly reports.) The formative evaluation is designed both to provide actionable information for quality improvement and to help inform/explain the summative assessment and will therefore include analysis by individual CCO, as well as in the aggregate.

Data and findings resulting from all stages of the evaluation—formative, midpoint, or summative—will be shared widely as part of the state's commitment to feedback and continuous improvement. Key pathways for dissemination and use of evaluation findings beyond the required reporting to CMS include:

- The Oregon Transformation Center, which will act as the state's hub for innovation and improvement. The CCO learning collaboratives to be convened by the Transformation Center will be a primary venue for sharing evaluation information, posing additional analytic questions, and sharing best practices or potential solutions to problems;
- The state's innovator agents, who are expected to help CCOs review their own data and identify opportunities for improvement;
- Formal publications and presentations (primarily for midpoint or summative evaluations) aimed at a variety of different audiences, including service providers, beneficiaries, and communities and their members; and
- Internal reporting for OHA leadership and program personnel.

The data sources identified to address specific evaluation questions will provide relevant information on several important aspects of the demonstration operations, for example: measures of beneficiary experience of care and provider engagement with Medicaid will feed into monitoring and policy development for network adequacy; and assessments of CCOs' actions to improve care coordination and integration will inform interpretation and resolution of grievances or appeals.

Table 1 shows the relevant formative research questions for the four topics listed above, as well as proposed measures and data sources. Note: rows shaded in light grey indicate research questions to be addressed in both the formative assessment and the midpoint assessment, described later in this section.

Table 1 – Formative Evaluation (shaded rows will be addressed in midpoint as well as formative)

Topic Area	Related Research Question(s)	Measures or data source(s)
OHA actions	To what extent has OHA effectively taken action to support transformation? For example: • Set expectations and monitor for care management • Develop global budget and quality incentive pool • Establish robust quality measurement and improvement strategy • Provide technical assistance and support, including Innovator Agent program • Patient-centered primary care home recognition, certification system for non-traditional health workers • Tracking method for flexible services	OHA documentation is the data source for most of these questions. Specific measures might include: • Incorporation of CCO transformation plans into individual contracts • Amount paid to CCOs in the form of quality incentives, vs. capitation • Attendance/participation rate at learning collaboratives • Measures of effectiveness from innovator agents document
CCO actions	To what extent have CCOs – in aggregate and individually – taken action to transform care delivery & payment? For example: • Encourage use of EHRs and participation in HIE • Use alternative payment mechanisms with providers • Maximize use of PCPCHs • Support and encourage providers to improve care coordination • Use quality metrics • Take action to reduce administrative waste • Provide flexible services where	• CCO Transformation plan tracking • Innovator agent contact database and monthly reports (see Innovator Agent document) • Office of Health IT tracking of EHR adoption and HIE participation (surveys) • Data from CCO quality assurance and oversight processes (monthly accountability team reviews, on-site operational reviews, etc., see Quality Strategy) • Surveys of CCO leadership and CCO Community Advisory members (see

Topic Area	Related Research Question(s)	Measures or data source(s)
	appropriate • Engage meaningfully with communities	Innovator Agent document) • Tracking of flexible services • Qualitative information from independent evaluations – SHARE and McConnell NIH study
	• To the extent that some CCOs have not taken actions for transformation, what has prevented them from doing so? • To the extent that some CCOs have been successful in taking action, what have been their keys to their success?	As above
Levers for transformation	To what extent are CCO members experiencing improved care coordination, with emphasis on PCPCH?	• PCPCH enrollment by tier • Metrics from *Oregon Measures Matrix* related to integrating primary care and behavioral health, reducing preventable hospitalizations, and reducing preventable and costly utilization
	To what extent have OHA and CCOs implemented payment methods that focus on value not volume?	• Which CCOs do and which do not use alternative payment methods internally? • What is the distribution of available incentive funds across CCOs? (OHA admin data) • *Potentially:* measures from soon-to-Catalyst for Payment Reform scorecard
	To what extent have CCOs integrated physical, behavioral, and oral health services? Other services?	• CCO Transformation plan tracking • Metrics from *Oregon Measures Matrix* related to integration, e.g. SBIRT, follow-up after hospitalization for mental illness, etc.
	To what extent have CCOs achieved administrative efficiencies?	• CCO financial reporting requirements, including OHA-developed Exhibits (see CCO core contract) • Office of Health IT tracking of EHR adoption and HIE participation • CCO Transformation plan tracking • CCO participation in statewide administrative simplification efforts (e.g.

Topic Area	Related Research Question(s)	Measures or data source(s)
		common credentialing)
	To what extent are beneficiaries using flexible services?	• TBD – tracking method for flexible services is still in development • CCO Transformation plan tracking
	To what extent are best practices being tested and disseminated?	• CCO participation in learning collaboratives and other technical support opportunities • Innovator agent monthly reports; Number and success of innovations adopted by a CCO; rate at which CCOs test new ideas and improve (see Innovator Agent document) • Successful implementation of CCOs' transformation plans, the measures for which will be developed upon completion of the plans
Demonstration / Medicaid Transformation Goals	Have CCOs– in aggregate and individually • Improved quality of care for members? • Improved access to care? • Improved members' experience of care? • Improved members' health status?	See impact assessment table
	Has Oregon reduced per-member cost growth?	See summative assessment table

Midpoint Assessment

The midpoint assessment will analyze activity through the midpoint of calendar year 2014, with a report due to CMS no later than August 2015. In addition to summarizing findings to date on select research questions from the formative and summative evaluations (indicated by shaded rows in Table 1 and Table 2), the midpoint assessment will connect the two via an explicit examination of the coordinated care model on changes in access and quality. (Access and quality should be read here to include experience of care.) The report will also include a high-level summary of expenditure and cost data, based on 2 percent test reporting described in Attachment H, Section B. The state anticipates contracting with independent researchers (as described above) to perform a rigorous analysis of the association between state transformation activities and changes in access and quality, controlling for external forces.

For instance, a contractor could employ a difference-in-differences analysis, assessing the average changes in scores over time from the baseline year among CCO enrollees and

subtracting out the average changes among a comparison group of matched individuals from a non-CCO, fee-for-service comparison group in order to arrive at the "net" impact of transformation, as follows:

- **Measures**: Measures of access and quality (including care coordination and beneficiary experience of care) would be drawn from the *Oregon Measure Matrix* listed in Part III, below. Measures of access and quality for future consideration are also listed in Part III, below. Because this is an evaluative assessment rather than a "test," there is no need to create an aggregate access or quality measure. The results of the formative evaluation to date will provide contextual information about the extent to which the transformation "levers" have been implemented.

- **Study Groups**: Contractors will provide for an adequate comparison group. Potential contractors will describe a plan for specifying the control group and specify criteria for case-matching or other adjustments to account for potential changes in group composition over time, as well as plans for the treatment of individuals who disenroll during the study period.

- **Data Years**: The contractor's plan should also address the appropriate data years for both study and comparison groups to identify to the extent possible any underlying movement in the scores that was occurring prior to implementation.

- **Statistical Approach**: Contractors will describe a statistical plan that accounts for the distribution of the dependent variables and uses appropriate modeling techniques. The state will work with the contractor to insure that the model is appropriately pre-specified while being sensitive to model choices that must account for the distribution of the data.

- **Strategies to Account for Potential 2014 Expansion**: If the state expands its Medicaid program to 133 percent FPL in accordance with the Affordable Care Act in 2014, the contractors will describe specific strategies to account for the effects of this expansion on access and quality and separate them from the impacts of Medicaid system transformation. (A DiD design is robust against such changes provided the expansion impacts both groups in the same way, but if expansion impacts CCO and comparison group members differently, the model's ability to identify the specific impacts of Medicaid transformation will be compromised.) Contractors will propose methods to account for the impacts of the expansion (with respect to both expanded eligibility and the availability of more expansive coverage for some adults previously eligible for the demonstration) and extract those impacts from the estimates of CCO effects. Separate tracking of new eligibles, described in the analytic approach column of Table 1, will

produce information that may be of use to contractors in accounting for expansion effects.

- **Subgroup Analysis**: Contractors will describe a plan that provides results separately for vulnerable populations or subgroups of interest and compares those results to the overall trends to identify differences in effects by subgroup. Depending on the degree of variation across the state or among CCOs and the stability of enrollee populations, it may also be possible to compare trends in access and quality across beneficiaries experiencing "low-dose" and "high-dose" transformation.

The midpoint assessment will produce a more nuanced picture of trends than the summary scores of the DSHP quality and access "tests." It will also provide the state and CMS with a sophisticated assessment of the relationship between the state's actions and beneficiary outcomes well in advance of the end of the demonstration period.

Finally, the midpoint assessment will include a narrative section regarding the progress of Oregon towards streamlining its reporting processes, including whether there are reports and/or evaluations the state would recommend combining, and specifically regarding progress towards use of automated data systems that will support the transmission of data through data portals and other electronic reporting channels, and progress towards an HIE infrastructure.

Summative Assessment

The impact assessment focuses on the outcomes depicted in the theory of action: reduced PMPM cost growth (demonstration goal 1), improvement or maintenance of quality and access (demonstration goal 2), and improvement or maintenance of beneficiaries' experience of care and health status. Table 2 lists the research questions associated with each outcome, as well as proposed measures and data sources and analytic approaches for addressing the question. The research questions should be read as including both CCO enrollees and those beneficiaries for whom services will be provided on a fee-for-service basis even after January 2013. Note: rows shaded in light grey indicate research questions to be addressed in both the summative assessment and the midpoint assessment, described earlier in this section.

Table 2 – Summative Assessment (shaded rows will be addressed in midpoint as well as summative)

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
Per capita Medicaid spending	How does annual change in per-capita Medicaid spending during demonstration period compare to projected trend?	state Medicaid program expenditure data Presidents' budget for projected trend	Align with methodology for expenditures for 2% test (including adjustment for 2014).

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
	Which beneficiary subpopulations* deviate from the statewide trends?	state Medicaid program expenditure data	Subpopulation analysis of expenditures by demonstration year.
	How does spending change for behavioral health compare to overall trends and physical health spending changes?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.
	How does spending change for primary care services compare?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.
	Are "flexible services" deterring higher-cost care?	TBD – tracking method for flexible services is still in development.	Depending on tracking method, approach may include: Estimation of the value of flexible services provided, by category Estimation of costs deterred Case studies of variation by CCO in flexible services offered
Quality of care	Is quality of care for Medicaid beneficiaries improved or at least maintained over time?	Quality measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Is coordination of care for Medicaid beneficiaries improved or at least maintained over time?	Care coordination measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in the quality of care or care coordination for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
	Did Medicaid system transformation result in improved quality of care or care coordination?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g. PQIs using HCUP data) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation assessing changes in quality for those enrolled in CCOs vs. not enrolled. Incorporate results of independent McConnell NIH study of changes in "contracted" and "non-contracted" quality measures For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group
Access to care	Has access to care for Medicaid beneficiaries improved or at least maintained over time?	Access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Has the rate of change in access to behavioral health kept pace with physical health access improvements?	Behavioral health access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Comparison of change over time in access measures by service type
	Have there been variations in any of the access to care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved access to	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g.

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
	care?		care delayed due to cost) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation comparing changes in access for those enrolled in CCOs vs. not enrolled. Incorporate results of independent McConnell NIH study assessing impact to CCOs on probability of members accessing care, by provider type For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group and analysis of provider survey data on Medicaid acceptance by primary care v. subspecialty
Member experience of care	Has beneficiary experience of care improved or at least maintained over time?	Experience of care measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in experience of care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved experience of care?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of externally-

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
			conducted SHARE evaluation comparing changes in experience of care for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group
Health Status	Is beneficiary health status improved or at least maintained over time?	Health outcome or status measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in health status measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved health status?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures, BRFSS) Incorporate results of externally-conducted SHARE evaluation comparing changes in health status for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group

* Categories of interest for sub-population analysis include:

- Beneficiary race and ethnicity

- Beneficiary primary language
- Individuals eligible for Medicare and Medicaid
- Individuals with mental illness
- Disability status
- Rural vs. non-rural location

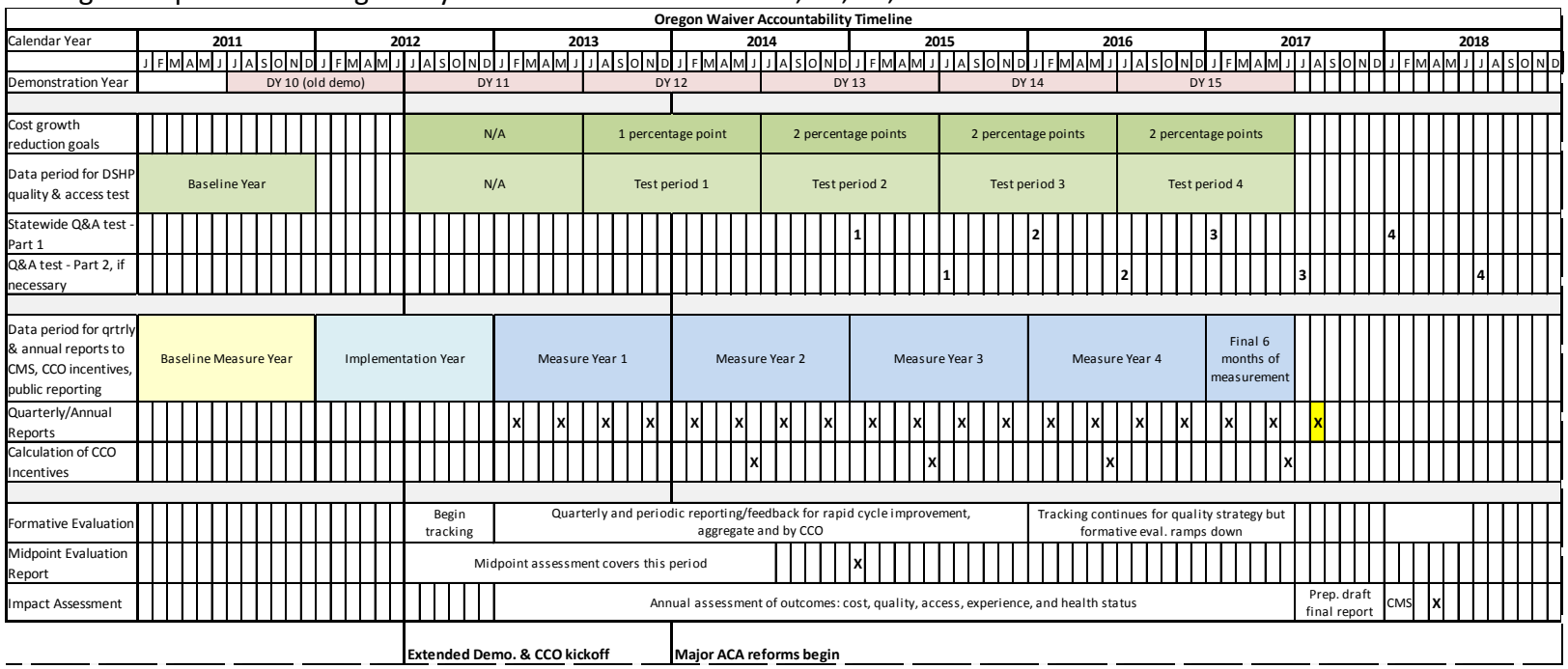
Ability to analyze outcomes by beneficiary sub-population will be dependent on the specific measure and data source. Provider measures for access will also be analyzed by subtype of provider.

Evaluation Plan Development

This plan was developed by a cross-division of OHA staff with experience in evaluation research and demonstration planning and reviewed by OHA leadership. External expertise and consultation was provided by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, as well as CMS staff. Because of the close connection between the formative evaluation plan described here and the state's Quality Strategy, the demonstration evaluation design will be reviewed annually along with the Quality Strategy.

Timeline

This figure depicts the timing of key deliverables under STCs 52, 54, 64, 86 and 88.



Part III: Oregon's Measurement Strategy 2012

Introduction

Oregon's Measurement Strategy (STCs 38, 39, 40, 42) outlines how the Oregon Health Authority will measure quality of care and access to care for individuals enrolled in Coordinated Care Organizations and for the Oregon Health Plan population as a whole. The metrics are also integral to the effort to monitor and correct pathways towards improvements in the quality of care and access to care for Medicaid beneficiaries under health system transformation efforts, as described in the Statewide Quality and Access Tests section above.

OHA Measurement Framework

Oregon has identified over 100 potential measures of cost, quality, access, patient experience, and health status that could be tracked over delivery settings and populations during the demonstration period. These measures come from several measure sets.

- Oregon CCO Incentive Measures
- Oregon Demonstration Core Performance Measures
- CMS Adult Core Set for Medicaid
- CMS Child Core Set for Medicaid and the Children's Health insurance Program

Oregon has committed to collecting and reporting on the CCO Incentive Measures and the Demonstration Core Performance Measures. Many of the CMS Adult Medicaid Quality Measures and CHIPRA Measures overlap with these measure sets, and Oregon has also committed to reporting on these two core sets even as they evolve to the extent feasible. *See Appendix 3.A for a listing of these measures by population and by domain.*

Oregon has submitted an application for an Adult Medicaid Quality Grant for the *Oregon CMS Adult Measures Project*, which would develop additional capacity for standardized collection and reporting of the CMS Adult Medicaid Quality Measures. Through this project, Oregon would test and evaluate methods for collection and reporting of the measures, improve measures so they are reliable, and develop capacity to report the data, analyze, and identify opportunities to improve health care quality for Medicaid beneficiaries. Work funded through this grant would inform the collection and reporting of the Demonstration Core Performance and CCO Incentive Measures.

Through participation in the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Program, Oregon has also collected all 24 CHIPRA measures and developed an understanding of standardization and comparability for these measures. Oregon will continue to participate in this program and collect and report on selected CHIPRA measures through 2015.

From these measure sets, Oregon has identified access measures, including CCO-level access improvement measures, and survey-based access measures. *These measures are also identified in the tables in Appendix 3.A.*

Incentive Measures

The Oregon Metrics and Scoring Committee have identified the year one incentive measures that will be tied to the quality pool as required by STC 37b.ii.[13] See Appendix 1.C: Quality Pool Structure above for a detailed description of the quality pool design and funding algorithm. Building on work completed by their predecessor committee, the Oregon Health Policy Board Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics[14], the Committee considered several core principles when selecting these measures. Among other principles, any selected measures should:

- Meet standard scientific criteria for reliability and face validity;
- Help drive system change;
- Successfully communicate to consumers what is expected of CCOs;
- Align with evidence-based or promising practices;
- Be nationally validated, a required reporting element in other health care quality initiatives, or align with national or other benchmarks for performance; and
- Usefully distinguish between different levels of CCO performance.

The majority of incentive measures selected overlap with Oregon's Demonstration Core Performance Measures, CMS Adult Medicaid Quality Measures, and CHIPRA Measures, ensuring that the incentive program is aligned with existing state and national quality measures. Selected incentive measures do strongly align with Oregon's quality improvement focus areas and all incentive measures have been included in the set of quality and access "test" measures. Specifications and data sources for the year one incentive measures can be found in Appendix 3.C and more detailed rationale for each of these incentive measures can be found in Appendix 3.D.

Through a public process, the Metrics and Scoring Committee established improvement and performance targets that a CCO must meet on the selected incentive metrics to be eligible for receiving funds from the quality pool. These targets are listed in Appendix 3.B.

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[13] http://www.oregon.gov/oha/pages/metrix.aspx

[14] http://www.oregon.gov/oha/OHPB/pages/health-reform/workgroups/outcomes-quality-efficiency.aspx

Oregon has also established benchmarks for the statewide quality and access test described below. Oregon's baseline data (2011) and benchmarks are included in Appendix 3.B.

Ensuring Continuous Quality Improvement

Incentive Measures

The Metrics and Scoring Committee will likely consider additional measures, either as part of the Oregon Health Authority's overall measurement framework or as incentive metrics in future years. The Committee will be reviewing CCO performance data, improvement over baseline, and distribution of the quality pool to determine if the initial incentive metrics selected were the right combination of measures to improve quality and access for the Oregon Health Plan population. Incentive measures may be added in subsequent years and it is likely that other measures will be retired from the list, either due to measurement concerns or progress. CCO performance may improve significantly enough on select measures that the Committee refocuses efforts to different areas needing improvement.

The Committee is charged with revisiting not only the selected incentive measures, but also the performance and improvement targets. It is critical that these targets take future CCO improvement into account and continue to provide stretch goals that CCOs must meet to be eligible for the quality pool. CCOs will not be allowed to coast on early success, or demonstrate improvement in just one domain.

Specifically, the initial decision by the Metrics and Scoring Committee was to reward improvement in incentive metrics as compared to a historical baseline, rather than to the prior year's performance. This structure may not be adequate to provide ongoing incentives for continued improvement and may be reexamined by the Metrics and Scoring Committee in consultation with CMS and the state as part of the midpoint assessment.

Likewise, the Oregon Health Authority will be revisiting selected quality and access measures in future years of the demonstration to ensure that quality of care and access to care are being tracked appropriately. A subset of quality and access test measures has already been identified for consideration in demonstration year 3. These are listed in Appendix 3.E.

OHA will also be exploring National Quality Forum (NQF)-endorsed and other healthcare disparities and cultural competency measures for inclusion in the measurement framework. As new measures are identified, potentially through the CMS Adult Core Quality Measures Grant, or endorsed, through NQF or Meaningful Use Stage 2, OHA will add and retire measures from the overall measurement framework.

Modification of Metrics for Statewide Quality and Access Test

Consistent with the recognized need for flexibility to modify plans over time and take into

account evidence and learning over time, as well as for unforeseen circumstances or other good cause, a CCO, CMS, or the state may request prospective changes to metrics or targets for any achievements that are well above or below the established targets based on progress to date through a modification process. CMS and the state must agree to modify the metrics; CMS retains the authority for final approval of such changes, which will be reflected in the quality strategy. Examples of when requests for changes may be appropriate are:

a. **Difficult metrics:** The CCO, CMS, or the state may suggest re-targeting of metrics in instances in which it appears that statewide targeted performance will not be achieved over the life of the demonstration.

b. **Topping out on metrics:** During any given year, the CCO, CMS, or the state may suggest re-targeting in instances in which targets have been achieved or surpassed. However, it appears that there is still substantial room for growth on selected projects (e.g., percentage improvement or volume metrics for subsequent years were already met because the original estimates were too low, but data suggest that more improvement could be done.)

c. **Mismatched metrics:** The CCO, CMS, or the state may suggest new metrics that better reflect local concerns when it is determined that the existing metrics are inadequate.

Data Collection

The Oregon Health Authority will be responsible for collecting data on all measures selected. Data sources for incentive measures are included in Appendix 3.B and descriptions of data sources are also included in section IV of the Quality Strategy. An external quality review organization (EQRO) will play a role in data collection and analysis where necessary, assisting with measures that require chart reviews and/or validation of information submitted by a CCO.

OHA will contract with the Oregon Health Care Quality Corporation (Quality Corp) for assistance in data cleaning and analysis, third party validation, and reporting. As a Robert Wood Johnson Foundation *Aligning Forces for Quality* grantee, Quality Corp is experienced in ensuring the production of transparent data and analytics that are highly valued and actionable.

Measurement Year

The first measurement year for the CCO incentive measures will be calendar year 2013. Results will be available in June 2014, in time for the first quality pool distribution by June 30, 2014. The second measurement year for incentive measures will be 2014. Medicaid adult quality and CHIPRA measures will be calculated during the same period. A detailed timeline for the

formative and summative assessments, and quarterly reporting as required by STC 64, is included in the Evaluation Plan above. Of note, the measurement period for the statewide quality and access tests will be the demonstration year, which runs from June to July, and so is offset from the measurement period for the CCO incentive measures by six months.

Data Analysis

OHA will also be responsible for conducting data analysis on these measures. Where possible, measures will be aggregated by the 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 vulnerable populations such as people experiencing homelessness and people with specific diagnoses (disabling conditions, SPMI, chronic conditions, addictions).

Where possible, measures will also be reported for the fee-for-service (FFS) population. For example, all measures from the Consumer Assessment of Health Plans and Systems (CAHPS) survey will be reported for the remaining FFS population.

Other subpopulations of interest for analysis include beneficiary primary language, individuals eligible for Medicare and Medicaid, and rural versus non-rural locations. OHA will involve data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders in clearly defining selected subpopulations for analysis before the measurement year begins in January 2013.

This 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 Part I (Oregon's CCO Quality Strategy). Data from selected measures will also be used to inform the evaluation questions described in Part II (Statewide Evaluations and Tests).

Data Reporting

The Oregon Health Authority has committed to transparency in health system transformation efforts: all selected measures will be reported publicly through reports made available on the Oregon Health Authority website. At a minimum, data will be reported publicly on an annual basis; however a subset of information will be reported more frequently to track patterns of utilization and highlight potential issues with performance. This will also allow OHA to work frequently with CCOs on metrics and possibly make course corrections prior to annual reports. Additional details on reporting are included in the Evaluation Plan timeline above.

Where possible and appropriate, measures will be reported by race and ethnicity, disability, and a where there is a diagnosis of serious and persistent mental illness (SPMI). Measures will be reported by CCO, and in aggregate. In addition, CCO dashboards will synthesize performance

data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries. OHA will not disclose any information otherwise protected by law.

Appendix 3.A: Measure Sets by Population and Domain

Table I: CCO Incentive Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient Experience	Systems
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√			√	√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√	√	√			
Mental and physical health assessment within 60 days for children in DHS custody (state measure)		√	√		√			
Follow up care for children on ADHD medication (NQF 0108)		√	√		√			
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Elective delivery before 39 weeks (NQF 0469)	√				√			
ED utilization without an admission per 1,000 member months (HEDIS)	√	√		√				
Colorectal cancer screening (HEDIS)	√		√		√			
Patient-Centered Primary Care Home (PCPCH) (state enrollment (state measure)	√	√	√	√				
Developmental screening by 36 months (NQF 1448)		√	√		√			
Adolescent well child visits (HEDIS)		√	√		√			
Controlling hypertension (NQF 0018)	√		√	√		√		
HemoglobinA1c poor control (NQF 0059)	√			√		√		
Access to Care: Getting Care Quickly (CAHPS Composites)	√	√	√				√	
Health Plan Satisfaction: Customer Service (CAHPS Composites)	√	√					√	
EHR adoption (composite – 3 questions)	√							√

Table II: Oregon Core Performance Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Getting needed care and getting care quickly (CAHPS Composites)	√	√	√				√	
Member health status, adults (CAHPS health status)	√	√				√		
Rate of tobacco use among CCO enrollees (Medicaid BRFFS, CAHPS)	√					√		
Rate of obesity among CCO enrollees (state measure)	√					√		
Ambulatory Care: Outpatient and emergency department visits (HEDIS)	√	√	√					
Potentially avoidable ED visits (Medi-Cal approach)	√	√		√				
Ambulatory-care sensitive hospital admissions (PQI #1: NQF 272; PQI #14: NQF 638)	√		√		√			
Medication reconciliation post-discharge (NQF 0554)	√				√			
All-cause readmissions (NQF 1789)	√			√				
Alcohol or other substance misuse (SBIRT)	√				√			
Initiation and engagement in alcohol and drug treatment (NQF 0004)	√		√		√			
Mental health assessment for children in DHS custody		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Effective contraceptive use among women who do not desire pregnancy (BRFFS)	√		√		√			
Low birth weight (NQF 0278, PQI 9)					√	√		
Developmental screening by 36 months (NQF 1448)		√	√		√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√		√			

Table III: CHIPRA Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Frequency of Ongoing Prenatal Care (NQF 1391)	√	√	√		√			
Low birth weight (NQF 1382)		√			√	√		
Childhood immunization status (NQF 0038)		√	√		√			
Immunizations for adolescents (NQF 1407)		√	√		√			
Developmental screening by 36 months (NQF 1448)		√	√		√			
Chlamydia screening for women (NQF 0033)	√		√		√			
Well-child visits in the first 15 months of life (NQF 1392)		√	√		√			
Well-child visits in the 3rd, 4th, 5th and 6th years of life (NQF 1516)		√	√		√			
Adolescent Well-Care Visit (NCQA)		√	√		√			
Child and adolescent access to Primary Care Practitioner (NCQA)		√	√		√			
Appropriate testing for children with pharyngitis (NQF 0002)		√			√			
Ambulatory Care: ED Visits (NCQA)	√	√	√	√	√			
Annual % of Asthma Patients with 1 or more Asthma-related ED visits (ages 2-20)		√	√	√	√			
Follow up Care for Children prescribed ADHD medication (NQF 0108)		√	√		√			
Annual pediatric hemoglobin A1C testing		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Mental health assessment for children in DHS custody		√	√		√			
CAHPS Health Plan Survey (child version with chronic conditions supplemental items)	√	√	√	√	√			

Table IV: Medicaid Adult Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Cervical cancer screening (NQF 0032)	√		√		√			
Medical assistance with smoking and tobacco use cessation (NQF 0027)	√		√	√	√			
Screening for clinical depression and f/u (NQF 0418)	√		√		√			
Plan All-Cause Readmissions (NCQA)	√	√	√	√	√			
Diabetes short-term complications admission rate (NQF 0272; PQI 01)	√		√	√	√			
COPD Admission Rate (NQF 0275, PQI 05)	√		√	√	√			
CHF Admission Rate (NQF 0277, PQI 08)	√		√	√	√			
Adult Asthma Admission Rate (NQF 0283, PQI 0283)	√		√	√	√			
Chlamydia Screening in Women age 21-24 (NQF 0033)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√				√			
Elective delivery before 39 weeks (NQF 0469, PC-01)	√			√	√			
Controlling hypertension (NQF 0018)	√			√	√	√		
Comprehensive Diabetes Care: LDL-C Screening (NQF 0063)	√		√	√	√			
Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF 0057)	√		√	√	√			
Antidepressant Medication Management (NQF 0105)	√		√		√			
Adherence to antipsychotics for individuals with schizophrenia (CMS-QMHAG)	√			√	√			
Annual monitoring of patients on persistent medications (NQF 0021)	√		√		√			
CAHPS Adult Survey (including NCQA Supplemental) (NQF 0006 and 0007)	√		√		√			
Prenatal and Postpartum Care: Postpartum Care Rate (NQF 1391)	√		√		√			

Appendix 3.B: Oregon Measures Matrix

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
Improving behavioral and physical health coordination	Alcohol or other substance misuse (SBIRT)	√	√			√	MN method[15] Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based

[15] The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore, the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								intervention).		intervention).
	Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from predecessor organization.	TBD
	Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available	90% (Note: Benchmark based on Metrics & Scoring	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data	90%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							by April 2013.	Committee consensus).	from predecessor organization.	
	Follow-up care for children prescribed ADHD meds (NQF 0108)	√			√	√	Oregon Medicaid baseline 2011: Initiation: 50% C&M: 57%	Medicaid 2012 NCQA National 90th percentile: Initiation: 51% C&M: 63%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid NCQA National 90th percentile: Initiation: 51% C&M: 63%
Improving perinatal and maternity care	Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 89%
	Prenatal and postpartum care: postpartum care rate (NQF 1517)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 66%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								90th percentile: 71%		
	PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per Oregon Association of Hospitals and Health Systems (OAHHS), could also use the 16% rate publically available from Joint Commission)	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per OAHHS, could also use the 16% rate publically available from Joint Commission)	5% or below.
Reducing preventable re-hospitalizations	Follow-up after hospitalization for mental illness	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO	2012 National Medicaid 90th percentile: 68%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	(NQF 0576)								baselines will be determined with 2011 data from predecessor organization.	
	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm
	All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a
Ensuring appropriate care is delivered in appropriate settings	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1	MN method with 3% floor. Individual CCO baselines will be determined	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							baseline (2011): 56 / 1,000 mm	/ 1,000 mm	with 2011 data from predecessor organization.	
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5-year period based on trends in Medicare and Commercial data).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile: 61.34 (Based on Metrics & Scoring Committee consensus)
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to	The percentage of dollars available to each CCO for this measure will be tied to the

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
									the percentage of enrollees in PCPCH, based on measure formula.	percentage of enrollees in PCPCH, based on measure formula.
	Developmental screening in the first 36 months of life (NQF 1448)	√	√		√	√	Oregon baseline: 19.6% using admin data only.	50% (Metrics & Scoring Committee consensus)	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	50% (Metrics & Scoring Committee consensus)
	Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 77.3%	n/a	n/a
	Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile:	MN method with 3% floor. Individual CCO	2011 National Medicaid 75th percentile: 56.9%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								56.9%	baselines will be determined with 2011 data from predecessor organization.	
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 27.5%	n/a	n/a
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a
	Appropriate testing for children with pharyngitis (NQF				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 76%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0002)							90th percentile: 84%		
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed or recommended medications with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a
Deploying care teams to improve care and reduce	Ambulatory Care: Outpatient and	√	√		√	√	TBD (baseline data available in Feb	TBD 2011 National	MN method with 3% floor.	2011 National Medicaid 90th percentile (ED

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
preventable of unnecessarily costly utilization by super users	ED utilization						2013) ED utilization baseline (2011): 56 / 1,000 mm	Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	Individual CCO baselines will be determined with 2011 data from predecessor organization.	utilization): 44.4/1,000mm
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and coordinating a broad set of resources, including CHW.	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%
	Comprehensive diabetes care: LDL-C Screening (NQF 0063)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 80% 90th percentile: 84%	n/a	n/a
	Comprehensive diabetes care: Hemoglobin A1c testing (NQF			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0057)							percentile: 86% 90th percentile: 90%		
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	TBD (baseline data available in Feb 2013)	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%
	PQI 01: Diabetes, short term complication admission rate (NQF 0272)		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 05: Chronic obstructive pulmonary disease admission (NQF		√	√		√	416.9 (2011)	10% reduction from baseline Benchmark set based on	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0275)							Oregon's data (2002-2011)		
	PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 15: Adult asthma admission rate (NQF 0283)		√	√		√	178.7 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy	√	√	√		√	**Access to Care** OR adult baseline: 79% OR child	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63%	MN method with 2% floor Access to Care OR adult	Average of the 2012 Medicaid 75th percentile for the adult and child rates.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	modules).						baseline 88% OR average: 83.5%	2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%	baseline: 79% OR child baseline 88% OR average: 83.5%	Access to Care 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√				
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 63% 90th percentile: 69%	n/a	n/a
	Cervical cancer screening (NQF			√		√	TBD (baseline data available in Feb	2012 National Medicaid benchmark 75th	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0032)						2013)	percentile: 74% 90th percentile: 79%		
	Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a
	Provider Access Questions from the Physician Workforce Survey: 4) To what extent is your primary practice accepting new Medicaid/OHP patients? (include: completely					√	In 2009: 52.4% of Oregon's physicians accepted new Medicaid patients without limitations; 29.7% accepted with some limitations; and 17.9% were completely closed. 84% of	TBD	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	closed, open with limitations, and no limitations). 5) Do you currently have Medicaid/OHP patients under your care? 6) What is the current payer mix at your primary practice?						physicians have Medicaid patients. The statewide payer mix for Medicaid is 15%.			
	Screening for depression and follow up plan									

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	(see above)									
	SBIRT (see above)									
	Mental and physical health assessment for children in DHS custody (see above)									
	Follow-up care for children on ADHD medication (see above)									
	Timeliness of prenatal care (see above)									
	Colorectal cancer screening (see above)									
	PCPCH enrollment (see above)									

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Developmental screening by 36 months (see above)									
	Adolescent well child visits (see above)									
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules)- report on identified Access to Care and Satisfaction with Care composites for incentive, waiver and test.	√	√	√		√	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	MN method with 2% floor. Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average: 78%	Average of the 2012 Medicaid 75th percentile for the adult and child rates. Satisfaction with Care 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71%
	CAHPS 4.0H (child version including Medicaid and children with chronic	√	√		√	√				

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	conditions supplemental items)- report on identified Access to Care and Satisfaction with Care composites for incentive, waiver and test.									National average: 83.95%
Meaningful Use	EHR adoption (Meaningful Use 3 question composite)	√				√	TBD (Baseline data available in April 2013)	TBD	TBD (Baseline data available in April 2013)	TBD

Appendix 3.C: CCO Incentive Measure Specifications

Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) 302

Follow up after hospitalization for mental illness 303

Screening for depression and follow up plan 304

Mental and physical health assessment for children in DHS custody 306

Follow up care for children prescribed ADHD medication 307

Prenatal and Postpartum Care: Timeliness of prenatal care 309

Elective delivery before 39 weeks 310

Emergency Department Utilization 312

Colorectal cancer screening 313

Patient-Centered Primary Care Home (PCPCH) enrollment 315

Developmental screening in the first three years of life 316

Adolescent well child visits 318

Controlling high blood pressure 319

Diabetes: HbA1c Poor Control 320

Access to Care: Getting Care Quickly 321

Satisfaction with Care: Health plan information and customer service 321

Electronic Health Record (EHR) Adoption 322

Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)

This is a non-standard measure based on recommendations from SAMHSA and CMS. The measure is modeled after the screening for depression and follow up measure, without the chart review component.

Numerator

- Individuals screened using SBIRT as indicated by billing codes: 99408, 99409, and 99420

Denominator

- All individuals age 18+

Exclusions

- No exclusions noted.

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
A very low rate of claims submitted in a 12 month period (using CPT codes or H codes). Assume 0% baseline.	n/a	n/a

Follow up after hospitalization for mental illness

NQF Measure #0576. Measure Steward: National Committee for Quality Assurance.

This measure tracks the percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment (had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner) within seven days of discharge.

Numerator

- Clients seen for a non-inpatient visit for mental health services within seven days of discharge for a psychiatric hospitalization defined by relevant DRG codes.

Denominator

- Discharges for psychiatric hospitalization with principal mental health diagnosis.

Exclusions

- If discharge is followed up by another hospitalization for any cause within seven days of discharge, the discharge should be excluded from denominator.
- If it can be determined that the client was transferred to Oregon State Hospital or Blue Mountain Recovery Center, the discharge should be excluded from the denominator. This should be signified by disenrollment from OHP.

Notes

HEDIS specification also defines a metric for 30 day follow up. Continuous enrollment specifications in HEDIS metric take this longer follow up period into account. In addition, the clinics that qualify for follow up visits are too prescribed within HEDIS specifications. It is recommended that OHA adapts to include visits to any setting for mental health services. HEDIS calls for a mental health practitioner to see the person within 7 days. HEDIS definition for MH practitioner includes practically all practitioners allowed to encounter a mental health service in Oregon.

Data Source(s) Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
51%	68% (2012)	58% (2012)

Screening for depression and follow up plan

NQF Measure #0418. Measure Steward: Centers for Medicare and Medicaid Services

This measure tracks the percentage of clients age 18 and older screened for clinical depression using a standardized tool and with a documented follow-up plan

Numerator

- Individuals screened for clinical depression using an age appropriate tool with follow-up plan documented.

Denominator

- All individuals age 12+.

Exclusions

A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.

Notes

This is a metric that will have initial specifications for CMS Adult Quality Measures Grant. It is not currently defined in NQF, despite notation.

Data Source(s)

- Administrative data and chart review.

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
Assume 0% baseline.	n/a	n/a

Mental and physical health assessment for children in DHS custody

This is a non-standard measure that tracks the percentage of children in DHS custody who receive a mental and physical health assessment with 60 days of initial custody date

Numerator

- The number of children brought into DHS custody within a given quarter that received a mental health assessment within 60 days of custody date. Mental Health assessment is defined through the following procedure codes: H0031; H1011; 90801; 90802; 96101; and 96102.
- The number of children brought into DHS custody within a given quarter that received a physical health assessment (procedure codes to be defined) within 60 days of custody date.

Denominator

- The number of children age 4+ taken into custody within a given timeframe (month, quarter or year) who remained in DHS custody for 60 days.

Exclusions

- Children must be continuously enrolled for the 60 day follow up period.
  Notes

Current agreed upon procedure codes (with predecessor Mental Health Organizations) may need to be updated with CCOs.

Committee proposed expanding this measure to include oral health screening in future years

Data Source(s)

- Administrative data and child welfare records (ORKids)

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
58% (Mental Health assessment)	n/a	n/a

Follow up care for children prescribed ADHD medication

NQF #0108. Measure Steward: NCQA

The measure tracks the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

2. *Continuation and Maintenance (C&M) Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Numerator

- Rate 1: Members from the denominator with one face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date.

- Rate 2: The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Denominator

- Members 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an attention deficit/hyperactivity disorder (ADHD) medication during the 12-month Intake Period.

Exclusions

- Initiation Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis or DRG for mental health or substance abuse during the 30 days after the IPSD.

- Continuation and Management Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis of mental health substance abuse during the 300 days after the IPSD.
- Patients diagnosed with narcolepsy (ICD-9-CM Code: 347) should be excluded from the denominators.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
2011 rate 1: 49.96%	2012 rate 1: 51%	2012 rate 1: 44%
2011 rate 2: 57.09%	2012 rate 2: 63%	2012 rate 2: 53%

Prenatal and Postpartum Care: Timeliness of prenatal care

NQF #1517. Measure Steward: NCQA

This measure tracks the percentage of deliveries of live births that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Numerator

- Number of live birth deliveries that received a prenatal care visit as a member of the CCO in the first trimester or within 42 days or enrollment.

Denominator

- Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Exclusions

- None.

Notes

Must be enrolled for 43 days prior to delivery with no gaps.

From July 1, 2009, managed care plans received global payments for prenatal, delivery, and postpartum services in addition to capitation rates: a significant portion of ambulatory services may not generate a claim. This could be addressed through chart review.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
30.4% (administrative data only)	92% (2012)	89% (2012)

Elective delivery before 39 weeks

NQF #0469. Measure Steward: The Joint Commission

This measure tracks the percentage of patients with elective vaginal deliveries or elective cesarean sections at >=37 and <39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).

Numerator

- Individuals with elective deliveries with ICD-9-CM principal procedure code or ICD-9-CM other procedure codes for one or more of the following: Medical induction of labor, Cesarean section while not in active labor or experiencing spontaneous rupture of membranes.
- Procedure codes are defined in Appendix A, Table 11.05 and 11.06 available online at http://manual.jointcommission.org

Denominator

- Patients delivering newborns with >= 37 and < 39 weeks of gestation completed.

Exclusions

- ICD-9-CM Principal Diagnosis Code of ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07.
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
0.8% (2012)		

Emergency Department Utilization

This measure summarizes emergency department utilization and is half of the HEDIS measure "outpatient and ED utilization."

Numerator

- Number of ED visits (multiple visits on one day are counted as one visit).

Denominator

- Per 1,000 member months.

Exclusions

- Emergency Department visits that result in hospital admission.
- HEDIS does not include mental health or chemical dependency if diagnoses are listed as primary.

Notes

Recommend OHA reports total utilization for all covered diagnoses per 1,000 member months, as well as grouping for physical health, mental health, and chemical dependency.

Each group should be reported by recommended race and ethnicity categories. Each group should also be broken out by the following age categories: 0-12; 13-17; 18-20; 21-64; 65-74; and 75+.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
56/1,000mm (2011)	44.4/1,000mm (2011)	55.2/1,000mm (2011)

Colorectal cancer screening

NQF #0034. Measure steward: NCQA

The measure tracks the percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Numerator

- Individual who had an appropriate screening if a submitted encounter / claim contains appropriate CPT code.

Codes used to identify (2012 HEDIS Specifications)

FOBT	CPT CODES: 82270, 82274 HCPCS: G0328 LOINC: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2
Flexible sigmoidoscopy	CPT CODES: 45330-45335, 45337-45342, 45345 HCPCS: G0104 ICD-9 CM PROCEDURE CODES: 45.24
Colonoscopy	CPT CODES: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 HCPCS: G0105, G0121 ICD-9 CM PROCEDURE CODES: 45.22, 45.23, 45.25, 45.42, 45.43

Denominator

- All eligible members meeting enrollment criteria and age 50-75 during measurement year.

Exclusions

- Continuous enrollment for measurement year and prior year. No more than one gap of up to 45 days.
- Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review.

Codes used to identify exclusions (2012 HEDIS specifications)

Colorectal cancer	HCPCS: G0213-G0215, G0231 ICD-9 CM DIAGNOSIS CODES: 153, 154.0, 154.1, 197.5, V10.0
Total colectomy	CPT CODES: 44150-44153, 44155-44158, 44210-44212 ICD-9 CM PROCEDURE CODE: 45.8

Notes

Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy. The diagnosis must have occurred by December 31 of the measurement year.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
30.5% (administrative data only)	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 90th percentile: 71.67. Adjustment factor for Medicaid: 4.12 Adjusted 90th percentile: 67.55	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile: 61.34

Patient-Centered Primary Care Home (PCPCH) enrollment

This measure identifies the number of members enrolled in patient-centered primary care homes by tier.

Numerator

- The number of PCPCH enrolled members by tier:
  - # of enrollees in tier 1 x 1
  - # of enrollees in tier 2 x2
  - # of enrollees in tier 3 x 3

Denominator

- All enrolled members x 3

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	n/a	n/a

Developmental screening in the first three years of life

NQF #1448. Measure Steward: Oregon Health & Sciences University

This measure tracks the percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Numerator

- Children in the relevant denominator who had a claim/encounter with CPT code 96110 (developmental testing, with interpretation and report) by their birthday.

Denominator

- The children in the eligible population who turned one during the measurement period
- The children in the eligible population who turned two during the measurement period
- The children in the eligible population who turned three during the measurement period

Children must be covered by Medicaid/CHIP program continuously for 12 months between last birthdate and this birthdate, regardless if they had a medical/clinic visit or not during the measurement period.

Exclusions

- Children with more than one 45 day gap in enrollment for 12 months prior to birthday are excluded.

Notes

Measure could be collapsed into one across described denominators.

If using hybrid methodology, OHA may need to accept other forms of evidence. This would need to be defined and standardized across plans. Hybrid methodology would lose comparison to national benchmarks.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
19.6% (administrative data only)		

Adolescent well child visits

This HEDIS measure tracks the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Numerator

- Members 12-21 years of age who received at least one comprehensive well-care visit during the measurement year.

Codes used to identify well-child visits (2012 HEDIS Specifications)

Well Child Visits	CPT CODES: 99381, 99382, 99391, 99392, 99432, 99461 HCPCS: G0438, G0439 ICD-9 CM DIAGNOSIS CODES: V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Denominator

- Members 12-21 years of age continuously enrolled in a specific health plan, FFS, or primary care management for the measurement year, with up to one 45-day gap in enrollment allowed.

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
26.7%	64.1% (2011)	56.9% (2011)

Controlling high blood pressure

NQF #0018. Measure Steward: NCQA

This measure tracks the percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator

- The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.

Denominator

- Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Exclusions

- Exclude from the eligible population all patients with evidence of end-stage renal disease (ESRD) (including dialysis or renal transplant), all patients who are pregnant, and all patients who had an admission to a non-acute inpatient setting on or prior to December 31 of the measurement year.
- Individual must be continuously enrolled during the measurement year with no more than one month gap in coverage.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	66% (2012)	60% (2012)

Diabetes: HbA1c Poor Control

NQF #0059. Measure Steward: NCQA

This measure tracks the percentage of adult patients with diabetes ages 18-75 years with most recent hemoglobin A1c level greater than 9.0% (poor control)

Numerator

- The number of patients in the denominator with HbA1c levels greater than 9.0% during the measurement year.

Denominator

- Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Exclusions

- Patients with a diagnosis of polycystic ovaries who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.
- Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
TBD	28% (2012)	34% (2012)

Access to Care: Getting Care Quickly

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: getting care quickly (adult) and getting care quickly (child).

The measure reports on the ease with which the members can access care quickly. The composite score is the overall percentage of members who responded "always" or "usually" to the following questions:

- In the last 6 months, when you needed care right away, how often did you get are as soon as you thought you needed? (Adult)
- In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? (Adult)
- In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed? (Child)
- In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 79%	Adult (2012):85.59%	Adult (2012): 83.63%
Child (2011): 88%	Child (2012):92.16%	Child (2012): 90.31%
Average (2011): 83.5%	Average (2012): 88.88%	Average (2012): 86.97%

Satisfaction with Care: Health plan information and customer service

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: health plan information and customer service (adult) and health plan information and customer service (child).

This measure reports members' customer service experiencing when contacting the health plan. The composite score is the percentage of members who responded "always" or "usually" to the following questions:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed? (Adult)
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? (Adult)
- In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed? (Child)
- In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 76%	Adult (2012):86.67%	Adult (2012): 83.19%
Child (2011): 80%	Child (2012): 88.99%	Child (2012): 84.71%
Average (2011): 78%	Average (2012): 87.83%	Average (2012): 83.95%

Electronic Health Record (EHR) Adoption

This measure is a composite of three Eligible Professional (EP) Meaningful Use Core Measures.

- #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)
- #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology).
- #5: Active Medicaid List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

Notes

Data Source(s)

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
TBD	n/a	n/a

Appendix 3.D: Rationale for Incentive Measures

Incentive Measures[16]	Brief Description	Rationale for Measure
Screening for clinical depression and follow-up plan	Percent of members age 12+ screened for clinical depression using an age-appropriate standardized tool and follow-up plan documented in chart.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Alcohol and Drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	Percentage of members age 18+ with routine visit in the measurement year screened for substance abuse and referred as necessary.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Bundled measure: mental health and physical health assessment for children in DHS custody	Percentage of children age 4+ who receive a mental health assessment and/or physical health assessment within 60 days of DHS custody date.	Oregon's baseline for mental health assessments for children in DHS custody is 58%. As this assessment is a requirement for the foster program, the rate should be much closer to 100%. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

[16] These measures will be publically reported by CCO, by race and ethnicity, and by other subpopulations where possible and appropriate, including people who are dually eligible, people with serious and persistent mental illness, people with disability, and people with special health care needs (e.g., chronic conditions, homelessness). Other analysis may include looking at beneficiary primary language, or rural versus non-rural locations.

Incentive Measures[16]	Brief Description	Rationale for Measure
Follow up care for children prescribed ADHD medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed	Oregon's baseline for follow-up care for children prescribed ADHD medication is 49.96% (rate 1) and 57.09% (rate 2). This is between the 2012 National Medicaid 75th and 90th percentiles. This measure addresses coordination of behavioral health and physical health care, as well as an emerging issue for children.
Follow-up after hospitalization for mental illness	Percentage of members age 6+ and mental health diagnosis with a follow-up visit within 7 days after hospitalization.	Oregon's baseline for follow-up after hospitalization for mental illness is 52%, between the 50th and 75th percentiles nationally (54% and 58%, respectively, 2012 Medicaid Benchmarks). Research has found patient access to follow-up care within 7 days of discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmissions.[17] In addition to potential cost savings from reducing readmissions, focusing on the integration between physical and behavioral health is a key component of Oregon's Health System Transformation. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

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

Incentive Measures[16]	Brief Description	Rationale for Measure
Prenatal care initiated in the first trimester	Percentage of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan.	Oregon's baseline for prenatal care is 30.4% based on administrative data, compared to the 25th percentile nationally of 77% (2012 Medicaid Benchmarks). However, ongoing measurement issues, including bundled payments for pre- and post-natal services, create an artificially low rate when just using administrative data. While Oregon's baseline is likely much higher than 30.4%, improving prenatal care is widely acknowledged as the most cost-effective way to improve the outcome of pregnancy for all women and infants.[18] As 43% of babies born in Oregon are covered by Medicaid (2009),[19]Oregon can achieve significant cost savings and better health outcomes by improving prenatal care. This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Reducing elective delivery before 39 weeks	Patients with elective vaginal deliveries or elective cesarean sections at >=37 and < 39 weeks of gestation completed.	The Leapfrog 2011 hospital survey indicates that rates of elective deliveries in Oregon range from 3.9 – 18.2%, compared to the recommended national benchmark of 5%. Complications for infants delivered by early cesareans include infections, five days or more of hospitalization, and the need for CPR. Additionally, babies born earlier average more visits during the first year of life compared to full-term babies (nine visits versus six, respectively). [20]

[18] A California Medi-Cal study found that women with no prenatal care were four times as likely to give birth to a baby of low birth weight and more than seven times as likely to give birth prematurely (2000). And a Missouri Medicaid study found a cost-savings of $1.49 for every $1 spent on prenatal care (1992).
[19] http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF
[20] http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Maternity_Care.pdf

Incentive Measures[16]	Brief Description	Rationale for Measure
		Total first year costs after initial hospitalization have been found on average to be three times higher for late preterm infants (>37weeks, <39 weeks) than for full-term infants. [21] This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Developmental screening by 36 months	The percentage of children with documentation that they were screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.	Oregon's baseline for developmental screening by 36 months is 19.6%. National survey for children's health indicates a range of 9% - 52% for developmental screening rates across the country. 52% was the highest performing state in the nation. Early developmental delays are often not identified until kindergarten entry or later – well beyond the period in which early intervention is most effective. Early identification and treatment of developmental delays leads to improved outcomes and reduced costs. This measure will help inform the quality improvement focus area: improving primary care for all populations.
Adolescent well care visits	The percentage of enrolled members age 12-21 who had at least on comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Oregon's baseline for adolescent well care visits is 26.3% (2010), well below the 25th percentile nationally of 39.7% (2011 Medicaid National Benchmark) and lower than the general population (in 2011, just over half of Oregon's 8th and 11th graders reported a well care visit in the past year – Oregon Healthy Teens). Youth who can easily access developmentally appropriate,

[21] McLaurin KK, Hall CB, Jackson EA, et al. Persistence of morbidity and cost differences between late-preterm and term infants during the first year of life. *Pediatrics*. 2009;123:653-659.

Incentive Measures[16]	Brief Description	Rationale for Measure
		evidenced-based preventive health services are more likely to be healthy.[22] This measure will help inform the quality improvement focus area: improving primary care for all populations.
Diabetes care: HemoglobinA1c poor control	Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control)	Addresses quality of care for a disease that impairs health and function in the individual and results in high costs due to complications and hospitalizations. By measuring HbA1c control, Oregon will assess the effectiveness of diabetes care. This measure will help inform the quality improvement focus area: Addressing discrete 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.
Controlling hypertension	Percentage of patients age 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year (2013).	According to 2010 BRFSS data, 39.4% of Oregon Health Plan adult enrollees have high blood pressure, compared to 31% of the general population. While baseline data for OHP members with controlled high blood pressure is not available, Oregon is likely below the 25th percentile nationally of 47% (2012 Medicaid Benchmarks) as studies indicate that as many as two thirds of those with hypertension are either undertreated or untreated.[23][24]

[22] Haas, S.A. & Fosse, N.E. (2008). Health and the educational attainment of adolescents: Evidence from the NLSY97.*Journal of Health and Social Behavior, 49,* (2), 178-92.

[23] *Trends in prevalence, awareness, treatment, and control of hypertension in the United States, 1988–2000.*JAMA.*2003; 290: 199–206*

Incentive Measures[16]	Brief Description	Rationale for Measure
		This measure will help inform the quality improvement focus area: Addressing discrete 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.
Colorectal cancer screening	Percentage of individuals age 50-75 who had appropriate screening for colorectal cancer, defined as: • Fecal occult blood test (FOBT) during the measurement year (2013); • Flexible sigmoidoscopy during the measurement year (2013) or the four years prior to the measurement year; or • Colonoscopy during the measurement year (2013) or the nine years prior to the measurement year.	Oregon's baseline for colorectal cancer screening is 30.5%, well below the 25th percentile of 51% (Regions 9 & 10, commercial population) and the overall screening rate in Oregon (63%)[25] Colorectal cancer is Oregon's second leading cause of cancer deaths.[26] Numerous studies have found that colorectal cancer screening is cost-effective or even cost-saving compared with no screening.[27] This measure will help inform the quality improvement focus area: improving primary care for all populations.
ED Utilization	Number of Emergency Department visits,	Oregon's baseline for Emergency Department utilization is 56 visits/1,000 member months (2011), close to the 75th

[24] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6135a3.htm?s_cid=mm6135a3_w
[25] 2008 BRFSS data. Screening is defined as fecal occult blood test within one year, sigmoidoscopy within 5 years, or colonoscopy within 10 years.
[26] www.oregon.gov/DHS/ph/oscar/arpt2006/colorectal06.pdf
[27] Cost-effectiveness of Colorectal Cancer Screening. *Epidemiol Rev (2011) doi: 10.1093/epirev/mxr004* First published online: June 1, 2011 http://epirev.oxfordjournals.org/content/early/2011/06/01/epirev.mxr004.full#abstract-1

Incentive Measures[16]	Brief Description	Rationale for Measure
	calculated per 1,000 member months	percentile nationally of 55.2/member months (2011 Medicaid Total Population National Benchmarks). Reducing ED utilization will result in cost savings.
Rate of PCPCH enrollment:	Percentage of members enrolled in patient-centered primary care homes, calculated by tier.	The Oregon Health Policy board estimates that up to $44 million in 3 years and up to $190 million in 10 years can be saved by implementing integrated health homes for Oregon Health Plan beneficiaries with chronic and/or comorbid conditions. Further savings will be possible when PCPCHs are expanded to public employees and other privately insured Oregonians.[28] This measure will help inform the quality improvement focus area: improving primary care for all populations.
CAHPS Composite: Getting Care Quickly Getting Needed Care	Percentage of members who responded "Always" or "Usually" to four CAHPS survey questions about getting needed care as soon as needed and getting appointments at a doctor's office or clinic as soon as needed. •	Improving access to effective and timely care has the potential to improve the overall quality of care and help reduce costs. [29] It is necessary to assess for the availability and proximity of providers, as well as barriers to access such as lack of transportation, or long waits to get an appointment.[30]Measuring access to care can also identify disparities based on race/ethnicity, gender, or geography.
CAHPS Composite:	Percentage of members who responded	Member satisfaction is a critical component of quality

[28]http://www.oregon.gov/OHA/OHPR/HFB/docs/Final_Report_12_2008.pdf

[29]Steinbrook R. Easing the shortage in adult primary care -- Is it all about money? N Engl J Med. 2009;360:2696-2699; Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff. April 7, 2004: w4.184-197.

[30] Hall A, Harris Lemak C, Steingraber H, et al. Expanding the definition of access: It isn't just about health insurance. J Health Care Poor Underserved. 2008;19:625-638

Incentive Measures[16]	Brief Description	Rationale for Measure
Health plan information and customer service	"Always" or "Usually" to four CAHPS survey questions about how often a health plan's customer service gave needed information or help and how often a health plan's customer service treated members with courtesy and respect.	analysis, from NCQA's HEDIS to the American Medical Association's Accreditation Program. Patient satisfaction is considered a key result of patient care. Healthier members tend to report better satisfaction with their health plan; although this has not been demonstrated conclusively, patient satisfaction could be used as a partial proxy for health status, particularly for managed care members.[31] Addressing patient satisfaction with health plans covers a number of variables, including patient interactions with individual providers, which may be less under the control of the health plan, but also the quality of communication of rules and benefits, and overall customer service provided by the plan.
EHR Composite (3Qs)	1. Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)	Creating a composite score from three Meaningful Use core measures will serve as a measure of EHR adoption across Oregon. The three MU measures selected address both quality and coordination of care, a critical component of the Coordinated Care model.

[31] http://www.dssresearch.com/Download/PSATwithHCHP_RG.pdf

Incentive Measures[16]	Brief Description	Rationale for Measure
	2. Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.) 3. Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	

Appendix 3.E: Measures for Consideration in Demonstration Year 3

Quality Improvement Focus Area	Measures
Reducing preventable rehospitalizations	• Pediatric central line associated bloodstream infections – Neonatal intensive care unit and pediatric intensive care unit
Addressing discrete health issues	
Reduce preventable and costly utilization	• Medication reconciliation post-discharge (NQF 0054) • Care transition – transition record transmitted to health care professional (NQF 0648)
Integrate primary care and behavioral health	• Antidepressant medication management (NQF 0105) • Behavioral health risk assessment for pregnant women (AMA PCPC1) • Depression remission at 12 months (NQF 710)
Improving access to timely and effective care	• Total eligible who received dental treatment services (ages 1-20) • Total eligible who received preventive dental services (ages 1-20) (NQF 1334)
Improving perinatal and maternity care	• Percentage of live births weighing less than 2500 grams (NQF 1382) • Prenatal and postpartum care: postpartum care rate (NQF 1391) • Behavioral health risk assessment for pregnant women (AMA PCPC1)
Improving primary care for all populations	• Annual monitoring of patients on persistent medications (NQF 0021)

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 46, 47, 48, and 49.

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 separately documented on the Tab entitled New FQHC/RHC and included in Level 2 tracking. In addition, any incremental increases in wrap payments associated with a change in scope after July 1, 2011 will also be tracked in this Tab and included as part of Level 2 tracking.

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.

Level 3: The per-member-per-month total expenditure to the state to provide care under Health System Transformation in Oregon.

On the tracking template, there are three administrative cost categories. For the first two on HIT and internal IT costs, specifically the costs funded by Medicaid AND undertaken exclusively to help make CCOs successful are included. The third, the transformation center and related supports, OHA will report the full budget and parse out the Medicaid funding share of that work. This will provide a full picture of the funds needed to support transformation directly. The following provides a more detailed description of the three administrative cost categories and what would be included:

1. **HIT/Interoperability Costs**

    - This category would include administrative expenditures by the state to implement and further statewide HIT/Interoperability *specific to CCOs*.
    - These expenditures would not include anything activities that are the responsibility of the CCOs and providers paid through the CCO global budget.
    - A couple examples of these state costs could include:
        - State monitoring and measuring the CCO progress in increasing EHR adoption rates within their networks
        - State evaluation of the HIT/HIE portions of the CCO Transformation Plans and measuring progress of those plans in those areas

2. **Internal IT system changes**

    - This category would include administrative costs to implement health system transformation that are above and beyond the intensity, frequency, or complexity of normal system changes and are undertaken for the sole purpose to successfully implement CCOs.
    - Examples would include:
        - Personal services focused on HST project direction, management, coordination.

- Hardware and software purchased to establish a new function or service (such as SharePoint for the CCO portal and collaboration)
- Contracted resources to assist with workload (such as documentation of business requirements, making system changes, implementation of new function/service, etc.)
- System changes needed to accommodate both transfer of pertinent data between the state and the CCOs, but also the changes required to support metrics, performance and quality measures and the payment processing attached to those requirements.

3. Transformation Center costs

- This would include the full cost of the transformation center, with Medicaid's share delineated.
- Medicaid's share could include analytic support, staff training, and other related administrative costs that are not funded by other grant funds.

Other Cost Treatment

- **Long-Term Care services**: Oregon has agreed to conduct an exploratory stakeholder process that would result in a report to CMS regarding the integration of DHS Medicaid-funded long-term care for the aged or people with disabilities into CCO global budgets. The report will identify opportunities, barriers, and strategies for integrating long term care, and address issues of scope, process and timeline for integration. The report will be submitted to CMS no later than December 31, 2013.
- **Uncompensated Care Costs:** CMS and OHA acknowledged that DSH audit reports have a significant lag between the review year and date of the actual audit report. State and CMS agree to use data from the most recently filed Medicare cost reports to evaluate the year-to-year trend in hospital uncompensated care. Most recently filed Medicare cost reports are available through the Healthcare Cost Report Information System (HCRIS) maintained by CMS. Six months following the end of the state fiscal year (beginning with SFY 2013), the state would extract HCRIS data for each of the two previous state fiscal years, calculate an aggregate year-to-year trend of uncompensated care and report it to CMS as a component of the quarterly report ending March 31 of each year.

To the extent uncompensated care is increasing more quickly than other health care costs, the state and CMS will attempt to identify underlying factors for the increase and to what extent the state and CMS have influence to affect such factors in the future.

Treatment of Populations Within the Workbook after January 1, 2014

The attached spending growth reduction template is now populated with actual expenditure data and caseload for CY 2011. Expenditure data is extracted from the OHA accounting system based on date of payment.

CMS has proposed a methodology for accounting for the influx of new enrollees in 2014 with the ACA Medicaid expansion. In discussions with the state, CMS has identified three particular populations that are identified in the waiver and subject to the two percent test for some portion of the expenditures for health care (also known as Level 1 service expenditures). The populations are:

A. State plan eligibles currently receiving the OHP Plus benefit package

B. Demonstration population that currently receives the OHP Standard benefit package but will move to the OHP Plus package on January 1, 2014 (approximately 60-70k enrolled individuals)

C. Newly covered individuals in the new section 1902(a)(10)(A)(i)(VIII) group (estimated at 220k individuals)

The current STCs require that the state begin achieving savings in state fiscal year 2014 (July 1, 2013 – June 30, 2014) for populations A and B based on calendar year 2011 base year expenditures for services identified as in the global budget. By June 30, 2014, the state is required to document a one percent savings for all groups covered in the demonstration. However, populations B and C will have major expenditure effects associated with mid-year changes attributable to implementation of ACA Medicaid expansions.

- Population A will not be affected as their benefit package will remain the same and the base year expenditures are still the relevant measure against which savings are determined.

- Population B will experience an increase in expenditures as of January 1, 2014, due to the expansion of their benefit package. CMS proposes that the state measure savings at the two percent level for the OHP Standard benefit package for the full 2014 period. The contracts in place with the CCOs would identify the capitated rate paid for the first half of the year. The state should document the proportion of the rate for the remainder of the demonstration year that is associated with the expanded (Plus) benefit package. The additional benefits available after January 1, 2014, are not subject to the spending growth reduction test for this demonstration year. For the subsequent demonstration year, the expenditures incurred over the final 6 months of the SFY 2014 demonstration year will be

used to develop a new SFY 2014 base (full expanded benefit package) against which SFY 2015 demonstration year (DY 13) will be measured.

- Population C will be new as of January 1, 2014 and therefore, expenditures from January 1 – June 30, 2014 will become the base against which SFY 2015 demonstration year (DY 13) expenditures are measured. The first year that the two percent will be applied is 2015 expenditures.

- If during demonstration year 2015 or 2016, the state is required to modify the rates for the expansion population based on actual experience of the CCOs due to a demonstrable difference in health status or a significant and identifiable increased pattern of utilization, the state will need to provide both of the following:

    1. Analyses that indicate population C has a higher case mix acuity requiring rates that are increased to reflect this higher "sicker population". The state will use the Chronic Illness and Disability Payment System Model (CDPS) to document this case mix and acuity differential and modify the base against which savings will be measured. The documentation must clearly demonstrate that the new population is clearly more expensive due to actual differences in population acuity (health) rather than simply increased utilization of services, poor management in CCOs, or other volume and care management issues.

    2. Analysis that population C has a significantly higher pattern of utilization when compared to the other Medicaid populations (rate groups). Significant increases in utilization that can be isolated to the expansion population are the result of either missed assumptions in the rate setting process or the result of untreated pent up demand. This state will demonstrate this discrepancy by documenting the base utilization assumptions used in setting the capitation rates for the expansion population and then compare those assumptions to the actual experienced utilization for specific services and activities identified prior to the population receiving services in 2014.

The state must provide the actual baseline service data, utilization assumptions, and health status indicators being targeted for review and analysis within the models employed under (1) and (2) for CMS approval prior to the population being enrolled in 2014. CMS understands that the contracts for this population will be negotiated between June and September of 2013 and would expect that the state would begin sharing this information during that period. If the detailed information described in this paragraph is not provided to CMS for review and approval, the state will not be able to request a change in the base for these populations.

Any modification to the base year would need to be agreed upon by CMS and Oregon through the underlying documentation and only for this specific population.

Return on Investment: The return on investment analysis focused on the federal investment represented by total federal financial participation (FFP) in DSHP claims plus additional FFP drawn by the state because it has additional state dollars in the same amount as the FFP drawn against the DSHP claims. This amount represents the total new federal investment into Oregon to support their delivery system transformation under the 1115 demonstration. This amount will be measured against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Description of Elements in the Work Book

Tab 1: PMPM Target – includes 2011 base year per member per month expenditures as developed using OHA expenditure information based on actual date of payment expenditure for 2011. 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. 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 2011 base year aggregate expenditures derived from Tab 8. CY 2011. Subsequent year expenditures for Tab 2 will be 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. Annual estimates will be updated quarterly based on the combination of actual and projections available each quarter.

Tab 4: Expenditure Actuals – includes actual aggregate expenditures derived from Tabs 8 through 13 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/Standard) for calculation of PMPMs.

Tab 6: New FQHC-RHC – provides a tracker of wrap payments made to FQHCs/RHCs established after 7/01/2011 and incremental increases in wrap payments due to increases in scope of service made after 7/01/2011. These calculations then feed into the FQHC/RHC wrap line items in Tabs 10-14.

Tab 7: ROI – includes calculations for the return on investment analysis outlined in STC 50 and above measuring the total DSHP investment against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Tabs 8-13: Yearly tabs that track actuals for the CY 2011 base year and 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. For each current demonstration year, the full year will be estimated, updated with actuals as they are available.

PMPM WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGET

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
	Without HST Baseline Growth (Per ST&Cs)	Base Year	5.40%	5.40%	5.40%	5.40%	5.40%
	Without HST Baseline Growth PMPM	$ 400	$ 421	$ 444	$ 468	$ 493	$ 520
	With HST Spending Reduction Growth Target	Base Year	5.40%	4.40%	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	$ 368					
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						
	Youth residential alcohol and drug treatment (OHP carve out)						
	Adult residential alcohol and drug treatment (OHP carve out)						
	Nurse Home Visiting program: Babies First! And CaCoon						
	Non-Emergent Medical Transportation						
	Adult Residential Mental Health Services						
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
	Young Adults in Transition Mental Health Residential						
	Targeted Case Management						
	Federally Qualified Health Center Wrap						
	Primary Care Case Management						
	Global Budget PMPM	$ 400	$ 421	$ 440	$ 459	$ 484	$ 510
Level 2: Total Expenditu	**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 Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system costs						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

TOTAL EXPENDITURES WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGETS

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget	**Capitation:**						
	Total Managed Care	$ 2,140,213,391					
	Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
	Incentive Payment Pool						
	Total Capitation	**$ 2,519,153,853**	**$ -**				
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030.00					
	Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
	Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
	Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
	Non-Emergent Medical Transportation	$ 43,416,273					
	Adult Residential Mental Health Services	$ 71,019,309					
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
	Young Adults in Transition Mental Health Residential	$ 376,116					
	Targeted Case Management	$ 9,846,177					
	Federally Qualified Health Center Wrap	$ 67,458,838					
	Primary Care Case Management	$ 153,133					
	Total Global Budget - No HST	**$ 2,733,284,427**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	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 Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system changes						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Total Administrative Expenses						

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

PMPM ACTUALS UNDER HEALTH SYSTEM TRANSFORMATION

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget	**Capitation:**						
	Total Managed Care						
	Total Fee For Service (for equivalent CCO services)						
	Incentive Payment Pool						
	Total Capitation PMPM	$ 368.32					
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing						
	Parents with Children under Age 18 (Targeted Case Management)						
	Youth residential alcohol and drug treatment (OHP carve out)						
	Adult residential alcohol and drug treatment (OHP carve out)						
	Nurse Home Visiting program: Babies First! And CaCoon						
	Non-Emergent Medical Transportation						
	Adult Residential Mental Health Services						
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
	Young Adults in Transition Mental Health Residential						
	Targeted Case Management						
	Federally Qualified Health Center Wrap						
	Primary Care Case Management						
	Global Budget PMPM	$ 399.63					
Level 2: Total Expendit	**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 Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system changes						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

TOTAL ACTUAL EXPENDITURES UNDER HEALTH SYSTEM TRANSFORMATION

	BASE TOTAL CY 2011	TOTAL SFY 2013	3.4% TOTAL SFY 2014	3.4% TOTAL SFY 2015	3.4% TOTAL SFY 2016	3.4% TOTAL SFY 2017
Level 1: Global Budget						
Capitation:						
Total Managed Care	$ 2,140,213,391					
Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
Incentive Payment Pool	$ -					
Total Capitation	**$ 2,519,153,853**					
Services Outside of Capitation + Subject to Evaluation						
ADDITIONAL SERVICES:						
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030					
Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
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Adult Residential Mental Health Services	$ 71,019,309					
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
Young Adults in Transition Mental Health Residential	$ 376,116					
Targeted Case Management	$ 9,846,177					
Federally Qualified Health Center Wrap	$ 67,458,838					
Primary Care Case Management	$ 153,133					
Total Global Budget	**$ 2,733,284,427**					
Level 2: Total Expendit						
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 Wrap for new centers and change of scope after 7/01/2011						
Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin						
Administrative Expenses						
HIT/Interoperability costs	$ -					
Internal IT system changes	$ -					
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Ar	$ -					
Total Administrative Expenses	**$ -**					

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Base Year Caseload and Projected Caseload								
	HST Population Groups	Base CY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Total PLUS		5,533,161						
Total Standard	ACA/OHP Standard	838,738						
Total ACA Expansion	ACA/OHP Standard							
Total CHIP	Child	816,558						
Total Plus, Standard, ACA and CHIP		**7,188,457**						
Cawem Prenatal	Non-disabled adult	16,324						
Breast and Cervical Cancer Program	Non-disabled adult	6,309						

Footnote for discussion:

[1]AB/AD w/o Medicare and AB/AD w/Medicare populations include disabled children

Less Duals Non-enrollees	**286,450**
Less TPL Caseload	**68,761**
Total Caseload not including Cawem Prenatal	**6,839,555**

TPL Caseload:	
kids	**9896**
Non-Dis	**4571**
Dis	**2842**
Duals	**50306**
Standard	**1146**
Total TPL	**68761**

FQHCs and RHCs who were either established after 7/01/2012 or have a change of scope since the CY 2011 baseyear

Note: these calculations will be fleshed out and linked to expenditure pages for FQHC payments lines.

Health Centers Established after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

DMAP Provider ID	FQHC/RHC Name	Type	Began	PPS Rate	CY 2011 Wrap	SFY 2012 Wrap	SFY 2013	SFY 2014
500637389	Women's Health Center	RHC	7/13/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637337	Ocean Medical Clinic	RHC	8/17/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637480	Naselle Clinic	RHC	8/17/2011	$86.32	$0.00	$0.00	$0.00	$0.00
544642552	MMoreCare	RHC	11/1/2011	$206.70	$0.00	$0.00	$0.00	$0.00
500640302	Centennial Medical Group	RHC	12/1/2011	$128.11	$0.00	$63,358.13	$0.00	$0.00
500642552	St. Charles Health Sys. Inc.	RHC	1/1/2012	$207.53	$0.00	$0.00	$0.00	$0.00
500646533	Firwood- Legacy Clinic	RHC	8/1/2012	$193.46	$0.00	$0.00	$0.00	$0.00
	Total				$0.00	$63,358.13	$0.00	$0.00

Incremental increases in wrap payments due to rate change effective after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

							SFY 2013		SFY 2014	
DMAP Provider ID	FQHC/RHC Name	Type	Pre-7/1/12 PPS Rate	New PPS Rate	Incremental Rate Change	Effective Date for New Rate	Total	Incremental Increase	Total	Incremental Increase
xxxxxxxxxxx	Example	FQHC	$ 200	$ 225	$ 25	1/1/2013	$ 2,250,000	$ 250,000		
	Total						$ 2,250,000	$ 250,000		

ROI Analysis

	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17
FFP DSHP Claimed (FMAP X TC)					
a. High Risk Pool					
b. Higher Education					
c. State identify Health Programs					
Total Claimed					
New FFP Available on Non-Federal Share {Total DSHP Claimed (line 7)/(1-FMAP)}-DSHP claimed					
Total Federal Investment (Line 7 + Line 9)					
Total Actual Savings (% reduction in Level I & 2 savings realized by the state X Level 1 & 2 spending)					
ROI (line 12/line 14)					

CY 2011 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care	$ 647,342,558	$ 489,607,766	$ 530,789,880	$ 105,277,560	$ 367,195,627		$ 2,140,213,391
Total Fee For Service (for CCO equivalent services)	$ 115,182,230	$ 48,275,516	$ 165,007,384		$ 50,475,332		$ 378,940,462
Incentive Payment Pool							$ -
Total Capitation	$ 762,524,788	$ 537,883,283	$ 695,797,264	$ 105,277,560	$ 417,670,958	$ -	$ 2,519,153,853
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						$ 1,206,030	$ 1,206,030
Youth residential alcohol and drug treatment (OHP carve out)						$ 3,010,303	$ 3,010,303
Adult residential alcohol and drug treatment (OHP carve out)						$ 9,982,229	$ 9,982,229
Nurse Home Visiting program: Babies First! And CaCoon						$ 227,973	$ 227,973
Non-Emergent Medical Transportation						$ 43,416,273	$ 43,416,273
Adult Residential Mental Health Services						$ 71,019,309	$ 71,019,309
Cost-sharing for Medicare skilled nursing facility care (day 21-100)						$ 7,434,193	$ 7,434,193
Young Adults in Transition Mental Health Residential						$ 376,116	$ 376,116
Taregeted Case Management						$ 9,846,177	$ 9,846,177
Federally Qualified Health Center Wrap						$ 67,458,838	$ 67,458,838
Primary Care Case Management						$ 153,133	$ 153,133
Total Global Expenditures	**$ 762,524,788**	**$ 537,883,283**	**$ 695,797,264**	**$ 105,277,560**	**$ 417,670,958**	**$ 214,130,575**	**$ 2,733,284,427**
Total Caseload	**4,146,385**	**858,410**	**603,435**	**393,733**	**837,592**		**6,839,555**
PMPM	**$ 183.90**	**$ 626.60**	**$ 1,153.06**	**$ 267.38**	**$ 498.66**		**$ 399.63**
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service	$ 13,891,529	$ 8,376,740	$ 61,414,236	$ 816,989	$ 10,748,475		$ 95,247,969
Long Term Care						$ 812,827,021	$ 812,827,021
School Based Health Services						$ 25,174,125	$ 25,174,125
Behavioral Rehabilitative Services (BRS)						$ 3,663,118	$ 3,663,118
Personal Care 20 Client Employed Provider						$ 988,176	$ 988,176
FQHC Wrap for new centers and change of scope after 7/01/2011						$ -	$ -
Total Services Outside of Capitation + NOT Subject to	**$ 13,891,529**	**$ 8,376,740**	**$ 61,414,236**	**$ 816,989**	**$ 10,748,475**	**$ 842,652,439**	**$ 937,900,408**
Administrative Expenses							
HIT/Interoperability costs							$ -
Internal IT system changes							$ -
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							$ -
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

C:\Documents and Settings\OR0181264\Local Settings\Temporary Internet Files\Content.Outlook\N9G5S3E3\[Attach H Exp Trend Review Template 121412.xls]1. PMPM Targets

SFY 2013 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2014 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2015 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2016 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2017 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment I
Tribal Health Facility Payment Program Claiming Protocol

The methodology outlined, as required by STC 59, below has been approved for structuring supplemental payments to IHS and tribal health facilities from the date of CMS approval of the amendment to this demonstration through December 31, 2014.

Using the methodology, the state shall make supplemental payments to IHS and tribal health facilities operating under ISDEAA 638 authority: 1) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010, for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, provided to individuals who have no Medicare, Medicaid, CHIP or other coverage with incomes up to 133 percent of the Federal Poverty Level (FPL). Beginning January 1, 2014, through December 31, 2014, the state shall only make supplemental payments to these facilities for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan).

Provider Claiming Methodology

1. Participating IHS or tribal health facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The service provided;
    b. Whether the service was provided to an IHS eligible individual;
    c. Whether the service was provided to an individual who is later found to not meet the eligible criteria to receive care at the facility;
    d. Whether the service was provided to a OHP beneficiary that is IHS eligible; and
    e. The service date.
2. Qualifying encounters shall not include encounters for which any payment was made under OHP at the IHS published rate.
3. Participating IHS and tribal health facilities shall maintain existing policies for pursuing third party liability, and shall have procedures to ensure that individuals who have a source of third party liability are not considered uninsured.
4. Participating IHS and tribal health facilities shall submit to Oregon Health Authority (OHA), on a quarterly basis, the number of qualifying uncompensated encounters, broken down by type of qualifying uncompensated service (primary care services above and below the funding line on the prioritized list), type of individual (OHP individual or non-OHP individual) and status of individual as IHS-eligible (Indian or Alaskan Native, or non-IHS).
5. Participating IHS and tribal health facilities shall submit to OHA, on a quarterly basis, the amount of third party payments received for OHP beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.

State Payment Process

6. OHA will process the reports from participating IHS and tribal health facilities and submit to CMS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1) specifying the number of qualifying

uncompensated encounters for each IHS/tribal health facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, OHA shall submit a certification, signed by the Director of Medical Assistance Plan (DMAP) of OHA that the information contained therein is current, complete, and accurate.
8. The state shall make supplemental payments to each participating facility based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the rate as established in the Oregon Medicaid state plan, offset by any third party payments received by each IHS or tribal health facility for uncompensated encounters involving OHP beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other OHP payments to the facility by the amount of such payments.
9. The state must maintain documentation sufficient to support the claims for supplemental payments and provide to CMS upon request.
10. The state may claim federal matching funding for supplemental payments to IHS and tribal health facilities at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated primary care services which fall below the funding line of the prioritized list to individuals who are both Medicaid-enrolled and status as IHS-eligible.

Attachment I
Tribal Health Facility Payment Program Claiming Protocol

Exhibit 1

Facility Name	IHS Eligible Individuals	
	Uninsured: non-OHP beneficiaries	OHP beneficiaries
Total Number of Encounters		
IHS Encounter rate		
Total Expenditures		
Less: Any other payments received		
Total Net Expenditures		

APPLICATION FOR AMENDMENT AND RENEWAL
Oregon Health Plan
1115 Demonstration Project
Appendices

APPENDICES	
Title	**Appendix**
CCO Application Timelines	A
Oregon Health Plan Transformation Public Process	B
CCO implementation proposal	C
CCO populations and schedule for inclusion in global budget	D
State Fund Only Program List	E
Initial Proposed CCO Accountability Metrics	F
CCO Proposed Measures--Crosswalk to Medicaid Adult, CHIPRA and Medicare ACO Measures	G
Summary of federal authority matrix	H
Federal authority matrix	I
Budget neutrality – Base	J
Budget neutrality – Change	K
Budget neutrality – Combined	L
Inventory of Medicaid services and timeline for inclusion in global budget	M

Appendix A

CCO Application Timeline

Event	1st Application Date	2nd Application Date	3rd Application Date	4th Application Date
CCO Request for Applications and Model Contract to CMS/Review Draft Posted on OHA and DMAP Websites	March 5, 2012	NA	NA	NA
CCO RFA Posted	March 19, 2012	March 19, 2012	March 19, 2012	March 19, 2012
CCO Letter of Intent Due to OHA Notice of Intent to Apply Due to CMS*	April 2, 2012	April 2, 2012	April 2, 2012	April 2, 2012
Part D Formulary Due to CMS*	April 30/May 14, 2012	April 30/May 14, 2012	April 30/May 14, 2012	***
CCO Technical Application Due	April 30, 2012	June 4, 2012	July 2, 2012	August 1, 2012
Medication Therapy Management Program Due to CMS*	May 7, 2012	May 7, 2012	May 7, 2012	***
CCO Financial Application Due	May 14, 2012	June 11, 2012	July 9, 2012	August 8, 2012
Award of Certification	May 28, 2012	July 2, 2012	August 6, 2012	September 5, 2012
Duals Benefit Package Due to CMS*	June 4, 2012	June 4, 2012	June 4, 2012	***
CCO-Medicaid Contract Signed	June 29, 2012	July 30, 2012	August 29, 2012	September 28, 2012
CCO-Medicaid Contract to CMS	July 3, 2012	August 1, 2012	August 31, 2012	October 1, 2012
CCO-Medicaid Contract Effective	**August 1, 2012**	**September 1, 2012**	**October 1, 2012**	**November 1, 2012**
CMS and OHA Certification for Duals*	July 31, 2012	July 31, 2012	August 6, 2012**	***
Three-Way Contract Signed*	Sept. 20, 2012	Sept. 20, 2012	Sept. 20, 2012	***
Dual Eligible Benefits Effective*	**January 1, 2013**	**January 1, 2013**	**January 1, 2013**	***

*Required for participation in CMS Financial Alignment Demonstration for Integrating Care for Individuals who are Dually Eligible. *See RFA Appendix F for more information.* Note, new Part D formularies are due April 30, and previously submitted formularies are due May 14.

**Currently under discussion with CMS due to risk that joint CMS/OHA readiness review for participation in CMS Financial Alignment Demonstration will not be completed in time to sign three-way contracts by Sept. 20, 2012.

***OHA is requesting that CMS allow CCOs to enter three-way contracts after Sept. 20, 2012, with details to be determined during the CMS/OHA Memorandum of Understanding process. Plans on later timelines may risk losing the ability to passively enroll individuals dually eligible for Medicare and Medicaid or other advantages.

Appendix B

Oregon Health System Transformation Public Process
2011-2012

Date	Meeting
Jan. 18, 2011, 9 am–4 pm	Oregon Health Policy Board meeting; public comment accepted[1]
Feb. 2, 2011, 6-9 pm	Public meeting: Weekly Health System Transformation Team [2]
Feb. 8, 2011, 1-3:30 pm	Oregon Health Policy Board meeting; public comment accepted
Feb. 9, 2011, 6-9 pm	Public meeting: Weekly Health System Transformation Team
Feb. 11, 2011, 9:30 am–2:30 pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 16, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Feb. 23, 2011, 6-9 pm	Tribal Health Services: SB 770 Meeting
Feb. 23, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 2, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 8, 2011, 8:30 am-noon:	Oregon Health Policy Board meeting; public comment accepted
Mar. 9, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 16, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 9 am-noon	Medicaid Advisory Committee
April 12, 2011, 12:30-4:30 pm	Oregon Health Policy Board meeting; public comment accepted
May 5, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
May 10, 2011, 8:30 am-noon	Oregon Health Policy Board meeting; public comment accepted
April 27, 2011, 9 am - noon	Medicaid Advisory Committee
April 29, 2011, 9 - 10 am	Tribal Consultation
May 16, 2011 9 - 10 am	Tribal Consultation
May 25, 2011, 9:30 am–2:30 pm	Tribal Health Services: SB 770 Meeting
June 2, 2011, 9-10 am	Tribal Consultation
June 2, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
June 23, 2011, 10-11 am	Oregon Health Policy Board meeting; public comment accepted
June 29, 2011	Senate passes House Bill 3650 by a vote of 22-7
June 30, 2011	House passes House Bill 3650 by a vote of 59-1
July 1, 2011	Governor Kitzhaber signs House Bill 3650, providing a framework for Coordinated Care Organizations and launching four workgroups and next round of public comments
July 12, 2011, 8 am-1 pm	Oregon Health Policy Board meeting; public comment accepted
July 19, 2011, 2 to 3 pm	Tribal Consultation
July 27, 2011, 9 am - noon	Medicaid Advisory Committee
Aug.4, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Aug. 9, 2011, 1-4:30 pm	Oregon Health Policy Board meeting; public comment accepted

[1] All OHPB meetings are live web-streamed statewide. All work papers and materials publicly posted for review.
[2] Appointed by Governor. All work papers and materials publicly posted for review. Members include stakeholders of all types and lawmakers of both parties

Aug. 16, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration[3]
Aug. 17, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Aug. 18, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Aug. 22, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Aug. 24, 2011, 9:30 am–2:30 pm	Tribal Health Services: SB 770 Meeting
Sept. 1, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Sep. 13, 2011, 8-12:30 pm	Oregon Health Policy Board meeting; public comment accepted
Sep. 20, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Sep. 21, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Sep. 22, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Sept. 22, 2011, 8-11 am	Legislature: Interim Joint Health Care Committee hearing
Sep. 26, 2011, 9 am-noon	Public Work Group: Metrics
Sep. 26, 2011, 6-8 pm	Community meeting: Roseburg
Sep. 27, 2011, 6-8 pm	Community meeting: Medford
Sept. 28, 2011, 9 am-noon	Medicaid Advisory Committee
Oct. 3, 2011, 6-8 pm	Community meeting: Pendleton
Oct. 5, 2011, 6-8 pm	Community meeting: Florence
Oct. 6, 2011, 6-8 pm	**C**ommunity meeting: Bend
Oct. 10, 2011, 6-8 pm	Community meeting: Portland
Oct. 11, 2011, 1-5 pm	Oregon Health Policy Board meeting; public comment accepted
Oct. 12, 2011, 6-8 pm	Community meeting: Eugene
Oct. 13, 2011, 6-8 pm	Community meeting: Astoria
Oct. 17, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Oct. 17, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Oct. 18, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Oct. 19, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Oct. 26, 2011, 9 am-noon	Medicaid Advisory Committee
Nov.3, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Nov. 8, 2011, 8:30 am-noon	Oregon Health Policy Board meeting; public comment accepted
Nov. 9, 2011 3:30-4:30 pm	Tribal Consultation
Nov. 14, 2011 1-5 pm	Tribal Health Services: SB 770 Meeting
Nov. 14, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Nov. 14, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Nov. 15, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Nov. 16, 2011, 8-11 am	Legislature: Interim Joint Health Care Committee hearing
Nov. 17, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Nov. 30, 2011 10:30-11:30 am	Tribal Consultation
Dec. 1, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Dec. 13, 2011, 1-6 pm	Oregon Health Policy Board meeting; public comment accepted
Dec. 20, 2011, all day	Legislature: Interim Joint Health Care Committee hearing
Dec. 20, 2011 9 am-12 pm	Tribal Consultation

[3] All work papers and materials publicly posted for review for all groups.

Jan. 10, 2012, 10 am-12 pm	Tribal Consultation
Jan. 10, 2012, 8:30 am-3 pm	Oregon Health Policy Board meeting; public comment accepted
Jan. 18, 2012, 8-11 am	Legislature: House Health Care Committee hearing
Jan. 20, 2012, 1-3 pm	Legislature: Senate Health Care and Human Services Committee hearing
Jan. 24, 2012, 8 am-noon	Oregon Health Policy Board meeting; public comment accepted
Jan. 25, 2012, 10 am-12 pm	Tribal Consultation
Jan. 25, 2012, 9-11 am	Medicaid Advisory Committee
Feb. 2, 2012, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Feb. 12, 2012, 9:30 am–2:30 pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 14, 2012, 1-4 pm	Oregon Health Policy Board meeting, public comment accepted
Feb. 14, 2012	Senate passes Senate Bill 1580 by a vote of 18-12
Feb. 16, 2012, 2-3 pm	Tribal Consultation
Feb. 23, 2012:	House passes Senate Bill 1580 by a vote of 53-7

Oregon Health Authority

Coordinated Care Organizations

Implementation Proposal

House Bill 3650
Health System Transformation
January 24, 2012

www.health.oregon.gov

Oregon Health Policy Board

The Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for the Oregon Health Authority. The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health. Board members are nominated by the Governor and are confirmed by the Senate. Board members serve a four-year term of office.

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Table of contents

1. **Executive summary** ..... **I**
2. **Existing market environment and industry analysis** **2**
   - *Target population* *2*
   - *Current delivery system for target population* *3*
   - *Population characteristics and health status* *4*
3. **Opportunities for achieving the Triple Aim: improving health, improving health care and reducing cost** **9**
   - *Financial projections for greater system efficiency and value* *9*
4. **Coordinated Care Organization (CCO) certification process** **12**
   - *Alternative dispute resolution* *13*
5. **Coordinated Care Organization (CCO) criteria** **15**
   - *Governance and organizational relationships* *15*
   - *Patient rights and responsibilities, engagement and choice* *18*
   - *Health equity and eliminating health disparities* *23*
   - *Payment methodologies that support the Triple Aim* *24*
   - *Health information technology* *26*
6. **Global budget methodology** **28**
   - *Populations included in global budget calculations* *29*
   - *Service/program inclusion and alignment* *29*
   - *Global budget development* *30*
7. **Accountability** **34**
   - *OHA accountability in supporting the success of CCOs* *34*
   - *CCO accountability* *35*
   - *Shared accountability for long-term care* *37*
8. **Financial reporting requirements to ensure against risk of insolvency** **38**
   - *Audited statements of financial position and guarantees of ultimate financial risk* *38*
   - *Financial solvency* *39*
   - *OHA monitoring and oversight* *41*
   - *Public disclosure of information* *42*

CCO licensure *42*

Corporate assets and financial management *43*

9. Medical liability 44

10. Implementation plan 46

Transition strategy *46*

Transitional provisions in HB 3650 ..... *46*

Implementation timeline *47*

11. Appendices 48

Coordinated Care Organization (CCO) Implementation Proposal
House Bill 3650 Health Care Transformation

1. Executive summary

Health care costs are increasingly unaffordable — to businesses, individuals, as well as the federal and state government. The growth in Medicaid expenditures far outpaces the growth in General Fund revenue, yet there has not been a correlating improvement in health outcomes.

In 2011 the Oregon Legislature and Governor John Kitzhaber created CCOs in House Bill 3650, aimed at achieving the Triple Aim of improving health, improving health care and lowering costs by transforming the delivery of health care. The legislation builds on the work of the Oregon Health Policy Board since 2009. Essential elements of that transformation are:

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care; and
- A global Medicaid budget tied to a sustainable rate of growth.

CCOs are community-based organizations governed by a partnership among providers of care, community members and those taking financial risk. A CCO will have a single global Medicaid budget that grows at a fixed rate, and will be responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid or dually eligible for both Medicaid and Medicare. CCOs will be the single point of accountability for the health quality and outcomes for the Medicaid population they serve. They will also be given the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

CCOs are the next step forward for Oregon's health reform efforts that began in 1989 with the creation of the Oregon Health Plan. Today's managed care organizations, mental health organizations and dental care organizations that serve our state's Medicaid population have done a good job in keeping health care costs down, but the current structure limits their ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. Additionally, the current payment system provides little incentive for the prevention or disease management actions that can lower costs, and OHP clients face a sometimes dizzying array of plans and rules while health care costs continue to outpace growth in income or state revenues.

Conventional wisdom is that there are three approaches to controlling what is spent on health care: reduce provider payments; reduce the number of people covered; or reduce covered benefits. Over the years these approaches have proven unsuccessful in reducing the actual cost of care and can squelch investments in health improvement that lead to lower future costs.

In the creation of CCOs, HB 3650 lays the foundation for a fourth pathway: Rather than spending less into an inefficient system, change the system for better efficiency, value and health outcomes.

To implement CCOs in our state, lawmakers called on the Oregon Health Authority to develop a proposal for governance, budgeting and metrics. This proposal has been developed through the Oregon Health Policy Board and is the result of the work of the board and four work groups comprising 133 people who met over four months, a series of eight community meetings around the state that brought input from more than 1,200 people, and public comment at the monthly Oregon Health Policy Board meetings.

Financial projections for greater system efficiency and value
There is ample evidence from initiatives in our local communities that the kind of transformation pointed to by HB 3650 can improve health outcomes and lower costs. National efforts show the same results.

Included in the proposal is work conducted on behalf of OHA and the Oregon Health Policy Board by Health Management Associates (HMA) that estimates total Medicaid spending in Oregon can be reduced by over $1 billion in the next three years and $3.1 billion over the next five years. In year one, the savings equate to $155 million to $308 million in total fund ($58 million to $115 million general fund) cost reductions, net of new investment. HMA believes these projections are conservative as there are certain opportunities that would move the system beyond what we currently understand as well-managed. It is also possible that greater potential savings could be achieved with faster implementation. Full details of HMA's analysis are included in the proposal.

This proposal outlines operational and key qualification guidelines for CCOs as recommended by the Oregon Health Policy Board, including:

- *Global budget*: CCO global budgets will be developed by OHA to cover the broadest range of funded services for the largest number of beneficiaries possible. OHA will construct the CCO global budgets starting with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets will include services that are currently provided under managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

  Once CCOs are phased in, quality incentives will be incorporated in the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

- *Accountability*: CCOs will be accountable for outcomes that bring better health and more sustainable costs. HB 3650 directed that CCOs be held accountable for their performance through public reporting of metrics and contractual quality measures that function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the direction of HB 3650. Accountability measures and performance expectations for CCOs will be introduced in phases to allow CCOs to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards.

  An external stakeholder group established a set of principles and recommendations for dimensions of measurement for OHA to use as a guide when establishing outcomes and quality metrics. Upon legislative approval to go forward, the next step is to establish a committee of technical experts from health plans and health systems to further define these metrics and a reporting schedule. The technical work group will be asked to establish both minimum expectations for accountability as well as targets for outstanding performance. *(See Appendix G.)*

- *Application process*: Beginning in spring/early summer of 2012, prospective CCOs will respond to a non-competitive request for applications (RFA) much like the process developed by the federal government for Medicare Advantage plans. The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

- *Governance*: CCOs will have a governing board with a majority interest consisting of representation by entities that share financial risk as well as representation from the major components of the health care delivery system. CCOs will also convene community advisory councils (CAC) to assure a community perspective; a member of the CAC will serve on the CCO governing board.

- *CCO criteria*: In their applications for certification, CCOs will demonstrate how they intend to carry out the functions outlined in HB 3650 including *(See Appendix D)*:
  - Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;
  - Ensuring member rights and responsibilities;
  - Working to eliminate health disparities among their member populations and communities;
  - Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;

- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency.

Assuming legislative approval, CCO criteria, the request for applications (RFA), and a model CCO contract will be publicly posted in spring 2012 so that communities interested in forming CCOs can begin preparing applications.

The Oregon Health Authority and the Oregon Health Policy Board are poised to begin implementation of the transformational change represented in HB3650.

Timeline

Federal permissions submitted	March 2012
CCO criteria publicly posted	Spring 2012
Request for application (RFA) and model contract posted	Spring 2012
Letters of intent submitted to OHA	Spring 2012
Evaluation of initial CCO applications	Spring/early summer 2012
First CCOs certified	June 2012
First CCOs begin enrolling Medicaid members	July 2012

Additional information and resources about Medicaid transformation and CCOs can be found at: www.health.oregon.gov.

2. Existing market environment and industry analysis

Target population

Projected enrollment

The target population includes all current and future Oregon Health Plan (OHP) enrollees. Between 2010 and 2011, enrollment grew rapidly, due primarily to growth within the expansion group. OHP staff estimates project modest (3%) annual enrollment growth through state fiscal year 2014, followed by a rapid increase between 2014 and 2015 when the Affordable Care Act Medicaid expansion goes into effect. (See Figure 1) While the vast majority of new enrollees are expected to be non-disabled adults, OHP is projecting that the annual rate of growth among the disabled and dual-eligibles, which is approximately 6 percent (excluding the year of the Medicaid expansion), will be roughly three times that of the TANF-related population's 2 percent. This trend is critical, as the disabled and dually eligible populations are, on average, far more costly than their TANF-related counterparts, and also stand to benefit most from effective care management.

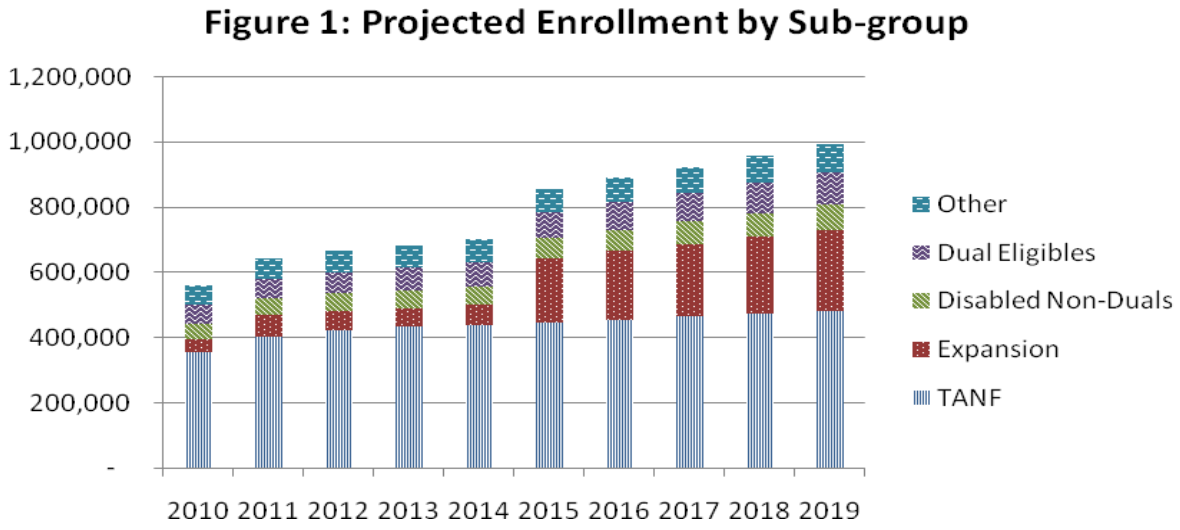

Table 1 shows the demographic distribution of the Oregon Medicaid population in 2011. The racial/ethnic makeup of the population has remained virtually unchanged over the last three years. The age profile of the Oregon Medicaid population has also remained stable over the last three years, though there has been a slight shift from the 0–18 age group to the adult group. This trend is expected to be much larger beginning in 2014, as the majority of new Medicaid enrollees will be previously uninsured adults. Approximately 56 percent of Medicaid enrollees are women and 44 percent are men. While this distribution has remained constant over the last several years, it is expected to shift somewhat toward men when the 2014 expansion is implemented.

Table 1: Oregon Medicaid Demographics (2011)

Demographic	%
Race/Ethnicity	
White	61%
African American	4%
Hispanic or Latino	22%
Asian, Native Hawaiian or Other Pacific Islander	3%
American Indian or Alaska Native	2%
Other/Unknown	8%
Age (in years)	
0-18	56%
19-64	37%
65+	7%
Gender	
Male	44%
Female	56%

Table 1: Data were extracted from the demographic reports published by the Oregon Health Plan, July 2011.

Current delivery system for target population

The current OHP program is fragmented, resulting in diluted accountability for patient care and likely duplication of infrastructure and services. Care is delivered through a system that includes three kinds of health plans (16 physical health organizations, 10 mental health organizations and eight dental care organizations), while some individuals continue to receive care on a fee-for-service basis. Specifically:[1]

- Approximately 78 percent of OHP clients are enrolled in physical health managed care.
- Nearly 90 percent of OHP clients are enrolled in managed dental care.
- Approximately 148,000 clients not enrolled in managed care receive services on a fee-for-service (FFS) arrangement — providers bill the state directly for their services based on a set fee schedule. Some providers receiving FFS also get a case management fee (in areas where there are no managed care plans).
- Approximately 88 percent of OHP enrollees are enrolled in capitated mental health organizations (MHOs). In many cases, the state provides capitated mental health organization (MHO) payments to the counties and the counties administer the programs. The counties function as the MHO, bearing full risk for the services and contract with panels of providers for direct services to enrollees. Addiction services for Medicaid clients are covered in fully capitated health plans, not through MHOs or counties.

Please see Appendix A for detailed information on current plan types and service areas.

[1] Oregon Health Authority. Oregon Health Policy Board meeting slides, Jan. 18, 2011

Population characteristics and health status

The need for more effective service integration and care management for OHP enrollees is evident in statewide and Medicaid-specific data. This section provides an overview of several key indicators of population health. Many of these indicators are also reflective of major cost-drivers within the Medicaid program.

- *Perinatal indicators.* Maternal and child health indicators are important factors in assessing the relative health of a community. Risk factors for poor birth outcomes such as low birth weight, short gestation, maternal smoking, inadequate maternal weight gain during pregnancy and substance abuse can often be addressed as a woman receives prenatal care.
- *Chronic conditions.* Experts estimate that chronic diseases are responsible for 83 percent of all health care spending.[2] Health care spending for a person with one chronic condition on average is 2-1/2 times greater than spending for someone without any chronic conditions.[3]
- *Smoking.* Direct Oregon Medicaid costs related to smoking are an estimated $287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon.[4] While overall tobacco use rates in Oregon are below national levels and trending downward, adult Medicaid clients are nearly twice as likely to smoke as Oregon adults in general.[5] Specifically, 37 percent of adult Medicaid clients smoke, compared to 17 percent of Oregon adults. In addition, studies have shown that economic status is the single greatest predictor of tobacco use.[6]
- *Obesity.* Similarly, Medicaid payments for obesity-related care accounted for nearly nine percent of Medicaid costs between 2004 and 2006, a figure that has likely grown as obesity rates have increased.[7]

Figure 2 shows statewide trends in perinatal indicator rates for the Medicaid population. Teen birth rates and low birth rate babies have remained relatively constant over the past 10 years. However, rates of late prenatal care have shown a troubling increase, and the percentage of Medicaid enrollees who smoke during their pregnancy has increased after dropping off in 2007.

[2] Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update.
[3] Ibid
[4] Oregon Health Plan, Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations. May 2011.
[5] Ibid.
[6] Ibid.
[7] Portland Pulse, from 2007 Oregon DHS data. See: http://www.portlandpulse.org/node/37.

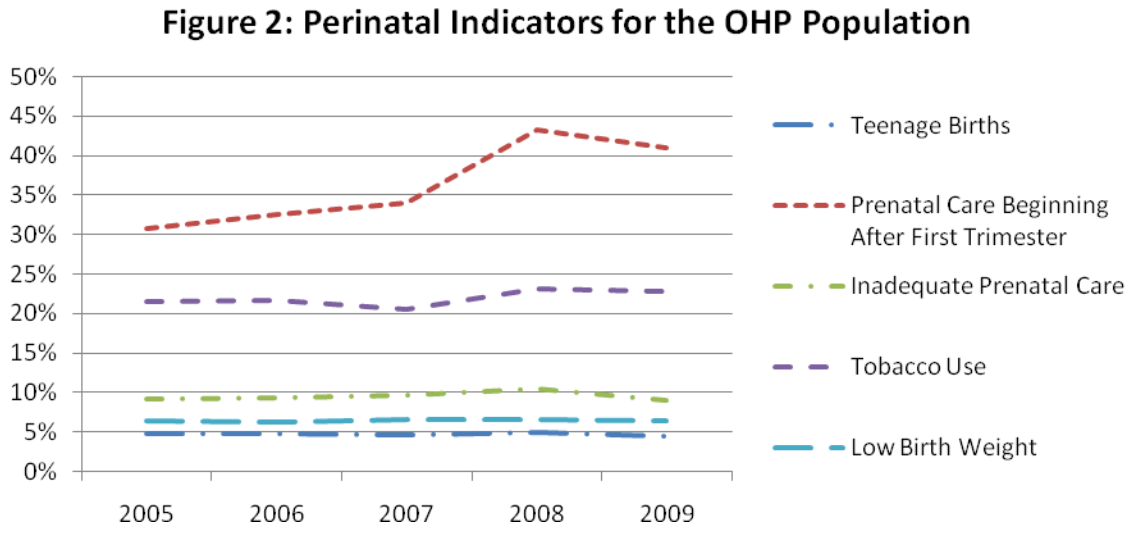

Figure 2: Oregon Vital Statistics Annual Reports 2005-2009

Figure 3 shows the variation across the state when looking at the prevalence of chronic conditions among current OHP enrollees based on diagnosis codes. The statewide bar shows the average across all seven regions for each of the seven chronic conditions. The regions are defined as follows:

- Region 1: Clatsop, Columbia, Tillamook, Lincoln
- Region 2: Coos, Curry
- Region 3: Benton, Clackamas, Linn, Marion, Multnomah, Polk, Washington, Yamhill
- Region 4: Douglas, Jackson, Josephine, Lane
- Region 5: Crook, Deschutes, Gilliam, Grant, Hood River, Jefferson, Morrow, Sherman, Wasco, Wheeler
- Region 6: Baker, Umatilla, Union, Wallowa
- Region 7: Klamath, Lake, Harney, Malheur

In many instances, there are large disparities across regions. For example, Region 2's population has a diabetes prevalence rate that exceeds the statewide average by more than 55 percent and exceeds the Region 5 prevalence rate by 96 percent. Similarly, Region 2's population has an asthma prevalence rate that exceeds the statewide average by 14 percent and the Region 6 rate by 25 percent.

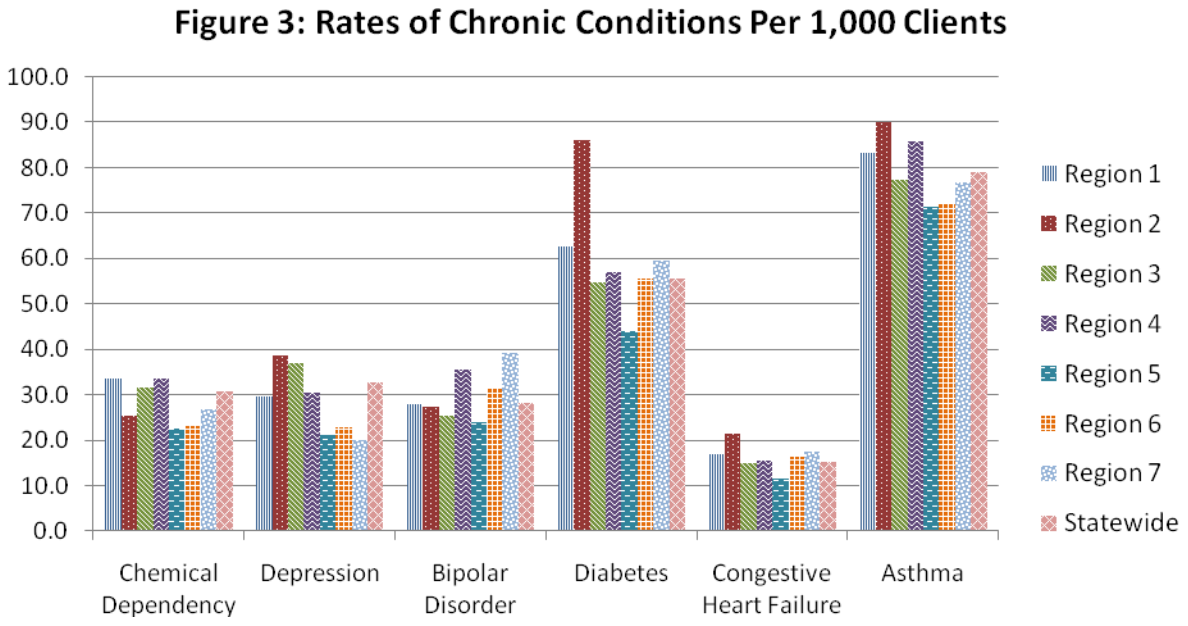

Figure 3: Oregon Health Authority Division of Medical Assistance Programs 8/15/2011.

Figure 4 illustrates the overweight/obesity trend in Oregon and nationally. The lower portion of each stack represents the percent of the population considered "obese" according to their body mass index (BMI). The total stack represents the percentage of the population considered "overweight or obese." While the percentage of the Oregon population considered "overweight or obese" has stayed relatively stable from 2002–2009, the portion that are classified as "obese" has grown. While overall rates of obesity in Oregon are below national levels, this is a troubling trend, as obesity is one of the most important risk factors for developing diabetes, as well as numerous other chronic conditions and certain types of cancer.

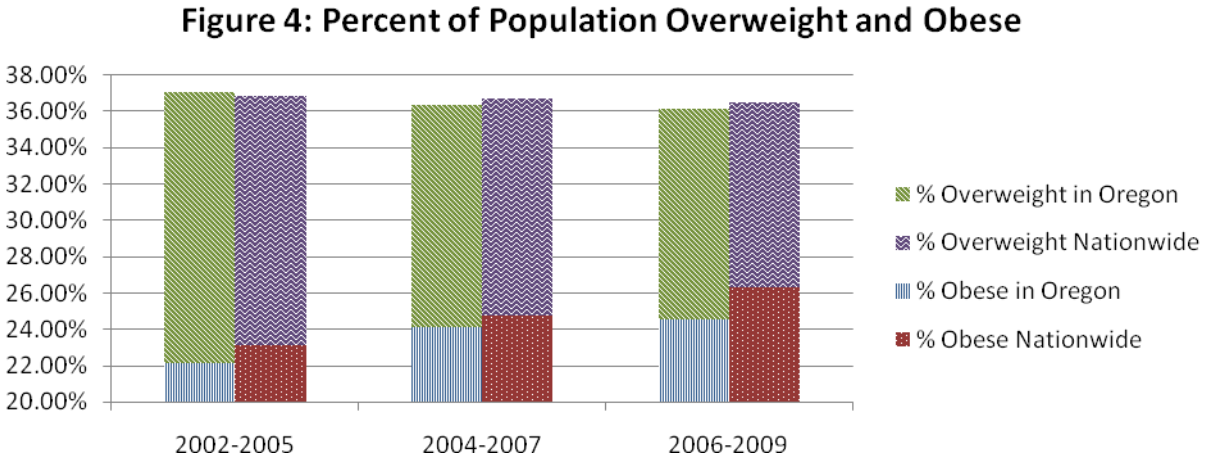

Figure 4: The lower stacks represent the percentage of the population classified as "obese." The total stacks represent the percentage of the population considered "overweight." The data comes from the Behavioral Risk Factor Surveillance System, accessed 12/2011.

Racial and ethnic disparities

In addition to overall rates of chronic disease and utilization of preventive services, it is important to look at disparities among racial and ethnic groups. A 2008 study by the Oregon Division of Medical Assistance Programs compared racial and ethnic disparities in Oregon and in the Oregon Health Plan and found that disparities exist but vary by race/ethnic group.[8] The prevalence of chronic disease is worse among certain minority groups compared to whites. For Oregon Health Plan clients, asthma prevalence was higher for American Indians and Alaska Natives than for any other group — and other minority groups' prevalence was lower than whites'. For Oregon Health Plan clients, all minority groups had a higher prevalence of diabetes, except for African Americans, where the prevalence was the same as for whites.

In its 2011 "State of Equity Report," the Department of Human Services and the Oregon Health Authority identified two disparities in key performance measures across race and ethnicity. For the first measure, the utilization rate of preventative services for children from birth to 10 years of age covered by the Oregon Health Plan, a higher rate is favorable. When comparing across the benchmark of non-Hispanic Whites, Figure 5 shows Native Americans utilizing preventive services at a rate of less than 75 percent of the utilization seen in the White population.

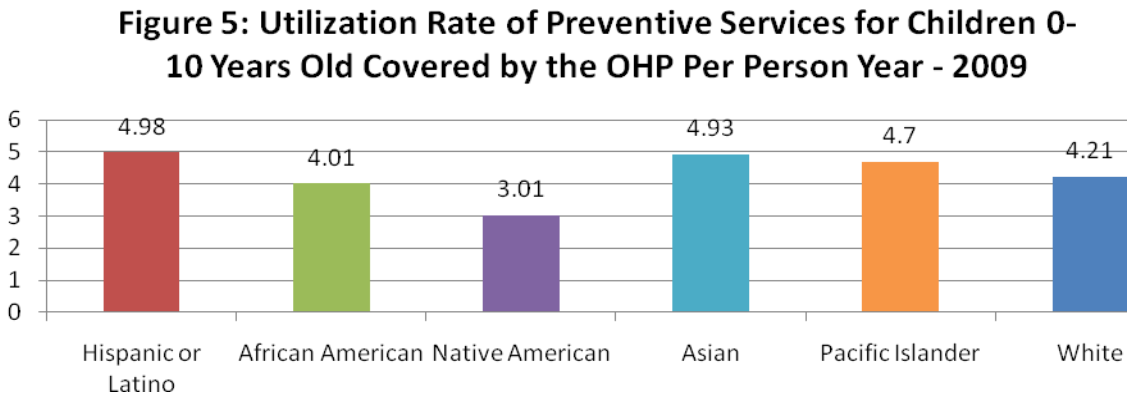

Figure 5: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011. Rates reflect the number of preventive services provided per person year.

In the second measure, the rate of ambulatory care sensitive condition hospitalizations of OHP clients, a lower rate is more favorable. As Figure 6 shows, when comparing rates to the benchmark of non-Hispanic Whites, the Native American population has a higher rate of potentially avoidable hospitalizations. . High rates of hospitalization for ambulatory care sensitive conditions indicate that a condition is not being properly managed. These two disparities together highlight a population in which there is a lack of health care needs being met and indicate a need for outreach and interventions targeted to specific groups.

[8] Division of Medical Assistance Programs and the Public Health Division, Oregon Department of Human Services' Efforts to Reduce Racial and Ethnic Health Care Disparities. May 23, 2008.

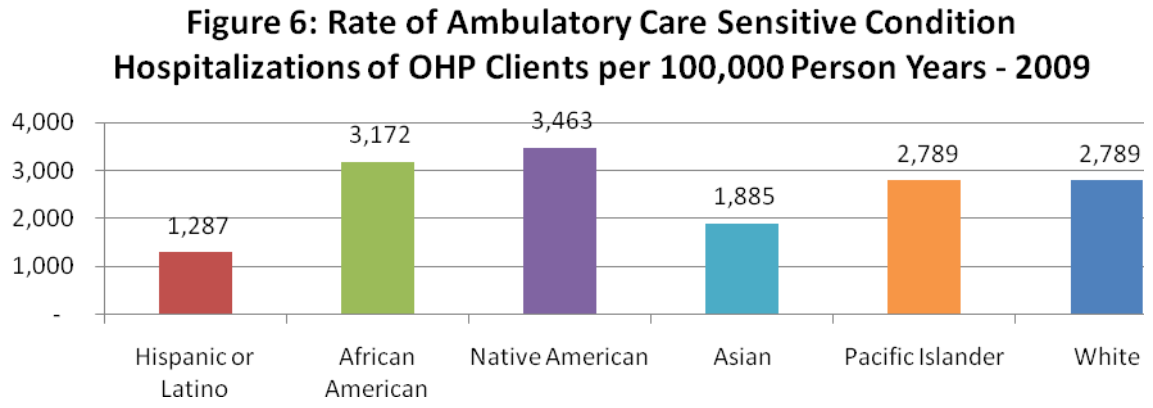

Figure 6: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011.

<u>Unsustainable cost growth</u>

Without implementing transformation, Health Management Associates estimates that Oregon's Medicaid costs will continue to surge at an average of 10 percent annual growth over the next seven years due to a combination of enrollment growth, increased utilization and inflation in the cost of medical products and services. This greatly exceeds the projected growth rate of General Fund revenue.

3. Opportunities for achieving the Triple Aim: improving health, improving health care and reducing cost

Financial projections for greater system efficiency and value

Current state

For the year ending June 30, 2013, total Oregon Medicaid expenditures are expected to approach $3.2 billion. Oregon's Medicaid enrollment has been growing in recent years and the base cost for services has increased historically and is expected to continue to do so. Inflationary factors include higher wages for care providers, changes in medical practice, and the introduction of new treatment protocols and new drugs and technology.

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as $11.7 billion in the FY 2017-2019 biennium with more than 950,000 individuals enrolled in the program. This figure includes approximately 250,000 newly eligible under federal health reform expansion provisions that take effect in 2014.

HB 3650 directs OHA to "prepare financial models and analyses to demonstrate the feasibility of a coordinated care organization being able to realize health care cost savings." OHA contracted with Health Management Associates to conduct this analysis.

Estimates of health transformation savings provided by Health Management Associates

The HMA analysis projects potential savings in six areas. The savings figures in parentheses represent anticipated percentage reductions in expenditures for that component that would take place after implementation is complete and fully scaled, which HMA estimates will take approximately three to five years. *(See Appendix B for more detailed tables)*:

- Improved management of the population (11–15% savings);
- Integration of physical and mental health (10–20% savings);
- Implementation of the Mental Health Preferred Drug List ($0 in the 2011–2013 biennium, $16 million in the 2013–2015 biennium);
- Increased payment recovery efforts (2% savings);
- Patient-centered primary care homes (4–7% savings);
- Administrative savings from MCO reductions (0.2–0.4% savings).

Improve to a well-managed system of care

In 2011, a report by Milliman for the Portland area Oregon Health Leadership Council projected savings for a well-managed Medicaid sub-population (Temporary Assistance for Needy Families, which is largely pregnant women and children) between $118 million and $141 million statewide. According to Milliman, well-managed status reflects attainment of utilization at defined levels equal to optimal benchmarks. Savings reflect the difference between existing service levels and those benchmarks. HMA

projected those findings to the entire Medicaid population by extending Milliman projections to the additional Medicaid groups: the aged, blind and disabled population as well as the expansion population. HMA considers these projections conservative because the complexity and level of chronic disease in these groups is higher and generally yields higher savings.

HMA states that the overall integration of care and payment mechanisms would reduce costs primarily on the Medicare side for dually eligible individuals. Based upon a study by the Lewin Group and in conjunction with the report from Milliman, HMA has estimated this rate at 8.5 percent. These savings come primarily from Medicare expenditures; a shared savings arrangement with Medicare is essential to obtaining a benefit to the state.

Integration of physical and mental health

A key strategy in Oregon's health system transformation efforts includes the integration of mental health and physical health. A study of integration savings projected results as high as 20 percent to 40 percent; however, HMA assumed a lower figure of 10 percent to 20 percent given the extent of other savings already applied in Oregon. This includes both the integration of physical health with certain mental health settings as well as the addition of mental health with physical health settings. Further, while HMA did not estimate the benefit of integrating dental health into the overall system, increased coordination should also reduce costs and increase the quality of the consumer's experience.

Implementation of Mental Health Preferred Drug List

This strategy will require legislative approval, so no savings are projected for year one. Clear evidence exists to demonstrate savings while maintaining the same level of treatment outcomes.

Increased payment recovery efforts

CCOs will audit claims to review Medicaid coverage criteria, inappropriate coding assignments, medical necessity, third party liability, coordination of benefits and other targeted areas, and recoup of overpayments.

Patient-centered primary care homes

The statewide implementation of the patient-centered primary care home model can further reduce costs. Early implementation of similar models has been shown to reduce total expenditures by up to 7 percent. By further enhancing the abilities of these homes through connections to specialty care and improving care transitions between levels of care, HMA believes Oregon can go beyond well-managed.

Administrative savings from MCO reductions

CCOs will be larger and more comprehensive than existing MCOs and MHOs. Consequently, economies of scale are available from the consolidation and redesign of current administrative functions.

Electronic health records and health information exchange

While not included in the table below, the savings from electronic connectivity and reduction in duplicate testing should be noted. Witter & Associates, LLC, estimate avoided services savings at $16

million a year from the widespread adoption and use of health information exchange (HIE). While implementation of statewide HIE is projected to take four to five years, the resultant savings over time are substantial. These estimates are not net of implementation costs. However, the federal investment in provider incentive payments is providing considerable financial support for these efforts. Additionally, we believe that the savings would be measurable if the costs of implementation could be shared across other payers.

HMA Estimates of Achievable Medicaid Savings Due to Health System Transformation
(each column represents expenditures and savings for that period only)

Low Savings – Total Funds	**7/12 to 6/13**	**7/13 to 6/15**	**7/15 to 6/17**	**7/17 to 6/19**
Average Enrolled	672,430	733,522	887,750	955,475
Projected Expenditures	**$3,178,000,000**	**$7,439,550,000**	**$10,018,650,000**	**$11,680,350,000**
Improve to "Well Managed"	($43,700,000)	($311,050,000)	($972,900,000)	($1,282,700,000)
Integration of Physical and Mental Health	($31,300,000)	($285,100,000)	($678,400,000)	($1,039,800,000)
Mental Health Preferred Drug List	$0	($16,000,000)	($27,000,000)	($53,100,000)
Program Integrity	($62,700,000)	($142,600,000)	($180,900,000)	($208,000,000)
Patient Centered Primary Care Homes	($11,000,000)	($99,800,000)	($237,500,000)	($363,900,000)
Admin Savings from MCO Reductions	($6,300,000)	($14,300,000)	($18,100,000)	($20,800,000)
Savings from Redesign	**($155,000,000)**	**($868,850,000)**	**($2,114,800,000)**	**($2,968,300,000)**
Projected Expenditures with Redesign	**$3,023,000,000**	**$6,570,700,000**	**$7,903,850,000**	**$8,712,050,000**
Percentage Change in Expenditures	-4.9%	-11.7%	-21.1%	-25.4%

High Savings – Total Funds	**7/12 to 6/13**	**7/13 to 6/15**	**7/15 to 6/17**	**7/17 to 6/19**
Average Enrolled	672,430	733,522	887,750	955,475
Projected Expenditures	**$3,178,000,000**	**$7,439,550,000**	**$10,018,650,000**	**$11,680,350,000**
Improve to "Well Managed"	($65,500,000)	($401,050,000)	($1,113,400,000)	($1,603,850,000)
Integration of Physical and Mental Health	($124,500,000)	($703,900,000)	($1,781,100,000)	($2,015,300,000)
Mental Health Preferred Drug List	$0	($16,000,000)	($27,000,000)	($51,800,000)
Program Integrity	($62,300,000)	($140,800,000)	($178,100,000)	($201,500,000)
Patient Centered Primary Care Homes	($43,600,000)	($246,300,000)	($623,400,000)	($705,400,000)
Admin Savings from MCO Reductions	($12,500,000)	($28,200,000)	($35,600,000)	($40,300,000)
Savings from Redesign	**($308,400,000)**	**($1,536,250,000)**	**($3,758,600,000)**	**($4,618,150,000)**
Projected Expenditures with Redesign	**$2,869,600,000**	**$5,903,300,000**	**$6,260,050,000**	**$7,062,200,000**
Percentage Change in Expenditures	-9.7%	-20.6%	-37.5%	-39.5%

4. Coordinated Care Organization (CCO) certification process

Pending direction and approval by the Legislature during the February 2012 session, the Oregon Health Authority will begin a non-competitive request for applications (RFA) procurement process that specifies the criteria organizations must meet to be certified as a CCO. Prospective CCOs will be asked to submit applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650, including being prepared to enroll all eligible persons within the CCO's proposed service area. Contracts with certified CCOs will be for multi-year periods, with annual renewal based on CCO compliance with DCBS and OHA requirements; this is similar to Medicare Advantage contract renewals. Health insurers certified by the Oregon Department of Consumer and Business Services Insurance Division retain their certification as long as they are in compliance with DCBS and OHA requirements, including financial solvency. For CCOs, OHA will establish a public recertification process in administrative rule.

In early spring 2012, OHA will promulgate administrative rules describing the CCO application process and criteria. Once the criteria have been finalized, the application process for prospective CCOs is planned as follows (see Section 9 of this document for a timeline):

- CCO criteria will be posted online by OHA.
- OHA will release a "Request for CCO Application."
- CCO applicants will submit letters of intent to OHA.
- CCO applicants will submit applications to OHA.
- OHA will evaluate CCO applications with a public review process.
- OHA will certify CCOs.
- CMS will collaborate with OHA evaluation of applications and certification of CCOs, or may follow with a separate certification with respect to individuals who are dually eligible.

Because CCOs will be responsible for integrating and coordinating care for individuals who are dually eligible for Medicare and Medicaid, the application will include the relevant Medicare plan requirements that will build on the existing CMS Medicare Advantage application process, streamlining the process for any plans that have previously submitted Medicare Advantage applications. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

Evaluation of CCO applications will account for the developmental nature of the CCO system. CCOs, OHA and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by HB 3650. Particular attention will be paid to community involvement in the governance of the CCO, and to the CCO's community needs assessment conducted with its community partners. In all cases, CCOs will be expected to have plans in place for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by HB 3650.

Alternative dispute resolution

HB 3650:

- ***Section 8(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.***
- ***Section 8 (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.***
- ***Section 8 (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.***
- ***Section 8 (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.***

HB 3650 requires the development of a dispute resolution process in establishing CCOs. If a health care entity (HCE) is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization, a process will be available to those parties that includes the use of an independent third-party arbitrator. Because "reasonable cost" is not defined, OHA will clarify in the rule-making process, to the best extent possible, the definition of reasonable cost.

A more complete description of the proposed process is provided in Appendix C. A summary of the primary objectives and components of the process is provided here.

A dispute resolution process using an arbitrator will follow after a good faith effort between the parties to agree to mutually satisfactory contract terms. If there is a question about whether the HCE is "necessary" for the certification of the CCO, the parties can consult with OHA. If there are technical questions that OHA can assist the parties with concerning the certification process, this consultation will be available. However, the primary goal is for the parties necessary to the certification of a CCO work together to agree upon the terms of a contract. Evidence of good faith negotiations should include at least one face-to-face meeting between the chief executive officer and/or chief financial officer of the HCE and of the organization applying for CCO certification, to discuss the contract offer that has been made and the reasons why the HCE has not accepted the offer. If that process does not result in a contract, either party can request the use of an arbitrator.

This dispute resolution process using an arbitrator applies when (and only when) an HCE is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization. This process is designed to be completed within 60 calendar days. When one party initiates the dispute resolution process, the other party and OHA will receive written notification. The parties will then identify a mutually acceptable arbitrator, who must be familiar with health care issues and HB 3650, and who agrees to follow the dispute resolution process described in Appendix C. In the first 10 days, both parties

must send their most reasonable contract offer to each other and the arbitrator, or an explanation of why no contract is desired; in the next 10 days, the parties can file a written explanation for why the offer or refusal to contract is reasonable or unreasonable. The arbitrator has 15 days to review these materials and issue a decision about whether the HCE refusal to contract is reasonable or unreasonable. Having received the decision, the parties have an additional 10 days to resolve their dispute and agree on a contract. At any point in the process, the parties can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

OHA realizes that occasions may arise when a CCO refuses to contract with an HCE. As part of implementation planning, a dispute resolution process will be developed to evaluate the reasonableness of such a refusal and to facilitate review of the dispute.

5. Coordinated Care Organization (CCO) criteria

In order to be certified as a CCO, an organization will be asked to address the criteria outlined in Sections 4 through 13 of HB 3650 and to illustrate how the organization and its systems support the Triple Aim. OHPB recommendations for CCO criteria, outlined below, were developed from a combination of stakeholder work group input, public comment, OHPB-sponsored community meetings held throughout the state, and public and invited testimony at board meetings, as well as board deliberations. Appendix D contains a consolidated list of the proposed CCO criteria along with minimum and transformational expectations for each criterion.

Governance and organizational relationships

HB 3650:

- ***Section 4(1)(o)(A-C): (o) Each CCO has a governance structure that includes: (A) a majority interest consisting of persons that share the financial risk of the organization; (B) the major components of the health care delivery system, and (C) the community at large to ensure that the organization's decision-making is consistent with the values of the members of the community.***
- ***Section 4(1)(i) Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met.***
- ***Section 4(2) The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.***
- ***Section 4(3) On or before July 1, 2014, each CCO will have a formal contractual relationship with any DCO in its service area.***
- ***Section 24(1-4): CCOs shall have agreements in place with publicly funded providers to allow payment for point of contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.***

<u>Governing board</u>

CCO organizational structures will vary to meet the needs of the communities they will serve. There is no single governance solution, and there is risk in being too prescriptive beyond the statutory definition of a CCO governing board. Instead, governing board criteria will support a sustainable, successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim. HB3650 requires that CCOs have a governance structure that includes a majority interest consisting of persons that share the financial risk of the organization. In the context of CCO governance, an entity has financial risk when it assumes risk for Medicaid health care expenses or service delivery either through contractual agreements or resulting from the administration of a global

budget. Entities are also considered at financial risk if they have provided funds that have a demonstrated risk of loss.

As part of the certification process, a CCO should articulate:

- How entities bearing financial risk for the organization make up the governing board's majority interest;
- How the governing board includes members representing major components of the health care delivery system;
- How consumers will be represented in the portion of the governing board that is not composed of those with financial risk in the organization;
- How the governing board makeup reflects the community needs and supports the goals of health care transformation; and
- The criteria and process for selecting members on the governing board, CAC and any other councils or committees of the governing board.

Community advisory council (CAC)

HB 3650 requires that each CCO convene a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership. It further requires that the CAC meets regularly to ensure that the health care needs of the consumers and the community are being met.

At least one member from the community advisory council (chair or co-chairs) will also serve on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations. There must be transparency and accountability for the governing board's consideration and decision making regarding recommendations from the CAC.

Clinical advisory panel

Potential CCOs will establish an approach to assuring best clinical practices. This approach will be subject to OHA approval, and may include a clinical advisory panel. If the CCO convenes a clinical advisory panel, this group should have representation on the governing board.

In addition, the CCO will need to address the following in its application:

- How will the CAC and any other councils or committees of the governing board support and augment the effectiveness of governing board decision making?
- What are the structures initially and over time that will support meaningful engagement and participation of CAC members, and how will they address barriers to participation?

Partnerships

HB 3650 encourages partnerships between CCOs and local mental health authorities and county governments in order to take advantage of and support the critical safety net services available through county health departments and other publicly supported programs. Unless it can be shown why such arrangements would not be feasible, HB 3650 requires CCOs to have agreements with the local mental health authority regarding maintenance of the mental health safety net and community mental health

needs of CCOs members, and with county health departments and other publicly funded providers for payment for certain point-of-contact services. OHPB directs OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.

Community needs assessment

CCOs should partner with their local public health authority and hospital system to develop a shared community needs assessment that includes a focus on health disparities in the community. The needs assessment will be transparent and public in both process and result. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, OHA is expected to work with communities and other relevant bodies such as the OHA Office of Equity and Inclusion and the Health Information Technology Oversight Council (HITOC) to create as much standardization as possible in the components of the assessment and data collection so that CCO service areas can be meaningfully compared, recognizing that there will be some differences due to unique geographic settings and community circumstances.

In developing a needs assessment, CCOs should meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community need that builds on community resources and skills and emphasizes innovation. OHA will define the minimum parameters of the community needs assessment with the expectation that CCOs will expand those as necessary to identify the needs of the diverse communities in the CCO service area. The Public Health Institute's "Advancing the State of the Art in Community Benefit" offers a set of principles that provide guidance for this work[9]:

- Emphasis on disproportionate unmet, health-related need, including disparities;
- Emphasis on primary prevention;
- Building a seamless continuum of care;
- Building community capacity;
- Emphasis on collaborative governance of community benefit.

[9] Public Health Institute, Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability. November, 2004.

Patient rights and responsibilities, engagement and choice

HB3650:

- ***Section 4(1)(a) Each member of the CCO receives integrated person-centered care and services designed to provide choice, independence and dignity.***
- ***Section 4(1)(h) Each CCO complies with safeguards for members as described in Section 8, Consumer and Provider Protections of HB 3650:***
  - ***Section 8(1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:***

  (a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

  (b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

  (c) Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

  (d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

  (e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

- ***Section 4(1)(k) Members have a choice of providers within the CCOs network and that providers participating in the CCO: (A) work together to develop best practices for care and delivery to reduce waste and improve health and well-being of members, (B) are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history, (C) emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication, (D) are permitted to participate in networks of multiple CCOs, (E) include providers of specialty care, (F) are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards, (G) work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members.***

Members enrolled in CCOs should be actively engaged partners in the design and, where applicable, implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices should be reflected in the development of treatment plans; member dignity will be respected. Under this definition, members will

be better positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against under-utilization of services and inappropriate denials of services.

In addition to any other consumer rights and responsibilities established by law, each CCO should demonstrate how it will:

- Use community input and the community needs assessment process to help determine the best methods for patient activation, with the goal of ensuring that patients act as equal partners in their own care;
- Encourage members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members;
- Engage members in culturally appropriate ways;
- Educate members on how to navigate the coordinated care approach;
- Encourage members to use wellness and prevention resources and to make healthy lifestyle choices;
- Meaningfully engage the community advisory council to monitor patient engagement and activation;
- Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities.

None of the patient rights and responsibilities identified above is intended to supplant Medicaid or Medicare law or rule.

Delivery system: access, patient-centered primary care homes, care coordination and provider network requirements
HB3650:

- ***Section 4(1)(b) Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings.***
- ***Section 4(1)(c) Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible.***
- ***Section 4(1)(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.***
- ***Section 4(1)(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health interpreters, community health workers, and personal health navigators who meet competency standards developed by the Authority.***
- ***Section 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.***

- ***Section 4(1)(j) Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.***
- ***Sec 4(1)(k)(G) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Section 4(1)(n) Each CCO participates in the learning collaborative described in ORS 442.210(3).Section 6(2) Each CCO shall implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology***.
- ***Section 6(3) Standards established by the authority for the utilization of patient centered primary care homes by CCOs may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.***
- ***Sec 20(4) 'Community health worker' means an individual who:***
  - ***c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;***
  - ***d) Assists members of the community to improve their health and increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness;***
  - ***e) Provides health education and information that is culturally appropriate to the individuals being served;***

Transformation relies on ensuring that CCO members have access to high-quality care. This will be accomplished by the CCO through a provider network capable of meeting health systems' transformation objectives. The following criteria focus on elements of a transformed delivery system critical to improving the member's experience of care as a partner in care rather than as a passive recipient of care.

<u>Patient-centered primary care homes</u>

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon's statewide standards. These standards were developed through a public process as directed by HB 2009 to advance the Triple Aim goals of better health, better care, lower costs by focusing on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's (and family's) physical and behavioral health care needs.

Building on this work, each CCO will demonstrate how it will use PCPCH capacity to achieve the goals of health system transformation including:

- How the CCO will partner with and/or implement a network of patient-centered primary care homes as defined by Oregon's standards to the maximum extent feasible, as required by HB 3650.;
- How the CCOs will require their other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, as required by HB 3650;
- How the CCO will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650, and members' experience of care and outcomes are improved (coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation);
- How the CCO's patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and services, as described in the bill, and that members are fully informed partners in transitioning to this model of care;
- How members will be informed about access to non-traditional providers, if available through the CCO. As described in HB 3650, these providers may include personal health navigators, peer wellness specialists where appropriate, and community health workers who, as part of the care team, provide culturally and linguistically appropriate assistance to members to access needed services and participate fully in all processes of care.

<u>Care coordination</u>

Care coordination is a key activity of health system transformation. Without it, the health system suffers costly duplication of services, conflicting care recommendations, medication errors and member dissatisfaction, which contribute to poorer health outcomes and unnecessary increases in medical costs.

CCOs should demonstrate the following elements of care coordination in their applications for certification:

- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care and, in the absence of full health information technology capabilities, how they will implement a standardized approach to patient follow-up;
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services;
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication;
- How they will meet state goals and expectations for coordination of care for individuals receiving Medicaid-funded long-term care services given the exclusion of Medicaid-funded long-term services from CCO global budgets.

CCO applicants should be able to describe the evidence-based or innovative strategies they will use within their delivery system networks to ensure coordinated care, especially for members with intensive care coordination needs, as follows:

- *Assignment of responsibility and accountability:* CCOs must demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions, as required by HB 3650.
- *Individual care plans:* As required by HB 3650, CCOs will use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.
- *Communication*: CCOs will demonstrate that providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities ((e.g., addressing issues of health literacy, language interpretation, having electronic health record (her) capabilities, etc.)).

Effective transformation requires the development of a coordinated and integrated delivery system provider network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. OHPB understands this work will occur over time. As each CCO develops, it will be expected to demonstrate the following:

- The CCO will ensure a network of providers to serve members' health care and service needs, meet access-to-care standards, and allow for appropriate choice for members as required by HB 3650. The bill also requires that services and supports should be geographically as close to where members reside as possible and, to the extent necessary, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.
- The CCO will build on existing provider networks and transform them into a cohesive network of providers.
- The CCO will work to develop formal relationships with providers, community health partners, and state and local government support services in its service area(s), as required by HB 3650, and how it will participate in the development of coordination agreements among those groups.

<u>Care integration</u>

- *Mental health and chemical dependency treatment:* Outpatient mental health and chemical dependency treatment will be integrated in the person-centered care model and delivered through and coordinated with physical health care services by the CCO. HB 3650 requires OHA to continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a CCO, but no later than July 1, 2013.
- *Oral health:* By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside. Shared financial accountability will encourage aligned financial incentives for cost-effectiveness and to discourage cost shifting.

- *Hospital and specialty services:* Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes and that specify the following: processes for requesting hospital admission or specialty services; and performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care.

Quality assurance and improvement

It is a continued goal of the OHA to require contracted Medicaid providers to meet established standards for quality assessment and improvement. As part of the certification process, CCOs will describe planned or established mechanisms for:

- A complaint/grievance and appeals resolution process, including how that process will be for communicated to members and providers;
- Establishing and supporting an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops;
- Participating in data collection and/or reporting for OHA accountability metrics;
- Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.

Health equity and eliminating health disparities

HB 3650:

- ***Section 2(2). The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.***
- ***Section 2(3)(b). The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including progress toward eliminating health disparities.***
- ***Sec 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.***
- ***Section 4(1)(k)(G). [Providers participating in a Coordinated Care Organization] work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Sec 19(1)(L) The authority shall: Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).***

- ***Sec 30(1)(a) Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:***
  (a) Demographics, including race and ethnicity.
  (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.

Health equity means reaching the highest possible level of health for all people. Historically, health inequities result from health, economic and social policies that have disadvantaged communities. These disadvantages result in tragic health consequences for vulnerable populations and increased health care costs to the entire system; these costs are borne by taxpayers, employers, workers and the uninsured. CCOs will ensure that everyone is valued and health improvement strategies are tailored to meet the individual needs of all members, with the ultimate goal of eliminating health disparities.

HB 3650 encourages CCOs and their associated providers to work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of members. Through their community needs assessment, CCOs will be expected to identify health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography or other factors in their service areas. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, the OHA Office of Equity and Inclusion should assist in identifying standard components (e.g., workforce) that CCOs should address in the assessment to ensure that all CCOs have a strong and comparable set of baseline data on health disparities.

CCOs will be expected to collect or maintain race, ethnicity and primary language for all members on an ongoing basis in accordance with standards jointly established by OHA and the Oregon Department of Human Services. CCOs can then track and report on any quality measure by these demographic factors and will be expected to develop, implement and evaluate strategies to improve health equity among members.

Payment methodologies that support the Triple Aim

HB 3650:

- ***Section 5(1). The OHA shall encourage CCOs to use alternative payment methodologies that: (a) reimburse providers on the basis of health outcomes and quality instead of the volume of care; (b) hold organizations and providers responsible for the efficient delivery of quality care; (c) reward good performance; (d) limit increases in medical costs; (e) use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination.***

To achieve improvements in quality and efficiency in the delivery system, it will be necessary for CCOs to move from a traditionally fee-for-service payment system to alternative methods that link payment to desired outcomes, promote patient-centered care, and compensate providers for prevention, care coordination, and other activities necessary for keeping people healthy. These methods should include transparent measurement of outcomes aligned with the Triple Aim and be guided by the principles outlined by the OHPB Incentives and Outcomes Committee in 2010:

- *Equity* - Payment for health care should provide incentives for delivering evidence-based care (or emerging best practices) to all people.
- *Accountability* - Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals.
- *Simplicity* - Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse.
- *Transparency* - Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers.
- *Affordability* (cost containment) - Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency.

In their applications for certification, CCOs will be expected to describe how they will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for their members. Examples include but are not limited to:

- Per-member per-month or other payments designed to support patient-centered primary care homes;
- Bundled payments (case rates, fee-for-service rates with risk sharing, or other) for acute episodes, or for episodes of chronic care defined by a calendar period;
- Incentives for service agreements between specialty and primary care physicians;
- Gain-sharing arrangements with providers, if volume is sufficient;
- Quality bonuses or other payment incentives for performance improvement on Triple Aim-focused quality, efficiency and outcomes metrics; and
- Incentives for the use of evidence-based and emerging best practices and health information technology.

While CCOs will have flexibility in the payment methodologies they choose to use, CCOs are encouraged to rely on previously developed and tested payment approaches where available. Efforts to create incentives for evidence-based and best practices will be expected to increase health care quality and patient safety and to result in more efficient use of health care services. To ensure successful transition to new payment methods, it will be necessary for CCOs to build network capacity and to help restructure systems and workflows to be able to respond effectively to new payment incentives.

Health information technology

HB 3650:

- ***Section 4(1)(g) Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent possible.***

OHPB requested that the Health Information Technology Oversight Council (HITOC) provide advice on appropriate health information technology (HIT) certification criteria for CCOs. In order to ensure that coordinated care delivery is enabled through the availability of electronic information to all participants, HITOC suggests that CCOs will need to develop the HIT capabilities described below. CCOs will span different provider types across the continuum of care and different geographic regions across the state, each of which is at different stages of HIT adoption and maturity. The proposed approach for achieving advanced HIT capability is to meet providers and communities where they are and require improvement over time. CCOs will ultimately need to achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and to develop their own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement and other health IT).

<u>Electronic health records systems (EHRs)</u>

CCOs should facilitate providers' adoption and meaningful use of EHRs. EHRs are a foundational component of care coordination because they enable providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to achieve advanced EHR adoption and meaningful use, CCOs will be expected to:

- Identify EHR adoption rates (rates may be divided by provider type and/or geographic region);
- Develop and implement strategies to increase adoption rates of certified EHRs;
- Consider establishing minimum requirements for EHR adoption over time (requirements may vary by region or provider type).

<u>Health information exchange (HIE)</u>

CCOs will facilitate electronic health information exchange in a way that allows all providers to exchange patients' health information with any other provider in that CCO. HIE is a foundational component of care coordination because it enables providers to access pertinent health information when and where it is needed to provide the best care possible and to avoid performing duplicative services. CCOs will be expected to ensure that every provider is:

- **Either** registered with a statewide or local direct-enabled health information service provider (HISP);
    - Direct is a way for one provider to send secure information directly to another provider without using sophisticated information systems. Direct secure messaging will be available to all providers as a statewide service. While EHR vendors will continue to develop products with increasingly advanced direct functionality, using direct secure messaging does not require an EHR system. Registration will ensure the proper identification of participants and secure routing of health care messages, and the email address provided with direct secure

messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time.

- **Or** is a member of an existing health information organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

CCOs should also consider establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

CCOs will leverage HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, CCOs should initially identify their current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in the following areas:

- Analytics (to assess provider performance, effectiveness and cost-efficiency of treatment, etc.);
- Quality reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the performance of the CCO);
- Patient engagement through HIT (using existing tools such as email, etc.);
- Other HIT (telehealth, mobile devices, etc.).

6. Global budget methodology

HB 3650:

- **Section 13(2)(b) Using a meaningful public process, the Oregon Health Authority shall develop…a global budgeting process for determining payments to CCOs and for revising required outcomes with any changes to global budgets.**

CCO global budgets are designed to cover the broadest range of funded services for the most beneficiaries possible. The construction of global budgets start with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets should include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

Once CCOs are phased in, quality incentives will be incorporated into the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

CCO global budgets will be comprised of two major components: capitated and non-capitated. The capitated portion will include funding for all services that can be disbursed to CCOs in a prospective per-member per-month payment. Initially, the capitated portion should include all services currently provided by physical health, mental health and — by 2014 if not before — dental care organizations. The non-capitated portion of the global budget calculation will be for programs and services that are currently provided outside of managed care. The CCO will receive payment and be accountable for the provision of those services.

This approach provides a flexible format that recognizes that not all current Medicaid funding lends itself neatly to a per-member per-month calculation. As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

Primary components of the CCO global budgets and shared accountability arrangements:

Medicaid services currently capitated under managed care	**Medicaid services <u>not</u> currently capitated under managed care**	**Exclusions from CCO global budgets**
Physical health services	Physical health services	Long-term care services
+ Mental health services	+ Mental health services	+ Mental health drugs
+ Oral health services (if included)	+ Medicaid-funded public health services	+ Services postponed from inclusion
Per-member per-month capitated payment	*Non-capitated portion; payment basis may vary.*	*Shared accountability for outcomes and costs may be possible.*

CCO Global Budget

Populations included in global budget calculations

With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. An overview of the eligible CCO populations and their current managed care enrollment can be found in Appendix E. Approximately, 78 percent of people who are eligible for Medicaid are enrolled in a capitated physical health plan, 88 percent in a mental health organization, and 90 percent in a dental care organization.[10] HB 3650 directs OHA to enroll as many of the remaining eligible individuals (including those who are currently in fee-for-service Medicaid) into a CCO as possible. Section 28 of HB 3650 specifically exempts American Indians, Alaska Natives and related groups from mandatory enrollment in CCOs.

Service/program inclusion and alignment

One of the primary goals of the global budget concept is to allow CCOs flexibility to invest in care that may decrease costs and achieve better outcomes. The more programs, services and funding streams that are included in CCO global budgets, the more flexibility and room for innovation exist for CCOs to provide comprehensive, person-centered care. In addition, leaving necessary care outside of the global budget creates conflicting incentives where the action of payers outside of the CCO, who have little reason to contribute to CCO efficiencies, may have an undue effect on costs and outcomes within the CCO.

In considering which Medicaid funding streams should be included in the global budget, the budget will start with the presumption that all Medicaid dollars are in the global budget (with the exception of the services explicitly excluded by HB 3650.) See Appendix F for a list of the services funded by Medicaid funds. Without exception, funding and responsibility for all current services provided by managed physical and mental health organizations as well as non-emergent transportation will be included in each CCO's global budget. The services that are currently capitated under physical and mental health organizations account for approximately 80 percent of Oregon's non-long-term care Medicaid expenditures. Non-emergent transportation represents another 2 percent of expenditures.

Currently, 5 percent of Oregon's non-long-term care Medicaid expenditures are associated with payments for dental care through DCOs. Dental expenditures will be included in global budgets based on individual CCO determination, as HB 3650 allows until July 1, 2014 to incorporate these services.

With respect to the remaining 13 percent of non-long-term care Medicaid expenditures, OHPB believes exceptions to service or program inclusion in the global budgets should be minimal. However, consideration could be given to CCO requests to postpone inclusion of one or more services or programs on the grounds that their inclusion would negatively affect health outcomes by reducing available funding, access or quality. CCOs are strongly encouraged to develop strategic partnerships within their communities in order to successfully manage comprehensive global budgets.

[10] Citizen Alien Waived Emergent Medical (CAWEM) beneficiaries and individuals who are partially dual eligible for Medicaid and Medicare—including qualified Medicare beneficiaries (QMB) and specified low-Income Medicare beneficiaries (SLMB)—are not included in this calculation.

In the case of services that are postponed or excluded from CCO global budgets, it is anticipated that CCOs will enter into shared accountability arrangements for the cost and health outcomes of these services in order to ensure that incentives are aligned in a manner that facilitates optimal coordination. HB 3650 excludes mental health drugs and long-term-care services from CCO global budgets. As described in the Accountability section below, these and other exclusions from CCO global budgets weaken incentives for coordinated care, which must be addressed.

Global budget development

The overall global budget strategy will hold CCOs accountable for costs but not enrollment growth. This strategy suggests an overall budgeting process that builds off of the current capitation rate methodology, but also includes a broader array of Medicaid services and/or programs. CCOs' first-year global budgets will include two Medicaid components:

A capitated portion that includes the per-member per-month payments for services currently provided through the OHP physical health plans, mental health organizations and (if included) dental care organizations; and,

An add-on component to the capitated portion for the remaining Medicaid services or programs not currently included in capitation payments.

Additionally, CCO global budgets will also include Medicare funding to blend with their Medicaid funding to care for individuals eligible for both programs. After the development of an initial baseline of quality and outcome data, OHA will develop a quality incentive component to the global budget methodology to reward CCOs for improved health care outcomes and controlling costs.

<u>Capitated portion of the global budget methodology</u>

At least initially, the capitated portion of CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011–13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the communities the CCOs serve.
Under this approach, potential CCOs will submit a completed base cost template using internal cost data that is representative of a minimum base population. This will not be a competitive bidding process, but OHA actuaries will review the submission for completeness and soundness in order to establish a base rate. Once a base rate is established, the state actuaries will use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

More specifically, in order to establish rates, OHA will gather estimated costs that use the most reliable cost data from potential CCOs in order to produce a base cost while addressing actuarial soundness, CCO viability and access to appropriate care. This cost data will indicate the lowest rate a CCO can accept in its base region, based on current population, geographic coverage and benefit package (the CCO Base Cost Template referenced above). OHA will use the CCO Base Cost Template as the foundation

for the CCO capitation rates. If CCOs propose to operate in geographic areas where they have little or no experience, state actuaries will use a population-based risk adjustment methodology based on the currently used Chronic Illness and Disability Payment System (CDPS), to develop the rates in these new areas.

It is anticipated that initial CCO global budget amounts be established for one year, but that stakeholders and OHA will explore the possibility of establishing global budgets that could be enacted on a biennial or multi-year basis thereafter. For subsequent years, stakeholders have indicated support for continuing to adjust payments to CCOs based on member risk profiles under the current CDPS process. Stakeholders have encouraged OHA to investigate the possibility of including pharmacy data and expanded demographic data into CDPS.

Pending direction and approval by the Legislature during the February 2012 session, it is expected that OHA carry out the following process for prospective CCOs (see Section 10 of this document for a timeline):

- Finalize CCO definition/scope and process;
- Release CCO estimated cost submission process document;
- Collect comments on estimated cost submission process document;
- Make final changes to estimated cost submission process;
- Release of CCO base cost template;
- Release notice of intent to contract as CCO;
- Collect base cost template from prospective CCOs;
- Review and certification of CCO rates;
- Conduct final review of CCO capitation rates;
- Submit CCO capitation rates to CMS;
- Submit contracts to CCOs.

CCO contractors will provide a notice of intent to contract as a CCO followed by a submission of base costs to OHA not later than the beginning of May 2012. OHA's Actuarial Services Unit will be available for technical assistance and work closely with potential CCOs to help them prepare and submit their base cost estimates. If a potential CCO declines to provide a base cost template, OHPB does not recommend certifying a capitation rate for the CCO or issuing the CCO a contract.

The CCO's submitted rates will be reviewed by OHA's actuary and assessed for reasonableness based on documentation that the CCO is capable of:

- Attaining identified efficiencies without endangering its financial solvency;
- Providing adequate access to services for its enrollees; and
- Meeting all necessary federal standards, including but not limited to explanatory notes detailing planned actions, such as initiatives to increase efficiency.

OHA's actuary will assess actuarial soundness at the CCO and region level, and will confer with the CCO regarding any questions or issues that need to be resolved. Additional calculations may be required to ensure that CCO rates in aggregate meet the 2011–2013 legislatively approved budget.

Non-capitated or supplemental portion of the Global Budget Methodology

As previously stated, the OHPB recommended approach to global budgets starts with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. The non-capitated portion of the global budget calculation will encompass programs and services that are currently provided outside of managed care. The CCO will now receive payment and be accountable for the provision of those services.

However, the board recognizes that it may not be feasible or optimal to initially wrap all Medicaid services that have been traditionally outside of managed care capitation into a per-member per-month payment calculation. This may be the case when communities provide the state matching funds for certain Medicaid services. New financing arrangements between the state, CCO and county will be needed to ensure the ability to match local funds is not compromised. In other cases, there may not be adequate experience to comfortably base a per-member per-month calculation, at least initially.

As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

Blended funding for individuals who are dually eligible for Medicare and Medicaid

In HB 3650, the Legislature directed OHA to seek federal waivers and permissions necessary to allow CCOs to provide Medicare and Medicaid services to individuals who are eligible for both programs. Inclusion of dually eligible enrollees in the CCOs and the associated Medicare funding in the global budget is important for a number of reasons. Medicare spending covers the majority of the costs for individuals who are dually eligible, and the vast majority of costs not associated with long-term care. Medicare is the primary payer for dually eligible beneficiaries, and therefore covers the preponderance of medical services. Including Medicare funding in the global budget creates a larger pool of funding to leverage and will allow CCOs to find economies of scope and scale. Including Medicare funding also will provide a significant opportunity to use these funding streams more flexibly and integrate care more effectively. Better coordination of care for Oregon's dually eligible population holds promise for better health and health care for them and lower Medicare and Medicaid spending.

Quality incentive payments

CCO global budget payments should be connected to quality metrics for both clinical processes and health outcomes. However, the board recognizes such an incentive structure will be difficult to initiate in the first year of CCO operation. So initially, metrics will be used to ensure adequate CCO performance for all programs or funding streams in the global budget and to create a data baseline. After the initial period, metrics should be used to determine exceptional performers who would qualify for incentive rewards. The board supports Oregon's discussions with CMS on developing an incentive program as early as possible and is following the progress of the Massachusetts Blue Cross/Blue Shield Alternative

Quality Contract and other new incentive models such as the Five-Star Quality Rating for Medicare Advantage plans to garner lessons that may be applied to CCO global budget development. The board has emphasized that any incentive design should include shared savings approaches so that CCOs are not penalized for successfully lowering costs.

7. Accountability

OHA accountability in supporting the success of CCOs

OHA will be an active partner in health care transformation and support CCOs by:

- Providing accurate and timely data and feedback to CCOs.
- Implementing and supporting learning collaboratives in partnership with CCOs, as required by HB 3650.
- Identifying and sharing information on evidence-based best practices, emerging best practices and innovative strategies in all areas of health care transformation, including patient engagement and activation.
- Providing technical assistance to CCOs to develop and share their own best practice approaches. OHA should develop a system to monitor the development of best practices and the accumulation of evidence supporting new practices or innovations, and should then support widespread adoption of the innovations or best practices.
- Reducing and streamlining administrative requirements.

Further, HB 3650 requires that OHA report back to the Legislature regularly on the progress of payment reform and delivery system change. It further directs OHA to publish data on quality, costs and outcomes at the CCO level.

HB 3650:

- ***Sec 2(3)(b) The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including:***
  - ***a) The achievement of benchmarks;***
  - ***b) Progress toward eliminating health disparities;***
  - ***c) Results of evaluations;***
  - ***d) Rules adopted;***
  - ***e) Customer satisfaction;***
  - ***f) Use of patient-centered primary care homes;***
  - ***g) The involvement of local governments in governance and service delivery; and***
  - ***h) Other developments with respect to coordinated care organizations.***
- ***Section 10(2) The authority shall evaluate on a regular and ongoing basis key quality measures, including health status, experience of care and patient activation, along with key demographic variables including race and ethnicity, for members in each coordinated care organization and for members statewide.***
- ***Section 10(3) Quality measures identified by the authority under this section must be consistent with existing state and national quality measures. The authority shall utilize available data systems for reporting and take actions to eliminate any redundant reporting or reporting of limited value.***
- ***Section 10(4) The authority shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, by coordinated care organization:***
  (a) Quality measures;

(b) Costs;
(c) Outcomes; and
(d) Other information, as specified by the contract between the coordinated care organization and the authority, that is necessary for the authority, members and the public to evaluate the value of health services delivered by a coordinated care organization.

CCO accountability

HB 3650:

- ***Section 10(1) The Oregon Health Authority through a public process shall identify objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCO contracts to hold the organizations accountable for performance and customer satisfaction requirements.***

Accountability for each aspect of the Triple Aim — better health, better care and lower costs — is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality and efficiency measures identified by OHA through a robust public process and in collaboration with stakeholders. CCO accountability metrics will function both to ensure that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650. Further, members and the public deserve to know about the quality and efficiency of their health care so metrics of outcomes, quality and efficiency will be publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of their community CCO.

Accountability measures for CCOs will build on OHPB committee work during the past two years, beginning with the Incentives and Outcomes Committee and followed by the Outcomes, Quality and Efficiency Metrics Work Group. The next stage of metrics development will be for OHA to establish a technical advisory group of experts from health plans, health systems and to include consumers to build measure specifications, including data sources, and to finalize a reporting schedule. This stage of the work will be completed by May 2012. Further technical work, such as establishing benchmarks based on initial data, will follow as outlined below.

<u>Measurement and reporting requirements</u>

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. In the first year, accountability will be for reporting only. In future years, CCOs will be accountable for meeting specified performance benchmarks (see accountability standards below). Initially, years will be based on the effective date of each CCO's contract; that is, year one for a CCO that starts operation in July 2012 run through June 2013 and year one for a CCO that is certified in November 2012 will run through October 2013. However, all CCOs must meet performance benchmarks by January 2014. CCOs that begin operation less than a year before that date will have a shorter reporting-only accountability period and CCOs that start on or after January 2014 will have no phase-in period at all.

Depending on the measure and data source, reports may flow from CCOs to OHA or the reverse. For example, it may be advantageous for OHA to collect member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs. While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, OHA will assess performance more frequently (e.g., quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections and rapid improvement.

Specific areas of CCO accountability metrics

Based on input from OHPB-sponsored stakeholder workgroups, CCO metrics will include both core and transformational measures of quality and outcomes:

- Core measures will be Triple-Aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. They will be uniform across CCOs and will encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health, etc.).
- Transformational metrics will assess CCOs' progress toward the broad goals of health systems transformation and will therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

The initial set of CCO accountability metrics and data sources will be established in consultation with the CMS and the technical advisory group in early 2012, in advance of the request for CCO applications. See Appendix G for examples of potential CCO accountability metrics and an example of how accountability for transformation can be shared across the system.

Accountability standards, monitoring and oversight

With the assistance of the technical advisory work group, OHA will establish two levels of CCO performance standards: minimum expectations for accountability and targets for outstanding performance. Performance relative to targets will affect CCOs' eligibility for financial and non-financial rewards. CCOs' performance with respect to minimum expectations will be assessed as part of OHA monitoring and oversight; subpar performance will lead to progressive remediation building on current accountability mechanisms for MCOs including technical assistance, corrective action plans, financial and non-financial sanctions, and, ultimately, non-renewal of contracts. (See OHA Monitoring and Oversight in the next section.) As outlined in proposed CCO criteria, CCOs will be expected to assess their own performance, to develop quality improvement plans and goals, and to demonstrate progress toward those goals over time. However, OHA will facilitate the provision of technical assistance to assist CCOs to improve their performance with respect to accountability metrics.

As with the reporting expectations, accountability standards will be introduced over time. During every phase of reporting:

- Year one — accountability for reporting only, reporting without budgetary or contractual consequences;
- Years two and three — CCOs expected to meet or exceed minimum performance expectations set for core measures and to improve on past performance for transformational measures.

Quality incentive payments may be offered after year one. The board supports Oregon's discussions with CMS to develop an incentive program as early as possible.

OHA, in cooperation with the technical advisory group described above, will use data from CCOs' first reporting periods to establish baselines and to set benchmarks for both minimum and outstanding performance using those baselines. The technical work group will also advise OHA on adopting and retiring measures or on moving "transformational" measures to the core set.

Annual review of CCO accountability metrics

The board expects that CCO accountability metrics will evolve over time based on ongoing evaluation of the metrics' appropriateness and effectiveness. OHA will establish an annual review process that draws on technical work group expertise and ensures participation from representatives of CCOs and other stakeholders, including consumers and community partners.

Shared accountability for long-term care

Medicaid-funded long-term care services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the state, creating the possibility of misaligned incentives and cost-shifting between the CCOs and the long-term care (LTC) system. Cost-shifting is a sign that the best care for a beneficiary's needs is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTC system. Other elements of shared accountability between CCOs and the LTC system will include: contractual elements, such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems through a memorandum of understanding, a contract or other mechanism; and reporting of metrics related to better coordination between the two systems.

Further, since individuals receiving Medicaid-funded LTC services and supports represent a significant population served by CCOs, CCOs should include these individuals and the LTC delivery system in the community needs assessment processes and policy development structure.

8. Financial reporting requirements to ensure against risk of insolvency

HB 3650:

- ***Section 13(3) The Authority, in consultation with the Department of Consumer and Business Services shall develop a proposal for the financial reporting requirements for CCOs to be implemented under ORS 414.725(1)(c) to ensure against the organization's risk of insolvency. The proposal must include, but need not be limited to recommendations on:***
  - ***a) The filing of quarterly [statements] and annual audited statements of financial position, including reserves and retrospective cash flows, and the filing of quarterly and annual statements of projected cash flows;***
  - ***b) Guidance for plain-language narrative explanation of the financial statements required in paragraph a) of this subsection;***
  - ***c) The filing by a CCO of a statement of whether the organization or another entity, such as a state or local government agency or a reinsurer, will guarantee the organization's ultimate financial risk;***
  - ***d) The disclosure of a CCO's holdings of real property and its 20 largest investment holdings, if any;***
  - ***e) The disclosure by category of administrative expenses related to the provision of health services under the CCO's contract with the authority;***
  - ***f) The disclosure of the three highest executive salary and benefit packages of each CCO;***
  - ***g) The process by which a CCO will be evaluated or audited for financial soundness and stability and the organization's ability to accept financial risk under its contracts, which process may include the use of employed or retained actuaries;***
  - ***h) A description of how the required statements and the final results of evaluations and audits will be made available to the public over the Internet at no cost to the public;***
  - ***i) A range of sanctions that may be imposed on a CCO deemed to be financially unsound and the process for determining the sanctions, and;***
  - ***j) Whether a new category of license should be created for CCOs recognizing their unique role but avoiding duplicative requirements by Department of Consumer and Business Services (DCBS).***

OHA will collaborate with DCBS, as required by HB 3650, to review CCO financial reports and evaluate financial solvency. HB 3650 specifies that CCOs should not be required to file financial reports with both OHA and DCBS; DCBS will be the recipient of these reporting requirements. The following section provides an overview of proposed requirements related to the above items and addresses additional information on organizational structure, corporate status and structure, existing contracts and books of business, and risk management capacities that CCOs shall report.

Audited statements of financial position and guarantees of ultimate financial risk

The Department of Consumer and Business Services defines the purpose of financial regulations of insurers as being to:

> "[E]nsure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of $2.5 million of capital and surplus for an insurer to be authorized to transact insurance. This floor increases as the company assumes more insurance risk. Capital and surplus is the amount a company's assets exceed liabilities." "Health Insurance in Oregon," DCBS; January 2009; p8

CCOs will submit financial information consistent with that required for insurers, including the use of statutory accounting principles (SAP). Application of these principles would allow for standardization of accountability and solvency assurances across health plans enrolling Medicaid, Medicare and commercial populations, and will address the CMS's interest in having organizations that enroll Medicare beneficiaries regulated by the state's Insurance Division. The filing requirements include: quarterly and annual statements of financial position using the form developed by the National Association of Insurance Commissioners (NAIC); annual actuarial certification of unpaid claim reserves, annual calculation of risk-based capital; and annual audited financial statements (using SAP). Included in the NAIC form is a schedule of retrospective cash flows and quarterly and annual statements of projected cash flows. A plain language narrative explanation of the required statements of financial position, statements of projected cash flow, and statements of the sources and uses of public funds will be developed and made publicly available as required by statue (HB 3650 Section 13(3)(b)).

A key element for monitoring financial solvency is an understanding of a CCO's relationship and transactions with its parent, subsidiaries and affiliates. CCOs will be required to submit holding company information consistent with that required for insurers. Such information would include description of any management, service or cost-sharing arrangements and an annual consolidated audited financial statement.

Further, to the extent permissible, financial information collected as required by HB 3650 should be transparent and made available online. This kind of transparency will enable the community to evaluate the financial condition of the CCO and increase confidence in the effectiveness of its governance. A high level of transparency also will enable the CCO board to take early corrective actions. It is critical that CCOs provide understandable, comprehensive and reliable information about their financial status and performance.

Financial solvency

It is expected that information from the NAIC financial reports will be used by financial analysts from DCBS and the Division of Medical Assistance Programs and by OHA's Actuarial Services Unit to track the financial solvency of CCOs as they gain (or lose) enrollment over time and build their financial reserves and other risk management measures commensurately. In addition, CCOs will be subject to periodic on-site financial examinations consistent with those performed on insurers. The factors below have been identified as gauges of a CCO's financial solvency; final financial reporting and solvency terms will be negotiated with CMS, which will participate regarding inclusion of Medicare funding for individuals who are dually eligible:

- *Risk-bearing entity*: As required by HB 3650, the CCO will identify whether the CCO itself or some other entity (such as a state or local government agency, or a reinsurer) will guarantee the CCO's ultimate financial risk, in full or in part. In some cases, CCOs may enter into contracts with hospitals, physician groups, or other providers to share in the financial risk (and rewards) associated with the difference between targeted or projected expenditures and actual expenditures. The extent to which these arrangements reduce the risk borne by the CCO itself will be factored into an actuary's determination of the CCO's reserves.
- *Reinsurance*: Provided through the state or purchased individually by CCOs, reinsurance will act to limit the financial risk of the CCO by capping its risk exposure on either a case-by-case or aggregate basis.
- *Claims reserves*: An adequate amount of liquid assets to satisfy claims liability is required of health plans providing commercial, Medicare and Medicaid coverage in Oregon. Claims reserve requirements for CCOs will be actuarially determined to reflect the CCO's enrollment level and its mix of covered lives based on rate category.
    - *Medical loss ratio*: This is the ratio of expenditures (or claims) incurred for the provision of health care services divided by total health care service revenue. Expenditure incurred for health care services is the amount paid plus the change in the unpaid claim liability. The unpaid claim liability is an estimate for claims already reported but not yet paid and an estimate of the claims for health care services used by a member that have not yet been submitted for payment.
    - *Size of the organization and risk characteristics*: Total number of insured lives and the risk characteristics across all lines of business will be considered ("risk-based capital").
    - *Enrollment level*: The predictability of CCO expenditures and the ability of the CCO to bear risk are reduced at lower enrollment levels. CMS currently requires that Medicare Advantage Plans have a minimum enrollment level of 5,000 beneficiaries. OHPB recommends that CCOs be required to file their actual and projected enrollment levels by rate category.
    - *Organizational liability*: As required by HB 3650, CCOs will be required to file a statement identifying the entity that will be the guarantor of the CCO's ultimate financial risk and any other entities or persons sharing in that risk (in addition to identifying contracting providers bound by risk-sharing agreements with the CCO).
    - *Real property, investments and executive compensation*: As required by HB 3650, each CCO will be required to disclose their real property holdings, their 20 largest investment holdings, and executive compensation. The NAIC form for annual statements includes schedules that provide details on each of these items.
    - *Operating budget*: As described below, OHPB recommends that each CCO be required to describe an annual operating budget including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting any alternative payment methodologies implemented. This operating budget will serve both to indicate the financial soundness of the CCO and to demonstrate that the CCO has developed its budget to reflect the requirements and objectives of health systems transformation.

- *Administrative expenses*: As required by HB 3650, each CCO will be required to outline, by category, administrative expenses relating to provision of services under its CCO contract. The NAIC form for annual statements includes a schedule of expenses by expense category. The expense schedule would show CCO expenses for all of its populations — those incurred under its CCO contract as well as contracts for other populations, including Medicare, PEBB, OEBB and other commercial insurance. Other schedules and note disclosures required by the NAIC form will provide information about expense arrangements with a parent or affiliate organization and detail amounts paid for such service arrangements. A comprehensive understanding of CCO administrative expenses will make possible a more accurate evaluation of the CCO's overall sustainability.

OHA monitoring and oversight

OHA must work in partnership with CCOs to ensure health system transformation success. OHA will institute a system of progressive accountability that maximizes the opportunity to succeed but also protects the public interest. Actions taken when access, quality or financial performance are jeopardizing members should be aligned with the categories that currently exist with DCBS. These categories reflect that OHA would become increasingly involved over time if an entity continues to miss performance guidelines with increased monitoring, technical assistance and supervision. To the extent permissible, OHA monitoring and oversight efforts and documents will be made public.

<u>Quality, access and financial monitoring</u>

Measures for monitoring and oversight in these areas should be aimed initially at root cause analysis and assisting the CCO in developing improvement strategies. Technical assistance for performance improvement will be the primary strategy in the first year of CCOs' operation, when their accountability will be for reporting only. Informal interim reporting (quarterly or semi-annually) will facilitate timely feedback and allow for mid-course corrections such that CCOs will be prepared to meet specified quality standards in year two, whether those standards are absolute benchmarks or expected improvement on past performance. When the evidence indicates that a CCO is not meeting performance standards, steps taken should be progressive, building on current accountability mechanism for MCOs, and may include:

- Technical assistance to identify root causes and strategies to improve;
- Increased frequency of monitoring efforts;
- Corrective action plan;
- Restricting enrollment;
- Financial penalties;
- Non-renewal of contracts.

Conversely, OHA may choose to offer a simplified, streamlined recertification or contracting process to high performing CCOs, in addition to the possibility of financial performance incentives.

If quarterly reports or other evidence suggest that a CCO's financial solvency is in jeopardy, OHA and DCBS will act as necessary to protect the public interest. These measures have two objectives: first, to

restore financial solvency as expeditiously as possible; and second, to identify the causes of the threat to solvency and implement measures to prevent such threats in the future. Actions may include:

- Increased reinsurance requirements;
- Increased reserve requirements;
- Market conduct constraints;
- Financial examinations.

The ultimate action, if no effective remedy is feasible, will be loss of licensure and liquidation of assets as necessary to meet financial obligations.

Public disclosure of information

Current DCBS rules require the public disclosure of information pertaining to licensed insurers. As required by HB 3650, OHA will ensure that CCO financial information is transparent and made available online.

CCO licensure

A new licensure category will be created for CCOs by DCBS in collaboration with OHA. This new licensure category will reflect the unique requirements and objectives of health systems transformation. This will also allow the application of certain insurance code provisions to CCOs that will allow for consistency of reporting and financial solvency and comparability among CCOs and insurers but will not subject CCOs to insurance code provisions that are not necessary given their unique contracting relationship with OHA. A separate licensure category also will facilitate the blend of flexibility and accountability that will be needed for successful implementation and operation of CCOs. DCBS and OHA staff will determine whether statutory changes are required to implement a licensure category specific to CCOs, and propose such changes through the 2012 legislative process. In the interim, existing licensure categories will be used as appropriate to the populations covered.

CCOs will be expected to provide information on corporate status, participation in the Oregon Health Plan, and other contracts:

- Corporate status: where incorporated; affiliated corporate entity or entities involved under potential CCO contract; current Department of Consumer and Business Services (DCBS) licensure/certification;
- Oregon Health Plan MCO or MHO status: current OHA MCO or MHO contractor status; organizational changes involved in CCO application; whether CCO is formed through MCO or MHO partnership; and MCO or MHO service area vs. CCO service area;
- Other state contracts: Oregon Medical Insurance Pool (OMIP); Healthy Kids/Kids Connect; PEBB; OEBB;
- Medicare contracts: CMS contracts with CCO to provide Medicare services;
- Commercial contracts: both group and individual markets;
- Administrative services or other management contracts.

Corporate assets and financial management

As part of the certification process, CCOs will provide information relating to assets and financial and risk management capabilities, including:

- Tangible net equity and other assets;
- Risk reserves, current and scheduled, based on enrollment and projected utilization;
- Risk management measures;
- Delegated risk;
- Reinsurance and stop-loss;
- Incurred but not reported (IBNR) tracking;
- Claims payment;
- Participation in the All Payer All Claims reporting program as required by Section 4(k)(L);
- Internal auditing and financial performance monitoring;
- Administrative cost allocation across books of business (including Medicaid, Medicare and commercial).

9. Medical liability

HB 3650:

- ***SECTION 16. Health care cost containment. (1) The Oregon Health Authority shall conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures, while protecting access to health care services for those in need and protecting their access to seek redress through the judicial system for harms caused by medical malpractice. The study and recommendations should address but are not limited to:***
  - ***(a) An analysis of the cost of defensive medicine within the Oregon health care delivery system and its potential budget impact, and containment and savings that would result from recommended changes.***
  - ***(b) Identification of costs within the health care delivery system, including costs to taxpayers and consumers related to care and utilization rates impacted by defensive medical procedures or medical malpractice concerns.***
  - ***(c) An analysis of utilization, testing, services ordered, prescribed or delivered through centers or facilities in which there is a financial interest between the provider requesting a test or service and the entity or individual providing the test or service, including an examination of Stark laws exceptions and exemptions.***
  - ***(d) Establishment of criteria for evaluation and reduced utilization of services and procedures where the health of those served is not negatively impacted or necessarily improved.***
  - ***(e) Identification and analysis of the benefits and impact of caps on medical liability insurance premiums as well as the benefits and potential cost saving from the extension of coverage through the Oregon Tort Claims Act to those who serve or act as agents of the state.***
  - ***(f) A path for a cap on damages for those acting on behalf of the state and serving individuals who receive medical assistance or have medical coverage through other publicly funded programs.***
  - ***(g) An examination of the possible clarifications and limitations on joint and several liability requirements for coordinated care organizations so that these organizations can assume the risk of their actions but are not liable for the actions of others within the coordinated care organization or its contracted services.***
  - ***(h) The effectiveness of binding and nonbinding medical panels in addressing claims of medical malpractice.***

(2) The authority shall coordinate with the Department of Consumer and Business Services and other appropriate agencies, including nongovernmental agencies, in order to collect and analyze the data generated by the study and to make complete recommendations to the Legislative Assembly.

(3) The authority shall secure assistance and input from stakeholder organizations in an effort to secure the best information available relevant to the impacts on administrative costs resulting from litigation, as well as to identify cost containment or cost reduction mechanisms.

(4) The authority shall focus its efforts on the medical malpractice marketplace and coverage throughout Oregon and the impact of implementing medical malpractice liability caps, in order to provide complete information to the Legislative Assembly as it studies the collective elements of health system transformation.

(5) The authority shall present the study and recommendations for addressing health care cost containment and cost reductions to the Legislative Assembly at the same time that the coordinated care organization qualification criteria and global budgeting process are presented to the Legislative Assembly for approval under section 13 of this 2011 Act.

Section 16 of HB 3650 directed the Oregon Health Authority (OHA) to conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures. Specifically, Section 16 directed the OHA to explore the costs, benefits and impacts of defensive medicine and consider several types of medical liability reform options.

To accomplish this work, OHA contracted with consultants with expertise in the areas of medical liability reform and health care data analysis and worked with the Oregon Department of Justice (DOJ) on a legal analysis of related policy. OHA also solicited input from stakeholders regarding medical liability reform options in the Oregon marketplace. Final reports for each of the analyses can be viewed at www.oregon.gov/OHA/OHPR/ by clicking on the "Documents, Reports, Presentations" page.

These analyses do not suggest that there is any single solution that will solve all the issues of the health care system. The medical liability system is a critical aspect of an efficient health care system, but it also has an impact on Oregon's work force as it relates to provider education, retention and recruitment. Further, it strains work force capacity when time is spent providing unnecessary lab or X-ray studies, or hospital stays ordered for defensive medicine purposes.

Ultimately, any reforms chosen need to balance three key factors: reduction of costs, improved patient safety, and equity for those individuals who are injured as a result of medical errors.

Therefore, OHA recommends that the appropriate body or — in the case that no appropriate body is identified, the Oregon Health Policy Board— review these studies in detail, outline advantages and disadvantages as to how options meet the desired policy goals and, as appropriate, draft legislative concepts for the 2013 Legislature. Such suggestions may include:

- Consider the key next steps for an Administrative Compensation System (ACS) in Oregon. This evaluation should include assessing the best design for such a system and include an actuarial evaluation, specifically estimating the premiums paid and the potential number of injured, including a definition of "fault" vs. "no-fault," and setting payment thresholds.
- Evaluate the suggested refinements to Oregon's Joint and Several Liability statutes and assess the feasibility of making those changes in the 2013 legislative session.
- Evaluate the feasibility and affordability of extending the OTCA or another type of liability funding arrangement for Oregon providers.
- Evaluate the viability of pursuing caps on non-economic damages, considering our current partial caps for wrongful death, prenatal and perinatal injury.
- Evaluate how CCOs could partner with hospitals in their community to adopt optimal apology and offer arrangements among their networks, and assess any needed statutory changes or other barriers to implementation.
- Evaluate the use of safe harbors through establishing a standard of care, with consideration of the results of Oregon's AHRQ grant-funded analysis of safe harbor closed-claims analysis.

10. Implementation plan

Transition strategy

In addition to accommodation through appropriate levels of flexibility, incentives to form CCOs as early as possible should be integrated into the CCO certification process. OHPB recommendations for such incentives include, but are not limited to, the following options:

- *Financial incentives*: Global budget adjustments, annual trend rates, and incentive payments or enhanced federal financial payments, if available, could be structured to support CCOs, providing financial incentives to form the new organization early. This approach provides not only strong incentives and resources for CCOs, but also underscores the urgency and priority of health system transformation.

- *Enrollment incentives*: Building sufficient enrollment to mitigate risk is essential for CCO start-up. New eligibles and those due for annual redetermination should be automatically enrolled in CCOs. This strategy will need to take into account the choice and notification of enrollees, including those eligible for both Medicare and Medicaid.

- *Flexibility incentives*: Efforts to provide flexibility in service delivery and administration should be directed first and foremost to CCOs.

- *Technical assistance and training incentives*: CCOs will benefit from the learning collaborative that OHA will establish, as required by HB 3650, and from state-level work to accumulate evidence about and disseminate information on innovative service delivery practices. If OHA successfully applies for and receives enhanced federal financial contributions for workforce training, then these funds would also be made available to CCOs that invest in developing the alternative workforce identified in HB 3650, including community health workers, peer wellness specialists, and personal health navigators.

Transitional provisions in HB 3650

In the case of an area of the state where a CCO has not been certified, Sections 13 and 14 of HB 3650 require continued contracting with one or more prepaid managed care health services organizations in good standing and already serving that area. In addition, HB 3650 requires these organizations to fulfill a substantial portion of CCO responsibilities including specific service offerings, organizational structure, patient-centered primary care homes and other system delivery reforms, consumer protections, and quality measures. Continued contracting with prepaid managed care health services organizations will reflect these statutory requirements. MCO contracts will be amended to reflect the requirements of HB 3650 parallel to the certification process for CCOs.

Implementation timeline

The sequence below indicates key time frames for MCOs and MHOs transitioning to CCO status (dates are approximate and subject to legislative and CMS approval):

Rules:

March 2012	OHA will release temporary administrative rules defining CCO criteria and other administrative rule changes as necessary.
June-September 2012	OHA administrative rules process to finalize CCO/MCO changes that include the required Rules Advisory Committee.

CCO applications:

March 2012	OHA will release CCO application, with Letter of Intent.
April 2012	CCO applicants will submit applications to demonstrate that they meet CCO criteria to OHA.
April-May 2012	OHA will evaluate CCO applications.
June 2012	OHA will certify CCOs (CMS will approve CCOs for enrollment of the dually eligible).

Contracts:

March 2012	CCO estimated cost submission process defined (including public comment process) and release of CCO Base Cost template.
April 2012	CCO applicants will submit notices of intent to contract and, subsequently, base cost estimates.
April-July 2012	State to negotiate CCO contracts and budget (CMS will participate regarding inclusion of Medicare funding for the dually eligible).
April-May:	OHA review and certification of CCO rates
May:	Final review of CCO budget
June:	CCO budget submitted to CMS
June:	Contract to CCO
July 1:	Effective date of CCO contract
July 31:	Three-way contracts signed between CCO/state/CMS (may come behind OHA contracts, as a contract amendment or rider)

Implementation:

June-August 2012	State and CMS conduct “readiness review” of certified CCOs for inclusion of the dually eligible (CMS will participate regarding inclusion of Medicare funding for the dually eligible).
July-September 2012	CCOs passing Medicare “readiness review” can begin preparing for enrolling dually eligible individuals for Medicare services.
July 2012	First CCOs enroll Medicaid beneficiaries.
July 2012	HB 3650 Sections 4, 6, 8, 10 and 12 take effect for MCOs.
Sept. 30, 2012	Current MCO contracts due for renewal.
January 2013	CCOs begin providing Medicare services to dually eligible beneficiaries.

11. Appendices

A. Managed care plan types and service areas
B. Financial projections and potential savings tables
C. Proposed Alternative Dispute Resolution (ADR) process
D. CCO Criteria Detail Matrix
E. Table of eligibles for CCO enrollment and current managed care enrollment status
F. Program list
G. Accountability framework and examples

Appendix A: Current managed care plans and service areas

Fully capitated health plans (FCHP) and physician care organizations (PCO)

Plan	Organization type	Counties served
Care Oregon, Inc.	FCHP	Clackamas, Clatsop, Columbia, Coos, Douglas, Jackson, Klamath, Lincoln, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Washington, Yamhill
Cascade Comprehensive Care, Inc.	FCHP	Klamath
DCIPA, LLC	FCHP	Douglas
Docs of the Coast South	FCHP	Coos, Curry
Family Care, Inc.	FCHP	Clackamas, Clatsop, Jackson, Josephine, Marion, Morrow, Multnomah, Umatilla, Washington
Intercommunity Health Network	FCHP	Benton, Lincoln, Linn, Tillamook
Kaiser Permanente or Plus, LLC	PCO	Clackamas, Marion, Multnomah, Polk
Lane Individual Practice Association	FCHP	Benton, Lane, Linn
Marion Polk Community	FCHP	Benton, Clackamas, Linn, Marion, Polk, Yamhill
Mid-Rogue Holding Company	FCHP	Curry, Douglas, Jackson, Josephine
ODS Community Health, Inc.	FCHP	Baker, Clatsop, Columbia, Jackson, Malheur, Union, Wallowa, Yamhill
Oregon Health Management Services	FCHP	Douglas, Jackson, Josephine
Pacific Source Community Solutions, Inc.	FCHP	Crook, Deschutes, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Sherman, Wasco, Wheeler
Providence Health Assurance	FCHP	Clackamas, Multnomah, Washington, Yamhill
Tuality Health Alliance	FCHP	Washington

Mental health organizations (MHO) and dental care organizations (DCO)

Plan	Organization type	Counties served
Access Dental Plan, LLC	DCO	Clackamas, Multnomah, Washington
Accountable Behavioral Health	MHO	Benton, Lincoln
Advantage Dental	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Malheur, Morrow, Multnomah, Polk, Sherman, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Capitol Dental Care, Inc.	DCO	Benton, Clackamas, Clatsop, Columbia, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Umatilla, Wasco, Washington, Yamhill
Clackamas Mental Health Organization	MHO	Clackamas, Hood River, Sherman, Wasco
Family Care, Inc.	MHO	Clackamas, Multnomah, Washington
Family Dental Care	DCO	Clackamas, Multnomah, Washington
Greater Oregon Behavioral Health, Inc.	MHO	Baker, Clatsop, Columbia, Douglas, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler
Jefferson Behavioral Health	MHO	Coos, Curry, Jackson, Josephine, Klamath
Lane Care	MHO	Lane
Managed Dental Care of Oregon	DCO	Clackamas, Multnomah, Washington
Mid Valley Behavioral Care Network	MHO	Linn, Marion, Polk, Tillamook, Yamhill
Multicare Dental	DCO	Clackamas, Multnomah, Washington

Plan	Organization type	Counties served
Verity Integrated Behavioral Healthcare Systems	MHO	Multnomah
ODS Community Health, Inc.	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Crook, Deschutes, Hood River, Jackson, Jefferson, Josephine, Lane, Linn, Marion, Malheur, Multnomah, Polk, Tillamook, Wallowa, Wasco, Washington, Yamhill
Pacific Source Community Solutions, Inc.	MHO	Crook, Deschutes, Jefferson, Klamath
Washington County Department of Mental Health	MHO	Washington
Willamette Dental Group	DCO	Benton, Clackamas, Clatsop, Columbia, Deschutes, Douglas, Jackson, Josephine, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Washington, Yamhill

Appendix B: HMA financial projections and savings estimates implementation of "well-managed" by program

Data are by calendar year but were prorated and accumulated into state fiscal years for the summary report.

TANF

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	351,738	$1,312,400,000	$0	$1,312,400,000	$0	$1,312,400,000	$0
2011	398,997	$1,528,000,000	$0	$1,528,000,000	$0	$1,528,000,000	$0
2012	422,055	$1,658,900,000	($12,200,000)	$1,646,700,000	($24,700,000)	$1,634,200,000	($12,500,000)
2013	430,829	$1,738,200,000	($38,900,000)	$1,699,300,000	($51,800,000)	$1,686,400,000	($12,900,000)
2014	435,565	$1,803,600,000	($67,100,000)	$1,736,500,000	($94,000,000)	$1,709,600,000	($26,900,000)
2015	444,300	$1,888,300,000	($140,600,000)	$1,747,700,000	($168,600,000)	$1,719,700,000	($28,000,000)
2016	453,200	$1,977,300,000	($220,700,000)	$1,756,600,000	($235,500,000)	$1,741,800,000	($14,800,000)
2017	462,300	$2,070,300,000	($246,500,000)	$1,823,800,000	($308,100,000)	$1,762,200,000	($61,600,000)
2018	471,500	$2,167,800,000	($258,100,000)	$1,909,700,000	($322,800,000)	$1,845,000,000	($64,700,000)
2019	480,900	$2,270,100,000	($270,300,000)	$1,999,800,000	($338,000,000)	$1,932,100,000	($67,700,000)

Disabled Non-dual

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	49,000	$745,800,000	$0	$745,800,000	$0	$745,800,000	$0
2011	50,300	$800,100,000	$0	$800,100,000	$0	$800,100,000	$0
2012	53,500	$872,300,000	($4,800,000)	$867,500,000	($9,800,000)	$862,500,000	($5,000,000)
2013	55,100	$946,200,000	($15,900,000)	$930,300,000	($21,300,000)	$924,900,000	($5,400,000)
2014	56,700	$1,024,800,000	($28,800,000)	$996,000,000	($40,200,000)	$984,600,000	($11,400,000)
2015	60,700	$1,115,600,000	($62,600,000)	$1,053,000,000	($75,100,000)	$1,040,500,000	($12,500,000)
2016	64,300	$1,214,700,000	($102,200,000)	$1,112,500,000	($108,900,000)	$1,105,800,000	($6,700,000)
2017	68,100	$1,322,500,000	($118,500,000)	$1,204,000,000	($148,300,000)	$1,174,200,000	($29,800,000)
2018	72,100	$1,440,100,000	($129,200,000)	$1,310,900,000	($161,400,000)	$1,278,700,000	($32,200,000)
2019	76,400	$1,568,000,000	($140,700,000)	$1,427,300,000	($175,800,000)	$1,392,200,000	($35,100,000)

Expansion

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	40,572	$219,500,000	$0	$219,500,000	$0	$219,500,000	$0
2011	68,806	$389,400,000	$0	$389,400,000	$0	$389,400,000	$0
2012	58,851	$348,400,000	($2,600,000)	$345,800,000	($5,200,000)	$343,200,000	($2,600,000)
2013	58,550	$362,600,000	($8,100,000)	$354,500,000	($10,800,000)	$351,800,000	($2,700,000)
2014	62,199	$402,900,000	($15,000,000)	$387,900,000	($21,000,000)	$381,900,000	($6,000,000)
2015	198,550	$1,345,300,000	($100,200,000)	$1,245,100,000	($120,100,000)	$1,225,200,000	($19,900,000)
2016	211,050	$1,495,800,000	($167,000,000)	$1,328,800,000	($178,200,000)	$1,317,600,000	($11,200,000)
2017	223,550	$1,657,300,000	($197,300,000)	$1,460,000,000	($246,600,000)	$1,410,700,000	($49,300,000)
2018	236,050	$1,830,500,000	($217,900,000)	$1,612,600,000	($272,600,000)	$1,557,900,000	($54,700,000)
2019	248,550	$2,016,100,000	($240,100,000)	$1,776,000,000	($300,200,000)	$1,715,900,000	($60,100,000)

Dual-eligibles -- Medicaid data

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	58,100	$168,300,000	$0	$168,300,000	$0	$168,300,000	$0
2011	61,600	$182,300,000	$0	$182,300,000	$0	$182,300,000	$0
2012	65,200	$201,800,000	($1,100,000)	$200,700,000	($2,300,000)	$199,500,000	($1,200,000)
2013	70,300	$227,600,000	($3,800,000)	$223,800,000	($5,100,000)	$222,500,000	($1,300,000)
2014	75,500	$255,700,000	($7,200,000)	$248,500,000	($10,000,000)	$245,700,000	($2,800,000)
2015	79,400	$281,300,000	($15,800,000)	$265,500,000	($18,900,000)	$262,400,000	($3,100,000)
2016	84,200	$314,600,000	($26,500,000)	$288,100,000	($28,200,000)	$286,400,000	($1,700,000)
2017	89,300	$351,900,000	($31,500,000)	$320,400,000	($39,500,000)	$312,400,000	($8,000,000)
2018	94,700	$393,600,000	($35,300,000)	$358,300,000	($44,100,000)	$349,500,000	($8,800,000)
2019	100,400	$440,500,000	($39,500,000)	$401,000,000	($49,400,000)	$391,100,000	($9,900,000)

Appendix C:
Alternative dispute resolution (ADR) process outline

HB 3650 required the development of a process that involves the use of an independent third party arbitrator to resolve disputes when a necessary health care entity (HCE) refuses to contract with an organization seeking to form a coordinated care organization (CCO). The process must be presented to the Legislative Assembly for approval. This outline was developed by the Oregon Health Authority (OHA), with input from an external stakeholder work group.

HB 3650 Section 8(4) to (7) provides as follows:

> (4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.
>
> (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.
>
> (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.
>
> (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.

Scope: Section 4 shows that this statutory process applies when an organization is seeking to form a CCO and participation by a health care entity (HCE) is necessary for the organization to qualify as a CCO. As a result, the proposed process is limited to the certification of CCOs and only when the HCE is necessary for the organization to qualify as a CCO. This limited scope also is consistent with the substantial statutory remedy in subsection (6) for an unreasonable refusal to contract by an HCE.

Who is qualified to serve as an arbitrator? Statute is silent about who is qualified to serve as an arbitrator in this process, except to require the "use of an independent third party arbitrator." OHA recommends that the CCO applicant and the HCE use any qualified independent third party arbitrator that they agree upon. The proposed process provides some minimal recommendations for the qualifications of the arbitrator. The arbitrator must:

- Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
- Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650.

Length of time for the arbitration process: Since Section 8 establishes this arbitration process when an organization is seeking to become qualified as a CCO, a dispute with a necessary HCE should be resolved

promptly. A timeline of 60 calendar days is recommended once an arbitration process is initiated by one of the parties. Extending the time should require the written agreement of both parties.

Process for resolving disputes under Section 8(4) to (7)

Preliminary good faith negotiations: GOAL – the parties voluntarily agree on terms and enter into contracts.

1. Organization is seeking to become certified as a CCO (Applicant) and:
   a. Applicant asserts that a health care entity (HCE) is necessary for Applicant to qualify as a CCO;
   b. An HCE asserts that its inclusion is necessary for Applicant to be certified as a CCO; or
   c. OHA, in reviewing Applicant information, identifies the HCE as necessary for Applicant to qualify as a CCO.
2. If there is disagreement between an Applicant and HCE regarding whether the HCE is "necessary," the Applicant or HCE can request review from OHA about whether the HCE may be considered "necessary" for an Applicant to qualify as a CCO.
   a. If the specific HCE is deemed by OHA as not "necessary" for Applicant to be certified as a CCO, then this specific process does not apply per Section 8.
   b. The process described below only applies where an HCE is deemed by OHA as "necessary" for the Applicant to be certified as a CCO (or the parties agree that the HCE is "necessary" for an Applicant to qualify as a CCO), in accordance with Section 8.
3. If deemed by OHA as "necessary" or the parties agree that the HCE is "necessary," the HCE and Applicant participate in contract negotiations.
   a. Goal: Applicant and HCE agree on terms and enter into a contract.
4. Request for technical assistance from OHA – voluntary.
   a. Either Applicant or HCE may request OHA technical assistance.
   b. OHA may offer technical assistance. OHA assistance will be confined to clarification of the CCO certification process and criteria, and other program requirements.
5. Before requesting referral to this dispute resolution process, the parties should take the following actions in an attempt to reach a good faith resolution between the Applicant and the HCE:
   a. The Applicant has provided a written offer of terms and conditions to the HCE and the HCE has explained to the Applicant the source of disagreement, if any.
   b. Before referral, the CFO or CEO of each organization has had at least one face-to-face meeting in a good faith effort to resolve the source of disagreement.
   c. Goal: Applicant and HCE agree on terms and enter into a contract.
6. If the Applicant and HCE are unable to reach agreement on contract terms within 10 calendar days of the HCE and Applicant face-to-face meeting in 5(b), either party can notify the other party in writing to initiate referral to an independent third party arbitrator. (At that time, the party initiating the referral will provide a copy of the notification to the OHA.) The arbitrator must:

a. Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
b. Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650.

Arbitration process: NOTE – At any point in this process, the CCO and HCE can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

1. After notification that arbitration is being initiated, the parties agree upon the arbitrator and complete paperwork required to secure the arbitrator's services – costs for arbitration to be borne by the parties. (Estimated 15 calendar days.)
    a. In consideration of potentially varied financial resources as between the parties that should not pose a barrier to the use of this process, the arbitrator should be permitted to respond to requests to allocate costs among the parties.
    b. Any changes to the time periods described in this process will require the written agreement of both parties.
2. Once referral is completed (step 1), the Applicant and HCE have 10 days to submit to each other and the arbitrator their most reasonable contract offer (10 calendar days) or submit a statement from the HCE that no contract is desired and why this is reasonable.
3. The parties then have 10 days from receipt of the other party's offer, or HCE statement that no contract is desired, to submit to the arbitrator and the other party their advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the Applicant. (10 calendar days.)
    a. Legal standards for arbitration:
        i. An HCE may reasonably "refuse to contract with a CCO if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service" – per Section 8(5).
        NOTE: Where federal or state statute or regulation establishes particular reimbursement requirements (e.g., Type A and B hospitals, federally qualified health centers, rural health centers, providers of Indian health services), those laws shall be applied.
        ii. In addition to subparagraph (i), an HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the legislative policies described in HB 3650. Some examples of facts or circumstances pertinent to what is a "reasonable" or "unreasonable" refusal to contract include, but are not limited to:

            1. Whether participation in the CCO contract imposes demands on the HCE that the HCE cannot reasonably meet without significant negative impact on HCE costs, or HCE obligations or structure, in the context of the proposed reimbursement arrangement or other CCO requirements, including, but not limited to, use of electronic health records, service delivery requirements, or quality or performance requirements.
            2. Whether refusal to contract by the HCE impacts access to covered services in the community that should be provided by the CCO. This factor alone should not be used to find a refusal to contract unreasonable, but it is recognized that HCEs and

CCOs should be encouraged to make a good faith effort to work out differences in order to achieve beneficial community objectives and the policy objectives of HB 3650.

3. Whether the HCE has entered into a binding obligation to participate in the network of a different CCO, and that HCE participation significantly reduces HCE capacity to participate in the Applicant's CCO.

4. Arbitrator determination and final opportunity to settle:
   a. The arbitrator must evaluate the final offers/statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' arguments about whether the refusal to contract is reasonable or unreasonable. (15 calendar days.)
   b. The arbitrator's determination will be provided to the parties and not disclosed publicly to the OHA for a period of 10 calendar days, to allow the parties an opportunity to resolve the contract issue themselves. (10 calendar days.)
   c. If the parties have not voluntarily reached an agreement regarding contract terms after the 10-day period, the arbitrator's decision must be released to OHA. Once released to OHA, the arbitrator's decision will be a public record, subject to protection of trade secret information if identified by one of the parties prior to submission to OHA.
   (Total time = 60 calendar days.)

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

This document reflects the statement of work and certification criteria for Coordinated Care Organizations (CCOs) that will contract with OHA under HB 3650 and has been developed through the work of the Oregon Health Policy Board and its four work groups, a series of eight community meetings around the state, public comment at the monthly Oregon Health Policy Board meetings, and comment from the legislature. **This is a working document and is for discussion purposes only.**

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Governance structure: **Each CCO has a governance structure that includes:** • **A majority interest consisting of the persons that share the financial risk of the organization;** • **The major components of the health care delivery system; and** • **The community at large, to ensure that the organization's decision making is consistent with the values of the members of the community.**	CCO will clearly articulate: • How it will meet governance structure criteria from HB 3650; • How the governing board makeup reflects community needs and supports the goals of health care transformation; • What criteria will are/were used to select for governing members; • How it will assure transparency in governance.	NA
Community advisory council: **Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of the membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met**	• A member of the CAC must sit on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations.	
Dental care organizations: **On or before 7/1/14, each CCO will have a formal contractual relationship with any DCO in its service area.**	• CCO adheres to HB 3650 requirements regarding DCOs.	• CCO enters into shared financial accountability arrangement with DCOs before 2014, to encourage aligned financial incentives for cost-effectiveness and discourage cost shifting.

Appendix D: Draft matrix of suggested CCO criteria
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Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Partnerships: **CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.**	• OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.	
Person-centered care: **Each member receives integrated person-centered care and services designed to provide choice, independence and dignity.**	• CCO describes how it will use PCPCH capacity to deliver person-centered care per HB 3650 and ensure members are fully informed partners in transitioning to this model of care.	
Safeguards for members: **OHA shall adopt rules for member safeguards including: protections against underutilization of services and inappropriate denials; access to qualified advocates; education and engagement to help members be active partners in their own care.**	• CCO adheres to HB 3650 requirements regarding member safeguards, including access to qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers, and to applicable Medicare and Medicaid regulations not waived. • CCOs will describe planned or established mechanisms for a complaint/grievance and appeals resolution process, including how that process will be for communicated to members and providers.	

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Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Patient engagement: **CCO operates in a manner that encourages patient engagement, activation and accountability for the member's own health.**	• CCO actively engages members in the design and, where applicable, implementation of their treatment and care plans • CCO ensures that member choices are reflected in the development of treatment plans and member dignity is respected.	• CCO uses community input and the community needs assessment process to help determine the best methods for patient activation • CCO develops approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members • CCO meaningfully engages the community advisory council to monitor patient engagement and activation.
Member access and provider responsibilities: **Members have *access* to a choice of providers within the CCO's network and providers in the network:** • **Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members;** • **Are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history;** • **Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision making and communication;** • **Are permitted to participate in networks of multiple CCOs;** • **Include providers of specialty care;** • **Are selected by CCOs using universal**	CCO describes: • How it will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services; • How it will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication; • How members will be informed about access to non-traditional providers, if available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and community health workers.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
application and credentialing procedures, objective quality information; are removed if providers fail to meet objective quality standards; • **Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members.**		
<u>Member and care team</u>: **Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings.**	• CCO demonstrates how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.	
<u>Holistic care through primary care homes</u>: **Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible.**	• CCO adheres to HB 3650 requirements regarding individualized care plans, particularly for members with intensive care coordination needs. • Care plans reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.	
<u>Transitional care</u>: **Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.**	• CCO demonstrates how it will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650, and members' experience of care and outcomes are improved. Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation. • CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Navigating the system: **Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, community health workers and personal health navigators who meet competency standards established by the Oregon Health Authority.**	• CCO demonstrates how members will be informed about access to non-traditional providers, if available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and community health workers.	
Accessibility: **Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.**	• CCO adheres to HB 3650 requirements for access to services and supports.	
High need members: **Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency; CCO involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions.**	• CCO uses individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.	
Learning collaborative: **Each CCO participates in the learning collaborative described in ORS 442.210.**	• CCO adheres to HB 3650 requirements for participation in learning collaborative.	
Patient-centered primary care homes: **Each CCO shall implement, to the maximum extent feasible, patient-centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse**	• CCO adheres to HB 3650 requirements for patient-centered primary care homes. • CCO demonstrates how the patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and	• All members enrolled in a PCPCH; member experience of care exceeds benchmarks; PCPCH's in advanced tiers.

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.	services, as described in the bill, and that members are fully informed partners in transitioning to this model of care.	
Health equity: **Health care services focus on improving health equity and reducing health disparities.** Ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors.	• CCO identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, or other factors through community needs assessment. • CCO collects or maintains race, ethnicity and primary language for all members on an ongoing basis in accordance with standards jointly established by OHA and Oregon Department of Human Services.	
Alternative payment methodologies: **OHA encourages CCOs to use alternative payment methodologies that:** • **Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;** • **Hold organizations and providers responsible for the efficient delivery of quality care;** • **Reward good performance;** • **Limit increases in medical costs;** • **Use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination.**	• CCO describes how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for members.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Health information technology: **Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable.**	• CCO documents level of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and develops a HIT improvement plan for meeting transformation expectations. • CCO participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.	• CCO providers have EHR/HIE capacity to send and receive patient information in real time, and CCOs have the analytic capacity to assess patient outcomes of care coordination.
Outcome and quality measures: **Each CCO reports on outcome and quality measures identified by the Oregon Health Authority under Section 10 and participates in the All Payer All Claims data reporting system.**	• CCO reports and demonstrates an acceptable level of performance with respect to OHA-identified metrics. • CCO submits APAC data in a timely manner according to program specifications.	• CCO demonstrates exceptional performance with respect to identified metrics.
Transparency: **CCO is transparent in reporting progress and outcomes.**	• CCO will clearly articulate how it will assure transparency in governance. • Financial, outcomes, quality and efficiency metrics will be transparent and publicly reported and available on the internet for each CCO.	
Best practices: **Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.**	• CCO describes capacity and plans for ensuring best practices in areas identified by HB 3650. • CCO establishes a clinical advisory panel (CAP) or uses other means to ensure clinical best practices. The CAP, if one is formed, should be represented on the CCO governing board, similar to the CAC. • CCO describes plans for: an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops; and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.	

Appendix E: Overview of CCO eligible populations

Oregon Medicaid caseload for inclusion in Coordinated Care Organization (CCO) global budgets (includes managed care and fee-for-service)

Populations included in CCO global budgets	Total eligibles	Medical		Dental		Mental health	
		FCHP + PCO*	FFS	DCO	FFS	MHO	FFS
OHP Plus (categorical pops)	**362,182**	287,049	75,132	320,790	41,392	314,177	48,005
SCHIP (ages 0-18)	**58,473**	52,236	6,237	55,721	2,753	55,314	3,160
OHP Standard (1115 expansion population)	**46,206**	38,471	7,735	42,084	4,122	42,058	4,148
Fully dual-eligible	**58,675**	33,967	24,709	52,080	6,595	50,532	8,143
Subtotal	**525,537**	**411,723**	**113,813**	**470,674**	**54,862**	**462,080**	**63,456**
To be decided							
Citizen Alien Waived Emergent Medical - Prenatal	**1,138**	-	1,138	-	1,138	-	1,138
Citizen Alien Waived Emergent Medical	**22,558**	-	22,558	-	-	-	-
Breast and Cervical Cancer Program - Medical	**444**	-	444	-	444	-	444
Subtotal	**24,140**	**-**	**24,140**	**-**	**1,582**	**-**	**1,582**
Grand total	***549,677***	***411,723***	***137,954***	***470,674***	***56,445***	***462,080***	***65,039***

* FCHP - Fully capitated health plan
PCO - Physician care organization

Notes:
· Medical, dental and mental health eligibles should *not* be added together to reach totals. Rather, most beneficiaries are eligible for all three types of services and are therefore counted separately under each.
· OHP Plus includes: Temporary Assistance to Needy Families-Medical, Poverty Level Medical Adults, Poverty Level Medical Children, Aid to the Blind and Aid to the Disabled, Old Age Assistance, and Foster Care, Substitute or Adoptive Care Children.
· SCHIP includes ages 0 to 18, excludes CAWEM Prenatal.
· Eligibility categories do not include Family Health Insurance Assistance Program, Healthy KidsConnect, CHIP employer-sponsored insurance.

Staff reference:
09-11 Dec Rebal; includes FFS and managed care.

Appendix F: Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid program/services	Description	Current intermediate entity, if any (e.g., counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Physical health programs*				
Physical health coverage, including emergency transport, FCHP administrative, hospital reimbursement allowances, FQHC wraparound, and pass through.	Depending on benefit package, includes medical care from a physician, nurse practitioner or physician assistant; hospital care; hospice care; laboratory and x-ray; medical equipment and supplies; emergency medical transportation; physical, occupational and speech therapy; prescription drugs (excluding mental health drugs); vision services and other covered services.	Fully capitated health plans, physician care organizations	Y	52%
		FFS only		18%
Dental coverage, including DCO administrative**	Includes basic dental services, urgent/immediate treatment and other services.	Dental care organizations	Y	5%
Non-emergency medical transportation	Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation for Medicaid eligibles to access OHP covered services when no alternative transportation is available.	Transportation brokerages and FFS		2%
Citizen Alien Waived Emergent Medical (CAWEM)	Emergency medical services to non-citizens who are eligible for medical assistance except they do not meet the Medicaid citizenship and immigration status requirements.	FFS only		1%
Citizen Alien Waived Emergent Medical (CAWEM) Prenatal Program	Prenatal care to pregnant women who are currently only eligible for CAWEM Emergency Medical (only in select counties; voluntary enrollment only).	FFS only		<1%
Breast and Cervical Cancer Program - Medical	Provides access to medical care for low-income, uninsured, and medically underserved women diagnosed with breast or cervical cancers	FFS only		<1%
Behavioral Rehabilitation Services (leverage)	Services provided by a child care agency in a shelter, residential or therapeutic foster care placement setting to remediate psychosocial, emotional and behavioral disorders.	FFS only		<1%
Targeted Case Management (leverage)	Assists eligible clients in gaining access and effectively using medical, social, educational and other services.	FFS only		<1%

* Class 7 and 11 mental health drugs are not included in this list because House Bill 3650 excludes them from CCO global budgets. However, they are included in the total expenditures used to calculated percentages in this table.
** Dental care organizations are not required to enter into contracts with CCOs until July 1, 2014, but may do so at an earlier date.

Appendix F: Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid program/services	Description	Current intermediate entity, if any (e.g., counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Addictions and Mental Health programs				
Mental health coverage including MHO administrative	Medicaid-funded ambulatory assessment and treatments (based on the prioritized list) of mental health conditions provided in community-based settings by licensed practitioners or non-licensed personnel employed by agencies with a certificate of approval by OHA/AMH.	Mental health organizations	Y	8%
		FFS only		1%
Adult community residential mental health services	Mental health services provided in a residential setting.	CMHP		3%
Addiction health coverage	Ambulatory assessment and treatments (based on the prioritized list) of substance use disorders provided by licensed professionals or non-licensed personnel employed by agencies.	FCHPS and PCOs	Y	1%
		FFS only		<1%
Adult residential alcohol and drug treatment***	Alcohol and drug treatment provided in a residential setting.	CMHP and direct contracts w/providers		<1%
Residential mental health for non-forensic children	Mental health services provided in a residential setting.	MHO plus provider direct billing to DMAP for non-MHO enrolled children	Y	<1%
Youth residential alcohol and drug treatment ***	Alcohol and drug treatment services provided in a residential setting	None - direct contracts with all providers		<1%
Psychiatric day treatment service for children	Psychiatric day treatment service delivered in a facility-based setting.	MHO-provider direct billing to DMAP for non-MHO enrolled kids	Y	<1%
Statewide Children's Wraparound	Services and supports for children with complex behavioral health needs and their families.	MHO	Y	<1%
Personal Care 20 client-employed provider for people with mental illness	Intensive community or in-home supports to assist Medicaid-eligible, disabled individuals with activities of community living.	Client employs provider		<1%

*** Residential alcohol and drug treatment providers are not required to enter into contracts with CCOs until July 1, 2013, but may do so at an earlier date.

Appendix F: Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid program/services	Description	Current intermediate entity, if any (e.g., counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Aging and People with Disabilities	**Descriptions**			
Payment of Medicare premiums for dual-eligibles	Medicare premium payments for dual-eligibles paid by Medicaid	N/A	Y	4%
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Applicable deductibles, coinsurance and copayment amounts for dually eligible enrollees.	N/A		<1%
OHP Post-Hospital Extended Care	Provides a stay of up to 20 days in a nursing facility to allow for discharge from a hospital to a nursing facility	FFS Only	Y	<1%
Public Health	**Descriptions**			
School-Based Health Center services	Comprehensive primary care clinics that provide physical, mental and preventive health services to school-aged children in a school-based setting.	Local public health authority (LPHA)		1%
Babies First!	A Medicaid-funded nurse home visiting program for families with babies and young children up to 5, with significant health and social risks. Provides health assessments, aligns community resources, strengthens parenting skills, and improves infant health outcomes.	Local health departments		<1%
Maternity Case Management	An education and support program for pregnant women on Medicaid with social or health concerns during pregnancy to improve health outcomes.	Local health departments (DMAP provides reimbursement for MCM services to a broader community of prenatal care providers not under the public health program)		<1%

Appendix G: Principles, domains and example CCO accountability metrics

OHPB Stakeholder Work Group on Outcomes, Quality and Efficiency Metrics

Potential CCO performance measures

At a minimum, any selected performance measure should meet standard scientific criteria for reliability and face validity. Potential measures also should be evaluated against the principles below, with the goal of establishing a set of CCO performance measures that reasonably balances the various criteria. OHA should re-examine selected measures on a regular basis to ensure that they continue to meet the criteria.

Principle	Selection criteria	Change criteria
Transformative potential	○ Measure would help drive system change	○ Measure reinforces the status quo rather than prompting change
Consumer engagement	○ Measure successfully communicates to consumers what is expected of CCOs	○ Measure is not understandable or not meaningful to consumers
Relevance	○ Condition or practice being measured has a significant impact on issues of concern or focus* ○ Measure aligns with evidence-based or promising practices	○ Lack of currency — measure no longer addresses issues of concern or focus*
Consistency with existing state and national quality measures, with room for innovation when needed	○ Measure is nationally validated (e.g., NQF endorsed) ○ Measure is a required reporting element in other health care quality or purchasing initiative(s) ○ National or other benchmarks exist for performance on this measure	○ Measure loses national endorsement ○ Measure is unique to OHA when similar standard measures are available
Attainability	○ It is reasonable to expect improved performance on this measure (can move the meter)	○ CCO or entity performance is “topped out” ○ Measure is too ambitious
Accuracy	○ Changes in CCO performance will be visible in the measure ○ Measure usefully distinguishes between different levels of CCO performance	○ Measure is not sensitive enough to capture improved performance ○ Measure is not sensitive enough to reflect variation between CCOs

Feasibility of measurement	○ Measure allows CCOs and OHA to capitalize on existing data flows (e.g., state All Payer All Claims reporting program or other established quality reporting systems) ○ Data collection for measure will be supported by upcoming HIT and HIE developments	○ Burden of data collection and reporting outweighs the measure's value
Reasonable accountability	○ CCO has some degree of control over the health practice or outcome captured in the measure	○ Measure reflects an area of practice or a health outcome over which CCO has little influence
Range/diversity of measures	○ Collectively, the set of CCO performance measures covers the range of topics, health services, operations and outcomes, and populations of interest	○ There is a surplus of measures for a given service area or topic ○ Measure is duplicative ○ Measure is too specialized

* These issues include, but are not limited to: health status, health disparities, health care costs and cost-effectiveness, access, quality of care, delivery system functioning, prevention, patient experience/engagement, and social determinants of health.

Domains of measurement

OHA should assess CCO performance in these domains:

- Accountability for system performance in all service areas for which the CCO is responsible:
  - Adult mental health;
  - Children's mental health;
  - Addictions;
  - Outpatient physical;
  - Inpatient physical;
  - Women's health;
  - Dental;
  - Prevention;
  - End-of-life care.

- Accountability for transformation:
  - Care coordination and integration;
  - Patient experience and activation;
  - Access;
  - Equity;
  - Efficiency and cost control;
  - Community orientation.

Potential CCO performance measures

Examples only

Measure	Data Type	Other initiatives that use the measure
Rate of tobacco use among CCO enrollees	Survey or medical record	7
Obesity rate among CCO enrollees	Survey or medical record	
Low birth weight	Vital statistics /medical record	2
Well child visits	Claims/encounter data	2, 5, 6
Dental visits (% of members with any visit in past year)	Claims/encounter data	6, 7
Depression screening	Medical record	1, 3, 4, 5
Initiation and engagement in drug, alcohol, and mental health treatment	Claims/encounter data	3, 5, 6
Penetration rate for mental health and chemical dependence treatment	Survey and administrative data	
Cholesterol control for patients with diabetes	Medical record	5
Glucose control for diabetics	Medical record	4
Cancer screening (1 of: cervical, breast or colorectal)	Claims/encounter data	1, 2, 4, 5, 6
Effective contraceptive use and unintended pregnancy	Survey	
Chlamydia screening	Claims/encounter data	1, 2, 5, 6
Fall risk screening (older adults)	Claims/encounter data	4, 6
Service engagement (% members who received no health services at all in x period)	Claims/encounter and administrative data	
Member or patient experience with: · Getting needed care and getting care quickly · Shared decision making and participation in care planning · Care coordination · Chronic disease self-management support · Primary provider or provider team · Overall experience of care	Survey	1, 2, 4, 5, 6
Primary care-sensitive hospital admissions (AHRQ PQIs)	Claims/encounter data	1, 4
ED visits by primary diagnosis (e.g. mental health, substance abuse, dental, other)	Claims/encounter data	
Hospital acquired infection rates	CDC reporting system	
Medication management (e.g., % discharges where medications were reconciled within 7 days)		4, 6
Follow-up after hospitalization (visit within 7 days of discharge for physical or mental health diagnosis)	Claims/encounter data	1, 2, 6
Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)	Claims/encounter data	1, 4, 6
End of life care preferences (e.g. % dual eligibles or age-specified members who have a POLST form on file)	Administrative data	
Health/functional status improvement	Survey	4

1 – Medicaid Adult Core Measures
2 – CHIPRA Core Measures
3 – Medicaid Health Home Core Measures
4 – Medicare ACO Quality Measures
5 – Oregon PCPCH
6 - HEDIS
7 – National Quality Strategy

Accountability by level

Illustrative examples for discussion purposes only

Example domain: Care coordination

	CCO criteria (structure)	Process metrics	Outcome metrics	Triple Aim
Macro: **OHA**	Establish recognition process for PCPCHs Administer EHR incentive program; facilitate HIE (e.g., connect regional HIOs, Direct Project)	• # of PCPCHs recognized • % of eligible providers and hospitals meeting Meaningful Use	• % of OHA-covered lives with access to PCPCH • OHA roll-up: ambulatory care-sensitive hospital admissions • Statewide EHR adoption • Statewide HIE participation • OHA roll-up: Medication errors, duplicate testing	Better care, lower costs
Meta: **CCO**	Incorporate OHA-recognized PCPCHs into CCO network Support clinical information exchange among CCO providers (e.g., act as or participate in regional HIO; use Direct)	• Member experience of care coordination (e.g., shared decision making composite) • % members with individual care plan • Medication management — % members with medications reconciled within 7 days of hospital discharge	• Rate of ambulatory care-sensitive hospital admissions • Member experience of care overall • Medication errors • Duplicate testing	Better health, lower costs Better care
Micro: **Practice or provider**	Implement PCPCH standards, seek recognition Identify, track and proactively manage patient care electronically using up-to-date information	• % members assigned to personal provider or team • Screening for depression and follow-up plan	• Benchmark for continuity of care • % patients showing improvement on clinically valid depression tool	Better care Better care, lower costs

Collected by OHA

Forecasted Average Monthly Caseload for 2011-2013 Biennium; Includes Managed Care and Fee-For-Service

	Total	Medical		Dental		Mental Health	
Populations Included in CCO Global Budgets	**Eligibles**	**FCHP + PCO***	**FFS**	**DCO**	**FFS**	**MHO**	**FFS**
OHP Plus (Categorical Pops)	**419,390**	345,012	74,378	389,398	29,992	371,350	48,040
SCHIP (ages 0-18)	**72,713**	63,410	9,303	67,845	4,868	61,584	11,129
OHP Standard (1115 Expansion Population)	**59,612**	50,680	8,932	54,211	5,401	54,056	5,556
Fully Dual Eligible	**65,360**	35,024	30,336	58,906	6,454	57,888	7,472
Breast and Cervical Cancer Program - Medical	**638**	-	638	-	638	-	638
Subtotal	**617,713**	**494,126**	**123,587**	**570,360**	**47,353**	**544,878**	**72,835**
Optional Populations							
Citizen Alien Waived Emergent Medical - Prenatal	**1,728**	-	**1,728**	-	**1,728**	-	**1,728**
Subtotal	**1,728**	**-**	**1,728**	**-**	**1,728**	**-**	**1,728**
Grand Total	***619,441***	***494,126***	***125,316***	***570,360***	***49,082***	***544,878***	***74,563***

* FCHP - Fully Capitated Health Plan
PCO - Physician Care Organization

Notes:

- Medical, Dental and Mental Health eligibles should *not* be added together to reach totals. Rather, most beneficiaries are eligible for all three types of services and are therefore counted separately under each.
- OHP Plus includes: Temporary Assistance to Needy Families-Medical, Poverty Level Medical Adults, Poverty Level Medical Children, Aid to the Blind and Aid to the Disabled (without Medicare), Old Age Assistance (without Medicare), and Foster Care, Substitute or Adoptive Care Children.
- SCHIP includes ages 0 to 18, excludes CAWEM Prenatal.
- Eligibility categories do not include Family Health Insurance Assistance Program, Healthy Kids Connect, CHIP Employer-Sponsored Insurance.

Staff reference:
11-13 Fall 2011 Rebal; includes FFS and Managed Care.

Appendix E State Fund Only Program List

Community Mental Health Program	
20 Non-Residential Adult	$8,106,392
22 Child and Adolescent	$680,649
24 Regional Acute Psychiatric Inpatient	$14,185,239
25 Community Crisis	$10,208,134
27 Residential Treatment for Youth	$241,446
34 Adult Foster Care	$406,568
35 Older/Disabled Adult	$587,176
37 Special Projects	$4,323,061
38 Support Employment	$723,108
39 Homeless	$500,000
28 Residential Treatment	$15,010,022
201 Non-Residential Adult (Designated)	$560,803
Total CMH Program	**$55,532,595**
Alcohol and Drug Treatment Program	
01 Local Admin	
60 A & D-Special Projects	$1,902,603
61 A & D Residential Treatment - Adult	$4,049,316
66 Continuum of Care	$10,397,186
Total A&D Treatment Program	**$16,349,105**
State Hospitals (OSH and BMRC)	
- Civil	31,845,689
- Forensic	94,397,533
- Gero-Neuro	13,687,590
Total Oregon State Hospital	**$139,930,811**
Children, Adults and Families	
System of Care	$ 1,162,626
Community Based Sexual Assault	$ 36,600
Community Based Domestic Violence	$ 198,966
Youth Investment Program	$ 194,075
Family Based Services	$ 3,687,007
Foster Care Prevention	$ 261,272
Regular Foster Care	$ 5,339,250
Enhanced Supervision	$ 2,219,528
Client Transportation	$ 1,331,619
Independent Living Services	$ 224,058
Nursing Assessments	$ 8,348
Foster Family Shelter Care	$ 1,220,850
Other Medical	$ 1,449,526

IV-E Waiver (Demo Project for Parenting, mentoring, enhanced superv	$	33,995
Contracted Foster Care	$	79,133
Interstate Compacts	$	139,801
Personal Care	$	419,306
Tribal	$	25,869
Residential Treatment	$	4,229,340
Target Children	$	1,200,382
Total CAF	**$**	**23,461,546**
Seniors and Persons with Disabilities:		
Oregon Project Independence	$	4,592,500
Oregon Supplemental Income Program	$	2,895,000
SE #150 Family Support	$	1,254,500
SE #151 Children Long-Term Support	$	2,732,880
SE #45 Nursing Facility Special Services	$	83,608
Total SPD	**$**	**11,558,488**
Public health services vital for healthy communities		
Emergency Medical Services	$	1,950,000
Vaccine Purchase	$	2,250,000
General Microbiology	$	420,863
Virology	$	440,229
Lab Compliance	$	11,467
Chlamydia	$	800,000
Other Test Fees	$	150,000
Newborn Screening	$	2,400,000
Prescription Drug Monitoring Program	$	800,000
HIV Community Services	$	575,000
HST (HIV/Sexually Transmitted Disease/Tuberculosis)	$	1,488,042
Sexually Transmitted Disease	$	60,000
Total Public Health	**$**	**12,695,600**
Other Programs Supporting Transformation		
Oregon Medical Insurance Pool	$	219,947,958
Undergraduate and graduate education -OHSU		27,989,281
Department of Community Colleges and Workforce Development:		
One-year health services certificates	$	18,760,000
AAS (two-year) health services degrees	$	47,400,000
Oregon University System:		

Enrollment Funding for Health Professions		$7,932,612
Health Professions - Targeted Program		$2,933,018
Collaborative Nursing - Targeted Program		$88,610
Department of Corrections:		
Drug and Alcohol Treatment	$	6,841,106
Mental Health Treatment	$	15,044,154
Oregon Youth Authority:		
Drug and Alcohol Treatment	$	2,900,000
Mental Health Treatment	$	5,500,000
Total Other Programs Supporting Transformation	**$**	**107,399,499**

TOTAL STATE FUND ONLY PROGRAMS	**$**	**446,944,790**

Appendix F **Initial Proposed CCO Accountability Metrics (transparency metrics also listed)**

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
1. Experience of Care*^ – Key domains TBD from member experience survey (version TBD and may alternate by year) *Domain(s):Member experience & activation* *Data type: Survey (collected by OHA)* *Also part of:* Medicaid Adult Core, CHIPRA, Medicare ACOs, Medicare Part C, OR PCPCH, others 2. Rate of tobacco use among CCO enrollees*^ *Domain(s): Prevention, outpatient physical, overall health status, cost control* *Data type: Survey* *Also part of: Nat'l Quality Strategy* 3. Access – Outpatient and ED utilization per member-month*^ *Domain(s):Access, community engagement* *Data type: Claims/encounter* *Also part of: CHIPRA Core, NCQA HEDIS* 4. BMI assessment & follow-up plan*^ / Weight assessment and counseling for children and adolescents *Domain(s): Prevention, outpatient physical* *Data type: Medical record* *Also part of: Medicare ACOs, OR PCPCH, CHIPRA* 5. Screening for clinical depression and follow-up plan^ *Domain(s):Mental health* *Data type: medical record* *Also part of: Adult Medicaid Core, Medicare ACOs*	1. Rate of early childhood caries *Domain(s):Oral health* *Data type: Medical record* *Also part of: HP 2020* 2. Wrap-around care for children – **TBD** (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure) *Domain(s):Care coordination, mental health* *Data type: TBD* *Also part of: TBD* 3. Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method *Domain(s):Women's health, prevention* *Data type: Survey* *Also part of:* 4. Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined) *Domain(s):End-of-life care, care coordination* *Data type: Administrative or medical record* *Also part of: Pending* 5. Health and functional status – (1) % members who report the same or better mental and physical health	CMS Adult Core Measures including: · Flu shots for adults 50-64 · Breast & cervical cancer screening · Chlamydia screening · Elective delivery & antenatal steroids, prenatal and post-partum care · Annual HIV visits · Controlling high BP, comprehensive diabetes care · Antidepressant and antipsychotic medication management or adherence · Annual monitoring and for patients on persistent medications · Transition of care record CHIPRA Core Measures including: · Childhood & adolescent immunizations · Developmental screening · Well child visits · Appropriate treatment for children with pharyngitis and otitis media · Annual HbA1C testing · Utilization of dental, ED care (including ED visits for asthma) · Pediatric CLABSI · Follow up for children prescribed

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
6. Alcohol misuse - Screening, brief intervention, referral for treatment (SBIRT)^ *Domain(s):Addictions* *Data type: medical record* *Also part of: OR PCPCH* 7. Initiation & engagement in of alcohol and drug treatment^ *Domain(s):Addictions* *Data type: Claims/encounter* *Also part of: Medicaid Adult Core, HEDIS, Meaningful Use, OR PCPCH* 8. Low birth weight <u>or</u> adequacy of prenatal care *Domain(s):Overall health status, MCH* *Data type: Claims/encounter* *Also part of: CHIPRA* 9. Primary-care sensitive hospital admissions (PQIs) for chronic conditions like diabetes, asthma, CHF, and COPD*^ *Domain(s): Outpatient physical, prevention, cost control* *Data type: Encounter/hospital discharge* *Also part of: Adult Medicaid Core, Medicare ACOs* 10. Healthcare-acquired conditions – TBD *Domain(s):Inpatient care* *Data type: Clinical* *Also part of: CDC and OR HAI reporting, Medicare value-*	status than 1 year ago*; (2) % members with Medicaid LTC benefit with improvement or stabilization in functional status *Domain(s): overall health outcomes* *Data type: Survey* *Also part of: Medicare ACOs, MA star ratings(1), SNP(2)* 6. ED visits – Potentially avoidable or other categorization TBD (*^) *Domain(s):Outpatient physical, care coordination, cost control* *Data type: Claims/encounter* *Also part of: TBD* 7. Access - % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members *Domain(s):Access, coordination and integration* *Data type: Survey* *Also part of: Unknown* 8. Improvement on disparities in health status or quality of health care identified by CCO in community needs assessment *Domain(s):Equity, cost control, potentially others* *Data type: mixed* *Also part of: Unknown* 9. Community Orientation - TBD	ADHD medications SAMSHA National Outcome Measures including: · Improvement in housing (adults) · Improvement in employment (adults) · Improvement in school attendance (youth) · Decrease in criminal justice involvement (youth) Others TBD, for example: · Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc. · Initiation and engagement of mental health treatment

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
based purchasing, CHIPRA 11. Follow-up after hospitalization^ - % of members with follow-up visit within 7 days after hospitalization for mental illness *Domain(s):Care coordination* *Data type: Claims/encounter* *Also part of: Adult Medicaid Core* 12. Readmission rates: (1) Plan all-cause readmissions*^; (2) readmissions to psychiatric care^ *Domain(s):Care coordination, cost control* *Data type: Claims/encounter* *Also part of: Adult Medicaid Core, Medicare ACOs* 13. High needs care coordination – TBD (e.g. % of members identified as high need assigned to intensive care coordination) *Domain(s):Care coordination* *Data type: TBD* *Also part of: TBD* 14. Medication management –TBD *Domain(s):Care coordination* *Data type: TBD* *Also part of: TBD* 15. MLR - % of global budget spent on health care and services *Domain(s):Efficiency, cost control*	*Domain(s):TBD* *Data type: TBD* *Also part of: TBD* 10. Timely transmission of transition record - % of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours *Domain(s):Care coordination* *Data type: Attestation* *Also part of: Adult Medicaid Core*	

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
Data type: Administrative *Also part of: Unknown*		
CCO-LTC System Joint Accountability Measures		
1. Care planning - % of members with Medicaid-funded LTC benefits who have a care plan in place. *Domain(s):Care coordination* *Data type: Administrative* *Also part of: Pending*	1. Transitions of care - % of LTC patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the care manager or AAA/APD within 1 business day *Domain(s):Care coordination* *Data type: Administrative* *Also part of: Unknown*	

* Report separately for members with severe and persistent mental illness

^ Report separately for individuals with Medicaid-funded Long-Term Care (LTC) benefit

Duals / Medicare 3-way Contract Accountability Measures – TBD pending negotiation with CMS

- Additional measures may apply related to quality and experience, outcomes, etc. for dually eligible individuals
- These measures will be determined in consultation with CMS by June 2012.
- Rewards for strong performance on these measures would come in part from the incentives that CMS has specified as part of the state demonstration to integrate care for dually eligible individuals, possibly in the form of a quality withhold.

Appendix G **CCO Proposed Measures--Crosswalk to Medicaid Adult Core Set, CHIPRA Core Set, and Medicare ACO Set**

NQF ID	Measure owner	Measure name	CCO Measures		Medicaid Adult Core	Medicare ACOs	CHIPRA Core
			Core	Transform-ational			
Access / Availability							
	NCQA/ HEDIS	% of children & adolescents (12 mo - 19 yrs) with visit to primary care pracitioner (4 breakdowns)					X
	NCQA/ HEDIS	Ambulatory care: Outpatient and ED visits per member month	X				X
		ED visits – Potentially avoidable or other categorization TBD		X			
		Access to specialty care: % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members		X			
		Measure of community orientation TBD		X			
Experience of Care, Patient & Family Engagement							
0007	AHRQ	CAHPS Health Plan Survey (adult, child, children with special healthcare conditions, etc.)	X - (Specific instrument and domains TBD)		X		X
0005	NCQA	CG CAHPS - Timeliness - Doctor Communication - Rating of Doctor - Access to specialists - Health promotion & education - Shared decision-making				X	
0006		Self-reported Health Status/Functional Status from Medicare Advantage HOS	Under consideration -			X	
		Improvement in functional status	Under consideration -				
Care Coordination, including transitions & medication management							
0097	NCQA	Medication Reconciliation: Reconciliation after discharge from an inpatient facility (acute inpatient or psychiatric)	Under consideration			X	
0021	NCQA	Annual Monitoring for Patients on Persistent Medications (ACE inhibitors or ARBs, digoxin, dieuretics, anti-convulsants)			X		
0648	AMA-PCPI	Timely Transmission of Transition Record to Health Professional (Inpatient Discharges to Home/ Self-Care or Any Other Site of Care).		Under consideration	X		
	NCQA/ HEDIS	Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase)					X
0576	NCQA	Followup After Hospitalization for Mental Illness	X		X		X
NA ...	NCQA	Plan All-Cause Readmission rate (also report separately for psychiatric)	X		X	X	
		High needs care coordination TBD - e.g. % of members identified as high need assigned to intensive care coordination	X				
		Wrap-around care for children – TBD (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure)		X			
Physical Health Screenings, Immunizations, Prevention							
Children							
0038		Childhood immunization status at 2 years (incl Tdap, polio, MMR, HiB, Hep A, Hep B, chicken pox, pneumococcal, rotavirus, and flu)					X
NA	NCQA	Adolescent immunizations - 13 year olds (incl meningococcal, Tdap or Td)					X
NA	NCQA/ HEDIS	% patients with all recommended well child visits to 15 mos					X
NA	NCQA/ HEDIS	Well-child visits years 3-6 (% 3-6 year olds with a well-child visit during measurement year)					X
NA	NCQA/ HEDIS	Adolescent well-care: % patients age 12-21 with at least on well-case visit to PCP or OB-GYN during measurement year					X
NA	CAHMI	% of patients w/ at least one validated developmental screening tool (ASQ, MCHAT, etc) by 36 mos					X

NQF ID	Measure owner	Measure name	Core	Transform-ational	Medicaid Adult Core	Medicare ACOs	CHIPRA Core
0024		Child/Adolescent weight screening	X				X
Adults							
421/ other	CMS	Adult BMI/Weight Screening (and follow-up)	X		(X)	X	X
0039, 0041	NCQA	Flu Shots for Adults Ages 50 and above			X	X	
0043, 0044		Pneumococcal Vaccination (ages 65 and over)				X	
0027, 0028	NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (age 18+)			X	X	
		Rate of tobacco use among members	X				
0031	NCQA	Breast Cancer Screening (women 40-69; mammography within last 24 months)			X	X	
0032	NCQA	Cervical Cancer Screening			X		
0034		Colorectal cancer screening (50-75 years)				X	
0033		Chlamydia screening			X		X
0101	NCQA/ HEDIS	Fall risk screening - % patients age 65 and older screened for fall risk within 12 months				X	
Behavioral Health Screening and Treatment							
NA ...	RAND	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment (SBIRT)	X				
0418	CMS	Screening for Clinical Depression and Follow-up Plan	X		X	X	
0004	NCQA/ HEDIS	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X		X		
0105	NCQA	Antidepression Medication Management			X		
NA ...	CMS-QMHAG	Adherence to antipsychotics for individuals with schizophrenia			X		
Maternal & Child Health							
		Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method		X			
	NCQA/ HEDIS	Frequency of ongoing prental care (% distribution of pregnancies in previous year by completion of expected prenatal visits)	Under consideration				X
	NCQA/ HEDIS	Prenantal and Post-partum care: Timeliness of prenatal care (% live births where prenatal care started in first trimester OR within 43 days of enrollment)					X
0469	Hospital Corp. of America	Elective delivery prior to 39 completed weeks gestation			X		
	CA	Cesarean rate: % of women with first, live, singleton birth (not breach) who had cesarean					X
	CDC	Low birth weight (<2,500g) births as % of total	Under consideration				X
0476	Providenc e	Appropriate Use of Antenatal Steroids.			X		
1391	NCQA/ HEDIS	Prenatal and Postpartum Care: Postpartum Care Rate			X		
Management of Chronic Conditions							
Ambulatory-care sensitive hospital admissions							
0272	AHRQ	PQI 01: Diabetes, short-term complications	X (tentative)		X		
0273	AHRQ	PQI 02: Perforated appendicitis					
0274	AHRQ	PQI 03: Diabetes, long-term complications					
0275	AHRQ	PQI 05: Chronic obstructive pulmonary disease	X (tentative)		X	X	
0276	AHRQ	PQI 07: Hypertension					
0277	AHRQ	PQI 08: Congestive heart failure	X (tentative)		X	X	
0280	AHRQ	PQI 10: Dehydration					
0279	AHRQ	PQI 11: Bacterial pneumonia					
0281	AHRQ	PQI 12: Urinary Tract Infection Admission Rate					
0282	AHRQ	PQI 13: Angina without procedure.					
0638	AHRQ	PQI 14: Uncontrolled Diabetes Admission Rate					
0283	AHRQ	PQI 15: Adult asthma.	X (tentative)		X		
0285	AHRQ	PQI 16: Lower extremity amputations among patients with diabetes					
Cardiovascular Disease, Diabetes, Asthma, Heart Failure, Etc.							
	CMS	BP Screening - % adults 18+ with BP measured in last 2 years				X	

NQF ID	Measure owner	Measure name	Core	Transform-ational	Medicaid Adult Core	Medicare ACOs	CHIPRA Core
0018	NCQA	Controlling High Blood Pressure (% 18-85 years with hypertension diagnosis whose blood pressure is < 140/90 mm Hg)			X	X	
0074	AMA-PCPI	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol.				X	
0075	NCQA	Comprehensive Ischemic Vascular Disease Care: Complete Lipid Profile and LDL-C control rates.				X	
0068		Use of aspirin or other antithrombotic for Ischemic Vascular Disease				X	
0066		ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)				X	
0063	NCQA	Diabetes: Lipid profile.			X		
0057/ other	NCQA	Hemoglobin A1c testing			X		X
0059	NCQA	Diabetes: poor control (HbA1C > 9)				X	
0729		Diabetes composite (Hemoglobin A1c Control (<8%); Low Density Lipoprotein (<100); Tobacco Non Use; Blood Pressure <140/90; Aspirin Use)				X	
0083	AMA-PCPI	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)				X	
		Annual number of asthma patients (> 1 year-old) with > 1 asthma related ER visit					X
Other							
0403	NCQA	HIV/AIDS: Annual medical visit.			X		
Management of Acute Conditions + Safety							
0002	NCQA	Appropriate testing for kids with pharyngitis: % of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode					X
	AMA-PCPI	Otitis Media with Effusion - avoidance of inappropriate use of systemic antimicrobials					X
0298		Health Care Acquired Conditions - TBD	X				X (CLABSI)
Dental							
	CMS (EPSDT)	Preventive dental services: % of eligibles age 1-20 who received preventive service					X
	CMS (EPSDT)	Dental Tx: % of eligibles age 1-20 who received dental treatment services					X
		Rate of early childhood caries		X			
HIT Use / Capacity							
	CMS	% of PCPs who successfully qualify for Meaningful Use incentive				X	
Efficiency							
		MLR - % of global budget spent on health care and services	X				
Equity							
		Improvement on disparities (# TBD) in health status or quality of health care identified by CCO in community needs assessment		X			
End-of-Life Care							
		Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined)		X			

Federal authority to implement Coordinated Care Organizations (CCO) and Transform Managed Care Organizations (MCO) in Oregon
Summary

In addition to Oregon's existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow the following:

Potential new waiver authorities

Issue	CFR/SSA Reference
• Flexibility to make payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement • Alternative provider payment methodologies to reimburse on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care, and comprehensive care coordination • Flexibility to create PMPM payments to support Patient Centered Primary Care Homes for the remaining FFS Medicaid/SCHIP populations that do not meet the ACA sec. 2703 multiple chronic condition requirements. *(Oregon has submitted a SPA for the ACA Sec. 2703 population)* • Latitude to set rates inclusive of non-encounterable medical services (1902(a)(30)) • Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community • Latitude to set a sustainable fixed rate of per capita cost growth within CCO global budgets • Flexibility in design, implementation and scoring of performance improvement plans (PIPS) to align with Medicare processes	42 CFR § 438.6
• An alternative payment methodology for FQHCs to allow a unique FQHC prospective payment system (PPS)/alternative payment methodology (APM)	SSA § 1902(bb)
• Expansion of definition of "health care professional" expansion to include naturopathic physicians and other state-licensed providers	42 CFR § 438.2
• Flexibility for the state to optimize the use of electronic communications to OHP members where written materials are required, at member's request, as well as contractors and providers	42 CFR §422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230, CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708,

Issue	CFR/SSA Reference
	722; 42 CFR § 455.1; 42 CFR § 489
• Flexibility in marketing requirements for CCOs that serve Medicaid, Medicare, and commercial populations	42 CFR § 438.104
• Ability to streamline and simplify due process rights to reflect person-centered primary care and to align Medicaid and Medicare consumer protection processes to the greatest extent possible (1902(a)(3))	42 CFR § 438.400-424 42 CFR § 431.244
• Ability to fold non-emergency medical transportation into global budget in first contract year. This program is under a 1915(b) waiver.	42 CFR § 431.53; SSA § 1915(b)

Potential new expenditure authorities

Issue	CFR/SSA Reference
Federal financial participation (FFP) for designated state-funded health care programs (DSHP)	
An additional 6 percentage points in federal medical assistance percentage (FMAP) for current HCBS waivers	
County intergovernmental transfers as partial state match	

Potential changes to 1115 Demonstration Special Terms and Conditions (STC) narrative where no waivers are necessary

- Changes in selection and contracting policies and procedures
- Description of integrated delivery system elements such as coordinated care teams that include non-traditional providers and other workers, and streamlined referral and prior authorization procedures for those who use specialty care
- Network adequacy criteria
- Medicaid enrollment processes applicable to clients eligible for both Medicaid and Medicare under current waiver authority
- Changes in Medicaid appeals and other consumer protections processes to integrate with Medicare protections
- The Medicaid impact of the streamlining of Medicare/Medicaid EQRO reviews

Medicaid State Plan Amendments related to Health Systems Transformation

- Non-traditional workforce – e.g. CHW, personal health navigators, peer wellness specialists and doulas
- Patient-centered primary care homes (PCPCH)
- To restructure the FQHC alternative payment system (APM) under the CCO structure

Appendix I Federal authority to implement Coordinated Care Organizations (CCO) and Transform Managed Care Organizations (MCO) in Oregon[1]

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
CCO selection and contracting	• Request for Applications (RFA) much like the process developed by the federal government for Medicare Advantage plans • Ability to contract with CCO entity, adding the CCO delivery system to the State's current managed care delivery system	• 42 CFR 431.50– Statewide-ness and uniformity • 42 CFR § 431.51– freedom of choice	• State has a *waiver in place* (of 42 CFR 431.50) for contracting with managed care entities and other insurers. • State believes this would apply to CCOs. • State has a *waiver in place* (of 42 CFR 431.50) to allow local variation in service delivery.	• *State's 1115 Demonstration Special Terms and Conditions will reflect* changes in selection and contracting policies and procedures.		State will address selection and contracting provisions in Request for Application (RFA) approval process.

[1] The preamble to 42 CFR, part 438, specifies that states that had 1115 Demonstrations in place prior to the passage of the Balanced Budget Act (1997) and part 438, and whose waivers have continued to be renewed, will have continuing waiver authority under the ongoing demonstrations. Thus, Oregon will not need additional waivers of part 438 provisions that are covered by previous waiver authority under the SSA or parts other than 438 of the Code of Federal Regulations (CFR). The state must act in accordance with provisions in part 438 that are not currently waived, or seek additional waivers if necessary.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Delivery systems • Inclusive physical, dental, mental health and chemical dependency service delivery • Integrated care, including: ○ Hospital care ○ Specialty care ○ Services provided by non-traditional workforce – e.g. Community health workers (CHW), personal health navigators, peer wellness specialists and doulas ○ Patient-centered primary care home	• Single integrated, inclusive systems • CCO prioritizes working with members with high health care needs, multiple chronic conditions, mental illness or chemical dependency. • Patient-centered primary care homes (PCPCH) • Ability to establish per member/per month (pm/pm) payment for care coordination under PCPCH for clients who do not experience multiple chronic conditions (as described in the ACA, section 2703) • Use of non-traditional workforce	• 42 CFR 431.51– Freedom of choice • SSA § 1902(a)(10)– services required • 42 CFR § 438.12 provider discrimination prohibited • 42 CFR §438.608 and §610– program integrity • 42 CFR § 438.2– definitions	• State has a *waiver in place* (of 42 CFR 431.51) to allow: ○ Mandatory enrollment and auto-enrollment in managed care delivery system; ○ State to define the types of insurers to include in the delivery system; and ○ State to offer Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services only where available	• *Potential 1115 Demonstration amendment* to allow PMPM payments to support Patient Centered Primary Care Homes for Medicaid/SCHIP populations that do not meet the ACA sec. 2703 multiple chronic condition requirements as described in the ACA, section 2703 • as described in the ACA, section 2703. • *State's 1115 Demonstration Special Terms and Conditions will reflect*	• Patient-centered primary care homes (PCPCH) – (SPA submitted) • Non-traditional workforce – e.g. CHW, personal health navigators, peer wellness specialists and doulas (SPA in progress)	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
(PCPCH) ○ Care coordination ○ Special continuity of care services for vulnerable populations	• Flexibility for local system design elements and local governance based on community needs assessments	• 42 CFR § 438.214– provider selection, credentialing and non-discrimination • 42 CFR § 440.168– Primary care case management	through managed care providers. • State has a *waiver in place* (of 42 CFR 431.50) to allow local variation in service delivery.	the description of integrated delivery system elements such as coordinated care teams that include non-traditional providers and other workers and streamlined referral and prior authorization procedures for those needing specialty care.		
Global budget • Integrated funding for physical, dental, mental health and chemical dependency, possibly to include other Medical Assistance programs– e.g. School-Based	• Development of rates in tandem with CCOs based on spending and anticipated shared savings • Plan and provider accountability • Multiple integrated	• 42 CFR § 438.6– actuarial soundness– Capitation rates must not include		• *Potential 1115 Demonstration amendment* to integrate funding • *Potential 1115 Demonstration amendment* due to	• State has a SPA in progress to restructure the	• Pre-approval of rate-setting methodology would serve as the basis for the Global Budget.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Health Center Services, Babies First!, Maternity Case Management, non-emergency medical transportation	funding sources • Ability to pay for non-encounterable medical services – expanded understanding of *actuarial soundness* • Blended Medicare and Medicaid funding through 3-way contract for dually eligible individuals • Ability to establish per member/per month (pm/pm) payment for care coordination under PCPCH for clients who do not experience multiple chronic conditions as described in the ACA, section 2703	services plans perform outside contract. • 42 CFR § 436.6– certification of MCO data for rate setting • SSA § 1905(a)– services eligible for reimburse-ment • SSA § 1902(bb)– payments to FQHCs/RHCs • 42 CFR § 433.51–funds		unique FQHC Prospective payment system (PPS) and Alternative payment methodology (APM) • *Potential 1115 Demonstration amendment* to allow PM/PM care coordination payments to PCPCH providers (outside of PCCM regulations) for providers serving PCPCH clients who do not experience multiple chronic conditions as described in the ACA, section 2703	FQHC Alternative Payment System (APM) under the CCO structure.	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		from units of government				
Global budget • Financial solvency, including reinsurance and reserves	• Financial solvency requirements–State is considering brokering re-insurance or stop-loss insurance.	• 42 C.F.R. § 434.50–protection against insolvency • 42 CFR § 438.116–solvency standards	• No new federal authority necessary • State will require CCOs to comply with federal solvency standards.			• State will address financial solvency provisions in CCO contracts for approval by CMS.
Global budget Risk arrangements	• CCOs are expected to have comprehensive risk contracts. • State is considering potential options for risk-sharing arrangements.	• 42 CFR § 434.20 and 21–basic HMO and PHP rules and contract requirements • SSA §	State has current federal CNOM (costs not otherwise matchable) authority under 42 CFR § 434.20 and 21 for State to contract for comprehensive services on a prepaid *or other risk*			

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		1902(a)(30): Payments must be consistent with efficiency, economy, and quality of care. • 42 CFR § 438.6(b)– comprehen-sive risk contracts	basis.			
Global Budget Incentive payments to CCOs for performance of infrastructure development, measurement and reporting of clinical practices and quality measures, and	• Ability to provide existing MCOs and potential CCOs with the incentive and resources to operationalize the CCO care model • Ability to shift the basis	42 CFR § 438.6		*Potential 1115 Demonstration amendment* to allow for payment in excess of 105 percent of the approved capitation payments attributable to the		

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
enrollee health outcomes	of payment over time from the provision of service to the attainment of health outcomes. •			enrollees or services covered by the incentive arrangement. *State's Special Terms and Conditions will reflect* the principles for CCO incentives and procedures for developing benchmarks and incentive payments.		
Global Budget Alternative payment methodologies – CCOs to providers	• Alternative provider payment methodologies to reimburse on the basis of outcomes and quality • Payment structures that incentivize prevention, person-centered care, and comprehensive care coordination	• SSA § 1902(a)(30) • 42 CFR § 430–grants to states for Medical Assistance • 42 CFR § 438.6–		• *Potential 1115 Demonstration amendment* to allow flexibility in alternative payment methodologies • *State's 1115 Demonstration*		

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		contract requirements		*Special Terms and Conditions will reflect* new methodologies.		
Global Budget Non-emergency medical transportation (NEMT)	Explore the possibility of folding NEMT into global budget in first contract year	• 42 CFR § 431.53 • SSA § 1915(b This program is under a 1915(b) waiver.				*The state would like to explore with CMS* the possibility of folding NEMT into the global budget during the first contract year.
Network adequacy	• Revised criteria for network adequacy to more closely align with Medicare and use of team-based person-centered primary care • Fully integrated care across physical, dental, mental health and chemical dependency. • Inclusion of non-traditional workforce e.g.	• 42 CFR § 438.206– availability of services and credentialed providers; responsibili-ties of health care professionals		• *State's 1115 Demonstration Special Terms and Conditions will reflect* network adequacy criteria.	• Patient-centered primary care homes (PCPCH) – (SPA submitted) • Non-traditional workforce – e.g. Community Health Workers (CHW) (SPA in progress)	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
	Community Health Workers and Healthcare Navigators					
Eligibility/enrollment • Mandatory • Auto • Choice of plan • Lock-in	No changes to current eligibility and enrollment policies and procedures	• 42 CFR § 431.51– freedom of choice • 42 § 438.52– choice of plan • 42 CFR § 438.50(f)(2)– equitable distribution of enrollees • 42 CFR §438.6– contract requirements • 42 CFR §438.10– required	• State has a w*aiver in place (of 42 CFR 431.51)* to allow mandatory managed care enrollment, auto-enrollment without choice of plan, and lock-in for Medicaid-eligible populations, including for those dually eligible for Medicaid and Medicare. • State will continue to provide choice among providers in plan.	• *State's 1115 Demonstration Special Terms and Conditions will describe* Medicaid enrollment processes applicable to clients eligible for both Medicaid and Medicare.		• Medicare enrollment will be addressed in duals demonstration MOU/3-way contracts

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		information, including available providers				
Consumer protections • Access • Grievances, Appeals, • Hearings • Accessibility • Cultural/linguistic appropriateness	• Ability to streamline and simplify due process rights such as complaints, appeals, and grievances to reflect person-centered primary care • Ability to have Medicaid consumer protection processes come more in line with the Medicare process–e.g. require clients to go through plan-level appeal prior to seeking a state fair hearing	• 42 CFR § 431.244–hearing decisions • 42 CFR § 438 Part F • 42 CFR § 438.206–availability of services and credentialed providers • § 438.207–assurances of adequate capacity • § 438.208–coordination/		• *Potential 1115 Demonstration amendment* to allow state to integrate Medicaid and Medicare processes • *State's 1115 Demonstration Special Terms and Conditions will reflect* changes in Medicaid appeals and other consumer protections processes to more closely align with Medicare.		• State will make internal modifications to the Medicaid program's grievance and appeals processes to align with Medicare. • State will continue to comply with 42 CFR § 438 Part F.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		continuity of care • § 438.209– direct access to specialists • § 438.210– coverage and authorization • § 438.228– grievance systems				
Benefits • Benefit package that integrates physical, dental , mental health and chemical dependency services [2]	• Latitude to include non-encounterable medical services	• SSA § 1902(a)(10)(A); 1902(B) • 42 CFR § 440.230-250– sufficiency of amount,	State has a w*aiver in place* (of 42 CFR 440.230-250) to: • Use the Prioritized List of Health Services. • Offer different	• *Potential 1115 Demonstration amendment* to include non-encounterable medical services in capitation rates.		

[2] There will be a separate long-term care benefit that will not be under CCO)s.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		duration, and scope • 42 CFR § 400-424- grievances and appeals • 42 CFR § 438.6(c)– services in addition to those covered under the State Plan that cannot be included when determining payment rates	benefits to different populations.	• *State's 1115 Demonstration Special Terms and Conditions will reflect* changes in scope of capitation payments.		
Quality improvement/assu-	• Ability to streamline and consolidate, including alignment of Medicaid	• 42 CFR § 438.206 • 42 CFR §§		• *State's 1115 Demonstration Special Terms and*		PIP requirements will be included in the 3-way contract to

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
rance reporting • Performance improvement plans (PIP) • Quality incentives, including physician incentives	and Medicare requirements for quality assurance and performance improvement, including performance incentives • Flexibility in validation of performance improvement plans (PIP) and required protocols used by External Quality Review Organizations (EQRO)	438.200-204, 438.240 (a)(2) and (d), 438.364 and 438.358– validation of PIPs and protocols for EQROs • 42 CFR § 438.240 (a)(2)–PIP topics • 42 CFR § 438.310– EQRO requirements • 42 CFR § 417.479(i)– physician incentive requirements		*Conditions will reflect* State flexibility in establishing an integrated quality/ performance improvement program for CCOs with efficient and effective EQRO protocols and standards that meet Medicare and Medicaid requirements for external quality reviews. • *State's 1115 Demonstration Special Terms and Conditions will reflect* the Medicaid impact of the streamlining of		combine the Medicare and state review of PIPs in order to streamline quality administration.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		(422.208-Medicare)		Medicare/ Medicaid PIP reviews.		
Workforce • Non-traditional providers	• Ability to use a non-traditional workforce such as Community health workers, personal health navigators, peer wellness specialists and doulas • Ability for State to determine qualification and certification standards. • Expand definition of "health care professional" to include naturopathic physicians, acupuncturists, and other licensed providers.	• SSA §1905(a) 42 USC § 1396–services • 42 CFR § 438.2– definition of health care professional • 42 CFR § 438.6 and § 438.206-210 health care professional • 42 CFR § 38.12– provider non-discrimination		*Potential 1115 Demonstration amendment* to expand the definition of "health care professional" in 42 CFR § 438.2 to include naturopathic physicians and other state-licensed providers	SPA to provide authority for payment for non-traditional workforce – e.g. CHW, personal health navigators, peer wellness specialists and doulas – (SPA in progress)	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Administrative Simplification and regulatory relief	**Fraud and Abuse** • Ability for CCOs and their provider networks to work within antitrust, Stark, anti-kickback and Civil Monetary Penalty Laws • Ability to implement administrative simplification and streamlining strategies in areas such as reporting requirements, coordination of managed care reporting to multiple state regulatory agencies and encounter data	• SSA § 1877 • 42 CFR §411–Stark physician referral law • 41 U.S.C. § 51–anti-kickback law • 42 CFR § 438.416–managed care reporting requirements • 42 CFR § 438.210–managed care communica-tion with clients				Pursuant to Section 17 of HB 3650, State may seek from the DHHS OIG: • Waivers or expansion of safe harbors related to the anti-kickback statutes, and • Waiver of or exemption from Stark laws as necessary to permit certain physician referrals related to integrated care and formation of CCOs.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Communications and Marketing	Flexibility in marketing requirements for CCOs that serve Medicaid, Medicare and commercial populations.	Marketing activities: 42 CFR § 438.104— restrictions on marketing by MCOs Communications: 42 CFR §422.128, 208, 210 42 CFR § 431. 200, 211, 213, 214, 220, 230, 42 CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708	*Potential 1115 Demonstration amendment* to provide marketing latitude for CCOs that would not violate Medicaid restrictions.	• *State's 1115 Demonstration Special Terms and Conditions will reflect* CCO marketing protocols. • *State's 1115 Demonstration Special Terms and Conditions will reflect* optimal use of electronic communications, including to OHP consumers, with consumer's permission.		The MOU and 3-way contract will determine marketing rules.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Federal Financial Participation (FFP) Selected state designated health programs (DSHP)	Ability to receive federal financial participation (FFP) for certain state-funded health care programs	SSA § 1115(a)		*Costs not otherwise matchable authority (CNOM)* under SSA § 1115(a) for federal financial participation (FFP)		

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Federal Financial Participation (FFP) Home and Community Based Services (HCBS) programs	An additional 6 percentage points in federal medical assistance percentage (FMAP) for current HCBS waivers, including: • Aged and physically disabled waiver • DD comprehensive services waiver • DD support services waiver • DD children's model waivers					

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Financial Participation County funds to be used for portion of state' matchable funds	Flexibility to accept local county funds for state match					

Citations from the Code of Federal Regulations (CFR) and the Social Security Act

References to 42 CFR § 438	Other CFR references	Social Security Act references
• 42 CFR § 438.2–Definitions • 42 CFR § 438.6– Contract requirements; actuarial soundness; entities eligible for comprehensive risk contracts; certification of MCO data for rate setting; services not covered under state plan • 42 CFR §438.10–Required information, including available providers • 42 CFR § 438.12 Provider discrimination prohibited • 42 CFR § 438.50(f)(2)–Equitable distribution of enrollees • 42 § 438.104–Marketing activities • 42 CFR § 438.116–Solvency standards • 42 CFR §§ 438.204–Elements of state quality strategies • 42 CFR § 438.206 – Availability of services and credentialed providers; responsibili-ties of health care professionals • 42 CFR § 438.207–Assurances of adequate capacity • 42 CFR § 438.208–Coordination/ continuity of care • 42 CFR § 438.209–Direct access to specialists • 42 CFR § 438.210–Coverage and authorization; communications with clients; EQRO requirements • 42 CFR § 438.240 (a)(2)–PIP topics • 42 CFR §§ 438.608 and 610–program integrity • 42 CFR § 438.228–Grievance systems • 42 CFR § 438.240–Quality assessment and program performance improvement • 42 CFR § 438.416–Managed care reporting requirements • 42 CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708–Member communications	• 42 C.F.R. § 430– Grants to states for Medical Assistance programs • 42 CFR § 431.51–Freedom of choice; funds from units of government • 42 CFR § 434.20 and 21–Basic HMO and PHP rules and contract requirements • 42 C.F.R. § 434.50–Protection against insolvency • 42 CFR § 417.479(i)–Physician incentive requirements (422.208-Medicare) • 42 CFR §422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230–Communications • 42 CFR § 431.53	• SSA § 1902(a)(10)(A)–Services required • SSA § 1902(a)(10)(B)–Amount, duration and scope • SSA § 1902(bb)–Payments to FQHCs/RHCs • SSA § 1905(a)–Services eligible for reimbursement • SSA § 1115(a)–costs not otherwise matchable (CNOM) authorities • SSA § 1915(b

Exhibit 2.1
Base Model
OHP Section 1115 Demonstration
Summary In Total Funds

Federal Fiscal Year		Neutrality Ceiling		Actual/Projected Expenditures		Surplus/Deficit
Original Waiver Period						
1994 Actual	$	390,951,750	$	346,190,634	$	44,761,116
1995 Actual	$	818,988,036	$	827,254,935	$	(8,266,899)
1996 Actual	$	892,465,451	$	885,011,152	$	7,454,299
1997 Actual	$	1,040,624,108	$	895,762,310	$	144,861,798
1998 Actual	$	1,224,165,720	$	1,051,592,807	$	172,572,913
Jan-99	$	112,450,962	$	95,260,442	$	17,190,520
Total Original Waiver	$	4,479,646,027	$	4,101,072,280	$	378,573,747
First Waiver Extension (beginning February 1999)						
1999 Actual (Feb - Dec)	$	1,236,961,227	$	1,071,151,312	$	165,809,915
2000 Actual	$	1,448,108,685	$	1,275,376,104	$	172,732,581
2001 Projection (1)	$	1,602,109,256	$	1,398,528,881	$	203,580,375
Jan-02	$	152,138,992	$	132,715,597	$	19,423,395
Total First Waiver Extension	$	4,439,318,160	$	3,877,771,894	$	561,546,266
Second Waiver Extension (beginning February 2002)						
2002 Actuals (Feb to Sept)	$	1,253,756,577	$	1,051,310,479	$	202,446,098
OHP2 Waiver Amendment						
DY 1 (FFY 03 Actual)	$	1,987,913,110	$	1,542,201,604	$	445,711,506
DY 2 (FFY 04 Actual)	$	2,093,044,450	$	1,494,082,316	$	598,962,134
DY 3 (FFY 05 Actual)	$	2,278,562,238	$	1,733,929,530	$	544,632,708
DY 4 (FFY 06 Actual)	$	2,454,368,136	$	1,558,038,076	$	896,330,060
DY 5 (FFY 07 Actual)	$	2,588,680,697	$	1,488,456,119	$	1,100,224,578
Total Second Waiver	$	11,402,568,631	$	7,816,707,645	$	3,585,860,986
OHP2 Waiver Extension						
DY 6 (FFY 08 Actual)	$	3,047,303,332	$	1,980,350,291	$	1,066,953,041
DY 7 (FFY 09 Actual)	$	3,210,937,225	$	1,857,765,840	$	1,353,171,385
DY 8 (FFY 10 Actual)	$	3,882,351,591	$	2,275,008,353	$	1,607,343,238
DY 9 (FFY 11 Actual)	$	4,521,446,161	$	2,847,833,594	$	1,673,612,567
DY 10 (FFY 12 Actual/Projection-9 mos)	$	3,761,911,867	$	2,075,993,645	$	1,685,918,222
Total OHP2 Waiver Extension	$	18,423,950,176	$	11,036,951,723	$	7,386,998,453
OHP2 Waiver - Health System Transformation						
DY 10 (FFY 12 Projection-3 mos)	$	1,253,970,622	$	691,997,882	$	561,972,741
DY 11 (FFY 13 Projection)	$	5,484,794,646	$	3,101,031,746	$	2,383,762,900
DY 12 (FFY 14 Projection)	$	7,144,866,029	$	4,031,369,406	$	3,113,496,623
DY 13 (FFY 15Projection)	$	8,206,432,253	$	4,736,820,942	$	3,469,611,311
DY 14 (FFY 16 Projection)	$	9,109,244,685	$	5,227,654,170	$	3,881,590,515
DY 15 (FFY 17Projection)	$	10,084,599,193	$	5,756,796,180	$	4,327,803,013
Total Waiver Extension	$	41,283,907,428	$	23,545,670,326	$	17,738,237,103
Cumulative Total	**$**	**81,283,146,999**	**$**	**51,429,484,347**	**$**	**29,853,662,652**

Exhibit 2.2
Base Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disabled	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance						
Parents	249,052	268,092				
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Total Member Months	**6,041,305**	**6,198,002**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)						
National Health Expenditures Growth Rate	CMS Approved PMPM	CMS Approved PMPM	*8.30%*	*5.90%*	*6.30%*	*6.00%*
Base Population PMPM						
AFDC	$ 474.53	$ 503.95	$ 545.78	$ 577.98	$ 614.39	$ 651.25
PLM-W	$ 1,806.87	$ 1,917.09	$ 2,076.21	$ 2,198.70	$ 2,337.22	$ 2,477.46
PLM-C	$ 691.61	$ 734.48	$ 795.44	$ 842.37	$ 895.44	$ 949.17
Old Age Assistance	$ 602.15	$ 632.26	$ 684.74	$ 725.14	$ 770.82	$ 817.07
Aid to Blind/Disabled	$ 1,959.64	$ 2,073.30	$ 2,245.38	$ 2,377.86	$ 2,527.67	$ 2,679.33
Foster Care & SAC	$ 830.04	$ 881.50	$ 954.66	$ 1,010.99	$ 1,074.68	$ 1,139.16
New Mandatory Adults (ACA)	$ -	$ -	$ 531.05	$ 562.38	$ 597.81	$ 633.68

Exhibit 2.2
Base Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Expansion Population PMPM						
General Assistance						
Parents	$ 367.33	$ 389.74				
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	$ 332.13	$ 352.72	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)						
Base Population Expenditures						
AFDC	1,055,604,797	$ 1,145,222,847	$ 1,204,826,435	$ 1,301,416,819	$ 1,411,060,450	$ 1,525,623,840
PLM-W	287,863,302	$ 295,435,072	$ 327,272,741	$ 355,948,315	$ 388,600,748	$ 423,050,482
PLM-C	1,230,418,455	$ 1,319,552,078	$ 1,431,795,312	$ 1,516,271,235	$ 1,611,796,323	$ 1,708,504,103
Old Age Assistance	256,213,019	$ 282,923,705	$ 320,879,671	$ 354,855,265	$ 393,911,749	$ 436,032,662
Aid to Blind/Disabled	1,908,221,005	$ 2,142,788,723	$ 2,712,946,926	$ 3,080,296,119	$ 3,510,595,572	$ 3,989,715,931
Foster Care & SAC	182,806,348	$ 191,318,116	$ 229,492,754	$ 247,931,071	$ 268,862,882	$ 290,738,315
New Mandatory Adults (ACA)	-	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Base	4,921,126,926	$ 5,377,240,541	$ 7,144,866,029	$ 8,206,432,253	$ 9,109,244,685	$ 10,084,599,193
Expansion Population Expenditures						
General Assistance	-	$ -	$ -	$ -	$ -	$ -
Parents	$ 91,484,271	$ 104,486,176	$ -	$ -	$ -	$ -
Adults/Couples	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - All Title XIX	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Existing	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Medicaid	$ 3,271,292	$ 3,067,929	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid		$ -	$ -	$ -	$ -	$ -
Total Expansion	$ 94,755,563	$ 107,554,105	$ -	$ -	$ -	$ -
Additional Health Services Expenditures						
Total Base + Expansion Allowable Expenditures	**$ 5,015,882,489**	**$ 5,484,794,646**	**$ 7,144,866,029**	**$ 8,206,432,253**	**$ 9,109,244,685**	**$ 10,084,599,193**

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

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disables	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance (3)						
Parents	249,052	268,092				
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Non-Allowable Expansion Population Member Months						
General Assistance		-	-	-	-	-
Adults/Couples	491,298	420,011	-	-	-	-
FHIAP - Existing	2,995	2,777	-	-	-	-
FHIAP - Non-Medicaid	54,564	40,767	-	-	-	-
Total Non-Allowable Expansion	548,857	463,555	-	-	-	-
Total Member Months	**6,590,164**	**6,661,557**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
PER MEMBER PER MONTH COSTS (PMPM) (1)						
National Health Expenditures Growth Rate			*8.3%*	*5.9%*	*6.3%*	*6.0%*
Base Populations PMPM						
AFDC	286.08	$ 285.12	$ 308.78	$ 327.00	$ 347.60	$ 368.46
PLM-W	1,164.12	$ 1,162.29	$ 1,258.76	$ 1,333.03	$ 1,417.01	$ 1,502.03
PLM-C	210.06	$ 214.85	$ 232.68	$ 246.41	$ 261.93	$ 277.65
Old Age Assistance	188.01	$ 177.43	$ 192.16	$ 203.49	$ 216.31	$ 229.29
Aid to Blind/Disables	916.92	$ 888.43	$ 962.17	$ 1,018.94	$ 1,083.13	$ 1,148.12
Foster Care & SAC	456.23	$ 463.64	$ 502.12	$ 531.75	$ 565.25	$ 599.16
New Mandatory Adults (ACA)			$ 531.05	$ 562.38	$ 597.81	$ 633.68
Expansion Population PMPM						
General Assistance (3)	$ -	$ -	$ -	$ -	$ -	$ -
Parents	$ 353.24	$ 353.09	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 23.41	$ 31.02	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Non-Allowable Expansion Population PMPM						
General Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	$ 579.63	$ 577.96	$ -	$ -	$ -	$ -
FHIAP - Existing	$ 97.21	$ 74.79	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 217.09	$ 253.35	$ -	$ -	$ -	$ -

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL EXPENDITURES (1)						
Base Populations Expenditures						
AFDC	636,388,175	$ 647,930,520	$ 681,655,182	$ 736,303,130	$ 798,336,264	$ 863,152,770
PLM-W	185,462,153	$ 179,115,146	$ 198,418,428	$ 215,804,384	$ 235,600,292	$ 256,486,190
PLM-C	373,710,983	$ 386,003,322	$ 418,828,590	$ 443,539,477	$ 471,482,464	$ 499,771,412
Old Age Assistance	79,999,681	$ 79,394,194	$ 90,047,799	$ 99,582,496	$ 110,542,738	$ 122,362,975
Aid to Blind/Disables	892,858,666	$ 918,208,416	$ 1,162,525,171	$ 1,319,937,991	$ 1,504,326,124	$ 1,709,633,687
Foster Care & SAC	100,478,248	$ 100,626,869	$ 120,705,784	$ 130,403,773	$ 141,413,065	$ 152,919,024
New Mandatory Adults (ACA)	-	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Leverages	113,980,333	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262
Total Base	$ 2,382,878,239	$ 2,752,814,729	$ 4,031,369,406	$ 4,736,820,942	$ 5,227,654,170	$ 5,756,796,180
Expansion Population Expenditures						
General Assistance (3)						
Parents	87,974,422	94,660,351	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 230,587	$ 269,837	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Total Expansion	$ 88,205,009	$ 94,930,188	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures						
General Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	284,771,824	$ 242,750,746	-	-	-	-
FHIAP - Existing	$ 291,175	$ 207,723	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 11,845,280	$ 10,328,360	$ -	$ -	$ -	$ -
Total Non-Allowable Expansion	$ 296,908,279	$ 253,286,829	$ -	$ -	$ -	$ -

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Additional Health Services Expenditures						
Health System Transformation Expenditures						
DSHP						
Total Base + Expansion Expenditures	**$ 2,767,991,527**	**$ 3,101,031,746**	**$ 4,031,369,406**	**$ 4,736,820,942**	**$ 5,227,654,170**	**$ 5,756,796,180**

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17

	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
NHE Growth Rate		8.30%	5.90%	6.30%	6.00%

Exhibit 2.1
Change Model
OHP Section 1115 Demonstration
Summary In Total Funds

Federal Fiscal Year	Neutrality Ceiling	Actual/Projected Expenditures	Surplus/Deficit
Original Waiver Period			
1994 Actual			
1995 Actual			
1996 Actual			
1997 Actual			
1998 Actual			
Jan-99			
Total Original Waiver	$ -	$ -	$ -
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)			
2000 Actual			
2001 Projection (1)			
Jan-02			
Total First Waiver Extension	$ -	$ -	$ -
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)			
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)			
DY 2 (FFY 04 Actual)			
DY 3 (FFY 05 Actual)			
DY 4 (FFY 06 Actual)			
DY 5 (FFY 07 Actual)			
Total Second Waiver	$ -	$ -	$ -
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)			
DY 7 (FFY 09 Actual)			
DY 8 (FFY 10 Actual)			
DY 9 (FFY 11 Actual)			
DY 10 (FFY 12 Actual/Projection)			
DY 11 (FFY 13 Projection)			
DY 12 (FFY 14 Projection)			
DY 13 (FFY 15 Projection)			
DY 14 (FFY 16 Projection)			
DY 15 (FFY 17 Projection)			
Total OHP2 Waiver Extension	$ -	$ -	$ -
OHP2 Waiver - Health System Transformation			
DY 10 (FFY 12 Projection)	$ 10,688,104	$ 231,535,785	$ (220,847,681)
DY 11 (FFY 13 Projection)	$ 140,907,240	$ 1,033,271,771	$ (892,364,531)
DY 12 (FFY 14 Projection)	$ 235,873,371	$ 740,715,774	$ (504,842,403)
DY 13 (FFY 15 Projection)	$ 258,774,969	$ 435,293,949	$ (176,518,980)
DY 14 (FFY 16 Projection)	$ 262,333,774	$ (467,652,851)	$ 729,986,625
DY 15 (FFY 17 Projection)	$ 263,142,134	$ (801,444,836)	$ 1,064,586,970
Total Waiver Extension	$ 1,171,719,592	$ 1,171,719,592	$ (0)
Cumulative Total	**$ 1,171,719,592**	**$ 1,171,719,592**	**$ -**

Exhibit 2.2
Change Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disabled						
Foster Care & SAC						
New Mandatory Adults (ACA)						
Total Base	-	-	-	-	-	-
Expansion Member Months (2)						
General Assistance						
Parents						
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Total Expansion	-	-	-	-	-	-
Total Member Months	**-**	**-**	**-**	**-**	**-**	**-**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)						
Base Population PMPM						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disabled						
Foster Care & SAC						
New Mandatory Adults (ACA)						

Exhibit 2.2
Change Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Expansion Population PMPM						
General Assistance						
Parents						
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)						
Base Population Expenditures						
AFDC	$ -	$ -	$ -	$ -	$ -	$ -
PLM-W	$ -	$ -	$ -	$ -	$ -	$ -
PLM-C	$ -	$ -	$ -	$ -	$ -	$ -
Old Age Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Aid to Blind/Disabled	$ -	$ -	$ -	$ -	$ -	$ -
Foster Care & SAC	$ -	$ -	$ -	$ -	$ -	$ -
New Mandatory Adults (ACA)	$ -	$ -	$ -	$ -	$ -	$ -
Total Base	$ -	$ -	$ -	$ -	$ -	$ -
Expansion Population Expenditures						
General Assistance						
Parents	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - All Title XIX	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Existing	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Medicaid	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ -	$ -	$ -	$ -	$ -	$ -
Total Expansion	$ -	$ -	$ -	$ -	$ -	$ -
Additional Health Services Expenditures	$ 10,688,104	$ 140,907,240	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Total Base + Expansion Allowable Expenditures	**$ 10,688,104**	**$ 140,907,240**	**$ 235,873,371**	**$ 258,774,969**	**$ 262,333,774**	**$ 263,142,134**

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

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disables						
Foster Care & SAC						
New Mandatory Adults (ACA)						
Total Base	-	-	-	-	-	-
Expansion Member Months (2)						
General Assistance (3)						
Parents						
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Total Expansion	-	-	-	-	-	-
Non-Allowable Expansion Population Member Months						
General Assistance						
Adults/Couples						
FHIAP - Existing						
FHIAP - Non-Medicaid						
Total Non-Allowable Expansion	-	-	-	-	-	-
Total Member Months	**1,510,326**	**6,198,002**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
PER MEMBER PER MONTH COSTS (PMPM) (1)						
Base Populations PMPM						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disables						
Foster Care & SAC						
New Mandatory Adults (ACA)						
Expansion Population PMPM						
General Assistance (3)						
Parents						
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Non-Allowable Expansion Population PMPM						
General Assistance						
Adults/Couples						
FHIAP - Existing						
FHIAP - Non-Medicaid						
HEALTH SYSTEM TRANSFORMATION PMPM	$ (51.11)	$ (49.82)	$ (89.37)	$ (119.53)	$ (216.41)	$ (244.77)

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL EXPENDITURES (1)						
Base Populations						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disables						
Foster Care & SAC						
New Mandatory Adults (ACA)			$ -	$ -	$ -	$ -
Total Base	$ -	$ -	$ -	$ -	$ -	$ -
Expansion Population Expenditures						
General Assistance (3)						
Parents						
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Total Expansion	$ -	$ -	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures						
General Assistance						
Adults/Couples						
FHIAP - Existing						
FHIAP - Non-Medicaid						
Total Non-Allowable Expansion	$ -	$ -	$ -	$ -	$ -	$ -

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Additional Health Services Expenditures	$ 10,688,104	$ 140,907,240	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Health System Transformation Expenditures	$ (77,197,144)	$ (308,788,576)	$ (698,044,526)	$ (1,033,158,439)	$ (1,939,664,045)	$ (2,274,264,390)
DSHP	$ 298,044,826	$ 1,201,153,107	$ 1,202,886,929	$ 1,209,677,419	$ 1,209,677,419	$ 1,209,677,419
Total Base + Expansion Expenditures	**$ 231,535,785**	**$ 1,033,271,771**	**$ 740,715,774**	**$ 435,293,949**	**$ (467,652,851)**	**$ (801,444,836)**

Exhibit 2.1
Combined Model
OHP Section 1115 Demonstration
Summary In Total Funds

Federal Fiscal Year	Neutrality Ceiling	Actual/Projected Expenditures	Surplus/Deficit
Original Waiver Period			
1994 Actual	$ 390,951,750	$ 346,190,634	$ 44,761,116
1995 Actual	$ 818,988,036	$ 827,254,935	$ (8,266,899)
1996 Actual	$ 892,465,451	$ 885,011,152	$ 7,454,299
1997 Actual	$ 1,040,624,108	$ 895,762,310	$ 144,861,798
1998 Actual	$ 1,224,165,720	$ 1,051,592,807	$ 172,572,913
Jan-99	$ 112,450,962	$ 95,260,442	$ 17,190,520
Total Original Waiver	$ 4,479,646,027	$ 4,101,072,280	$ 378,573,747
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)	$ 1,236,961,227	$ 1,071,151,312	$ 165,809,915
2000 Actual	$ 1,448,108,685	$ 1,275,376,104	$ 172,732,581
2001 Projection (1)	$ 1,602,109,256	$ 1,398,528,881	$ 203,580,375
Jan-02	$ 152,138,992	$ 132,715,597	$ 19,423,395
Total First Waiver Extension	$ 4,439,318,160	$ 3,877,771,894	$ 561,546,266
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)	$ 1,253,756,577	$ 1,051,310,479	$ 202,446,098
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)	$ 1,987,913,110	$ 1,542,201,604	$ 445,711,506
DY 2 (FFY 04 Actual)	$ 2,093,044,450	$ 1,494,082,316	$ 598,962,134
DY 3 (FFY 05 Actual)	$ 2,278,562,238	$ 1,733,929,530	$ 544,632,708
DY 4 (FFY 06 Actual)	$ 2,454,368,136	$ 1,558,038,076	$ 896,330,060
DY 5 (FFY 07 Actual)	$ 2,588,680,697	$ 1,488,456,119	$ 1,100,224,578
Total Second Waiver	$ 11,402,568,631	$ 7,816,707,645	$ 3,585,860,986
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)	$ 3,047,303,332	$ 1,980,350,291	$ 1,066,953,041
DY 7 (FFY 09 Actual)	$ 3,210,937,225	$ 1,857,765,840	$ 1,353,171,385
DY 8 (FFY 10 Actual)	$ 3,882,351,591	$ 2,275,008,353	$ 1,607,343,238
DY 9 (FFY 11 Actual/)	$ 4,521,446,161	$ 2,847,833,594	$ 1,673,612,567
DY 10 (FFY 12 Actual/Projection-9 mos)	$ 3,769,927,946	$ 2,075,993,647	$ 1,693,934,299
Total OHP2 Waiver Extension	$ 18,431,966,255	$ 11,036,951,725	$ 7,395,014,530
OHP2 Waiver - Health System Transformation			
DY 10 (FFY 12 Projection-3 mos)	$ 1,256,642,649	$ 923,533,666	$ 333,108,982
DY 11 (FFY 13 Projection)	$ 5,633,570,577	$ 4,142,172,208	$ 1,491,398,369
DY 12 (FFY 14 Projection)	$ 7,380,739,399	$ 4,772,085,180	$ 2,608,654,219
DY 13 (FFY 15 Projection)	$ 8,465,207,222	$ 5,172,114,891	$ 3,293,092,331
DY 14 (FFY 16 Projection)	$ 9,371,578,459	$ 4,760,001,319	$ 4,611,577,140
DY 15 (FFY 17 Projection)	$ 10,347,741,327	$ 4,955,351,344	$ 5,392,389,983
Total Waiver Extension	$ 42,455,479,633	$ 24,725,258,608	$ 17,730,221,024
Cumulative Total	**$ 82,462,735,282**	**$ 52,609,072,631**	**$ 29,853,662,651**

Exhibit 2.2
Combined Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disabled	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance						
Parents	249,052	268,092				
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Total Member Months	**6,041,304**	**6,198,002**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)	CMS Approved PMPM	CMS Approved PMPM				
Base Population PMPM						
AFDC	$ 474.53	$ 503.95	$ 545.78	$ 577.98	$ 614.39	$ 651.25
PLM-W	$ 1,806.87	$ 1,917.09	$ 2,076.21	$ 2,198.70	$ 2,337.22	$ 2,477.46
PLM-C	$ 691.61	$ 734.48	$ 795.44	$ 842.37	$ 895.44	$ 949.17
Old Age Assistance	$ 602.15	$ 632.26	$ 684.74	$ 725.14	$ 770.82	$ 817.07
Aid to Blind/Disabled	$ 1,959.64	$ 2,073.30	$ 2,245.38	$ 2,377.86	$ 2,527.67	$ 2,679.33
Foster Care & SAC	$ 830.04	$ 881.50	$ 954.66	$ 1,010.99	$ 1,074.68	$ 1,139.16
New Mandatory Adults (ACA)	$ -	$ -	$ 531.05	$ 562.38	$ 597.81	$ 633.68
Expansion Population PMPM						
General Assistance						
Parents	$ 367.33	$ 389.74	$ -	$ -	$ -	$ -
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	$ 332.13	$ 352.72	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						

Exhibit 2.2
Combined Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)						
Base Population Expenditures						
AFDC	$ 1,055,604,797	$ 1,145,222,847	$ 1,204,826,435	$ 1,301,416,819	$ 1,411,060,450	$ 1,525,623,840
PLM-W	$ 287,863,301	$ 295,435,072	$ 327,272,741	$ 355,948,315	$ 388,600,748	$ 423,050,482
PLM-C	$ 1,230,418,453	$ 1,319,552,078	$ 1,431,795,312	$ 1,516,271,235	$ 1,611,796,323	$ 1,708,504,103
Old Age Assistance	$ 256,213,019	$ 282,923,705	$ 320,879,671	$ 354,855,265	$ 393,911,749	$ 436,032,662
Aid to Blind/Disabled	$ 1,908,221,006	$ 2,142,788,723	$ 2,712,946,925	$ 3,080,296,119	$ 3,510,595,572	$ 3,989,715,931
Foster Care & SAC	$ 182,806,350	$ 191,318,116	$ 229,492,754	$ 247,931,071	$ 268,862,882	$ 290,738,315
New Mandatory Adults (ACA)	$ -	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Base	$ 4,921,126,926	$ 5,377,240,541	$ 7,144,866,028	$ 8,206,432,253	$ 9,109,244,685	$ 10,084,599,193
Expansion Population Expenditures						
General Assistance						
Parents	$ 91,484,272	$ 104,486,176	$ -	$ -	$ -	$ -
Adults/Couples	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - All Title XIX	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Existing	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Medicaid	$ 3,271,292	$ 3,067,929	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid		$ -	$ -	$ -	$ -	$ -
Total Expansion	$ 94,755,564	$ 107,554,105	$ -	$ -	$ -	$ -
Additional Health Services Expenditures	$ 10,688,104	$ 148,775,931	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Total Base + Expansion Allowable Expenditures	**$ 5,026,570,594**	**$ 5,633,570,577**	**$ 7,380,739,399**	**$ 8,465,207,222**	**$ 9,371,578,459**	**$ 10,347,741,327**

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

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disables	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance (3)						
Parents	249,052	268,092	-	-	-	-
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Non-Allowable Expansion Population Member Months						
General Assistance						
Adults/Couples	491,298	420,011	-	-	-	-
FHIAP - Existing	2,995	2,777	-	-	-	-
FHIAP - Non-Medicaid	54,564	40,767	-	-	-	-
Total Non-Allowable Expansion	548,857	463,555	-	-	-	-
Total Member Months	**6,590,161**	**6,661,557**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
PER MEMBER PER MONTH COSTS (PMPM) (1)						
National Health Expenditures Growth Rate			8.3%	5.9%	6.3%	6.0%
Base Populations PMPM						
AFDC	$ 286.08	$ 285.12	$ 308.78	$ 327.00	$ 347.60	$ 368.46
PLM-W	$ 1,164.12	$ 1,162.29	$ 1,258.76	$ 1,333.03	$ 1,417.01	$ 1,502.03
PLM-C	$ 210.06	$ 214.85	$ 232.68	$ 246.41	$ 261.93	$ 277.65
Old Age Assistance	$ 188.01	$ 177.43	$ 192.16	$ 203.49	$ 216.31	$ 229.29
Aid to Blind/Disables	$ 916.92	$ 888.43	$ 962.17	$ 1,018.94	$ 1,083.13	$ 1,148.12
Foster Care & SAC	$ 456.23	$ 463.64	$ 502.12	$ 531.75	$ 565.25	$ 599.16
New Mandatory Adults (ACA)			$ 531.05	$ 562.38	$ 597.81	$ 633.68
Expansion Population PMPM						
General Assistance (3)						
Parents	$ 353.24	$ 353.09	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 23.41	$ 31.02	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Non-Allowable Expansion Population PMPM						
General Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	$ 579.63	$ 577.96	$ -	$ -	$ -	$ -
FHIAP - Existing	$ 97.21	$ 74.79	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 217.09	$ 253.35	$ -	$ -	$ -	$ -
HEALTH SYSTEM TRANSFORMATION PMPM	$ (51.11)	$ (49.82)	$ (89.37)	$ (119.53)	$ (216.41)	$ (244.77)

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL EXPENDITURES (1)						
Base Populations Expenditures						
AFDC	$ 636,388,175	$ 647,930,520	$ 681,655,182	$ 736,303,130	$ 798,336,264	$ 863,152,770
PLM-W	$ 185,462,153	$ 179,115,146	$ 198,418,428	$ 215,804,384	$ 235,600,292	$ 256,486,190
PLM-C	$ 373,710,983	$ 386,003,322	$ 418,828,590	$ 443,539,477	$ 471,482,464	$ 499,771,412
Old Age Assistance	$ 79,999,681	$ 79,394,194	$ 90,047,799	$ 99,582,496	$ 110,542,738	$ 122,362,975
Aid to Blind/Disables	$ 892,858,667	$ 918,208,416	$ 1,162,525,171	$ 1,319,937,991	$ 1,504,326,124	$ 1,709,633,687
Foster Care & SAC	$ 100,478,249	$ 100,626,869	$ 120,705,784	$ 130,403,773	$ 141,413,065	$ 152,919,024
New Mandatory Adults (ACA)	$ -	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Leverages	$ 113,980,333	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262
Total Base	$ 2,382,878,241	$ 2,752,814,729	$ 4,031,369,406	$ 4,736,820,942	$ 5,227,654,170	$ 5,756,796,180
Expansion Population Expenditures						
General Assistance (3)						
Parents	$ 87,974,422	$ 94,660,351	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 230,587	$ 269,837	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Total Expansion	$ 88,205,009	$ 94,930,188	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures						
General Assistance						
Adults/Couples	$ 284,771,824	$ 242,750,746	$ -	$ -	$ -	$ -
FHIAP - Existing	$ 291,175	$ 207,723	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 11,845,280	$ 10,328,360	$ -	$ -	$ -	$ -
Total Non-Allowable Expansion	$ 296,908,279	$ 253,286,829	$ -	$ -	$ -	$ -

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Additional Health Services Expenditures	$ 10,688,104	$ 148,775,931	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Health System Transformation Expenditures	$ (77,197,144)	$ (308,788,576)	$ (698,044,526)	$ (1,033,158,439)	$ (1,939,664,045)	$ (2,274,264,390)
DSHP	$ 298,044,826	$ 1,201,153,107	$ 1,202,886,929	$ 1,209,677,419	$ 1,209,677,419	$ 1,209,677,419
Total Base + Expansion Expenditures	**$ 2,999,527,315**	**$ 4,142,172,208**	**$ 4,772,085,180**	**$ 5,172,114,891**	**$ 4,760,001,319**	**$ 4,955,351,344**

Appendix M

Proposed CCO Global Budget Inclusion/Exclusion of Oregon Medicaid Services Programs

Program Area	Program/Service/Function	Notes	% of non-LTC Medicaid Expenditures (based on 09-11)	Timeline for Inclusion in Global Budgets				Payment Methodology		New to Budget Neutrality in Waiver Amendme						
				July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned	Pre-CCO Global Budget	Under CCO Global Budget		FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	58%	X				Capitation/FFS	Capitation	No						
Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	9%	X				Capitation/FFS	Capitation	No						
Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities) and Medicare Advantage premiums for dual eligibles	Basis of payment currently depends on whether or not a beneficiary is enrolled in a Medicare Advantage plan, Medicaid physical health managed care plan.	Included in OHP physical health coverage above	X				FFS/Capitation	Capitation	No						
Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	2%	X				Capitation/FFS	Capitation	No						
Additional Enrollees	Breast and Cervical Cancer Medical (BCCM) (not inclusive of screening)	Clients currently receive care on a FFS basis, but would benefit from coordinated care. Benefits mirror those currently paid through capitation.	< 1%	X				FFS	Capitated? Specifics under development	Yes	$ 4,004,905	$ 16,756,501	$ 16,756,501	$ 16,756,501	$ 16,756,501	$ 16,756,501
Additional Enrollees	Eligible clients with third party insurance	Approach under development	< 1%	X				FFS	Capitation portion? Specifics under development	No						
Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Cost sharing for Medicare eligibles also eligible for a full Medicaid benefit and enrolled in a CCO will be included in blended capitation rates under CMS demonstration.	< 1%	X				FFS	Capitation portion	Yes	$ 1,946,099	$ 7,806,803	$ 8,179,617	$ 8,453,716	$ 8,791,864	$ 9,197,643
Mental Health	Children's Statewide Wraparound Projects	Services and supports for children with complex behavioral health needs and their families. Paid in the capitation rate for 3 MHOs currently.	< 1%	X				Capitation	Capitation	No						
Mental Health	Exceptional Needs Care Coordinators	Specialized case management service provided to clients identified as aged, blind or disabled who have complex medical needs. Currently paid through capitation	< 1%	X				Capitation	Capitation portion	No						
Mental Health	Non-forensic intensive treatment services for children	Currently paid through capitation for managed care enrolled clients and FFS for eligible clients not enrolled in managed care.	< 1%	x				Capitation/FFS	Capitation portion	No						
Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	Currently in the capitation rate for those in managed care for the first 20 days of care.	< 1%	X				Capitation/FFS	Capitation portion	No						
Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Program currently operates in a limited number of counties.	< 1%	Optional in counties where currently operating	X			Invoiced	TBD	Yes	$ -	$ 2,192,325	$ 2,961,100	$ 2,996,634	$ 3,044,580	$ 3,050,573
Addictions	Youth residential alcohol and drug treatment (OHP carve out)	HB 3650 states that OHA shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.	< 1%	Optional	Optional until July 1, 2013			FFS	Capitation?	Yes	$ 939,800	$ 3,823,106	$ 3,872,807	$ 3,919,280	$ 3,981,989	$ 3,989,828
Mental Health	Adult residential alcohol and drug treatment (OHP carve out)	HB 3650 states that OHA shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.	< 1%	Optional	Optional until July 1, 2013			FFS	Capitation?	Yes	$ 3,797,300	$ 15,447,416	$ 15,648,233	$ 15,836,012	$ 16,089,388	$ 16,121,060

Appendix M

Proposed CCO Global Budget Inclusion/Exclusion of Oregon Medicaid Services Programs

Program Area	Program/Service/Function	Notes	% of non-LTC Medicaid Expenditures (based on 09-11)	July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned	Pre-CCO Global Budget	Under CCO Global Budget	Budget Neutrality in Waiver Amendme	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Program is only one year old and has only operated in one county, with one additional county likely to begin operation soon.	< 1%	Optional in counties where currently operating	X			Invoiced	TBD	No						
Transportation	Non-Emergent Medical Transportation	Not currently in capitated rates, but inclusion necessary for coordination and access to care. Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation.	2%		X			Payment to brokerages on per ride basis	Methodology TBD	Yes	$ -	$ 23,606,072	$ 31,474,762	$ 31,474,762	$ 31,474,762	$ 31,474,762
Mental Health	Adult Residential Mental Health Services	High-cost, low-frequency services linked to management of census at state hospitals. CCOs will need to manage utilization and develop alternative services such as access to housing with necessary supports for independent living.	2%		X			FFS	Methodology TBD	Yes	$ -	$ 70,675,805	$ 95,459,454	$ 96,604,967	$ 98,150,647	$ 98,343,857
Targeted Case Management	HIV/AIDS Targeted Case Management	Overall services supported by Medicaid and CDC block grant funds.	< 1%		X			Invoiced	TBD	No						
Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon	Considering inclusion in second year of CCO operation or later in order to determine how to best integrate public health nurses into transformation.	< 1%		X			Invoiced	TBD	Yes	$ -	$ 599,213	$ 798,950	$ 798,950	$ 798,950	$ 798,950
Targeted Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)	Considering inclusion in second year of CCO operation or later in order to determine how to best integrate public health nurses into transformation.	< 1%		X			Invoiced	TBD	No						
Dental	OHP dental coverage	HB 3650 states that dental care organizations may choose to operate until 7/1/14 or opt to become part of a CCO sooner.	5%	Optional	Optional	Optional Until July 1, 2014		Capitation	Capitation	No						
Additional Enrollees	Citizen Alien-Waived Emergency Medical (CAWEM) Prenatal	Program currently operates in a limited number of counties.	1%	Optional	Optional	X		FFS	TBD	No						
Mental Health	Community crisis services, immediate mental health crisis assessment, triage, and intervention services available 24/7	Services are delivered by community mental health programs and are paid on a monthly basis to the counties. Excluded initially to avoid service disruption.	< 1%			X		Monthly allotment	TBD	Yes	$ -	$ -	$ 9,381,089	$ 12,658,217	$ 12,860,748	$ 12,886,065
Mental Health	Young Adults in Transition Mental Health Residential	Clients age 15-26 yrs. Eligibility currently determined by state. Integration with non-Medicaid funding sources and limited number of providers make it difficult to include in GB initially.	< 1%			X		FFS	TBD	Yes	$ -	$ -	$ 1,766,314	$ 2,383,346	$ 2,421,480	$ 2,426,246
Mental Health	Personal Care 20 Client Employed Provider	Providers are individuals selected by service recipient who require minimal ADL assistance (no more than 20 hours per month); Small volume makes inclusion initially in GB difficult.	< 1%			X		FFS	TBD	Yes	$ -	$ -	$ 902,783	$ 1,218,155	$ 1,237,645	$ 1,240,082
Mental Health	Community adult outpatient MH treatment services, case management, vocational and social services, locating housing, peer delivered services	A mix of county, Medicaid, general fund, and federal block grant funding.	1%			X		Monthly allotment	TBD	Yes	$ -	$ -	$ 32,264,667	$ 43,535,791	$ 44,232,364	$ 44,319,435
Mental Health	Mental health support services including supported employment, community geriatric psych specialists, preadmission screening/resident review (PASRR), housing renovations, homelessness supports, housing development	County funding that is a mix of Medicaid, general fund, and federal block grant. Difficult to put into GB initially due to this complexity.	1%			X		Monthly allotment	TBD	No	$ -	$ -	$ 16,407,094	$ 22,138,638	$ 22,492,857	$ 22,537,134
Long Term Care	Long term care institutional and community supports	Specifically excluded from CCO global budgets by statute	N/A				X	Varies		No						
Mental Health	OHP-covered mental health drugs	Specifically excluded from CCO global budgets by statute	3%				X	FFS		No						

Appendix M

Proposed CCO Global Budget Inclusion/Exclusion of Oregon Medicaid Services Programs

Program Area	Program/Service/Function	Notes	% of non-LTC Medicaid Expenditures (based on 09-11)	July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned	Pre-CCO Global Budget	Under CCO Global Budget	Budget Neutrality in Waiver Amendme	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
Other	Hospital Leverages: DSH, GME, Pro-Share, and UMG		3%				X	FFS/reconciliation		No						
Other	FQHC Full-Cost Settlements		2%				X	FFS/reconciliation		No						
Additional Enrollees	Citizen Alien-Waived Emergency Medical (emergency only, excludes CAWEM prenatal)	Emergency services only. Not predictable enough to forecast.	1%				X	FFS		No						
Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)	Program provides assessments, care plans, referrals and related activities specific to the developmentally disabled population, which CCOs may not have the experience to manage at this time.	< 1%				X	FFS		No						
Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)	Program provides assessments, care plans, referrals and related activities specific to the developmentally disabled population, which CCOs may not have the experience to manage at this time.	< 1%				X	FFS		No						
Mental Health	State Hospital Care - Forensic		< 1%				X	Direct Expenditure		No						
Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations		< 1%				X	Direct Expenditure		No						
Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)	This is a state hospital level of care. Low frequency-high cost utilization makes inclusion in cap difficult. The youth are court committed or transferred by OYA due to crisis.	< 1%				X	Direct Expenditure		No						
Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB	If determined necessary, care is provided at the state hospital and paid on a FFS basis. Low frequency - high cost utilization makes inclusion in capitation initially difficult.	< 1%				X	FFS		No						
Mental Health	Supervision services for persons under the jurisdiction of the Psychiatric Security Review Board (PSRB)	These are monitoring and reporting functions done by the community mental health programs on behalf of the PSRB and are paid monthly by AMH to the counties.	< 1%				X	Monthly payment		No						
Other	A & B Hospital Facilities Settlements		< 1%				X	Settlement		No						
Targeted Case Management	Child Welfare Youth (Targeted Case Management)	Difficult to initially put in CCO scope of work.	< 1%				X	Direct Expenditure		No						
Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)	Education based service provided by school or ESD staff.	< 1%				X	Invoiced?		No						
Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)	Difficult to initial put in CCO scope of work.	< 1%				X	Direct Expenditure		No						
Targeted Case Management	Tribal Targeted Case Management	Program is managed by tribes. State statute prohibits mandatory enrollment of tribal members into CCOs.	< 1%				X	Invoiced		No						
										Total	$ 10,688,104	$ 140,907,240	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134

JOHN A. KITZHABER, MD
Governor

February 29, 2012

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Sebelius,

I am pleased to share with you the State of Oregon's request of the federal government to approve amendments to the Oregon Health Plan Waiver Demonstration under Section 1115(a) of the Social Security Act. With these amendments, the Demonstration will serve to transform and improve the health care delivery system for Oregonians for years to come by improving health, improving health care and containing costs.

As Oregon forges ahead to implement its most ambitious health care transformation plan to date, focusing on integrated, coordinated care and alignment of incentives, we are also requesting approval to use federal savings earned under the OHP waiver to help launch our initiatives. Specifically, Oregon is requesting an amendment to our OHP 1115 Demonstration to authorize federal financial participation (FFP) for selected state designated health programs (DSHP). These programs would be authorized by Section 1115(a) cost not otherwise matchable authority (CNOM).

Since established in 1994, the Oregon Health Plan Waiver Demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth, saving the federal and state government more than $15 billion over the life of the waiver.

As we look to the future, Oregon is ready to build on that success and to take it further to meet three goals:

1. Transform Oregon's Medicaid delivery system to focus on prevention, integration, and coordination of health care across the continuum of care with the goal of improving outcomes and bending the cost curve;
2. Promote the Triple Aim of better health, better health care, and lower per capita costs; and
3. Establish supportive partnerships with CMS to implement innovative strategies for providing high-quality, cost-effective, person-centered health care under Medicaid and Medicare.

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 373-3111 FAX (503) 378-4863
WWW.OREGON.GOV

We estimate that there will be approximately 200,000 additional Oregonians eligible for Medicaid with the implementation of federal health reform in 2014. This proposal envisions a system anchored by the creation of community-based Coordinated Care Organizations (CCOs) that focus on prevention and primary care and the needs of their particular communities. With these reforms, we believe Oregon will be well-positioned to provide access to health care for newly eligible people, meet the three goals outlined above, and, at the same time, effectively use federal and state resources to support integrated care.

CCOs will integrate and coordinate care across physical, behavioral, and oral health care services through a strong focus on primary and preventive care, evidence-based services, and more effective management of care. The CCOs will not directly provide long-term services and supports (LTSS) at this time; however, in order to reduce cost-shifting and ensure shared responsibility for delivering high-quality, person-centered care, the CCOs and LTSS system will coordinate care and share both programmatic and financial accountability.

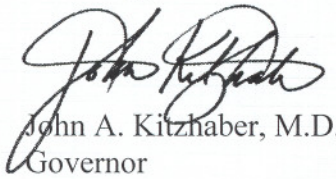
With this waiver amendment, Oregon is requesting, first, that all of the state's existing 1115 Demonstration authorities remain in place. These authorities will allow the State to implement a significant portion of the transformed system, including contracting with CCOs; enrolling individuals, including those eligible for Medicaid and Medicare, in managed care and establishing integrated benefit packages. Specific new flexibilities are outlined in our attached request. The State also requests approval of a three-year extension through October 31, 2016. The current Demonstration is scheduled to expire October 31, 2013.

Our desire is to continue to work collaboratively with CMS in moving these requests forward as expeditiously as possible. Oregon expects to contract with the first CCOs in July 2012. In order to accomplish that, we respectfully request expedited CMS review and approval. Our target date for approval of our DSHP request is April 1, 2012 and of the overall waiver amendments and extension, June 1, 2012.

The State of Oregon looks forward to your support and to working with you as we implement health system transformation and enter a new 1115 Demonstration renewal period and as we continue to fulfill the mission of the Oregon Health Authority: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Thank you for your consideration of these amendment and extension requests. If you have any questions or would like further information, please do not hesitate to contact our Medicaid Director, Judy Mohr Peterson at (503) 945-5768.

Sincerely,



John A. Kitzhaber, M.D.
Governor

C:
The Honorable Jeff Merkley, U.S. Senator
The Honorable Ron Wyden, U.S. Senator
The Honorable Earl Blumenauer, U.S. Representative
The Honorable Peter DeFazio, U.S. Representative
The Honorable Kurt Schrader, U.S. Representative
The Honorable Greg Walden, U.S. Representative
The Honorable Suzanne Bonamici, U.S. Representative
Bruce Goldberg, Director, Oregon Health Authority
Michael Bonetto, Office of Governor John Kitzhaber, Senior Health Policy Advisor
Sean Kolmer, Office of Governor John Kitzhaber, Assistant Health Policy Advisor
Judy Mohr Peterson, Director, Division of Medical Assistance Programs, Oregon Health Authority
Bruce Hanna, Speaker, House of Representatives
Arnie Roblan, Speaker, House of Representatives
Peter Courtney, Senate President
Cindy Mann, Director, CMCS
Terri Fraser, CMCS
Carol Peverly, CMS Region X Administrator
Cecile Greenway, CMS, Region X
Wendy Hill-Petras, CMS, Region X

APPLICATION FOR AMENDMENT AND RENEWAL
Oregon Health Plan
1115 Demonstration Project

Medicaid and Children's Health Insurance Program

MARCH 1, 2012

Oregon Health Authority

APPLICATION FOR AMENDMENT AND RENEWAL
Oregon Health Plan
1115 Demonstration Project

Table of Contents

AMENDMENT AND RENEWAL REQUEST	
Topic	**Page**
I. Policy Context	4
II. Conditions on the Ground in Oregon - Legacy of OHP	6
III. Integration of Care for Medicare and Medicaid Enrollees	8
IV. Stakeholder and CMS Collaboration	10
V. Oregon's Medicare-Medicaid Demonstration Design Contract	12
VI. Certification of CCOs	13
VII. Design Elements of CCOs	13
VIII. Federal Authority Requests	20
IX. Budget Neutrality	24
X. Evaluation Plan	27

APPENDICES	
Title	**Appendix**
CCO Application Timelines	A
Oregon Health Plan Transformation Public Process	B
CCO implementation proposal	C
CCO populations and schedule for inclusion in global budget	D
State Fund Only Program List	E
Initial Proposed CCO Accountability Metrics	F
CCO Proposed Measures--Crosswalk to Medicaid Adult, CHIPRA and Medicare ACO Measures	G
Summary of federal authority matrix	H
Federal authority matrix	I
Budget neutrality – Base	J
Budget neutrality – Change	K
Budget neutrality – Combined	L
Inventory of Medicaid services and timeline for inclusion in global budget	M

RENEWAL AND AMENDMENTS TO
Oregon Health Plan
Medicaid and Children's Health Insurance Program
1115 Demonstration Project
February 2012

I. Policy Context

This document outlines proposed modifications to Oregon's existing Demonstration under Section 1115(a) of the Social Security Act. Since established in 1994, the Oregon Health Plan Demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth, saving the federal and state government more than $15 billion over the life of the waiver. With this renewal and amendment, Oregon seeks to build on our long history of demonstrated leadership and to meet three key goals:

1. Transform Oregon's Medicaid delivery system to focus on prevention, integration, and coordination of health care across the continuum of care with the goal of improving outcomes and bending the cost curve;
2. Promote the Triple Aim of better health, better health care, and lower per capita costs; and
3. Establish supportive partnerships with CMS to implement innovative strategies for providing high-quality, cost-effective, person-centered health care under Medicaid and Medicare.

We estimate that there will be approximately 200,000 additional Oregonians eligible for Medicaid with the implementation of federal health reform in 2014. This proposal envisions a system anchored by the creation of community-based Coordinated Care Organizations (CCOs) that focus on prevention and primary care and the needs of their particular communities. With these reforms, we believe Oregon will be well-positioned to provide access to health care for newly eligible people, meet the three goals outlined above, and, at the same time, effectively leverage federal and state resources to support integrated care. As Oregon forges ahead to implement its most ambitious health care transformation plan to date, focusing on integrated, coordinated care and alignment of incentives, we are also requesting approval to use federal savings earned under the OHP waiver to help launch our initiatives.

While Oregon will be requesting some new flexibilities, in addition to those in the state's current 1115 Demonstration authorities for the CCOs to effectively integrate and coordinate care, these flexibilities are not comprehensive and are not intended to supplant current federal and state statute governing health insurance and Medicaid managed care. Nor are the waivers requested in this application intended to reduce any current flexibilities under Oregon's 1115 Demonstration waivers.

The ultimate goal of the CCOs is to move from fragmentation to integration and deliver the right care in the right place at the right time within a patient-centered care model. CCOs will integrate and coordinate care across physical, behavioral, and oral health care services through a strong focus on primary and preventive care, evidence-based services, and more effective management of care. Not

only will CCOs change how services are delivered, but this new model will also serve a broader population by enrolling beneficiaries who would otherwise receive care on a fee-for-service basis, including those dually eligible for both Medicare and Medicaid. Experience in enrolling new beneficiary groups will help prepare CCOs to transform health care delivery for the expanded Medicaid population that will become eligible in 2014.

Oregon and its stakeholders are committed to transforming the delivery system without compromising the overall capacity to provide care. This will require a phased implementation of CCO requirements. However, the sustainability of Oregon's Medicaid program depends on successfully achieving system transformation in a timely manner. As outlined below, in order to proceed apace, Oregon may certify and contract with CCOs to provide care to Medicaid clients before the state's planning to integrate dually eligible beneficiaries is completed with CMS *(See Appendix A, CCO Application Timelines).* The Medicare-Medicaid Coordination Office is prepared to do the same with respect to integrated care for individuals who are dually eligible for Medicare and Medicaid beginning in January 2013. Regardless, Oregon will work with CMS to ensure that CCOs can successfully meet the needs enrollees, including those eligible for both Medicare and Medicaid.

Oregon's proposed health care transformation was initially outlined in the Oregon Legislature under House Bill 3650 of 2011,[1] which was passed with broad bipartisan support. The law creates a new delivery model for Oregon called the Integrated and Coordinated Health Care Delivery System in which CCOs are used to improve health; increase the quality, reliability, availability and continuity of care; and reduce the cost of care. Using alternative payment methodologies, and ongoing community needs assessments, CCOs will provide medical assistance recipients with integrated health care services that focus on prevention and use patient-centered primary care homes, evidence-based practices, health information technology and employ a broader use of non-traditional health care workers (e.g., community health workers, peer wellness specialists) to improve health and reduce health disparities. Within a fixed global budget, CCOs will be accountable for care management and provision of integrated and coordinated health care for their members. Care coordination will be an integral part of CCOs, which will provide services in a patient-centered primary care home setting to the maximum extent possible. Patients will choose or be assigned to a consistent provider/clinic or team to increase continuity and ensure individual responsibility for care coordination functions.

CCOs will developed a person-centered plan for beneficiaries with high or special health care needs, based both on their needs and personal preferences. Care plans will address key access, tracking, referral, and care coordination goals. There is a strong expectation that there will most likely be co-management for beneficiaries with mental health or substance abuse diagnoses and specialty services and supports for people with developmental disabilities and others who may need long term care and services and supports. Co-location of behavioral health and primary care is strongly encouraged. Patient-centered primary care homes (PCPCH)/health home services will function under the direction of a licensed health professionals, including physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

[1] http://www.leg.state.or.us/11reg/measpdf/hb3600.dir/hb3650.en.pdf

HB 3650 required OHA to submit specific proposals detailing CCO criteria for qualification and a CCO global budget methodology before the state would proceed with requests for federal flexibilities or implementation of the Medicaid delivery system transformation outlined in the legislation. Through a robust public process *(See Appendix B, Oregon Health System Transformation Public Process*), the Oregon Health Policy Board developed a detailed CCO Implementation Plan *(See Appendix C, CCO Implementation Proposal)* that included the CCO criteria for qualification and the CCO global budget methodology. The Implementation Plan was submitted to the legislature for consideration in late January 2012. Senate Bill 1580, which essentially approves the CCO criteria and global budget process and enables the creation of CCOs, was introduced by Governor John Kitzhaber, at the request of the Oregon Health Authority (OHA) on February 1, 2012. SB 1580 was passed with broad bipartisan support (53-7) on February 23, 2012.[2]

Building on the current managed care structure, Oregon's health system transformation efforts are the next stage of evolution for the state's Medicaid system. While there are similarities between CCOs and Medicare Accountable Care Organizations, Oregon's CCOs are risk-bearing entities. The CCO model emphasizes community-driven rather than provider-led governance; community needs assessments; person-centered care management; alternative payment methodologies; global budgets that increase at a fixed rate of growth, and a focus on metrics and outcomes. The key elements of the state's approach are patient-centered primary care homes, improved coordination of care, and aligned incentives that reward providers and beneficiaries for achieving good outcomes.

II. Conditions on the Ground in Oregon - Legacy of Oregon Health Plan

From 2009-2011, Oregon's Medicaid expenditures increased at an unsustainable annual rate that far outpaced the growth in general fund revenue. This growth in expenditures occurred despite the success of the Oregon Health Plan (OHP), which has saved the state and federal government an estimated $16 billion since its inception in 1994.

The Centers for Medicare & Medicaid Services (CMS) granted Oregon its initial section 1115 Demonstration to implement the innovative OHP nearly two decades ago, phasing in coverage under the initial Demonstration beginning in 1994. CMS approved Oregon's current section 1115 Demonstration, known as Oregon Health Plan 2 (OHP2), in 2002. The Demonstration has been renewed on several occasions and is currently scheduled to expire in October 2013. With this amendment, Oregon requests an extension of this Demonstration under Section 1115(a) of the Social Security Act, through October 31, 2016. Under the OHP2, the state currently provides coverage to more than 650,000 Oregonians and is available to individuals with incomes at or below 100 percent of the federal poverty level regardless of age, disability, or family status. The primary objectives of OHP2 are to achieve:

- Health care coverage for uninsured Oregonians;
- A basic benefit package of effective services;
- Broad participation by health care providers;
- Decreases in cost-shifting and charity care;

[2] http://www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.en.pdf

- A rational process for making decisions about resources and the provision of health care for Oregonians; and
- Control over health care costs.

Under OHP2, the majority of Oregonians covered through Medicaid and the Children's Health Insurance Program (CHIP) receive services through a combination of physical, behavioral, and dental managed care entities. Oregon's Demonstration is unique in its longstanding use of a prioritized list of health care conditions and treatments that enables the state to focus resources on prevention and use of the prioritized list as a method to control health care costs and assure accountability. It is envisioned that under this waiver modification, the prioritized list would continue to be used.

In 2009, Oregon established the Oregon Health Authority (OHA) as the guiding structure for the state's health and health care purchasing agencies, including the state employee's health program. OHA is overseen by the Oregon Health Policy Board (OHPB), a nine-member citizen board. OHA's mission focuses on "helping people and communities achieve optimum physical, mental and social well-being through partnership, prevention and access to quality, affordable health care." As part of a larger agency dedicated to the vision of a healthy Oregon, the Medicaid program and OHP2 are well-positioned to serve as an essential and leading component of the transformation of the Oregon health system.

As mentioned above, the OHP2 provides an important foundation to support the health system transformation to CCOs. Oregon's transformed system will leverage lessons learned from its managed care, behavioral health, and dental care organizations. The CCOs will build on the successes of current pilot programs focused on coordinating care for high-need, high-cost Medicaid beneficiaries. The state anticipates that CCOs will fundamentally reform the current delivery model by providing improved quality and benefits across all Oregon communities, paying providers for prevention and outcomes, and coordinating care for individuals with chronic conditions to achieve improved health outcomes and avoid preventable specialty care and unnecessary hospitalizations and emergency care.

While health plan performance is generally strong, there are still significant opportunities to enhance access to care, improve care delivery, and advance health outcomes at the community level. Although the number of children and adults served by the Oregon Health Plan who receive preventive services has increased annually, barriers still exist including health care providers that do not accept Medicaid and lack of knowledge among some beneficiaries and their families regarding the importance of routine health visits. Similarly, although appropriate prenatal visits have increased annually, there is still a lack of beneficiary understanding concerning the importance of prenatal visits, even when a pregnancy is going normally.

With the transition to CCOs, Oregon will be positioned to improve the satisfaction of beneficiaries with both their ability to get care and the quality of care they receive. At the same time, the CCOs will help the state achieve a sustainable level of health care spending through global payment strategies and reductions in unnecessary health care costs through better coordination of chronic care and a reduction of health disparities.

Economic conditions and revenue constraints

Oregon, like the rest of the United States, is experiencing a slow and tenuous economic recovery. The state's jobless rate has improved, showing a decline from 10.4 percent unemployment in January 2011, to 8.9 percent in December 2011, but it is still above the national unemployment rate of 8.5 percent during the same period. In addition, while Oregon is seeing slight increases in state revenues, overall revenues to the state have decreased, in part due to the expiration of the enhanced Medicaid Federal Medical Assistance Percentage (FMAP) funds. Oregon's budget reality is that state expenditures are outpacing revenues. This shortfall is driven in part by a rate of increase in Medicaid and public employees' health care expenditures, one area of spending that is growing faster than statewide general revenue. Without a change in its health care spending trajectory, Oregon is faced with making serious reductions in payments to Medicaid providers or adjustments to covered benefits to achieve its budget targets in FY2013.

This weak fiscal climate creates not only an imperative, but a unique opportunity for Oregon to do what it has done time and again – innovate. Through the CCO initiative, Oregon has developed an innovative redesign of the State's health care delivery system to achieve better value for all stakeholders while improving outcomes. With 80 percent of health care dollars spent on 20 percent of the patients, Oregon sees an opportunity to focus its health care transformation, in part, on improving coordination for patients with chronic health issues and increasing integration across physical, mental, dental and other health care services to enhance outcomes and reduced costs. If successful, this transformation will help Oregon reduce future costs to the OHP, stabilize the delivery system, and preserve available services.

III. Stakeholder and CMS Collaboration

OHA initiated discussions with CMS about the CCO model in early fall of 2011 and specifically addressed the state's desire to begin the transition to the CCO model beginning July 1, 2012. Through the CMS Medicaid State Technical Assistance Team (MSTAT) process, weekly calls and consultation have kept CMS officials informed of Oregon's progress, and a series of concept papers have more fully described components of Oregon's proposed health system transformation. Within Oregon, preparations and a robust stakeholder and public engagement process related to Oregon's waiver request began in the early days of the State's consideration of the new system. *(See Appendix B, Oregon Health Plan Transformation Public Process)*:

- In February, 2011, Governor Kitzhaber appointed 44 stakeholders to the "Health System Transformation Team." This group was made up of representatives of major components of the health care system, advocacy organizations and Oregon's tribes. It met every Wednesday evening in three-hour sessions over eight weeks to develop a conceptual framework for transformation of Oregon's health system. The work of this group resulted in the legislative concept that became HB 3650, which was signed by the Governor on July 1, 2011.
- In August 2011, Governor Kitzhaber selected 133 people—from nearly 500 applicants—to serve on four workgroups to inform the development of the CCO Implementation Proposal. The four work groups, chartered under the Oregon Health Policy Board (OHPB), included:

- CCO Criteria;
- Global Budget Methodology;
- Outcomes, Quality and Efficiency Metrics; and
- Medicare-Medicaid Integration of Care and Services.

The workgroups, which ranged in size from 35 to 40 members, were selected to represent the diversity of Oregon health care stakeholders. The workgroups met monthly for three-hour sessions, between August and November, each month providing input to the OHPB. All of the meetings were public, and the discussion topics and meeting materials were posted online for additional public comment.[3] Because of the size of the workgroups, the meetings were structured so that organizational and background information was presented in a large group setting, followed by structured, facilitated discussions in small group breakouts of 12 to 15 members each. The discussions from each of the workgroup meetings were summarized and presented to the OHPB along with a summary of public input.

- The Medicaid Advisory Committee considered issues related to Oregon's health system transformation in March, April, July, September and October 2011, and in January and February 2012.

- The Oregon Health Authority engaged with Oregon tribes about health system transformation in consultations and in regular meetings with tribal health care leadership in February, April, May, June, July, August, November, and December of 2011 and in January and February of 2012.

- The Oregon Health Authority engaged and held discussions of health system transformation with Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) representatives in May, June, August, September, November and December of 2011 and in February 2012.

- In late August and early September 2011, more than 1,200 Oregonians provided input through eight public meetings that were held around the state (Portland, Medford, Astoria, Bend, Roseburg, Eugene, Florence, and Pendleton; and through online surveys.

- Each month since the passage of HB 3650, the Oregon Health Policy Board meetings have focused on specific aspects of the CCO Implementation Proposal with both invited testimony and open public testimony. Two meetings were held in January 2012 to finalize the OHPB's recommendations to the legislature. These meetings are always live-streamed on the web.

- There were two open public comment periods on the Board's CCO Implementation Proposal in December 2011 and January 2012.

[3] http://health.oregon.gov/OHA/OHPB/health-reform/workgroups/index.shtml

IV. Integration of Care for Medicare and Medicaid Enrollees

Integration of Medicare and Medicaid services and financing for dually eligible Medicare-Medicaid enrollees is key to realizing Oregon's Triple Aim of better health, better health care, and lower costs. Medicare-Medicaid enrollees are a disproportionately high-cost population, making up 15 percent of the Medicaid population nationally, but accounting for 39 percent of Medicaid costs.[4] In Oregon, Medicare-Medicaid enrollees make up 17 percent of the Medicaid population, but account for 40 percent of the state's Medicaid expenditures for acute and long-term services and supports (LTSS). Similarly, Medicare-Medicaid enrollees make up 21 percent of the Medicare population nationally (15 percent in Oregon), but account for 36 percent of Medicare costs.[5] There are approximately 59,000 Medicare-Medicaid enrollees in Oregon.

Under the Demonstration authority for Medicare-Medicare enrollees (hereafter referred to as the "Medicare-Medicaid Demonstration"), financial alignment will result in savings for this population, for example, through:

- Reductions in avoidable hospitalizations and emergency room utilization;
- Reductions in avoidable specialty care
- Reductions in unnecessary or duplicative drug utilization; and
- Administrative efficiencies from new flexibilities to align Medicare and Medicaid regulatory and administrative requirements.

Enrollees participating in the Medicare-Medicaid Demonstration will receive primary, acute, mental health and chemical dependency care, and prescription drugs through their CCO. The CCOs will not directly provide long-term services and supports (LTSS); however, in order to reduce costs in both systems and ensure shared responsibility for delivering high-quality, person-centered care, the CCOs and LTSS system will coordinate care and share both programmatic and financial accountability.

Promising models and pilot projects exist in Oregon for better coordinating care between the medical and LTSS systems. Practices that are used in these projects (alone or in combination) are described below.

- *Co-Location or Team Approaches:* These models include co-location of staff such as LTSS case managers in medical settings (hospitals or primary care), care coordination positions jointly funded by the LTSS and medical systems, or team approaches such as a multi-disciplinary care team including LTSS representation.
- *Services in Congregate Settings:* In these models, a range of LTSS and medical services are provided in congregate settings to a group of common beneficiaries. Services can be limited to one type of service, such as personal care provided in an apartment complex.

[4] 2007 data - The Kaiser Family Foundation Program on Medicare Policy. (January 2011). *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*. Menlo Park. CA: Jacobson, Gretchen, Neuman, Tricia, Damico, Anthony, Lyons, Barbara. http://www.kff.org/medicare/upload/8138.pdf Oregon specific data: Kaiser Family Foundation, State Health Facts (2007 data). www.statehealthfacts.org

[5] Ibid.

- *Physician Extender/Home-Based Programs:* These models rely on the use of nurse practitioners, physician assistants or registered nurses who perform assessments, plan treatments, and provide interventions to the person in their home, or another community-based setting, or a nursing facility setting.

To achieve system-wide alignment, models such as these will be brought to scale under the Medicare-Medicaid Demonstration and supported by mechanisms that promote shared accountability. A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTSS system, including those that reflect better coordination between the two systems. Other elements of shared accountability between CCOs and the LTSS system will include:

- Contractual elements, including specific requirements for coordination between the two systems;
- Requirement to clearly define roles and responsibilities between the two systems through a memorandum of understanding, contract, or other mechanism between the CCO and the local Area Agency on Aging (AAA) or the state's Aged and People with Disabilities (APD) local office; and
- Reporting of metrics related to better coordination between the two systems.

As with the rest of the CCO development process, in establishing these structures for shared accountability across CCOs and the LTSS system, it will be important to balance prescriptiveness and local flexibility. OHA and Oregon's Department of Human Services (DHS) will set broad goals for integration of care for Medicare-Medicaid enrollees, and local entities interested in becoming CCOs will propose approaches within their individual capacity to address the needs of beneficiaries. OHA and DHS will approve proposals that reduce the cost-shifting and uncoordinated care that can result in fragmented care and poor outcomes for beneficiaries.

The CCO care delivery model is uniquely suited to meet the needs of complex populations through its patient-centered approach and community focus. It provides an ideal platform for development of the Medicare-Medicaid Demonstration. Oregon will work with CMS to align the CCO design and and model requirements with the Medicare Advantage Model of Care standards in order to ensure that the final three-way contract includes the elements necessary to meet the needs of Medicare-Medicaid enrollees. The final Memorandum of Understanding (MOU) will outline the clinical and non-clinical care elements to be provided through the Demonstration.

For example, in the MOU, CMS and the state will agree on how to align enrollment processes and beneficiary safeguards, such as appeals. In addition, guidelines for beneficiary information will be included in the Medicare-Medicaid Demonstration MOU and three-way contracts with CCOs. Beneficiary information about options for enrollment will be integrated with Medicare to the extent possible, and be accessible and understandable to beneficiaries, including those with disabilities or limited English proficiency. CMS and the state will prior approve all outreach and marketing materials, subject to a consistent and integrated single set of rules.

V. Oregon's Medicare-Medicaid Demonstration Design Contract

In April 2011, Oregon was selected to receive a $1 million contract from CMS for a 12-month planning process to design a new approach to integrate care for dually eligible Medicare and Medicaid enrollees. OHA is preparing a formal implementation proposal, through which CMS may offer additional funding for the Medicare-Medicaid Demonstration. This proposal is due in April 2012. This proposal will closely follow the Capitated Financial Alignment model, in order to take advantage of the new opportunity to pursue three-way contracts between health plans, the state, and CMS for blended Medicare and Medicaid payment to plans. The blended rates, which will be paid to CCOs, will reflect savings for both Medicare and Medicaid. However, as a design contract state, Oregon is not limited to proposing this model, and as such the proposal to CMS may also be an opportunity to pursue other promising models, such as housing with services and a more flexible Program of All-Inclusive Care for the Elderly (PACE) program.

Oregon will work with CMS to negotiate the terms and program structure for the Medicare-Medicaid enrollee population to ensure that its proposal meets Oregon's requirements and CMS standards and conditions for including Medicare funding for Medicare-Medicaid enrollees. After signing an MOU between the state and CMS, CMS will participate in the contracting process as relevant for Medicare funding, likely on a timeline following the state contracting process, leading to the signing of three-way contracts among CMS, the state, and CCOs.

Through the Medicare-Medicaid Demonstration, regular calls and meetings have kept CMS officials abreast of Oregon's progress. Oregon state officials have engaged internal and external stakeholders to gather feedback about the current system and how to most effectively structure the proposed new system. Staff attended focus groups organized by CMS that provided valuable insights into how consumers interact with and view the current system and areas of potential improvements. One of the external stakeholder workgroups established by Governor Kitzhaber to assist in developing the CCO framework focused specifically on integration of care and services for Medicare-Medicaid enrollees. This workgroup included participants from a variety of perspectives, including consumers, medical and LTSS providers, local AAAs, health insurance plans, unions, and advocates. The workgroup met four times to address:

- What is working and what needs to improve in the delivery of coordinated, integrated services for dually eligible individuals;
- Development of metrics that reflect the needs of this population;
- Strategies for structuring care coordination and transitions of care; and
- Strategies for shared accountability with long-term care

Staff also conducted listening groups with Medicare-Medicaid enrollees and participated in workgroups with state leadership and subject matter experts to analyze policy options and ensure that the needs of individuals who are dually eligible are addressed throughout Oregon's health system transformation effort.

VI. Certification of CCOs

Throughout the stakeholder process, OHPB received recommendations about the key certification requirements for CCOs. In March 2012, OHA will begin a non-competitive request for applications (RFA) procurement process that specifies the criteria that organizations must meet to be certified as a CCO (*See Appendix A, CCO Application Timelines*). Prospective CCOs will be asked to submit applications to OHA describing their capacity and plans for meeting the requirements established by HB 3650 and its successor laws, including being prepared to enroll all eligible persons within each CCO's proposed service area. Contracts with certified CCOs will be for multi-year periods, with annual renewal based on CCO compliance with OHA requirements; this is similar to Medicare Advantage contract renewals. Certification will be for six-year periods; CCOs will retain their certification between certification periods as long as they are in compliance with OHA requirements, and in the future, with Division of Insurance requirements. Recertification will include public process to be established in rule by OHA.

In mid spring 2012, OHA will promulgate administrative rules describing the CCO application process and criteria. Once the criteria have been finalized, the state will initiate the application process for prospective CCOs in March 2012. It is expected that CMS will provide guidance to OHA in its evaluation of applications and certification of CCOs in order to be certified to take Medicare risk.

Because CCOs will be responsible for integrating and coordinating care for Medicare-Medicaid enrollees, the application will build on the existing CMS Medicare Advantage application process, streamlining the process for any plans that have previously submitted Medicare Advantage applications. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas. Evaluation of CCO applications will account for the evolutionary nature of the CCO system. CCOs, OHA, and partner organizations will need time to develop capacity, relationships, systems, community needs assessments, and the experience necessary to fully comply with HB 3650.

VII. Design Elements of CCOs

In a final report in January 2012, OHPB made the following recommendations for the key design elements of the CCOs. *(See Appendix A, CCO Application Timelines)*

a. Global budget

CCO global budgets are designed to cover the broadest range of funded services for the most beneficiaries possible. The construction of global budgets start with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets will include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services, achieve economies of scale and scope and to contain per capita costs to a sustainable fixed rate of growth. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

Medicaid Populations Included in Global Budget Calculations. With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. An overview of the eligible CCO populations and their current managed care enrollment can be found in *Appendix D, CCO populations and schedule for inclusion in global budget*. Approximately, 78 percent of people who are eligible for Medicaid are enrolled in a capitated physical health plan, 88 percent in a mental health organization, and 90 percent in a dental care organization.[6] HB 3650 directs OHA to enroll as many of the remaining eligible individuals (including those who are currently in fee-for-service Medicaid) into a CCO as possible. Section 28 of HB 3650 specifically exempts American Indians, Alaska Natives and related groups from mandatory enrollment in CCOs.

Medicaid Service/Program Included in Global Budgets. One of the primary goals of the global budget concept is to allow CCOs flexibility to invest in care that may decrease costs and achieve better outcomes. The more programs, services and funding streams that are included in CCO global budgets, the more flexibility and room for innovation exist for CCOs to provide comprehensive, person-centered care. In addition, leaving necessary care outside of the global budget creates conflicting incentives where the action of payers outside of the CCO, who have little reason to contribute to CCO efficiencies, may have an undue effect on costs and outcomes within the CCO.

The inclusion of Medicaid services in CCO global budgets will be phased in to balance accountability, incentives, and enrollee care concerns. *Appendix M, Inventory of Medicaid services and timeline for inclusion in global budget*, provides an inventory of Medicaid funded services and the current plan for inclusion of those services in CCO global budgets.

Without exception, funding and responsibility for all current services provided by managed physical and mental health organizations will be included in each CCO's global budget. The services that are currently included in capitationunder physical and mental health organizations account for approximately 70 percent of Oregon's non-long-term care Medicaid expenditures.

Currently, five percent of Oregon's non-long-term care Medicaid expenditures are associated with payments for dental care through DCOs. Dental expenditures will be included in global budgets based on individual CCO determination, as HB 3650 allows until July 1, 2014 to incorporate these services.

With respect to the remaining non-long-term care Medicaid expenditures, *Appendix D* provides the schedule for inclusion in the global budget. Careful consideration needs to be given to when and how these services are folded in. CCOs are strongly encouraged to develop strategic partnerships within their communities in order to successfully manage comprehensive global budgets. While these partnerships are developing we do not want to fold in services that may reduce the quality or access of current high need or targeted services. Over time, the OHPB feels strongly that all exclusions need to be addressed to ensure a robust CCO global budget structure.

[6] Citizen Alien Waived Emergent Medical (CAWEM) beneficiaries and individuals who are partially dual eligible for Medicaid and Medicare—including qualified Medicare beneficiaries (QMB) and specified low-Income Medicare beneficiaries (SLMB)—are not included in this calculation.

Components of the Global Budgets. The overall global budget strategy will hold CCOs accountable for costs but not enrollment growth. This strategy suggests an overall budgeting process that builds on the current capitation rate methodology, but includes a broader array of Medicaid services and/or programs. After establishing the baseline global budget, the State proposes to contain CCO global budgets to a sustainable, fixed rate of per capita cost growth and would like to work with CMS to develop that methodology.

Major components of the CCO global budgets include:

A capitated portion that includes the per-member per-month payments for services currently provided through the OHP physical health plans, mental health organizations and (if included) dental care organizations.

At least initially, the capitated portion of CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011–13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the communities the CCOs serve. Under this approach, potential CCOs will submit a completed base cost template using internal cost data that is representative of a minimum base population. This will not be a competitive bidding process, but OHA actuaries will review the submission for completeness and soundness in order to establish a base rate. Once a base rate is established, the state actuaries will use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

CCO optional services that can be included in individual CCO global budgets if all integral community partners support the inclusion. These services include residential alcohol and drug treatment services, OHP dental coverage, and selected targeted case management programs that are offered in only one or a few counties. HB 3650 specifies that the first two are optional for inclusion until July 1, 2013 and July 1, 2014 respectively. We anticipate that they could be paid on a per member per month basis. The reimbursement methodology for the selected targeted case management programs is under development as local matching funds serve as the state Medicaid match. *Appendix D* provides a timeline for statewide inclusion of these and any remaining Medicaid funded services not listed here. In the interim, Medicaid services not included in the global budget initially will continue to be reimbursed as they are currently.

CCO transformation incentive payments that will be outside of the capitated portion to provide 1) infrastructure for metric reporting and delivery system transformation efforts in year 1 of the global budgets, and 2) incentive for continual transformation and improvement through meeting both cost and health outcomes metrics.

Additionally, CCO global budgets will include Medicare funding to blend with Medicaid funding to provide care and services to individuals eligible for both programs. Discussion of this methodology is addressed in the State's proposal for the Medicare-Medicaid Demonstration.

Finally, Oregon would like to explore with CMS the implications of phasing non-emergency medical transportation (NEMT) into the CCO global budgets during the first contract year. Oregon operates this program under a 1915(b) waiver.

b. Accountability

CCOs will be accountable for outcomes associated with better health and more sustainable costs. HB 3650 directed that CCOs be held accountable for their performance through public reporting of metrics and contractual quality measures. These strategies function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in accordance with HB 3650. Accountability measures and performance expectations for CCOs will be phased in to allow CCOs time to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards. An external stakeholder group established as part of Oregon's health system transformation developed a set of measurement recommendations for OHA to use as a guide. SB 1580 creates a nine-member Metrics and Scoring Committee within OHA, to be appointed by the Director. This group is directed to identify "objective outcome and quality measures including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations." It further requires that quality measures adopted by the committee must be consistent with existing state and national quality measures.[7]

i. Quality Measurement

OHA has distinguished CCO accountability metrics (including both core and transformational measures as described below) from measures and reporting requirements designed to promote CCO transparency and community engagement and to enable state and federal monitoring and evaluation of CCO structure and operations.

As defined by the OHPB and its Quality, Outcomes, and Efficiency workgroup, there are two types of CCO accountability measures:

- *Core Measures*: Triple-Aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes in the selected domains.
- *Transformational Measures*: Measures that assess CCO's progress toward the broad goals of health systems transformation, which may require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

To conduct this measurement, it will be important for reports and data to flow from CCOs to OHA and from OHA to CCOs. While annual reporting will serve as the basis for holding CCOs accountable to contractual

[7] http://www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.en.pdf

expectations, OHA will assess performance more frequently (e.g., quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

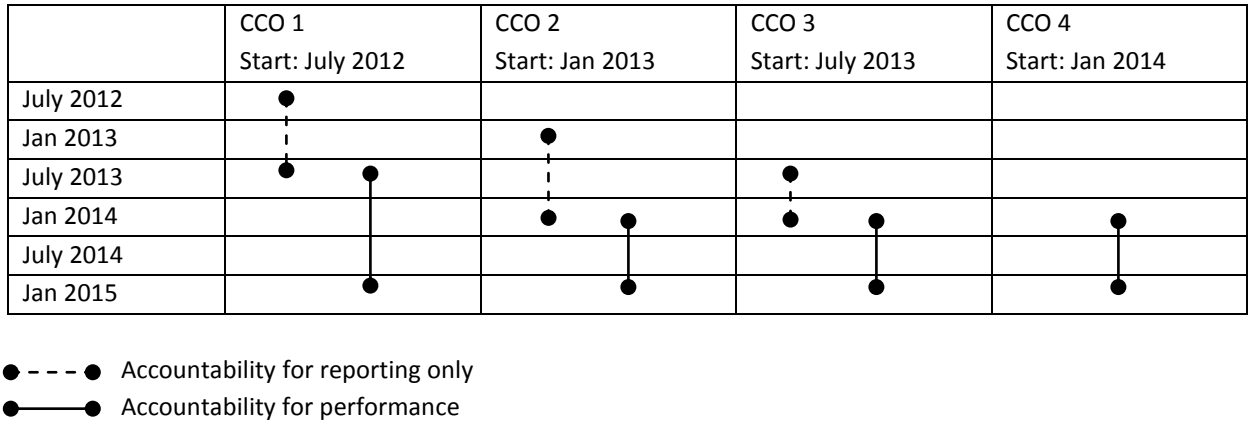
Initial core and transformational measures are shown in *Appendix F*, and, where applicable, alignment with national quality measure sets is also exhibited.[8] Many of the measures proposed for CCO accountability are the same as or closely aligned with items used in federal measurement initiatives including Medicaid Adult and CHIPRA core sets, Medicare Advantage reporting requirements, and Medicare's Shared Savings (ACO) and Hospital Value-based Purchasing programs. *Appendix G* exhibits both proposed core measures and transformational measures. In addition, Oregon will collect and report other measures, also shown in *Appendix G*, to satisfy federal reporting requirements and to provide communities with information about the performance of their CCO(s). Oregon will continue to work with CMS as part of the Medicare-Medicaid Demonstration to identify performance measures to promote joint accountability between CCOs and the long-term services and supports system (LTSS).

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. *(See Figure 1 below).* In year 1, CCO accountability will be for reporting only. In years 2 and 3, CCOs will be accountable for meeting minimum standards on core measures and improving on their past performance for transformational measures. OHA plans to offer incentives to reinforce these reporting and performance expectations, with the specific incentive design to be determined.

Initially, these accountability years will be based on the effective date of each CCO's contract; that is, year 1 for a CCO that starts operation in July 2012 will be July 2012-June 2013, and year 1 for a CCO that starts operation in November 2012 will be November 2012-October 2013. However, all CCOs will be required to meet minimum accountability standards by January 2014, regardless of their start date. CCOs that begin operation less than a year before that date will have a shorter reporting-only period and CCOs that start on or after January 2014 will have no phase-in period at all, as depicted in Figure 1 below.

[8]Appendix F represents measures currently under consideration, not a final list. The next stage of metrics development will be for OHA to establish a technical advisory group of internal and external experts (including consumers) to build measure specifications, including data sources, and to finalize a reporting schedule. Development of joint CCO-LTSS accountability measures will also be part of this task. Further technical work, such as establishing benchmarks based on initial data, will follow.

Figure1: Phasing in of CCO Accountability Measures



CCO accountability metrics will evolve over time based on ongoing evaluation of the metrics' appropriateness and effectiveness. OHA's Metrics and Scoring Committee will establish an annual review and revision process that draws on the expertise of the technical workgroup described above and that ensures participation from representatives of CCOs and other stakeholders, including consumers and community partners. To guide its annual review, OHA and the Committee will utilize the OHPB's Quality, Outcomes, and Efficiency workgroup principles for measure selection and revision along with national frameworks like the Institute of Medicine's stepwise approach to "measuring what matters."[9]

ii. Quality Assurance and Performance Improvement (QAPI)

CCOs will be required to maintain QAPI plans, as managed care organizations do today, including requirements for utilization guidelines and review, member protections, quality and access reporting, and fraud and abuse protections. In keeping with Oregon's goals for health system transformation and the proposed structural and operational criteria for CCOs, the following are likely focus areas for quality assurance and performance improvement (QAPI) at the state and CCO levels:

- *Person-(or patient) Centered Care* -- Patient engagement and activation including shared decision making; involvement of patients in developing a plan of care and planning for care transitions; and mechanisms for engaging patients outside the health care setting and improving self-management skills, including planning for end-of-life care.
- *Governance and Partnerships* – Collaboration with safety net providers, dental care organizations and residential chemical dependency service providers (if not incorporated into CCO initially), local public and mental health authorities, the long-term care system, and other systems or agencies like the Governor's Early Learning Council; and involvement of consumers (or beneficiaries) in CCO governance.

[9] Institute of Medicine. (April 2011). Child and Adolescent Health and Health Care Quality: Measuring What Matters. Available at: http://www.iom.edu/Reports/2011/Child-and-Adolescent-Health-and-Health-Care-Quality/Report-Brief.aspx

- *Care Coordination and Integration* – Use of OHA-recognized patient-centered primary care homes (PCPCHs); timely communication between PCPCHs and other services; providers using electronic health information technology where available; real or virtual co-location of services; use of alterative payment methodologies to encourage coordination and integration of care; and coordination of care for individuals receiving Medicaid-funded long term care services given the legislative exclusion of Medicaid funded long-term services from CCO global budgets.
- *Capacity and Access* – Adequacy of provider network in relation to member needs and choice of providers; use of non-traditional health workers and availability of care in non-traditional settings; timely and appropriate access to hospital and specialty services; and use of population health management tools and strategies.
- *Reduction of Health Disparities* – Development of a needs assessment process to identify community needs, and health disparities; prioritization of health disparities for reduction in the community action plan; use of best practices and provision of culturally and linguistically appropriate care; and maintenance of data on member race, ethnicity, and primary language in accordance with state standards.

The focus areas above reflect many service expectations for CCOs that cannot be tracked using traditional medical coding systems. The state's QAPI activities and QAPI requirements for CCOs will allow for strong oversight of these services without imposing new and potentially burdensome reporting mechanisms that run counter to the CCO model and the intent of transformation. Oregon will work with CMS to develop a process to identify QAPI focus areas that include Medicare quality improvement priorities for dual eligibles.

The CCO accountability measures described above and related incentives will be core elements of the state's Quality Strategy. The measures will allow OHA to set clear expectations for care delivery and health systems transformation and to monitor CCOs' performance against those expectations. The state will work with independent entities (QIO/EQRO) to review CCO performance. While Oregon plans to utilize the QIO/EQRO for audits, the state will retain the responsibility to monitor CCOs as they come into compliance after findings are presented and as they maintain compliance. OHA will institute a system of progressive accountability that maximizes the opportunity to succeed but also protects the public interest.

Technical assistance for performance improvement will be the primary strategy in the first year of CCOs' operation, when their accountability will be for reporting only. Informal interim reporting (quarterly or semi-annually) will facilitate timely feedback and allow for mid-course corrections such that CCOs will be prepared to meet specified quality standards in year 2, whether those standards are absolute benchmarks or expected improvement on past performance. When the evidence indicates that a CCO is not meeting performance standards, steps taken will build on current accountability mechanisms for Medicaid MCOs and Medicare Advantage plans, and may include:

- Technical assistance;
- Increased frequency of monitoring efforts;
- Corrective action plan;

- Restricting enrollment;
- Financial penalties; and
- Non-renewal of contracts.

These consequences would phase in over time if sub-standard performance continues. For CCOs that perform well on accountability metrics and meet other contractual expectations, OHA may choose to offer a simplified, streamlined recertification or contracting process in addition to the possibility of financial performance incentives.

c. Application process

Beginning in March 2012, prospective CCOs will respond to a non-competitive RFA. The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements to the extent that these are known at that time. The RFA will be open to all communities in Oregon and will not be limited to certain geographic areas. OHA is required to contract with all certified CCOs. (*See Appendix A, CCO Application Timelines*)

d. Governance

CCOs will be required to have a governing board with a majority interest consisting of representation by entities that share financial risk as well as representation from the major components of the health care delivery system. In addition, the governance structure must include at least two health care providers in active practice, at least one whose practice is primary care; and a mental health or chemical dependency treatment provider. At least two members must be from the community at large. CCOs will also convene community advisory councils to provide a community perspective and a member of the council will serve on the CCO governing board.

e. Criteria

In their applications for certification, CCOs will demonstrate how they intend to carry out the functions outlined in HB 3650 and SB 1580, including:

Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;

- Ensuring member rights and responsibilities within the context of patient-centered care with the member as part of the primary care team;
- Addressing health disparities among member populations and communities, both to improve outcomes and the health of the community, and as an investment in containing costs;
- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency through reporting of quality data; and

- Complying with financial reporting requirements and assuring financial solvency.

(*For detailed criteria, go to: health.oregon.gov for a draft copy of the Request for Applications*)

VIII. Federal Authority Requests

With this waiver amendment, Oregon requests that its existing Medicaid waiver authority remain in place, both to waive certain provisions of the Social Security Act and to maintain authority for Costs Not Otherwise Matchable (CNOM). Oregon is also requesting additional waiver authority, new requests for CNOM as outlined below.

a. Waiver Authority

As detailed in the attached matrix, *Appendix I, Federal Authority to Implement Coordinated Care Organizations (CCOs) and Transform Managed Care Organizations (MCOs) in Oregon*, there are several changes that will occur to the OHP based on this amendment, but the state believes that its existing authority already allows for many of the proposed changes to the OHP. The state does anticipate significant changes to its Special Terms and Conditions to reflect the proposed programmatic changes. In addition, as described in *Appendices H and I*, the state will also be requesting state plan amendments to implement some features of the transformation, including the ability to use a non-traditional workforce.
Specifically, Oregon's current waiver includes authority that the state wishes to maintain. This authority allows the state to:

- Contract with managed care entities and insurers;
- Mandatorily enroll and auto-enroll individuals within managed care, and lock-in enrollment;
- Define types of insurers;
- Offer Federally Qualified Health Centers (FQHCs) and Rural Health Clinic (RHC) services only where available through managed care providers;
- Use Oregon's Prioritized List of Health Services;
- Provide different benefits to different eligible populations; and,
- Contract for comprehensive services on a prepaid or other risk basis.

In addition to Oregon's existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow for:

Issue	CFR/SSA Reference
• Flexibility to make payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement • Alternative provider payment methodologies to reimburse on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care, and comprehensive care coordination • Flexibility to create PMPM payments to support Patient Centered Primary	42 CFR § 438.6

Issue	CFR/SSA Reference
Care Homes for the remaining FFS Medicaid/SCHIP populations that do not meet the ACA sec. 2703 multiple chronic condition requirements. *(Oregon has submitted a SPA for the ACA Sec. 2703 population)* • Latitude to set rates inclusive of non-encounterable medical services (1902(a)(30)) • Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community • Latitude to set a sustainable fixed rate of per capita cost growth within CCO global budgets • Flexibility in design, implementation and scoring of performance improvement plans (PIPS) to align with Medicare processes	
• An alternative payment methodology for FQHCs to allow a unique FQHC prospective payment system (PPS)/alternative payment methodology (APM)	SSA § 1902(bb)
• Expansion of definition of "health care professional" expansion to include naturopathic physicians and other state-licensed providers	42 CFR § 438.2
• Flexibility for the state to optimize the use of electronic communications to OHP members where written materials are required, at member's request, as well as contractors and providers	42 CFR § 422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230; 42 CFR § 438.6, 10. 56. 100,102, 104, 210, 224, 228, 400-424, 702, 706, 708, 722; 42 CFR § 455.1;42 CFR § 489
• Flexibility in marketing requirements for CCOs that serve Medicaid and Medicare, and commercial populations	42 CFR § 438.104
• Ability to streamline and simplify due process rights to reflect person-centered primary care and to align Medicaid and Medicare consumer protection processes to the greatest extent possible (1902(a)(3))	42 CFR § 438.400-424 42 CFR § 431.244
• Ability to fold non-emergency medical transportation into global budget in first contract year	42 CFR § 431.53

b. Expenditure Authority

Designated State Health Programs (DSHP). In addition to the additional waiver authorities outlined above, Oregon is requesting an amendment to our OHP 1115 Demonstration to authorize federal financial participation (FFP) for selected state designated health programs (DSHP). These programs would be

authorized by Section 1115(a) cost not otherwise matchable authority (CNOM). Our target request is approximately $450 million per year (which represents approximately $750 million (FFP) in approved DSHP programs.

A list of identified programs is included as *Appendix E, State Fund Only Program List*. These programs are vital for the success of health system transformation, spanning mental health, public health, community services, and child health services. Currently, state funds support these services and programs to meet health needs that Medicaid, as it is currently structured, does not. Many of the Oregonians served by these dollars receive services along side of people who are Medicaid eligible, and many of them are individuals who churn in and out of Medicaid eligibility, creating a confusing and inefficient system for consumers and communities to navigate. We ask for federal investment in these programs in recognition that they are vital to improving the health of Medicaid enrollees and the communities in which they live.

The additional expenditures outlined in *Appendix E* will serve as a down payment on health reform in Oregon that will yield results in support of the triple aim. Oregon's request to CMS is patterned after similar approved requests in other states (e.g., California, New York and Massachusetts), and Oregon hopes to be given the same opportunity. The state anticipates that this additional federal investment can be ramped down as we approach implementation of federal reform in 2014 and begin to realize the additional savings from health system transformation. CMS approval of this request will allow Oregon to move forward with our mutual reform goals without eroding services that are vital for transformation.

Finally, the State would also like to explore with CMS the mechanism for using county Intergovernmental Transfers (IGT).

Additional FFP for Oregon's Home and Community Based Services (HCBS) programs. Oregon would also like to pursue a request for an additional 6 percentage points FFP for our current HCBS waiver, increasing the opportunity to connect long term care and services to Oregon's health system transformation. Oregon has long been a leader in placing eligible beneficiaries in community-based settings and is therefore not eligible for the CMS rebalancing incentives. While long term care is not part of the global budget that will be paid to Coordinated Care Organizations, Oregon is pursuing the same management strategies that would exist if long term care was included. Oregon is partnering and establishing strong accountability expectations between the acute and long term care systems. This strategy is comprehensive and is presented with specifics in Oregon's Dual Design proposal.

Currently, Oregon is serving a remarkably low 16.2% of its aged and physically disabled long term care population in nursing facilities. Zero percent of our developmental disability population is served in institutions. While this is outstanding from a cost/ independence factor, it does make care coordination more challenging as care coordination is easier when residents are served in large institutional settings. Approval of this request will facilitate additional investment towards ensuring Oregon's initiatives are successful.

Specifically, we are requesting:

1) An additional 6 percent FF for the aged and physically disabled waiver.
2) An additional 6 percent FF for the DD comprehensive services waiver.
3) An additional 6 percent in FF for the DD support services waiver.
4) An additional 6 percent in FF for the DD children's model waivers.

IX. Budget Neutrality

Oregon understands that the state must demonstrate budget neutrality for the Oregon Health Plan (OHP) Demonstration. Budget neutrality means that Oregon may not receive more federal dollars under the Demonstration than it would have received without it. The state is requesting amendment to its Section 1115 Demonstration in order to implement Oregon's health system transformation (HST) initiative. This document discusses the budget neutrality tests for the Section 1115 Demonstration.

The Section 1115 budget neutrality test performed for this Demonstration amendment will build upon the methodology that was adopted for the OHP Demonstration approvals that were originally granted in 1993 and most recently extended in 2010.

When submitting a combined Section 1115, states are required to include an initial showing that the Demonstration is expected to be budget neutral. This is the state's best estimate of cost and caseload at the time it submits its request. The test for budget neutrality will be applied according to the terms and conditions for the Demonstration that have been agreed to by the state and CMS, and will be measured periodically throughout the course of the Demonstration approval period and will finally be measured at the conclusion of the Demonstration.

This section is organized into three parts:

- Oregon's management tools to manage budget neutrality;
- The components of the budget neutrality test; and,
- Oregon's cost and caseload estimates, the key assumptions that underlie those estimates.

Additional details of the cost and caseload estimates are reflected in a series of exhibits.

a. Budget Neutrality Management Tools

While the design of the Demonstration must satisfy the requirements for federal budget neutrality in order to be approved by CMS, it must also satisfy the requirements for state budget neutrality in order to be implemented by Oregon.

In order to provide for administrative efficiency and management flexibility, the Demonstration is designed so that the state may invoke any of the budget neutrality management strategies, with appropriate notice to CMS. Oregon requests continuation of this flexibility which has included two primary management tools:

- The adjustable enrollment cap used to limit the size of the OHP Standard and FHIAP Demonstration populations, and is established based on funding availability and/or budget neutrality capacity.
- An adjustable benefit level through moving the coverage line further up or down the Oregon Prioritized List of Health Care Services for both OHP Standard and OHP Plus populations, subject to Legislative direction and CMS approval. Additionally the state has the flexibility to add or remove services that are not part of the fixed set of OHP Standard services, depending on available state funds.

In addition to these two very important budget management tools, the state is working toward the implementation of global budgets that will provide certainty in funding over time for both the state and Coordinated Care Organizations. Please see "Global Budget" p. 10 for discussion of the global budget methodology.

b. Components of the Budget Neutrality Test

Oregon requests that the current Section 1115 Demonstration methodology be used for the purpose of evaluating budget neutrality for the five year HST extension period. This methodology uses a set of specified annual per capita costs multiplied by the actual or allowed enrollment for each year of the five year Demonstration. The result of this calculation is an aggregate allowable expenditure level. *Appendices J, K and L* contain all budget neutrality calculations.

Oregon proposes to continue use of the CMS approved DY 2010 per capita costs for the various eligibility groups under the current Demonstration extension for determination of the base year allowable costs.

Trending Factors. The base year allowable per capita rates are trended by CMS approved trend rates through Demonstration year (DY) 11 (FFY 2013). The proposed Demonstration extension is based on the Medicaid specific National Health Expenditure projected trend rates of 8.3 percent for DY 12 (FFY 2014), 5.9 percent for DY 13 (FFY 2015), 6.3 percent for DY 14 (FFY 2016), and 6.0 percent for DY 15 (FFY 2017).

With the implementation of health system transformation, Oregon anticipates savings over the five year waiver. These savings, based on recent modeling performed for the state by Health Management Associates (HMA), are incorporated into the budget neutrality calculations through a per member per month adjustment to the projected per capita spending estimates.

Beneficiaries and Services Included. In the implementation of health system transformation, Oregon proposes to include individuals diagnosed with breast and cervical cancer and Citizen/Alien-Waived Emergency Medical (CAWEM) pregnant women. Per capita calculations are included for these populations for both the allowable and actual spending estimates in *Appendices J, K and L*.

The budget neutrality test will be expanded beyond the historical Oregon acute care and behavioral health programs that have been included. *The State Fund Only Program List at Appendix E* outlines the additional services that Oregon expects to be affected under this HST extension period. Budget neutrality calculations provide a per capita adjustment applied equally to the allowable and actual waiver estimates to account for these additional services as a "pass through". Medicaid services and populations (e.g., QMB/SLMB, long-term care) for which the state has no immediate plans to move into CCO global budgets are excluded from budget neutrality calculations.

Historical Savings. Oregon is a demonstrated leader in delivering high quality care and containing spending growth in its Medicaid program. Oregon is requesting to continue use of the historical Demonstration savings (currently estimated at $16 billion total funds). This figure reflects the savings estimates identified by Oregon and CMS through the twenty year life of the OHP Demonstration.

Administrative costs will continue to be reimbursed based on the current federal matching rates of 50 percent, 75 percent and/or 90 percent of the administrative expense and are not subject to the budget neutrality test.

c. Caseload and Cost Estimates

This section describes the caseload and cost estimates for this Demonstration amendment request, as well as additional background information and key assumptions that underlie the estimates.

Demonstration Renewal Time Frame. The State also requests approval of a three-year extension through October 31, 2016. The current Demonstration is scheduled to expire October 31, 2013.

For purposes of budget neutrality, CMS has previously instructed Oregon to use Federal Fiscal Years ending September 30, 2013. This is how budget neutrality is presented for this waiver extension. The proposed flexibility policy options, for purposes of budget neutrality, are projected to begin on July 1, 2012. The cost and caseload estimates are based on these begin and end dates.

Caseload Estimates. All populations are reported as the average number of persons covered for the entire period. These estimates , were prepared by the Office of Forecasting, Research and Analysis, Department of Human Services, with the exception of the FHIAP caseload provided by the Office of Private Health Partnerships and initial estimates of enrollment increases attributable to federal reform in 2014 provided by the Office for Health Policy and Research.

Cost Estimates. Budget neutrality spreadsheets provide the forecast of expenditures for the Title XIX program and present the budget neutrality for the requested Section 1115 demonstration. These spreadsheets provide:

- the budget neutrality summary from the beginning of the OHP demonstration project through this extension request.
- the calculation of Oregon' budget neutrality ceiling using allowable per capita and projected populations; and,
- the state's actual and projected expenditures. At the end of the seventeen-year demonstration, the state is projecting a surplus of $16.3 billion total funds.

Designated State Health Programs. Oregon is requesting approval to use federal savings earned under the OHP demonstration to help launch health system transformation. Oregon proposes to receive Medicaid matching funds on certain state only funded programs to support the implementation of the state's health system transformation. That request of $750 million in federal funds a year for five years is included in

Appendices K and L. CMS can provide Oregon with a "down payment" on health reform that will yield results in support of the CMS triple aim.

X. Evaluation Plan

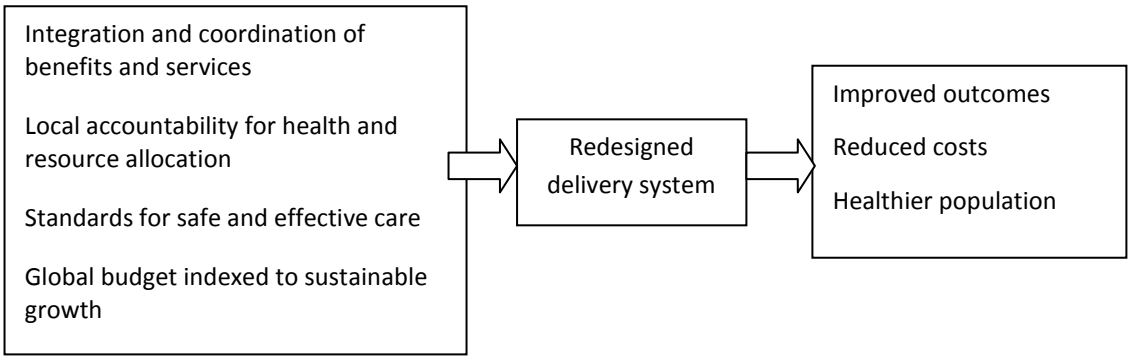
As described within this waiver amendment, Oregon's goal is to create a health care system that emphasizes prevention and integrates financing and care delivery for physical, behavioral, and oral health care services within community-based CCOs. Each community-based CCO will operate within a global budget such that the CCO has flexibility to achieve the greatest possible health within available resources and is held accountable for improved quality and outcomes. Oregon recognizes the importance of closely assessing the performance of the transformed delivery system. Thus, the state will maintain a robust monitoring of system performance and will continue to assure that standards of access, program operation, and quality are met and that standards evolve to match progress in achieving the policy objectives of health system transformation. Many oversight mechanisms used today will continue in the future; the transition from managed physical and mental health care organizations (and dental care organizations, over time) to CCOs probably has greater implications for QAPI focus areas than for methods of oversight.

Oregon is also committed to working with CMS and our local partners on a robust evaluation of the system transformation and its impact on patient experience and safety, improved care outcomes, and costs.

a. Evaluating the Transformation Initiative

While it is closely linked to performance measures and quality improvement, the evaluation component of Oregon's Demonstration will focus on the implementation and impact of Medicaid reform and of health system transformation as a whole. As mentioned throughout this waiver amendment, Oregon's Medicaid transformation initiative is firmly grounded in the Triple Aim of better health, better health care, and lower costs. Accordingly, the state expects that the proposed changes in financing and delivery will lead to improvements in health status and in the quality of care provided to Medicaid and dual eligible beneficiaries and that these improvements, along with greater efficiency and a sustainable growth rate for expenditures, will help bend the cost curve. The state also believes that these reforms can be expanded to commercial insurance through adoption by the PEBB and OEBB programs, which administer health insurance for state employees and for education districts, respectively.

Transformation Elements, System Change, Triple Aim Goals



Using the framework of the Triple Aim to assess the implementation and outcomes of Medicaid transformation suggests overall evaluation questions such as:

- *Better health*: What impact does the transition to CCOs have on health status, health equity, or health behaviors among Medicaid eligibles, including important subsets of members like dual eligibles or children with special healthcare needs? What elements of CCO design or operation are associated with improved health? How does the transition to CCOs impact the health of all communities within the CCO service area?
- *Better care*: What impact does the transition to CCOs have on care integration and coordination, as measured by care processes, utilization, client outcomes, member experience, and costs? What elements of CCO design or operation are associated with improved care integration and coordination?
- *Lower or controlled costs*: What impact does the transition to CCOs have on overall costs, cost growth, distribution of expenditures by service type or payor (Medicaid or Medicare), or costs for unnecessary or inappropriate care? What elements of CCO design or operation are associated with improved cost control (or reduced cost growth) and potential savings? Do savings or efficiencies lead to reinvestment in improved care? Do investments in improved care for Medicaid and dually eligible members improve care or improve health for the community at large?

Oregon will work with CMS and with local partners, including the active health services research community in Oregon that has led the Oregon Health Study, to produce a draft evaluation design in accordance with standard waiver Terms and Conditions within 120 days of the waiver's approval. The state will also collaborate with the Research Triangle Institute (RTI) and the Urban Institute to align the evaluation design with national plans for evaluating state Demonstrations to integrate care for dual eligibles.

b. Evaluation Plan for Medicare-Medicaid Demonstration

In addition to the state's own monitoring and evaluation activities, the Medicare-Medicaid Demonstration requires active participation in a national evaluation conducted by CMS' evaluation contractor. OHA will cooperate with all aspects of CMS' evaluation activities, including submitting required data to the contractor. The state will follow the preferred Medicare-Medicaid alignment process of an integrated quality and performance improvement process for CCOs and request an exemption from existing Medicaid standards for performance improvement projects as negotiated through the MOU and three-way contract process.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

October 29, 2013

Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301-1097

Dear Dr. Goldberg:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your June 18, 2013 request to amend Oregon's section 1115 Oregon Health Plan demonstration (21-W-00013/10 and 11-W-00160/10). Approval of this demonstration amendment is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter through December 31, 2013.

This amendment allows the Oregon Health Authority (OHA) to make supplemental payments to participating Indian Health Service (IHS) facilities including participating tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority: 1) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, provided to individuals who have no Medicare, Medicaid, CHIP or other coverage with incomes up to 133 percent of the Federal Poverty Level (FPL).

CMS shares the state's goal of maintaining the financial viability of IHS and tribal health facilities to ensure the continued availability of their health care service delivery for current and future Medicaid beneficiaries.

This demonstration approval is conditioned upon acceptance and compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs, waiver, and expenditure authorities within 30 days of the date of this letter.

Written acceptance should be sent to your project officer, Ms. Terri Fraser. Ms. Fraser's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mailstop: S2-01-16
7500 Security Boulevard,
Baltimore, MD 21244-1850
Telephone: (410) 786-5573
Email: Terri.Fraser@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Carol Peverly, Associate Regional Administrator in our Seattle Regional Office. Ms. Peverly's contact information is as follows:

Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
2201 Sixth Avenue, MS RX-43
Seattle, WA 98121
Telephone: (206) 615-2515
Email: Carol.Peverly@cms.hhs.gov

If you have questions regarding this correspondence, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647. We look forward to continuing to work with you and your staff on the Oregon Health Plan demonstration.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Carol Peverly, Associate Regional Administrator, Region X

CENTERS FOR MEDICARE & MEDICAID SERVICES AMENDED WAIVER LIST AND EXPENDITURE AUTHORITY

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

All requirements expressed in Medicaid and Children's Health Insurance Program (CHIP) laws, regulations and policies apply to this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Such deviations from Medicaid requirements are limited in scope to expenditures related to the following populations affected by the demonstration:

Populations Affected by OHP

The following title XIX and title XXI state plan populations, and demonstration-only expansion populations are affected by this demonstration and are listed for purposes of references in the waiver list and expenditure authorities.

Title XIX State Plan Populations

Population 1: Medicaid mandatory pregnant women included in the state plan with income from 0 to 133 percent of the federal poverty level (FPL).

Population 2: Medicaid optional pregnant women included in the state plan with income from 133 to 185 percent of the FPL.

Population 3: Medicaid children 0 through 5 included in the state plan with income from 0 up to 133 percent of the FPL and infants (age 0 to 1) born to women receiving Medicaid benefits at the time of birth with incomes to 185 percent of the FPL.

Population 4: Medicaid children ages 6 through 18 included in the state plan with income from 0 up to 100 percent of the FPL, and beginning January 1, 2014, Medicaid children with income from 100 to 133 percent of the FPL.

Population 5: Medicaid mandatory foster care and substitute care children (as defined in the special terms and conditions, also referred to as STCs).

Population 6: Medicaid mandatory AFDC section 1931 low-income families (as defined in the STCs).

Population 7: Medicaid mandatory elderly, blind, and disabled individuals with incomes at the Supplemental Security Income (SSI) level of the FPL (as defined in the STCs).

Population 8: Medicaid optional elderly, blind and disabled individuals with incomes above the SSI level of the FPL (as defined in the STCs).

Population 21: Women under the age of 65 who have been screened and diagnosed through the State's National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast and cervical cancer, and are not otherwise covered under creditable coverage with respect to the needed treatment for breast and cervical cancer.

Demonstration Expansion Populations

On January 1, 2014 expenditure authority for many demonstration expansion populations will end. When the state amends its Medicaid or CHIP state plan to include some or all of these populations after that date, the state will submit an amendment to the demonstration updating the populations that will be affected by the demonstration.

Population 9: Until January 1, 2014, general assistance expansion individuals with income from 0 through 43 percent of the FPL (as defined in the STCs).

Population 10: Until January 1, 2014, expansion parents ages 19 and older with income from 0 to 100 percent of the FPL (as defined in the STCs).

Population 11: Until January 1, 2014, expansion childless adults age 19 and older with income from 0 to 100 percent of the FPL (as defined in the STCs).

Population 14: Until January 1, 2014, participants who would have been eligible for Medicaid but choose Family Health Insurance Assistance Program (FHIAP) instead.

Population 16: Until January 1, 2014, uninsured children ages 0 through 5 with income from 133 through 200 percent of the FPL, and uninsured children ages 6 through 18 with income from 100 up to and including 200 percent of the FPL (as defined in the STCs) who meet the title XXI definition of a targeted low-income child, and who choose voluntary enrollment in premium assistance under FHIAP.

Population 17: Until January 1, 2014, uninsured parents of children who are eligible for Medicaid or CHIP, who are themselves ineligible for Medicaid/Medicare with income from 0 through 200 percent of the FPL enrolled in FHIAP (as defined in the STCs).

Population 18: Until January 1, 2014, uninsured childless adults who are not eligible for Medicaid/Medicare with income from 0 through 200 percent of the FPL enrolled in FHIAP (as defined in the STCs).

Population 20: Uninsured children ages 0 through 18 with income from above 200 through 300 percent of the FPL, who meet the title XXI definition of a targeted low-income child and choose voluntary enrollment in premium assistance under Healthy Kids Employer Sponsored Insurance (ESI).

Population 22: Children ages 0 through 5 with income from 133 to and including 200 percent of the FPL and uninsured children from ages 6 through 18 with income from 100 through 200 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP state plan; title XXI children ages 0 through 18 with income above 200 through 300 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP state plan (under Healthy KidsConnect); and targeted low-income children from conception to birth with income from 0 to 185 percent of the FPL under the CHIP state plan.

Population 12 is no longer applicable (in prior demonstration periods, this population included individuals with incomes from 0 to 170 percent of the FPL who were enrolled in FHIAP as of September 30, 2002), but all such individuals would be otherwise covered in other populations in the current demonstration.

Population 13: is no longer applicable (in prior demonstration periods, this population included, pregnant women with incomes from 170 through 185 percent of the FPL, but has been combined with Population 2, which now covers all pregnant women with incomes from 133 through 185 percent of the FPL, under the title XIX state plan.)

Populations 15 and **19** are no longer applicable (under prior demonstration periods, these were for individuals covered under the title XXI state plan as of November 1, 2007), and are no longer subject to this demonstration.

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project. Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan beginning with the approval of this demonstration renewal and amendment from through June 30, 2017. As specified below, on January 1, 2014 certain waiver authorities will end. When the state amends its Medicaid or CHIP state plan to include some or all of these populations after that date, the state will submit an amendment to the demonstration updating the populations that will be affected by the demonstration.

1. Statewideness/Uniformity **Section 1902(a)(1)**
42 CFR 431.50

To enable the state to provide benefits through contracts with managed care entities that operate only in certain geographical areas of the state. (Applies to all populations listed above except 14, 16, 17, 18, 20 and the portion of population 22 with income from above 200 up to and including 300 percent of the FPL.)

2. Amount, Duration and Scope of Services **Section 1902(a)(10)(A)**
1902(a)(10)(B)
42 CFR 440.230-250

To enable the state to modify the Medicaid benefit package and to offer a different benefit package based on condition and treatments than would otherwise be required under the state plan to mandatory Medicaid populations, and to enable the state to limit the scope of services for optional and expansion populations. (Applies to populations 1 -11, 21 and the direct coverage portion of population 22, with the exception of population 3 for children 0 up to 1 year of age.)

3. Eligibility Standards **Section 1902(a)(17)**
42 CFR 435.100 and
435.602-435.823

Until January 1, 2014, to enable the state to waive income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming restrictions, and to base eligibility on household family unit (rather than individual income). (Applies to populations 1, 2, 3, 4, 9, 10, 11, 14, 17, 18 and 22).

4. Eligibility Procedures **Section 1902(a)(10)(A) and**
1902(a)(34)
42 CFR 435.401 and
435.914

Until January 1, 2014, to enable the state to apply streamlined eligibility rules for individuals. The three month retroactive coverage will not apply, and income eligibility will be based only on gross income. (Applies to populations 1, 2, 3, 4, 9, 10, 11, 14, 17, 18 and 22.)

5. Freedom of Choice **Section 1902(a)(23)(A)**
42 CFR 431.51

To enable the state to restrict freedom-of-choice of provider by offering benefits only through managed care entities (and other insurers) in a manner not authorized by section 1932 of the Social Security Act (the Act) because beneficiaries may not have a choice of managed care entities. This does not authorize restricting freedom of choice of family planning providers. (Applies to all populations listed above.)

6. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) — **Section 1902(a)(10)(A) and 1902(a)(43)(C)**

To allow the state to restrict coverage of services required to treat a condition identified during an EPSDT screening to the extent that the services are beyond the scope of the benefit package available to the individual. The state must arrange for, and make available, all services within the scope of the benefit package available to the individual that are required for treatment of conditions identified as part of an EPSDT screening. (Applies to all populations above.)

7. Disproportionate Share Hospital (DSH) Reimbursements — **Section 1902(a)(13)(A)**

To the extent necessary to allow the state to not pay disproportionate share hospitals payments when hospital services are furnished to managed care enrollees. (Applies to populations 1-11, 13, 21 and for population 22, applies only to those in OHP direct services.)

8. Prepaid Ambulatory Health Plan Enrollment — **Section 1902(a)(4) as implemented in 42 CFR 438.56(c)**

To enable managed care entities to permit enrollees a period of only 30 days after enrollment to disenroll without cause, instead of 90 days. (Applies to all populations 1-11, 21 and the direct service population of 22.)

9. Reasonable Promptness — **Section 1902(a)(8) 42 CFR 435.906, 435.911, 435.914, and 435.930(a)**

Until January 1, 2014, to permit the state to implement a reservation list as a tool to manage enrollment in OHP-Standard and FHIAP. (Applies to populations 10, 11, 14, 17, and 18.)

10. Premiums — **Section 1902(a)(14) insofar as it incorporates 1916 and 1916(A)**

To enable Oregon to impose premiums and cost sharing in excess of statutory limits on demonstration eligible individuals enrolled in the FHIAP and Healthy Kids ESI programs through December 31, 2013.

Title XXI Waiver Authority

All requirements of the CHIP expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project. Under the authority of section 1115(a)(1) of the Act, the following waivers of the CHIP state plan requirements contained in title XXI of the Act are granted in order to enable Oregon to carry out OHP beginning with the approval of this demonstration renewal and amendment from through June 30, 2017. The following waivers apply to title XXI demonstration Populations 16, 20 and 22.

1. Benefit Package Requirements **Section 2103**

To permit the state to offer a benefit package for demonstration populations 16, 20 and 22 that does not meet the requirements of section 2103 of the Act, as defined in federal regulations at 42 CFR 457.410(b), but instead equals the private or ESI plan coverage that the beneficiary has elected.

<u>Title XXI - Costs Not Otherwise Matchable (CNOM)</u>

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A) of the Act, state expenditures for the provision and administration of child health assistance to the demonstration populations described below (which would not otherwise be included as matchable expenditures under title XXI), shall for the period of this project and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's title XXI state plan. All requirements of the title XXI statute will be applicable to such expenditures, except as specified below as not applicable to these expenditure authorities.

a. **Population 16:** Until January 1, 2014, uninsured children ages 0 through 5 with incomes from 133 up to and including 200 percent of the FPL, and uninsured children ages 6 through 18 with incomes from 100 up to and including 200 percent of the FPL (as defined in the STCs) who meet the title XXI definition of a targeted low-income child, and who choose voluntary enrollment in premium assistance under FHIAP.

b. **Population 20:** Until January 1, 2014, uninsured children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL; and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI.

CHIP Requirements Not Applicable to the CHIP Expenditure Authorities:

1. Cost Sharing **Section 2103(e)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to demonstration populations 16 and 20 to the extent necessary to enable the state to subject beneficiaries to the cost sharing required under the private or ESI plan coverage that the individual has elected.

Title XIX - Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) the Act, expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX state plan.

1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in an MCO.

2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.

3. Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.

4. Expenditures for costs for certain mandatory and optional Medicaid eligibles who have elected to receive coverage through a private or ESI plan. Such enrollment in a plan that offers a limited array of services or in a private or employer-sponsored plan is voluntary and the family may elect to switch, if eligible, to direct state coverage at any time, and families will be fully informed of the implications of choosing FHIAP rather than direct state coverage. (Applies to population 14.)

5. Until January 1, 2014, Expenditures for health care-related costs for demonstration Populations 9, 10, 11, 14, 17, and 18.

6. Designated State Health Programs (DSHP). Subject to the conditions outlined in paragraph 54 and as described in section IX, a limited amount of expenditures for approved designated state health programs (DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. This expenditure authority will not be renewed or extended after June 30, 2017.

7. **Uncompensated Care for Tribal Health Facility Program:** Expenditures for supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority: 1) for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2)for uncompensated care costs resulting from primary care services on the prioritized list that are provided to individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who have no Medicare, Medicaid, CHIP or other coverage.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan

AWARDEE: Oregon Health Authority

I. PREFACE

The following are the special terms and conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115 (a) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to these STCs are the Oregon Health Authority (formerly Oregon Department of Human Services) (state) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These amended STCs are effective July 1, 2012, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. The amended STCs are effective July 1, 2012, through June 30, 2017, unless otherwise specified.

The STCs have been arranged into the following areas:

I. Preface
II. Program Description, Objectives, Historical Context;
III. General Program Requirements;
IV. The Oregon Health Plan;
V. Delivery System Transformation;
VI. Capitation Rates and Performance Measures;
VII. Measurement of Quality of Care and Access to Care;
VIII. Calculating the Impact of Health Systems Transformation and Reductions in Designated State Health Program Funding;
IX. Designated State Health Programs;
X. Tribal Health Program for Uncompensated Care;
XI. General Reporting Requirements;
XII. General Financial Requirements for Title XIX;
XIII. General Financial Requirements for Title XXI;
XIV. Monitoring Budget Neutrality for the demonstration;
XV. Evaluation of the demonstration; and
XVI. Additional attachments have been included to provide supplementary information and guidance for specific STCs.
1. Attachment A: Quarterly Report Guidelines
2. Attachment B: Evaluation Guidelines

3. Attachment C: Glossary of Terms
4. Attachment D: Summary Chart of demonstration Populations
5. Attachment E: Menu Set of Quality Improvement in Focus Areas
6. Attachment F: CCO Services Inventory
7. Attachment G: DSHP Claiming and Documentation Protocols
8. Attachment H: Calculating the Impact of Health Systems Transformation
9. Attachment I: Tribal Health Program for Uncompensated Care Claiming Protocol

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan (OHP) is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. OHP began in phases on February 1994. Phase I of the Medicaid demonstration Project started on February 1, 1994. Originally, the demonstration affected Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II added the aged, blind, disabled, and children in state custody/foster-care. Following the creation of title XXI of the Act by Congress in 1997, Oregon's Children's Health Insurance Program (CHIP) was incorporated into the OHP. From its inception, Oregon's CHIP provided eligibles with the same benefit package available to all OHP-Medicaid clients.

Objectives

Under the demonstration, Oregon strives to promote the objectives of title XIX and title XXI by:

- Providing health care coverage for uninsured Oregonians;
- Providing a basic benefit package;
- Insuring broad participation by health care providers;
- Decreasing cost-shifting and charity care;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Making Medicaid available to people living in poverty regardless of age, disability or family status;
- Structuring benefits (what is covered), using a prioritized list of health care conditions and treatments.
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing the per capita costs of care for populations through such improvements.

Historical Context: Demonstration Extensions and Amendments

1994 Initial Demonstration Approval

CMS initially approved the Oregon Health Plan (OHP) section 1115 demonstration for a five-year period beginning February 1, 1994. Oregon sought to expand eligibility and manage costs by using managed care and a Prioritized List of Health Services. This list is updated every 2 (two) years, whereby services are added, deleted, or moved to a different ranking within the list.

1998 Demonstration Extension

The OHP was extended by CMS for a 3 (three) year period through 2001.

2002 Demonstration Extension and Amendment

CMS approved Oregon's application to extend and amend OHP to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration for 5 (five) years through 2007. With this approval, Oregon was able to expand the demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

2005 Demonstration Amendment

CMS approved a demonstration amendment that changed coverage under the demonstration which placed a new emphasis on preventive care and chronic disease management in the recognition that the utilization of these services can lead to a reduction in more expensive and often less effective treatments provided in the crises stages of a disease.

2007 Demonstration Extension

CMS revised the structure of the populations within the demonstrations to reflect updated law and CMS policy. Uninsured adults not eligible for Medicaid or CHIP were removed from the title XXI expansion populations and moved into title XIX expansion populations. In addition, title XXI targeted low-income children (TLIC) in Oregon from ages 0 through 5 years with incomes from 133 percent to 185 percent of the FPL and ages 6 through 18 with incomes from 100 percent up to 185 percent of FPL, were made eligible under the CHIP state plan regardless of whether the child opts for CHIP direct state plan coverage (OHP Plus) or premium assistance (Family Health Insurance Assistance Program/FHIAP). In addition, it was clarified that mandatory pregnant women and children 0 to 1 year of age receive full Medicaid state plan benefits, subject to necessary pre-authorizations.

2009 Demonstration Extension and Amendment

CMS approved an amendment to the demonstration that restructured and expanded coverage for children through the "Healthy Kids," initiative. Healthy Kids provides coverage through its various components for otherwise uninsured children through age 18 in the state with family incomes from 0 up to and including 300 percent of FPL. The state also provides access to coverage for children above 300 percent of FPL, but does not receive FFP for this population. Healthy Kids includes four different program components: 1) Existing CHIP direct coverage (OHP Plus), 2) premium assistance through FHIAP, 3) Child-only premium assistance administered by the Office of Private Health Partnerships (Healthy Kids ESI), and 4) A private insurance component (Healthy KidsConnect). Through Healthy Kids, children from 0 up to and including 200 percent of the FPL have the choice between title XXI CHIP direct coverage, premium assistance through FHIAP, or Healthy Kids ESI. Children from above 200 up to and

including 300 percent of the FPL have the choice between Healthy Kids ESI or coverage under Healthy KidsConnect.

In addition, the last CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed the methodology for use of a 'reservation list" to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance program; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

2012 Demonstration Amendment

As reflected in these STCs, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and a reduction of other benefits (reflected in 13 lines of the Prioritized List of Health Services for FFY12-13). This amendment is effective January 1, 2012.

2012 Demonstration Extension and Amendment

In July 2012, CMS approved an amendment and extension related to Oregon's Health System Transformation

The amendment and extension of OHP seeks to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve a three-part aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The design and implementation of the Oregon demonstration will be driven locally; overall, the amended 1115 demonstration seeks to achieve two equally important and inter-related goals:

- **Goal 1: Medicaid Statewide Spending Growth Reduction.** The demonstration will bend the Medicaid cost curve to achieve a 2 percentage point reduction in Medicaid per capita trend by year 13 of the demonstration. Progress toward and ultimate achievement of this goal will be measured by reviewing the state and federal cost of purchasing care for individuals enrolled in Coordinated Care Organizations (CCOs).

- **Goal 2: Improving Statewide Care Quality and Access.** Oregon Medicaid beneficiaries will experience improved access to care and quality of care over the five-year program period of July 2012 – June 2017, compared to a baseline level of performance.

The demonstration authorizes expenditures on certain Designated State Health Programs (DSHP), and in order to align incentives and support progress, if demonstration goals are not

realized after interventions have been pursued to reorient progress, CMS will reduce DSHP funding as described in Section VIII.

Oregon seeks to achieve these goals without any diminution of eligibility or benefits. Instead, the state will pursue several different approaches, or "levers" to drive savings and quality improvement:

- Lever 1: Improved care management experienced by beneficiaries in CCOs
- Lever 2: Administrative efficiencies in CCOs
- Lever 3: Integration of physical and behavioral health for beneficiaries in CCOs
- Lever 4: Improved care coordination experienced by beneficiaries aligned with patient-centered primary care homes (PCPCH)
- Lever 5: Use of flexible services

Oregon plans to realize these goals through better care management, increased provider and community accountability, payment reform, administrative efficiencies, use of flexible services, promoting the provision of services by nontraditional health workers, and expanding access through improvements to the state's health care workforce.

2013 Demonstration Amendment

In October 2013, CMS approved an amendment to add tribal health programs uncompensated primary care payments to the demonstration. The amendment allows the state to make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority: 1) for uncompensated care costs resulting from primary care services on the prioritized list which are no longer funded effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) to pay for uncompensated care costs resulting from primary care services on the prioritized list provided to individuals not enrolled in Medicaid, Medicare, CHIP or other coverage who have incomes up to 133 percent of the Federal Poverty Level (FPL).

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in federal law, regulation, or policy, come into

compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the date such state legislation becomes effective, or the date such legislation was required to be in effect under federal law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, reservation list, sources of non-federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in the these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Consistent with Oregon's community-focused health systems transformation approach, the state shall undertake a robust public process to ensure community engagement in the development and submission of amendments to the demonstration. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15, prior to submission of the requested amendment;

   b. A data analysis which identifies the specific impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total

computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**

a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

b. Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:

i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. special terms and conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR section 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's

suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

e. Post Award Forum: Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraphs 64 and 65 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 66.

10. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA)**
Upon implementation of the Affordable Care Act (ACA) expansion to adults with incomes at or below 133 percent of the FPL in January 2014, expenditure authority for many demonstration expansion populations will end. To the extent that the state seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP state plan, the state will, by April 1, 2013, submit proposed state plan amendments for any such populations. Concurrently, the state will submit proposed amendments to the demonstration to the extent that such populations will be subject to the demonstration. In addition, the state will submit by April 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

    a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the state must:

        i. Determine eligibility under all January 1, 2014, eligibility groups for which the

tate is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the state identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b. Cost-sharing Transition: The Plan must include the state's process to come into compliance with all applicable federal cost-sharing requirements,

c. Transition Plan Implementation:

i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

In states with fly recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

17. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the state for premiums paid by beneficiaries shall not be used as a source of state match for FFP.

IV. THE OREGON HEALTH PLAN

18. **Overview of the Oregon Health Plan (OHP).** OHP provides health care coverage to low-income Oregonians through programs administered by the Division of Medical Assistance Programs (DMAP). Four separate benefit packages are offered by OHP: OHP Standard benefits, OHP Plus benefits, FHIAP premium assistance, and HealthyKids ESI premium assistance. Beneficiaries enrolled in OHP also may receive services identified in subparagraph (e.viii) below, which are not included in the OHP or affected by this demonstration. During the demonstration period, the state may not reduce eligibility or covered benefits.

    a. **ACA Implementation.** As set forth in paragraph 13 and upon implementation of the ACA expansion to adults with incomes under 133 percent of the FPL on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII); benefits; and cost sharing will revert to the Medicaid state plan and comply with Medicaid regulatory and subregulatory guidance. Benefits under the Oregon Health Plan demonstration will include the provision of Essential Health Benefits identified in the Medicaid/CHIP state plan.

    b. **OHP Populations.** The state will provide health care coverage through the OHP programs defined within these special terms and conditions (STCs)to the Medicaid mandatory and optional groups under the Oregon state plans, as well as demonstration expansion groups as defined in the "**Summary Chart of Demonstration Populations"** (Attachment D).

    c. **Applicability of Medicaid and CHIP Laws and Regulations.** All requirements expressed in Medicaid and CHIP laws, regulations and policies apply to all the

populations affected by this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration

d. **Screening for Medicaid, CHIP and other Health Insurance Products for Children**. Children (population 16 and 20 in Attachment D) seeking or obtaining coverage through OHP will be screened for Medicaid and CHIP eligibility at initial application at least every 12 months, and prior to enrollment in FHIAP or Healthy Kids ESI . Applicants will be offered an informed choice of voluntary enrollment in direct coverage under the Medicaid or CHIP HealthyKids program depending on the program for which they may be eligible. Should a child opt to enroll in premium assistance under FHIAP, or Healthy Kids ESI, and subsequently disenroll from any of these programs, eligible children will be notified of their potential eligibility in Medicaid or CHIP.

e. **Summary of OHP Benefit Structure.** The Oregon Health Plan demonstration has four components, two offered directly through public sector programs (OHP Plus and OHP Standard) and two through a combination of public and private sector funds (premium assistance under FHIAP, or Healthy Kids ESI, both of which will be ending on December 31, 2013). Most beneficiaries under the public sector programs receive services through managed/coordinated care delivery systems.

i. Mandatory Medicaid state plan eligibles receive the OHP Plus benefit (populations 1, 3, 4, 5, 6, 7 and 21 in Attachment D) unless they are children who have elected direct Medicaid coverage outside of OHP, administered by Oregon Health Authority (OHA) (formerly Oregon Department of Human Services (DHS)). In addition, certain Optional and demonstration Medicaid populations, including pregnant women up to 185 percent of the FPL, receive coverage under OHP Plus (populations 8, 2 and 9 in Attachment D).

ii. Adults who are not eligible under the state plan are enrolled in OHP Standard (populations 10 and 11 in Attachment D) except if the condition in iii is met.

iii. Until December 31, 2013, enrollment in FHIAP is required for adults eligible for OHP Standard (populations 10 and 11 in Attachment D) if ESI is available.

iv. All mandatory and optional Medicaid state Plan eligible children younger than 21 years old are entitled to elect to receive direct Medicaid coverage outside of OHP including all state plan and EPSDT covered services (populations 3, 4, 5, 6 7, and 8 in Attachment D).

v. Through December 31, 2013, FHIAP is Oregon's primary premium assistance program. Through FHIAP, eligible uninsured Oregonians (adults and children in populations 12, 14, 16, 17 and 18, as set forth in Attachment D) can elect to receive premium subsidies for the purchase of private health insurance instead of

direct coverage. This option applies to enrollment in both individual and employer-sponsored insurance. Both adults and children applying for FHIAP benefits are subject to the FHIAP reservation list.

vi. Children enrolled in CHIP in families with income from zero up to and including 200 percent of the FPL (population 16 in Attachment D) can instead receive premium assistance through Healthy Kids ESI if employer-sponsored insurance is available and voluntarily chosen by the family. These children apply for coverage through OHA and are not subject to the FHIAP reservation list.

vii. Children in families with income above 200 up to and including 300 percent of the FPL can receive premium assistance through Healthy Kids ESI if employer-sponsored insurance is available and chosen by the family (population 20 in Attachment D) and coverage under Healthy KidsConnect.

viii. The following Medicaid services and expenditures are not affected by the OHP demonstration, and are available as otherwise provided under the state plan:

1. Mental Health Facility – DSH Adjustment Payments;
2. Long Term Care Services;

    a. Nursing Facility Services
    b. Home- and Community-Based Services
    c. Community Supported Living Services
    d. Programs of All-Inclusive Care Elderly

3. ICF/MR Services;
4. Medicare Premium Payments;

f. **Prioritized List of Health Services.** One of the distinguishing features of the OHP demonstration is that OHP benefits are based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services.

i. **Oversight**

1. **The Health Evidence Review Commission (HERC) -** The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Office for Oregon Health Policy and Research. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse.

The Health Evidence Review Commission performs a biennial review of the Prioritized List and will amend the List as required.

ii. **Modifications to the Prioritized List**. Modifications to the Prioritized List require federal approval through submission of an amendment, as described in paragraph 7 in order to ensure the Prioritized List is comprehensive enough to provide Medicaid beneficiaries with an appropriate benefit package. A current version of the prioritized list of health services is maintained by the state of Oregon at the following website: http://www.oregon.gov/OHA/OHPR/HERC/Current-Prioritized-List.shtml. During the demonstration period and as specified below the state will not reduce benefits.

iii. **Ordering of the Prioritized List. Th**e Prioritized List is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g. common colds); (b) are primarily cosmetic in nature (e.g. benign skin lesions); or (c) have no effective treatments available (e.g. metastatic cancers).

iv. **Updating the Prioritized List**. The Commission is charged with updating the list for every biennial legislative session. The Oregon State Legislature determines how much of the list to cover (subject to federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.

v. **Non-covered Condition and Treatment Pairs**. In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

The state must adopt policies that will ensure that before denying coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the prioritized list of health services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, providers will be instructed to provide the specified treatment. The

state shall provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

g. **Funding Line for the "2012-2013" Prioritized List of Health Services.**

i. Beginning January 1, 2012, the 2012-2013 Prioritized List of Health Services contains 692 lines. Lines 1-498 are funded to provide the OHP Plus and Standard benefit packages.

ii. The 2012-2013 Prioritized List will stay in effect until September 30, 2014 to allow time for a transition from the ICD-9 code system to the new, more extensive ICD-10 codes, which is currently underway.

iii. Beginning October 1, 2014, the 2014-2015 Prioritized List of Health Services will go into effect and will change the line number, structure and composition as a result of the biennial review and the conversion to ICD-10-CM. The state will maintain the funding line at the same position relative to the 2012-2013 List (currently between Chronic Sinusitis and Keratoconjunctivitis and Corneal Neovascularization) on the 2014-2015 List and for the remainder of the demonstration.

h. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

i. The state will maintain the cutoff point for coverage at the same position on the List relative to the 2012-2013 List for the remainder of the demonstration as noted above in subparagraph (g). For a legislatively directed line change to increase benefit coverage or a legislatively approved biennial list with substantive updating of benefits due to new evidence, an amendment request (in compliance with paragraph 7) will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in Section XIV.

ii. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.

iii. For a change to the list not defined above that meets the terms of paragraph 6, an amendment request.

i. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The EPSDT benefit under OHP Standard and OHP Plus is limited by the coverage under the applicable benefit package, but all other requirements of EPSDT, including the

provision or arrangement of all covered services to treat a condition identified during an EPSDT screening that is within the scope of the benefit package available to the individual.

j. **Non Traditional Health Workers (NTHW).** NTHWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and doulas. NTHWs may serve individuals currently enrolled in Managed Care Entities (MCEs), and/or through the state's FFS delivery system.

k. **Patient Centered Primary Care Homes (PCPCH):** The state includes PCPCH services in the OHP Standard and Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement and obtaining agreement to participate. The state will work with CCOs to provide the enrollee with notice that s/he has been enrolled in a PCPCH. In addition this notice will provide the participant with information informing them of their right to opt out.

19. **Oregon Health Plan Standard (OHP Standard)**

a. **Eligibility and Enrollment.** Until January 1, 2014, the OHP Standard benefit package is provided to uninsured parents and childless adults ages 19 and older (Populations 10 and 11, in Attachment D respectively). These individuals are only eligible for benefits by virtue of Oregon's Section 1115 Medicaid demonstration.

i. **Screening and Enrollment.** Parents and childless adults who are found eligible for OHP Standard (populations 10 and 11) and have employer-sponsored insurance available are *required* to pursue eligibility under FHIAP.

1. If a parent or childless adult is found eligible for FHIAP, OHP Standard eligibility ends. (The parent or childless adult would then be eligible as defined in populations 17 and 18, in Attachment D respectively.)

2. If a parent or childless adult is found ineligible for FHIAP, the uninsured parent or childless adult will be enrolled in OHP-Standard as long as enrollment slots are available.

ii. **Reservation List**. Until January 1, 2014, the state may employ a reservation list as a method of adding clients to the OHP Standard program. (Applies to populations 10 and 11 in Attachment D)

1. Applications for OHP Standard will be provided to potential clients based on the projected budget limitations of the OHP Standard program.

2. The state may impose an enrollment cap upon the OHP Standard program in order to remain under the budget neutrality limit or to address projected budgetary limitations of the OHP Standard program. The state will be required to provide written notice to CMS at least 60 days prior to changing the budget-driven ceiling.

3. The state will be required to provide written notice to CMS at least 60 days prior to instituting any enrollment cap/ceiling or re-establishing program enrollment. The notice to CMS, at a minimum, must include:

    i. Data on current enrollment levels in the program;
    ii. An analysis of the current budget neutrality agreement; and
    iii. The projected timeframe for the enrollment cap to be in effect or the period for enrollment into OHP Standard.

iii. **Managing enrollment and revising the Reservation List**.

1. For the OHP Standard population described in paragraph 19(a), the state may employ additional caseload management strategies to include: lowering the FPL used to determine eligibility; and/or suspending eligibility and/or intake into the program; or discontinuing coverage. No later than 60 days prior to the date of implementation, the state shall submit its plan to CMS. CMS shall complete a review of the plan for implementation and notify the state of a decision within 60 days of receiving the state's plan.

2. Beginning with the December 1, 2009 approval of this amendment to the demonstration, the state will begin to use a new reservation list.

3. The state will perform targeted outreach to those individuals on the existing (2008) reservation list to afford those individuals the opportunity to sign up for the new reservation list if they are still seeking coverage. Outreach materials will remind individuals they can apply for OHP Plus programs at any time.

4. Periodically, the state will send notices to those individuals on the reservation list, at a minimum of every 12 months asking if they want to remain on the reservation list. If so, these individuals will be given a chance to update their contact information. These notices will remind individuals that they can apply for OHP Plus programs at any time. These notices should be a vehicle for ensuring the OHP Standard reservation list is populated with individuals who are still seeking coverage. Based on the state's budgetary constraints, OHA will periodically select individuals from the reservation list, using a randomized sampling methodology. The state will:

i. Send applications to selected individuals.
ii. Determine eligibility for the selected individuals who submit applications.

iv. **Eligibility Redeterminations.** Parents and childless adults ages 19 and older (populations 10 and 11, in Attachment D respectively) enrolled in the OHP Standard program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for any open OHP program. An enrollee may apply for any open OHP program at any time for any reason. The state will determine eligibility and enroll individuals in programs for which they are found eligible.

b. **Disenrollment.** Enrollees in OHP Standard may be disenrolled if they:

i. Are approved for and seeking enrollment in FHIAP or become eligible for OHP Plus;
ii. Exceed income limits allowed for the program at redetermination;
iii. Exceed resource limits allowed for the program at redetermination;
iv. Voluntarily withdraw from the program;
v. No longer reside in the State of Oregon;
vi. Become incarcerated or are institutionalized in an IMD;
vii. Obtain health insurance;
viii. Become eligible for Medicare; or
ix. Are no longer living.

c. **The OHP Standard Benefit Package** consists of a core set of fixed services and other add-on services. The complete set of covered services is overlaid by the Prioritized List of Health Care Services. The OHP Standard benefit package consists of the following core set of fixed services: physician services; ambulance; prescription drugs; laboratory and x-ray services; medical supplies; outpatient chemical dependency services; and emergency dental services. In addition to this fixed set of core services, OHP Standard also includes a full inpatient hospital benefit and a hospice benefit as add-on services. This benefit package will be offered through December 31, 2013.

d. **Changes to the OHP Benefit Package.** Any increase in the OHP Standard benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in section XIII. Any increases to the approved OHP Standard core set of services shall not include abortion or Death with Dignity services.

COVERED SERVICES	OHP STANDARD
Acupuncture	Limited
Chemical Dependency Services	✓
Dental	Limited
Emergency/urgent hospital services	✓
Hearing aids an**d hearing aid exams**	**n/a**
Home Health	n/a
Hospice Care	✓
Hospital Care	✓
Immun**izations**	✓
Labor and Delivery	✓
Laboratory and X-ray	✓
Medical Equipment and Supplies	Limited
Medical Transportation	Limited
Mental Health Services	✓
Physical, Occupational, & Speech Therapies	n/a
Physician Services	✓
Prescription Drugs	✓
Private Duty Nursing	n/a
Vision	Limited

e. **Cost Sharing under OHP Standard through December 31, 2013:**

i. OHP Standard co-payments were discontinued on June 19, 2004.
ii. However, some OHP Standard clients pay premiums.
iii. For those who are required to pay premiums, the premium charge is between $9-20 a month.
iv. The state is permitted to require clients to be current on their premium payments to reapply for another 12-month eligibility period.
v. OHP Standard clients with household income 10 percent or less of the federal poverty level at the time of enrollment do not pay premiums.
vi. Any increase in premiums or cost-sharing must be submitted to CMS for notification purposes and approval as a demonstration amendment as per paragraph 7.

20. **Oregon Health Plan Plus (OHP Plus) through December 31, 2013**

a. **Eligibility -** Through December 31, 2013, the Medicaid state plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8, 9 and 21 in Attachment D) who have not elected benefits through FHIAP are served in the component known as OHP Plus.

b. **Eligibility Redeterminations.** Medicaid state plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8, 9 and 21 in Attachment D) enrolled in the OHP Plus program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for any OHP program. Any enrollee may apply for any OHP program at any time for any reason. The state will determine eligibility and enroll individuals in programs for which they are found eligible. An enrollee found at redetermination to be ineligible on the basis of income for OHP Plus but eligible for OHP Standard will be transferred to OHP standard with no interruption in coverage.

c. **Benefits.** The OHP Plus benefit package is the Prioritized List of Heath Care Services through the line on the list funded by the Oregon State Legislature as of January 1, 2012.

   i. The benefits table in paragraph 0(d) provides a high-level summary of the services funded and covered on the prioritized list.

   ii. OHP Plus is the Medicaid state plan Services Benefit Package for Mandatory pregnant women and children 0 up to 1 year of age (populations 1 and 3, in Attachment D respectively), subject to necessary pre-authorization.

d. **Benefits Table for OHP Plus.**

COVERED SERVICES	OHP PLUS[1]
Acupuncture	✓
Chemical Dependency Services	✓
Dental	Limited**
Emergency/urgent hospital services	✓
Hearing aids and hearing aid exams	✓
Home Health	✓
Hospice Care	✓
Hospital Care	✓
Immunizations	✓
Labor and Delivery	✓
Laboratory and X-ray	✓
Medical Equipment and Supplies	✓

[1] No benefit limitations apply to children under the age of 19 with Medicaid or CHIP direct coverage.

Medical Transportation	✓
Mental Health Services	✓
Physical, Occupational, & Speech Therapies	✓
Physician Services	✓
Prescription Drugs	✓ *
Private Duty Nursing	✓
Vision	Limited***

* For individuals with Medicare Part D, the OHP Plus benefit package does not cover drugs covered by Medicare Part D.
** Limited Dental coverage as described in the state plan
***Limited Vision coverage as described in the state plan

e. **Cost Sharing under OHP Plus**

i. For OHP Plus, individuals may be liable for nominal copayments. No copayment liability will be imposed on pregnant women or children under the age of 19.
ii. The approved copayments are included in the Title XIX state plan.
iii. Oregon uses the state plan amendment process to make changes to its OHP Plus copayment policies.
iv. There are no premiums for OHP Plus enrollees.

f. **Disenrollment from OHP Plus.** Enrollees in OHP Plus may be disenrolled if they:

i. Are approved for and seeking enrollment in FHIAP;
ii. Exceed income limits allowed for the program at redetermination;
iii. Exceed resource limits allowed for the program at redetermination;
iv. Voluntarily withdraw from the program;
v. No longer reside in the State of Oregon;
vi. Become incarcerated or are institutionalized in an IMD;
vii. Are no longer pregnant;
viii. No longer have a qualifying disability; or
ix. Are no longer living.

21. **Breast and Cervical Cancer Treatment Program (BCCTP)**

a. The Breast and Cervical Cancer Treatment Program (BCCTP), formerly known as BCCM, provides medical assistance to women under the age of 65 who have been screened and diagnosed through the Breast and Cervical Cancer Treatment Program (BCCTP) and found to need treatment for breast or cervical cancer, or specific precancerous conditions, and are receiving such treatment. Such individuals are uninsured or underinsured with respect to necessary treatment.

b. Women determined to be eligible for BCCTP (population 21 in Attachment D) will be enrolled on the Oregon Health Plan for the duration of their treatment.

c. BCCTP Presumptive Eligibility

   i. Any licensed health care provider qualified to diagnose cancer or pre-cancerous conditions can determine presumptive eligibility under the BCCTP
   ii. Presumptive eligibility provides immediate, temporary coverage for women who appear to meet basic eligibility criteria.
   iii. Presumptive coverage lasts approximately a month before full determination of coverage through OHP.

d. Eligible individuals remain eligible for a period of 12 months. At the end of the 12 months:

   i. A redetermination application is sent to the client;
   ii. The client's provider verifies if patient still requires treatment and submits verification to OHP;
   iii. If the client still needs treatment, coverage is extended for additional year;
   iv. Not have creditable health insurance to cover her treatment; and
   v. Be in need of treatment for breast or cervical cancer, including qualifying precancerous conditions.

22. **Premium Assistance.** As of January 1, 2014, individuals who are currently enrolled in premium assistance under FHIAP or Healthy Kids ESI (demonstration populations 14, 16, 17, 18 and 20), and remain eligible for the Medicaid or CHIP state plan will be seamlessly enrolled in coverage through Medicaid or CHIP and will be enrolled in a CCO. Individuals currently receiving premium assistance who do not appear to be eligible under the approved Medicaid or CHIP state plans based on an initial assessment will be afforded a full eligibility determination prior to termination. Individuals denied Medicaid or CHIP eligibility will have their information electronically transmitted to the state Affordable Insurance Exchange (or other insurance affordability program as appropriate) to be treated as an application for eligibility and benefits through the Exchange.

a. **Overview of Premium Assistance Options**

   i. **Family Health Insurance Assistance Program (FHIAP)** (populations 12, 14, 16, 17, and 18 in Attachment D). The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA), administers FHIAP. This premium assistance program provides subsidies to help families and individuals with income from 0 up to and including 200 percent of the FPL, including children

and adults, pay for health insurance offered either through employer-sponsored insurance (ESI), or private health insurance carriers that provide coverage in the individual market. Children eligible for FHIAP have the choice between FHIAP and direct stateplan coverage.

ii. **Healthy Kids Employer Sponsored Insurance (ESI)** (populations 16 and 20 in attachment D). Healthy Kids ESI provides child only premium assistance for available employer sponsored insurance (ESI) for families with children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL; and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI.

iii. **Oregon Medical Insurance Pool (OMIP)** Oregon operates a high-risk medical insurance pool for individuals denied coverage for pre-existing medical conditions. Effective with the implementation of the ACA, and with the implementation of the Oregon Health Insurance Exchange (ORHIX), individuals eligible for OMIP will be transitioned to coverage under the ORHIX. Some individuals enrolled in OMIP are eligible for Medicaid or CHIP, and will be transitioned to coverage under those programs.

b. **Eligibility**

i. **FHIAP through December 31, 2013.** Premium assistance for children, adults and families from zero through 200 percent of the FPL who choose voluntary enrollment in FHIAP (populations 12, 14, 16, 17, and 18 in Attachment D). Premium assistance can be used for employer-sponsored insurance (ESI) or individual health insurance. Eligible participants include: 1) Families (including parents), 2) childless adults, and 3) children (populations 14 and 16 in Attachment D) in families with parents who apply for premium assistance directly through the FHIAP reservation list.

ii. **Healthy Kids ESI.** Healthy Kids ESI provides child only premium assistance for families with children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI. (Populations 16 and 20 in Attachment D). These children apply for coverage through DHS or OHA and voluntarily choose to receive subsidies for ESI. Children with income above 200 up to and including 300 percent of the FPL also have the option of electing coverage under the CHIP state plan through Healthy KidsConnect (population 22 in Attachment D).

c. **Enrollment for Children:**

i. **FHIAP.**

1. **Enrollment through FHIAP Reservation List Process.** Children from zero up to and including 200 percent FPL may elect to receive premium assistance for individual health insurance or ESI (populations 14 and 16 in Attachment D). These children can apply for subsidies through the FHIAP reservation list process. OPHP determines eligibility, enrolls them and pays subsidies. Children receive a 100 percent subsidy.

ii. **Healthy Kids.** Alternatively, children with family incomes from 0-200 percent of the FPL may receive direct coverage under the CHIP state plan by applying for Healthy Kids through OHA and DHS. At the time they request a FHIAP application and are put on the reservation list, families are provided with information about direct coverage through Healthy Kids, including the differences between Healthy Kids direct coverage and FHIAP benefits, cost-sharing and other provisions. They are also provided a Healthy Kids application and are encouraged to apply for immediate coverage rather than wait on the FHIAP reservation list. These children can switch between direct coverage and FHIAP at any time.

1. **Healthy Kids ESI.** Children who have been found eligible for Healthy Kids direct coverage may choose premium assistance under Healthy Kids ESI instead. These children must be informed about the difference in benefits, cost sharing and other provisions between direct coverage and Healthy Kids ESI and be provided with the choice to enroll in Healthy Kids direct coverage at any time. Subsidies are paid at 100 percent for children through age 18. If a child is determined eligible and the family chooses ESI, DHS or OHA refers the child to OPHP for enrollment and subsidy payment.

iii. **Healthy Kids Connect.** Children with family incomes above 200 and up to 300 percent of the FPL apply for coverage through OHA or DHS for eligibility for direct coverage under the CHIP state plan. The child may elect such coverage, or may elect Healthy Kids ESI premium assistance, if employer sponsored insurance is available, on a sliding scale based on family income. These children must also be informed of the differences in benefits, cost sharing and other provisions between Healthy Kids ESI and coverage under the CHIP state plan through Healthy KidsConnect. These children can switch between these two options at any time.

d. **Cost Effectiveness for Children and Adults**

i. **FHIAP and Healthy Kids ESI**. Oregon compares the aggregate per member per month subsidy costs for demonstration populations 12, 14, 16, 17 and 18 in Attachment D in FHIAP and population 20 in Attachment D in Healthy Kids ESI relative to OHA direct coverage costs for demonstration populations 1 through 11.

e. **Enrollment for Adults**

i. **FHIAP.** Parents and childless adults from zero up to and including 200 percent FPL (populations 14, 17 and 18 in Attachment D) apply for premium assistance through FHIAP by first getting on a FHIAP reservation list. As program openings occur, applications are mailed to families on the list, with priority for OMIP applicants, and then on a first come first served basis. Subsidies can be used for ESI or individual health insurance. Adult subsidies are paid on a sliding scale based on income.

f. **Enrollee Education and Notification**

i. **Adults.** Parents and childless adults eligible for OHP Plus benefits (population 14 in Attachment D) must be periodically notified that they may choose direct coverage under the state plan at any time. The state will provide information prior to enrollment in FHIAP explaining the differences in benefits, cost sharing and other provisions between state plan direct coverage and private insurance options.

ii. **Children.** Families with children from zero up to and including 200 percent FPL (populations 14 and 16 in Attachment D) applying for FHIAP will receive written information explaining the differences in benefits, cost sharing and other provisions between direct state plan coverage and private insurance options. Children will also be screened for Medicaid and CHIP eligibility prior to actual enrollment in FHIAP and enrolled in the appropriate program if the family selects Medicaid or CHIP state plan direct coverage. Children in families with income from above 200 up to and including 300 percent of the FPL are eligible for Healthy Kids ESI and under the CHIP state plan. These families can also contact choice counselors who can help explain their insurance options.

iii. **Application Assistance.** Subject to available funding, the state will provide community-based assistance to potential applicants for Healthy Kids programs, including Healthy Kids ESI and Healthy KidsConnect, in completing and submitting their application in a timely manner.

iv. **Children and Immunization.** In the case of children, families are to be informed that all age-appropriate immunizations (in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), well-baby, well-child services and emergency services for Title XXI eligible children will be covered, regardless of whether the health insurance coverage includes such coverage. The state shall provide information as to where children may receive immunizations without charge and well-baby and well-child services and emergency services in the event these services are not

covered in the employer-sponsored plan or private health plan in which they are enrolled.

v. **Provider Reimbursement for Immunizations.** In the case of Title XXI eligible participants, the state must have a mechanism in place to reimburse providers for the cost of immunizations, well-baby and well-child services and emergency services so that families will not be held responsible for the costs associated with these services.

vi. **Period of Uninsurance.** As used in the tables below, the term "uninsured" means an individual who is not covered by creditable private health insurance as defined in 45 CFR 146.113 for a specified period. OHP coverage is not considered insurance in determining FHIAP eligibility. In addition, individuals with FHIAP coverage or those on the FHIAP reservation list who have met the required period of uninsurance but have since obtained coverage are exempt from the uninsurance period in determining OHP Standard or CHIP eligibility. The following are FHIAP exceptions to the period of uninsurance. The member:

1. Is currently enrolled in the OHP;
2. Was enrolled in the OHP within the last 120 days;
3. Is a former FHIAP member;
4. Has enrolled in a creditable health insurance plan while on the reservation list.
    a. Must have met the two-month period of uninsurance immediately prior to enrolling in the creditable health insurance plan;
5. Has coverage through the Kaiser Child Health Program or any benefit plan authorized by ORS 735.700 - 735.714;
6. Has a military health insurance plan;
7. Has enrolled in group coverage within the 120 days prior to getting on the FHIAP reservation list;
    a. Must have been without any creditable health insurance coverage for two consecutive months immediately prior to becoming insured under the group plan.

8. Has recently become unemployed and lost health insurance coverage as a result;

9. Has lost health insurance coverage while still employed (e.g. reduction in hours, employer stops providing coverage, etc); or

10. Is an OMIP member or an applicant to OMIP.

vii. The state must establish and maintain procedures that will:

1. Ensure that children who enroll in premium assistance are enrolled in creditable coverage;

2. Ensure the consent of the responsible adult family member to receiving premium assistance under FHIAP instead of coverage through Medicaid or CHIP;

3. Allow Medicaid or CHIP eligible participants to opt out of FHIAP and receive direct coverage at any time, with the exception of Medicaid eligible participants who would otherwise qualify for OHP Standard. OHP Standard direct coverage is governed by the reservation list. In addition, OHP Standard eligible participants with ESI would not be able to opt out of FHIAP and into direct coverage;

4. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in individual or ESI coverage with premium assistance (if appropriate) and the individual's/family's share of the premium is being paid;

5. Require eligible participants to immediately notify the state if they change or terminate their individual or ESI coverage under premium assistance (if appropriate);

6. Ensure that the total amount of premium subsidies provided to an individual or family does not exceed the amount of the individual or family's financial obligation toward their coverage (if appropriate);

7. Provide for recovery of payments made for months in which the individual or family did not receive individual or ESI coverage with premium assistance; and

8. Provide for a redetermination of eligibility at least once every 12 months.

g. **FHIAP and Healthy Kids ESI Benefits.** FHIAP and Healthy Kids ESI participants (including children and adults in populations 12, 14, 16, 17, 18 and 20 in Attachment D), as described in these STCs, receive the benchmark plan as defined below for FHIAP. The plan is approved at a level actuarially equivalent to mandated Medicaid services.

i. **Changes to the FHIAP and Healthy Kids ESI Benchmark.** Any reduction to the benchmark below the approved level will be submitted to CMS for review and approval as per paragraph 7. Any increase to the benchmark above the approved level will not require approval, but will be subject to the requirements of budget neutrality, as described in these STCs.

1. **Administration of changes to the FHIAP and Healthy Kids ESI benchmark** are through the Office of Private Health Partnerships (OPHP), which is within the Oregon Health Authority (OHA). OPHP may annually survey Oregon's small group health insurance market to determine the most common benefits and cost-sharing levels, and may adjust the benchmark accordingly. The FHIAP and Healthy Kids ESI benefit benchmark must be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

2. As directed by HB 2519 (2001 Oregon Laws), the benchmark reflects the benefits commonly offered in Oregon's small group health insurance market.

h. **Benchmark for FHIAP and Healthy Kids ESI.** The benchmark is based on the actuarial value of the member's out-of-pocket expense for the core benefit design (as listed in the benchmark chart.) The values in the chart reflect the actuarial equivalent of mandated Medicaid benefits. Actual benefit designs can vary slightly, but must meet the actuarial equivalency test and have all the required services to be eligible for federal funding.

FHIAP General Provisions	
Lifetime Maximum	$1,000,000
Medical Cost Sharing	
Annual Deductible	$750 per individual
Member Coinsurance Level	20 percent
Stop Loss Level	$10,000 per individual
Out-of-pocket Maximum (Includes Deductible)	$4,000 per individual
Required Serves Prescription Medication Cost Sharing	
Member Coinsurance level	50 percent
Out of Pocket Maximum	No out-of-pocket maximum

Other Required Services	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks	Covered Benefit
Dental*	Covered Benefit
Women's Health Care Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Room	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency/Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

* The state must wrap-around dental coverage (as specified in 2103(c)(5) of the Act) for children in employer sponsored insurance plans that do not offer dental coverage in either FHIAP or Healthy Kids ESI.

i. **Premium Assistance Levels**

i. **Premium Assistance Levels.** FHIAP and Healthy Kids ESI premium assistance levels are based on a family's average monthly gross income and are a percentage of premium cost after any applicable employer contribution.

Percentage of FPL	Subsidy Level
Parents and Childless Adults	
0 percent up to 125 percent FPL	95 percent subsidy
125 percent up to 150 percent FPL	90 percent subsidy
150 percent up to 170 percent FPL	70 percent subsidy
170 percent up to and including 200 percent FPL	50 percent subsidy
Children	
0 percent up to and including 200 percent	100 percent subsidy

FPL (Medicaid and CHIP Children in populations 12, 14 and 16))	
Above 200 percent up to and including 250 percent FPL (populations 20)	Approximately 90 percent subsidy
Above 250 percent up to and including 300 percent FPL (populations 20)	Approximately 80 percent subsidy

j. **Enrollee Contribution Verification.** People enrolled in an employer sponsored insurance plan are reimbursed for the premium withheld from their paychecks (minus the enrollee's share of the premium), provided the enrollee submits verification, at least quarterly, that the premium is being withheld. Copies of paycheck stubs or other employer-generated documentation serve as verification.

k. **Enrollees in the Individual Market**. People in the individual market are billed by FHIAP each month for their portion of the premium. FHIAP combines the member's portion with the premium assistance amount and pays the insurance carrier. Individuals who fail to pay their premium will be disenrolled. Members are billed one month in advance of the date premiums are due to the carrier so that FHIAP can pay carriers in a timely manner. FHIAP does not pay carriers until the member's portion is received. Members are provided a premium grace period of at least 30 days from the billing date. Reminder notices are mailed mid-way through this grace period. Premium assistance cancellation notices outlining the program's intent to terminate, are mailed at the end of the grace period. These notices also provide information on the members' right to appeal termination. Individuals are given no less than an additional seven days to remit premium. Terminated individuals are able to re-enroll in the program after being disenrolled for failure to pay premiums. In order to do so, however, they must get back on the FHIAP reservation list. They are placed at the bottom of the list using the request date. If the children of families from zero up to and including 200 percent of the FPL do not pay their premiums, these children can either enroll in Medicaid or CHIP direct coverage or get back on the FHIAP reservation list.

l. **FHIAP and Healthy Kids ESI Contribution Level.** Generally, the employer pays a portion of the premium for FHIAP and Healthy Kids ESI coverage, although there is no state specified minimum employer contribution level.

m. **FHIAP and Healthy Kids ESI Cost Sharing Excluding Premiums.** Cost-sharing requirements or levels for FHIAP and Healthy Kids ESI members are determined by private-sector insurance carriers or employers, not by the Medicaid or CHIP program.

n. **FHIAP Reservation Lists.** The state may employ two reservation lists as a method of continuously adding clients to the FHIAP program (populations 12, 14, 16, 17, and 18 in Attachment D). Individuals eligible for Medicaid or CHIP must be provided with the option to enroll in direct coverage at any time while awaiting premium assistance for health insurance provided under an employer-sponsored or an individual market plan.

i. **ESI Premium Assistance reservation list.** A separate list may be employed for individuals interested in obtaining premium assistance for health insurance available through their employers.

ii. **Individual Health Insurance reservation list.** A separate list may be employed for individuals interested in obtaining premium assistance to buy individual health insurance plans when coverage is not available through their employers.

iii. **Outreach to children in families with income from zero through 200 percent of the FPL (population 14 and 16 in Attachment D) currently on the FHIAP Reservation List:** The state will perform targeted outreach to families on the existing reservation list to ensure they are aware that children also have the option to receive direct state plan coverage at any time under Medicaid or CHIP. Families with children will be sent information about direct coverage through Healthy Kids, along with a Healthy Kids application, and a letter encouraging families to apply for immediate coverage rather than wait on FHIAP's reservation list. Families must either complete the application or actively decline direct coverage. All children that choose FHIAP at the point of application and choose to go on the reservation list will also receive information on direct coverage options and be informed that they can move from the FHIAP reservation list or decline CHIP or Medicaid coverage, but still be given the opportunity to choose to move to direct state plan coverage at any time.

iv. **Protections for Children on FHIAP Reservation List:** Families waiting for FHIAP assistance will not lose their place in line or experience any delay as a result of applying for Healthy Kids direct state plan coverage for their children. The state must also inform families that if circumstances change or they change their mind at a later date, they may move their child or children from FHIAP to direct Medicaid or CHIP coverage at any time.

v. **FHIAP Program Openings.** As program openings occur, applications are mailed to families on the FHIAP reservation list(s) on a first come first served basis. Subsidies can be used for ESI or individual health insurance.

vi. **Publication of Reservation List.** The reservation list must be well publicized. It is publicized on the State OHA website and the FHIAP website, and Oregon employers are informed of the reservation list on a regular basis through various state sources (e.g. Employment, Insurance).

vii. **Option for FHIAP Enrollment Cap.** The state may impose an enrollment cap upon the FHIAP program in order to remain under the budget neutrality limit or to address projected budgetary limitations of the FHIAP program.

viii. **Screening for Medicaid and CHIP Eligibility.** All children are screened for Medicaid and CHIP eligibility prior to enrollment in FHIAP. Children will also be screened for Medicaid and CHIP eligibility prior to actual enrollment in FHIAP and enrolled in the appropriate program if the family selects Medicaid or

CHIP state plan direct coverage. These families can also receive assistance from choice counselors who can help explain their insurance options.

ix. **Management of FHIAP.** For FHIAP populations 12, 14, 16, 17, and 18 in Attachment D the state may lower the FPL used to determine eligibility; and/or suspend eligibility and/or intake into the program; or discontinue subsidies.

1. No later than 60 days prior to the date of implementation, the state shall submit to CMS its plan for any of these approved actions for review. CMS will complete a review of the plan for implementation, and notify the state of a decision within 60 days of receiving the state's plan.

2. FHIAP will limit the enrollment in the program to a number that can be served within the state and federal resources allocated to the program, under the constraints of budget neutrality.

3. If sustained enrollment levels would cause FHIAP to exceed its biennial budget, enrollment levels will be allowed to fall either through natural attrition or by one of the caseload control mechanisms outlined above.

4. All children (including Medicaid and CHIP eligible children in demonstration populations 3, 4, 5, 6, 7, 8, and 16 in Attachment D) and certain adults (populations 1, 2, 6, 7 and 8 in Attachment D) who would be eligible for OHP Plus benefits always have the option of enrolling in OHP Plus, which includes Medicaid or CHIP state plan direct coverage children, at anytime and the state will keep families informed of this option.

x. **Limitations on the use of the Reservation List.** The FHIAP reservation list does not apply to children applying for Healthy Kids ESI with incomes from zero up to and including 300 percent of the FPL. Children from zero up to and including 200 percent of the FPL will be screened for Medicaid and CHIP enrollment under the Healthy Kids initiative prior to enrolling in Healthy Kids ESI.

o. **Healthy Kids Evaluation.** The Office for Oregon Health Policy and Research will analyze and evaluate the implementation of Healthy Kids, including premium assistance and coverage under the CHIP state plan. The Office will report on the following information using a variety of data sources including a statewide health insurance survey, program administrative data and other quantitative and qualitative data sources. This information will be provided in the state's annual report as specified in paragraph 66.

i. Biennial estimates of the number of children who are eligible for but not enrolled in any of the three Healthy Kids options,

ii. The number of children enrolled in each type (Healthy Kids ESI, and direct state plan coverage options) of program,

iii. The number of children disenrolled from each type of program, and reasons for disenrollment,

iv. Enrollment trends (from the inception of Healthy Kids) related to the number of children remaining on the FHIAP reservation list who do not opt for CHIP direct coverage ,

v. A description of any identified barriers to enrolling or maintaining enrollment of children in any of the program types,

vi. The quality of care received using nationally accepted HEDIS measures for children,

vii. Biennial estimates of the number children voluntarily not enrolling in employer-sponsored health coverage who enroll in the program.

p. **Premium Assistance Evaluation Related to Cost Effectiveness.** Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the state's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The state provides limited wrap around services.

i. The state will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:

1. FHIAP's (populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies);

2. OHA direct coverage (populations 1 through 11 in Attachment D) overall pm/pm costs.

ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in populations 12, 14, 16, 17, and 18 based on maximum plan out of pocket costs (excluding premium share) to:

1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.

iii. OPHP will monitor program expenditures for HK ESI (population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.

1. OPHP will report average aggregate cost sharing for HK ESI plans (population 20 in Attachment D) based on maximum plan out of pocket costs (excluding premium share).

2. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

3. This information will be provided in the state's annual report as specified in paragraph 66 as well as progress toward this goal in quarterly reports referenced in Attachment A.

V. DELIVERY SYSTEM TRANFORMATION

Description of the pre-Health System Transformation Managed Care Delivery System

23. **Pre-Health System Transformation Delivery Systems for OHP Plus and OHP Standard.** The majority of health care services under OHP Plus and OHP Standard are provided through a managed care delivery system. The managed care entities (MCEs) coordinate health care systems, including pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and comprehensive or targeted management of health services. The managed care services have been delivered through the entities in Table 1. Once the health system transformation has been fully implemented the current managed care providers will be replaced by the Coordinated Care Organizations.

Table 1. Existing Care Delivery Systems

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Fully Capitated Health Plan (FCHP) (a managed care entity)	An organization contracted to provide physical health services and chemical dependency treatment services, including inpatient hospitalization. Oregon contracts with FCHPs throughout the state to provide health care services to Oregon Health Plan members.	FCHP contract ends if the FCHP reorganizes as a CCO in a particular service area.	No new FCHP contracts after July 1, 2014.
Physician Care Organization (PCOs) (a managed care entity)	An organization contracted to provide physical health services, excluding payment for inpatient hospitalization.	The two PCO contracts will end if they join a CCO in the PCO service areas.	No new PCO contracts after July 1, 2014.
Mental Health Organizations (MHOs) – (a managed care entity)	An organization contracted to provide outpatient and acute inpatient mental health services. Mental Health services are provided by stand-alone organizations that specialize in such services and are paid on a capitated rate basis	MHO contract ends if the MHO reorganizes as, or joins, a CCO in a particular service area. MHOs will continue to serve enrollees currently FFS for physical health care until 11/1/12. After that date, MHO	No new MHO contracts after July 1, 2014.

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
		contracts will end.	
Dental Care Organizations (DCOs) – (a managed care entity)	An organization contracted to provide dental services, including preventive care, restoration of fillings, and repair of dentures. Dental services are contracted on a stand-alone basis through a DCO and are paid on a capitated rate basis to provide services to OHP members	CCOs will contract with DCOs in the CCO service area, but DCOs must be integrated into CCOs by July 1, 2014.	CCO/DCO contracts will be executed by July 1, 2014.
Primary Care Manager (PCM)	A physician or other OHP approved medical provider responsible for providing primary care and maintaining the continuity of care, supervising and coordinating care to patients, initiating referrals to consultants and specialist care. PCMs are not under contract with a managed care organization; they provide health care services through a FFS system, and receive a nominal management fee on a per member per month basis. Compensation to PCMs for direct services is non-risk based and in accordance with the state plan.	Some PCMs will continue to exist for the small FFS population remaining. The state will be working with PCMs to meet PCPCH requirements.	Ongoing and parallel to CCO timelines.
Fee-For-Service/ Open Card	The OHP participants may also receive services through the fee-for-services delivery system. The OHP participant that receives service through FFS may be served through a PCPCH.	FFS open card will be maintained only for small number of exempted or excluded populations or those outside CCO service areas.	Ongoing
Patient Centered Primary Care Homes (PCPCH)	The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care,	The PCPCHs are optional and will be available to OHP participants whether they are	Ongoing Transition over 3-5 years as more PCPCHs

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
	individual and family support services, and referral to community and social support services.	enrolled with a CCO or served through the FFS delivery system.	become certified

Health System Transformation Transition

24. The state will transform its delivery system through a shift to the delivery of care from current specialized MCEs to Coordinated Care Organizations (CCOs) beginning in August 2012. Initially, CCOs will be required to provide both medical and behavioral health services (formerly provided under different MCEs). Dental services must be merged into the CCO by July 2014. The state's contracting with the CCO will result in the phase out of new Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), and Mental Health Organization (MHO) contracts by July 1, 2014 and CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. The CCOs initially will be phased into the delivery system over four monthly cycles (or "waves") beginning in August 2012 and ending in November 2012.

    a. Transition of OHP Populations to CCOs

        i. Existing enrollees of an MCE that has transitioned to a CCO will be given a 30 day notice and transitioned (rolled over) to the new CCO when certification and contracting is complete. This roll over will include currently enrolled tribal members and dual eligibles, who will be able to opt-out if they wish. Existing members who are receiving services from out-of-area or non-participating providers will be moved to a CCO when their MCE transitions. For these members, the CCO will be expected to cover out-of-network or non-participating provider services authorized by the member's care team, Medical Director of the MCO or the Medical Director of the Division of Medical Assistance Programs, for a transitional period until the CCO establishes a relationship with the member and is able to develop a medically appropriate care plan.
            1. An MCO transitioning to become a CCO in any of the four initial contracting waves will retain its existing enrollees and those enrollees will be transitioned (rolled over) to the new CCO when certification and contracting is complete.

            2. For an MCO not transitioning to become a CCO in any one of the four waves, enrollment of existing members will continue in the plan until the member chooses another plan as described below, or until the OHA

determines on a case-by-case basis that members should be transitioned to other plans serving the geographic area.

ii. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.

1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.

2. All existing MCEs from Table 1 in paragraph 23 will be closed to new enrollment once sufficient capacity is determined to exist in the CCO(s) serving the area. If CCOs do not have sufficient capacity, new members may be enrolled only in MCOs on the path to becoming a CCO in one of the four waves until capacity in those plans is reached, then can be enrolled in any remaining MCOs.

iii. Individuals who are currently in FFS for physical health, other than dual eligibles and tribal members, will receive a 30 day notice and be required to enroll in CCOs by November 1, 2012 where sufficient capacity exists, and will be given their choice of plan.

1. Members not choosing a plan will be auto-assigned to a plan through an auto-enrollment process.

2. For members who are enrolled in an MHO for mental health services but otherwise receive physical health services through fee for service, if a CCO becomes operational in their area prior to November 1st, their mental health coverage will be through that CCO until they are enrolled in a CCO for both physical and mental health services in November.

iv. Tribal members and dually eligible individuals are both populations that must make an affirmative voluntary choice for CCO (and existing MCE) enrollment (i.e., cannot be auto-enrolled).

v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.

vi. OHA is planning member transition strategies for FFS members with special considerations:

1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements

such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:

- Care management requirements based on the beneficiary's medical condition
- Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations
- Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services)
- Availability of medically appropriate medications under the CCO formulary
- Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team

2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.

Description of Delivery System Transformation

25. **Definition and Role of Coordinated Care Organizations**. CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the state. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR Part 438 unless a requirement has been specifically identified in the waiver authorities for this demonstration. CCOs will provide a governance structure to align the specialized MCE services under one managed care organization. CCOs will partner with OHA to further the state's implementation of PCPCH and utilization of Non-Traditional Health Workers (NTHWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

a. **CCO Criteria**. The CCOs are required to meet the following criteria:

i. **Governance and Organizational Relationships.**

1. Governance. Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see 2 below); and at least two members from the community at large to ensure that the organizations decision making is consistent with the community members' values. .

2. Community Advisory Council (CAC). The CCOs are required to convene a CAC that include representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be ongoing bodies and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.

3. Clinical Advisory Panel. The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.

4. Partnerships. The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees and with county health departments and other publicly funded providers for certain point-of-contact services.

5. Community Health Needs Assessment. Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The state encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

b. **CCO quality and access measurement.** CCOs will be accountable for metrics for quality and access as described in Section VII and Attachment E, including measures to track progress in the quality improvement focus areas, measures to track quality broadly, and measures to track access. Specific measures, timeframes, and CCO reporting requirements will be determined by the state and approved by CMS during the supplemental 120-day planning period.

i. **Menu-set of CCO quality improvement focus areas.** OHA will ensure that each CCO will commit to improving care in at least 4 of the following 7 focus areas, which have the significant potential for achieving the demonstration's goals of improving the patient experience of care, improving population health, and reducing per capita Medicaid expenditure trend. Three of these four projects may serve as a CCO's Performance Improvement Projects in accordance with 42 CFR 438.358 and 438.240. Attachment E provides further details on each of these focus areas. The state and CCOs may add to this menu of focus areas but

should review Attachment E and provide a similar level of detail for anything not on the list below. The state will incorporate the PIP requirements into its CCO/MCE contracts within 120 days of the approval of the demonstration

1. Reducing preventable rehospitalizations.
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, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by "super-utilizers".
4. Integrating primary care and 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 model of care throughout the CCO network.

c. **Health Information Technology (Health IT).** The CCOs are directed to use HIT to link services and core providers across the continuum of care to the greatest extent possible. The CCOs are expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

i. Health IT:

1. CCOs must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the state's health information exchanges. If providers 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.

2. In order for CCOs to fully realize years 2-3 performance incentives, the state must require that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The related incentives must take into account the costs incurred in order to facilitate adoption and meaningful use of EHRs, as well as the existing incentives available to eligible providers.

3. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information

exchange. The state must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

4. All requirements must also align with Oregon's state Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

d. **Innovator Agents and Learning Collaboratives**. State shall utilize innovator agents to act as a single point of contact between the CCO and the Oregon Health Authority. Innovator agents will be assigned to each contracted CCO by January 15, 2013. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the demonstration's goals of improving quality and access while managing costs, within 120 days from the approval of the demonstration amendment the state will:

i. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.

ii. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as underperforming (as described above), the state will plan and execute intensified innovator/learning collaborative interventions.

iii. The information in (a) and (b) above will be incorporated into the CCO contracts by amendment.

26. **Alternate Delivery System**. The FFS delivery system applicable to some emonstration populations will continue under the health system transformation.

27. **Patient Rights and Responsibilities, Engagement and Choice.** The CCO is responsible for ensuring that its enrollee receives integrated person-centered care and services designed to provide choice, independence and dignity.

28. **Compliance with Managed Care Requirements.** The state must meet the requirements of 42 CFR Part 438 unless a requirement of part 438 has been identified in the waiver authorities for this demonstration.

29. **Managed Care Enrollment, Disenrollment, Opt Out and Transitions**

a. **Mandatory Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive benefits pursuant to Sections –

IV and V of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to 12 months. The Table below illustrates the mandatory and affirmative choice (i.e., "opt-in") populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given[2]
1-11	Individuals of the identified populations other than those footnoted. [3]	Mandatory; current FFS enrollees not transitioned for physical health until November 2012	Other CCO if available; MCO if no CCO in area; FFS with cause
21	Breast and Cervical Cancer Treatment Program Income: Up to 250% FPL Resource Limit: None	Not enrolled until November 2012, then Mandatory	Other CCO if available; MCO if no CCO in area; FFS with cause
22	Targeted low income children up to 200 percent of the FPL who are eligible for direct services under the CHIP state plan. Title XXI children ages zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income	Mandatory Out	Other CCO if available; MCO if no CCO in area; FFS with cause

[2] See (b) below for more information on disenrollment/plan change options and timelines.

[3] Exceptions include individuals who are: dually eligible for Medicare and Medicaid, American Indian or Alaska Native who are permitted to enroll, but not mandatorily enrolled. Current MCO enrollees will be rolled over to a CCO in November 2012, others may opt in. FFS populations who require special consideration (e.g., HIV/AIDs) will be transitioned in November 2012, after receiving individualized transition planning.

Population	Description	In/Out of CCOs	Disenrollment Options Given[2]
	child under the CHIP state plan (under Healthy KidsConnect)		
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
22	Targeted low-income children from conception to birth with income from 0 up to 185 percent of the FPL who are eligible under the CHIP state plan.	Optional	N/A
12, 14, 16-18, and 20	Individuals in FHIAP and Healthy Kids ESI	Out	N/A
1-11, 21 and 22	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid state plan	Individuals who are receiving non-OHP Medicare (QMB, SLMB, QI)	Out	N/A
Medicaid state plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A
Medicaid state plan	Individuals who are Transplant Rx only	Out	N/A

b. **Disenrollment.** The information in the table is applicable to all managed care enrollees.

Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR Part 438.
Eligibility redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change

	plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

30. **Network Adequacy and Access Requirements.** The state must ensure that any MCE and CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and services, considering the urgency of the service. Detailed standards for various levels of care (e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the sate's quality strategy required by 42 CFR 438.204.

31. **Required Notice for Change in CCO Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The state must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

32. **Contingency Planning.** In the event that a CCO contract is amended to significantly reduce its service area or the contract is terminated, the state will implement contingency planning in consultation with CMS to assure enrollee continuity of care.

33. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10(f)(4), 42 CFR 438.6(i) and 42 CFR 431.20, the state may allow the use of electronic methods for the beneficiary and provider communications as required by:

    - 42 CFR 438.10(b) – Special rule for mandatory enrollment states – timeframes for providing information;
    - 42 CFR 438.10(e) - Information for potential enrollees;
    - 42 CFR 438.10(f)(2), (3) and (6) - Right of enrollee to request and obtain information;
    - 42 CFR 438.10 (g)(2) and (3) – Other plan information, including PIPs;

- 42 CFR 438.10(h)(2) and (3) - For PAHPs only - Other plan information, including PIPs;
- 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
- 42 CFR 438.102(b)(1)(ii) – state policies on excluded services.

a. The state may allow the use of such electronic communications only if:

   i. The recipient has requested or approved electronic transmittal;
   ii. The identical information is available in written form upon request;
   iii. The information does not constitute a direct beneficiary notice related to an adverse action or any portion of the grievance, appeals, hearings or any other beneficiary rights or beneficiary protection process; and
   iv. Language and alternative format accommodations are available.
   v. Please note: All HIPAA requirements apply with respect to personal health information.

34. **Transparency/Public Reporting.**

a. The state must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).

b. The state shall publish data regarding CCOs' performance on state-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the state's progress toward achieving the two primary goals of this demonstration.

35. **State Oversight of the CCOs.** The state Agency must have in effect procedures for monitoring the CCO operations, including, at a minimum operations related to the following: recipient enrollment and disenrollment; processing of grievance and appeals; violations subject to immediate sanctions, as set forth in sub part I of 42 CFR 438; violations of the conditions for FFP, as set forth in subpart J; and all other provisions of the contract.

VI. CAPITATION RATES AND PERFORMANCE MEASURES

36. **Principles for Payment Methods that Support the Three-Part Aim.** The state will employ the following concepts in its payment methods to CCOs:

a. The state will transition to a payment system that rewards health outcomes improvement and not volume of services.

b. The state will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services. The global budget will be phased in, but will eventually consist of two parts: 1) a capitated per member per month (PMPM) payment; and 2) a separate PMPM payment for services not included under the capitation rate.

   Until January 2013, the global budget will include only capitated services (i.e., the first part above). After January 2013, the state will begin including additional services to the global budget (see Attachment F). These services may be included in the capitated portion of the global budget or in the separate PMPM payment methodology. The methodology for inclusion of additional services in the global budget will be mutually agreed upon by the state and CMS and phased in over the course of the demonstration. The state and CMS will finalize the methodology for inclusion of additional services within 120 days of this agreement.

   No payment will be made for CCO enrollees to FCHPs, MHOs and, if dental services are included in the CCO benefit package, DCOs.

      i. Attachment F provides a proposed schedule of inclusion of additional services into the CCO global budgets. Initial CCOs approved August through December 2012 will be at risk for Lines 1-8 through a PMPM global budget. The state intends to add service lines 9-22 to CCO global budgets over the course the demonstration. While the intent is to include as many services as possible within the PMPM payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding these services to the global budget. Until services are added to the global budget either through the PMPM or another methodology, CCOs are not at risk for services other than 1-8 in Attachment F. If the state wishes to add any services included in lines 23-38 in Attachment F, the state will work with CMS to determine the most appropriate methodology for inclusion of the additional services within the CCO global budgets and amend the Section 1115 waiver if necessary.

c. The CCO contract language will require the CCOs to consider alternative non-state plan services (the constellation of these services includes services known as "in-lieu of services," "substitute services," "flexible services," and "non-encounterable services" and hereafter referred to as "flexible services" in order to capture the array of potential services). CCOs are always at liberty to offer any *additional* health-related services at their discretion, as allowed under 42 CFR 438.6(e). Since enrollees may need additional services that are not substitutes for state plan services, which could ultimately improve the enrollee's health, the CCOs should use this option as necessary.

   i. The contract must not require specific, discrete service substitutions, but may require that the principle of "flexible services" (i.e., that CCOs look for more cost-effective services to replace or supplant the need for state plan services, as appropriate) be applied under the following circumstances:

      1. An enrollee's request to have a state plan service rather than a flexible service must be honored when medically necessary.

      2. All flexible services will be health related however the CCO will have broad flexibility in creating the array of services to improve care delivery and enrollee health. The state will report on the non-state plan services provided through the CCO contracts, including the effectiveness of the services in deterring higher cost care.

      3. Flexible services will be accounted for in the administrative expenses part of the capitation rate. Although flexible service will not be included in the medical expenses portion of the capitation rate, utilization assumptions may be applied.

   ii. The CCO contracts may levy performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. I.e., the more creative the CCOs are with flexible service delivery, health outcomes will improve and growth in per capita expenditures will decrease.

      1. As CCOs provide health care services that are more cost-effective than state plan services (which is what the capitation rate is based on), the capitation per capita growth rate should gradually decrease over the waiver period. The state will offset the decrease in capitation per capita rate growth with additional incentives outside of the capitation rate.

      2. Over time, the per capita expenditure trend should be lower through decreased use of unnecessary and costly services. This will happen when: 1)

Decreased utilization of unnecessary and costly services; 2) Financial reward of CCOs and their contracted providers for quality improvement, not volume of services; and 3) the health status of enrollees improves through coordination of care.

3. Success will be measured by and incentives paid based upon: 1) decreased rate of per capita Medicaid expenditure growth; 2) increased patient satisfaction with, and involvement in, care planning and quality of care; and 3) overall population health improvement.

d. In each year, the state and CCOs must track discrete services whether it is a state plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate.

37. **Structure.** Capitation rates and incentives for the Coordinated Care Organizations (CCOs) for each demonstration year (DY) will be structured as follows:

a. Demonstration Year 11:

i. Capitation rates. There will be no major changes in the currently approved rate-setting methodology for DY11.

ii. Incentives and Withholds. There will be no incentive payments made to CCOs or amount withheld from the CCOs.

iii. Special performance Standards. The state will apply special performance standards of timely and accurate data reporting in the first year.

b. Demonstration Years 12 through 15:

i. Capitation Rate Withhold. The first quarter of DY 12 will include a 1-percent capitation rate withhold that will be returned to CCOs successful in DY 11 performance metrics which reward timely and accurate data reporting A CCO that successfully meets the performance metrics of timely and accurate data reporting in DY 11 will receive the full capitation rate in this quarter. A CCO that does not meet the DY 11 performance metrics will not have the withhold restored, resulting in a 1-percent rate reduction. The state will determine the parameters for the special performance standards of timely and accurate data reporting within 120 days of this agreement.

ii. The state will have an additional 120 days after the agreement is in effect to address the details of DYs 12-15 so long as it is within the following parameters and subject to CMS approval:

1. Bonus Incentive Pool. The state will establish a separate bonus/incentive pool outside of the capitation rates (i.e., in addition to any capitation rate withholds). Incentives must be designed to reduce costs and improve health care outcomes. When developing the bonus pool, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing.

    a. The state will alert the CCOs that the bonus incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole bonus incentive pool amount will be at risk. The state will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark, and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance. Within 120 days of the demonstration approval, the state will submit and CMS will approve the specific requirements. The state will amend its CCO contracts to incorporate the changes immediately following the 120-day period.

2. CCO Provider Agreements. Incentives must be correlatively reflected in the CCO/provider agreements to insure that the incentives are passed through to providers to reflect the arrangement with the state-CCO contract.

iii. Each subsequent DY rates and incentives will be set in the DY preceding the implementation in order to apply program experience as the program matures (e.g., DY 13 rates and incentives will be set in DY 12). The state will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

VII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

38. **Overview.** Improving access and quality is a key component of the state health system transformation and measurement is necessary to determine whether the demonstration's goal of advancing the triple aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required.

39. **Metrics and Scoring Committee.** The state's strategy for a robust measurement includes the newly established Metrics and Scoring Committee. The Committee will review data and the relevant literature, determine which measures will be included in the CCO incentive program, and establish the performance benchmarks and targets to be used in this incentive program. The Committee will endorse/develop specifications for each measure. In future years, the Committee will review earlier decisions and make adjustments as needed. A transitional Metrics and Scoring Committee recommended a set of metrics for the first program year, which were described in CCO RFA contracts. Going forward, the permanent Metrics and Scoring Committee will recommend metrics that will be used to determine financial incentives for CCOs.

40. **Additional Quality Measures and Reporting at the CCO Level.** CMS developed an additional list of requirements for the Metrics and Scoring Committee that should be incorporated into the measurement planning and financial incentive determinations. This should not supplant the work of this committee, but rather provide some strategic direction to reach the two goals of this demonstration. The CCOs will be required to collect and validate data and report to the state on the metrics listed in this section, which may be revised or added to overtime as the demonstration matures, but these metrics will remain constant for the first 2 years of the demonstration. CMS also encourages the CCOs to report on the core set of performance measures for children and adults in Medicaid and CHIP.

    a. **Metrics to track quality improvement focus areas:** Pursuant to paragraph 25.b.i), the state and CMS will ensure the collection and validation of measures to track progress in the quality improvement focus areas. (See Attachment E)

    b. **Core set of quality improvement measures**. The initial core measures will track the following:

        i. Member/patient experience of care (CAHPS tool or similar);
        ii. Health and functional status among CCO enrollees;
        iii. Rate of tobacco use among CCO enrollees;
        iv. Obesity rate among CCO enrollees
        v. Outpatient and emergency department utilization;
        vi. Potentially avoidable emergency department visits;
        vii. Ambulatory care sensitive hospital admissions;
        viii. Medication reconciliation post discharge;

ix. All-cause readmissions;
x. Alcohol misuse-screening, brief intervention, and referral for treatment;
xi. Initiation & engagement in alcohol and drug treatment;
xii. Mental health assessment for children in DHS custody;
xiii. Follow-up after hospitalization for mental illness;
xiv. Effective contraceptive use among women who do not desire pregnancy;
xv. Low birth weight;
xvi. Developmental screening by 36 months; and
xvii. Difference in these metrics between race and ethnicity categories;

c. **Access improvement measures based on CCO data.** The state and CMS will identify and agree to additional access measures by 120 days after the approval of this demonstration planning period. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.

i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
ii. Percentage of adults with any outpatient visit.
iii. Percentage of adults with a chronic disease w/any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.
v. Percentage of children with at least one dental visit.
vi. Fraction of physicians (by specialty) 'participating' in the Medicaid program.
vii. Change in the number of physicians (by specialty) participating in Medicaid
viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
ix. Percentage of CCO enrollees with access to a PCPCH.

d. **Access improvement measures based on state survey data.** The state will identify and CMS will approve additional access measures, particularly measures based on survey data, by 120 days after the approval of this demonstration planning period. Additional survey-based measures could include:

i. Percent of beneficiaries with a usual source of care.
ii. Percent of beneficiaries with a preventive visit in past year.
iii. Percent of beneficiaries with a dental visit in past year.

iv. Percent of beneficiaries with any unmet needs.
v. Percent of beneficiaries delaying/deferring care due to cost.
vi. Percent of beneficiaries delaying/deferring care due to lack of available provider.
vii. Percent of beneficiaries delaying/deferring care due to provider office being. closed at time of illness.
viii. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

41. **Utilization of new services.** The state and CCOs must track discrete services whether it is a state plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement.

42. **Quality and Access Data Reporting from the State to CMS.** In accordance with paragraph 7765, "Monitoring to Assure Progress in Meeting demonstration Goals," the state will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the state will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 120 days of the demonstration approval, the state will submit and CMS will approve a reporting format.

43. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**

    a. **Statewide quality, access, and expenditure monitoring and analysis.** The state, working with the CCO Innovator agents, shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The state must report to CMS any CCO issues impacting the CCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights

    b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the state shall intervene promptly within 30 days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified.

Interventions may include but are not limited to focused learning collaboratives and/or innovator agents, targeting underlying issues affecting outcomes, performance, access and cost.

c. **Additional actions taken if goals are not achieved**. If the interventions undertaken pursuant to paragraph 43.b do not result in improved performance in identified areas of concern within 90 days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the state placing the CCO on a corrective action plan. The state must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the learning collaboratives and peer-support to the extent practicable.

44. **EQRO.** The state is required to meet all requirements found in 42 CFR 438, subpart E. The state will need to amend its current EQRO contract to require the reporting of outcomes information in the annual technical report related to performance measures and performance improvement projects. The state should generally have available its final EQR Technical Reports to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)]. In the first year of the transition to the CCO system and to a modified EQRO contract, CMS will use the quality and access data from the quarterly reports as identified in paragraph 42 to satisfy regulatory requirements.

45. **State Quality Strategy**. In accordance with CMS regulations, the state is required to submit a written strategy for assessing and improving the quality of managed care service offered by all managed care entities. This written strategy (also referred to as the "quality strategy") must meet all of the requirements found in 42 CFR 438, subpart D. Before implementing a final, approved quality strategy, the state is required to submit a draft quality strategy to CMS for approval within 120 days of the approval date of the demonstration. The state will submit a revised strategy to CMS within 60 days, whenever significant changes are made. The state will submit annual reports to CMS on the implementation and success of the strategy, by means of the annual EQRO technical report or a separate annual report that assesses the implementation and effectiveness of the quality strategy.

VIII. CALCULATING THE IMPACT OF HEALTH SYSTEMS TRANSFORMATION AND REDUCTIONS IN DESIGNATED STATE HEALTH PROGRAM FUNDING

This section establishes the parameters by which the state and CMS will annually measure the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved. Data specified in this section shall be reported on a quarterly and annual basis as specified in paragraph 65.

There are three levels of baseline and actual expenditures that the state must calculate and provide to CMS that will be measured and monitored annually under this demonstration. These levels are:

- 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,
- 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, and
- Level 3: The per member per month total expenditure to the state to *provide* care under Health System Transformation in Oregon.

46. The following section summarizes the specific populations, expenditures, and other variables that will be included in calculations of each of the expenditure levels described above.

a. **Level 1: Global Budget Expenditures**.

These expenditures are for services identified in Attachment F for all individuals enrolled in eligibility categories that are required to enroll in CCOs (mandatory populations) and for individuals that voluntarily enroll in CCOs that are in non-mandatory enrollment populations (voluntary populations). Expenditures would also include any incentive payments, shared savings payments made to CCOs as well as wrap-around or supplemental payments for services identified in the global budget and provided to these populations. This expenditure level is the level against which the health care cost trend targets and the associated funding consequences described in paragraph 54 will be based.

b. **Level 2: Medicaid Program Service Expenditures**

These expenditures are for all Medicaid services provided to all individuals enrolled in mandatory eligibility categories as well as those individuals enrolled in voluntary populations who voluntarily enroll in CCOs. This expenditure level includes all payments described in level 1 plus all other Medicaid payments for services provided under the demonstration or the state plan to individuals described in level 1 during a demonstration year. These additional expenditures would include services such as long

term care services that are not included in the global budget service package but are provided to individuals described in level 1.

c. **Level 3: Medicaid Program Costs for Health System Transformation**

This expenditure measure will capture total costs to support Health System Transformation (HST) and will include all costs in level 1 plus all costs that the state incurs for supporting HST including activities such as learning collaboratives, innovation agents, and other activities performed or contracted by the state to implement and operate HST.

47. **Calculating Baseline Expenditures.** The baseline expenditures to the state without Health Systems Transformation of these services will be developed using expenditure information from 2011 for the full calendar year. The costs will be developed for each level of spending for each eligibility group. These baseline costs will be transformed into aggregate per member per month costs based on total member months in 2011. The groups are:

Population	**Enrollment**
Children	Mandatory
Non-disabled Adults	Mandatory
Disabled Adults	Mandatory
Dual Eligibles	Voluntary

The baseline PMPMs for each level will be developed as follows:

a. Level 1: The actual baseline PMPM will include all costs for global budget services plus all wrap-around payments for all populations whose enrollment is mandatory or voluntary (as defined in Table 2 in paragraph 29). The base costs for global budget services will be divided by the total applicable member months to create an aggregate PMPM.

The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the state and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

b. Level 2: The actual baseline PMPM will include all level 1 costs plus all other Medicaid service expenditures attributable to 2011 for all individuals in both mandatory and voluntary populations. The total base costs for global budget services will be divided by the total applicable member months.

The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the state and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

c. Level 3: The actual baseline PMPM will include all level 1 costs by eligibility group and for the base year, should not differ from Level 1 expenditures as the additional costs in this category is expenditures supporting health system transformation.

The baseline PMPM in Level 1 will be the without Health System Transformation (HST) costs. The trend rate applied to the aggregate PMPM, which is based on the President's Budget estimates of the national rate of growth in Medicaid expenditures on a per member per month basis, is 5.4% for each year in the demonstration. If within the 120 day period following approval of the demonstration, the state provides analysis and data demonstrating that Oregon's trend differs substantially from this national average, and the Chief Actuary of CMS determines the difference to be valid and calculated reasonably and in accordance with general actuarial standards of practice, CMS will adjust this trend rate.

The PMPM calculation will be performed for each level (1, 2, and 3) described above in the aggregate.

48. **Calculating Actual Expenditures under Health System Transformation.** This measurement is based on actual DY expenditures for services and supports under HST. Actual HST PMPM expenditures will be calculated as follows:

a. Level 1: The actual HST expenditure PMPM will include all costs for global budget services plus all wrap-around payments.

For the mandatory populations, costs for global budget services will be included regardless of whether the CCO directly provided the services or not and whether or not individuals were enrolled in a CCO.

For voluntary populations, the costs for global budget services will be included regardless of whether the CCO directly provided the services or not. Expenditures and member months for individuals in the voluntary group will be included in this calculation only if they were enrolled in a CCO.

The state will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory populations and voluntary populations if they were enrolled in a CCO.

b. Level 2: The actual HST PMPM will include all Level 1 costs plus all other Medicaid service expenditures during the DY. For the mandatory populations, the total level costs will include both global budget services and all other Medicaid services provided to individuals in the mandatory eligibility groups.

For voluntary populations, costs will include all Level 1 costs plus all other Medicaid service expenditures during the DY only for individuals actually voluntarily enrolled in

CCOs. Individuals in the voluntary group will contribute their expenditures only if they were enrolled in a CCO.

The state will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory and voluntary populations.

c. Level 3: The HST PMPM will include all Level 1 costs by eligibility group and all costs incurred by the state for expenditures to support HST. The costs will include activities such as learning collaboratives, innovator agents, the quality and access metrics committee, and other administrative support the state may provide to facilitate the implementation and operation of CCOs and HST. The state will submit and CMS will approve within 120 days after the date of approval of the demonstration the activities and costs that will be included in the HST support expenditure category.

   For mandatory and voluntary populations, the HST calculation will include Level 1 aggregate expenditures plus aggregate, identified HST support expenditures divided by total Level 1 mandatory and voluntary member months.

49. **Calculation of Trend Reduction Targets:** The state must beginning immediately following DY 12 to annually demonstrate the savings achieved under HST using the without HST PMPM and the HST PMPM for Level 1 expenditures each DY. The savings requirements and penalties are described in paragraph 54.

    The PMPM savings percentages will be reported for each eligibility group and in the aggregate, although the savings reduction requirement will be applied only to the aggregate with and without HST expenditures. The aggregate HST PMPM must be below:

    a. the 5.4% without HST trend rate by 1 percentage point in DY 12 (i.e. aggregate PMPM expenditures in DY 12 must be no more than a 4.4% increase over DY 11 aggregate without HST PMPM expenditures).

    b. the 5.4% without HST trend rate by 2 percentage points in DY 13, 14 and 15 (i.e. aggregate PMPM expenditures in DY 13 must be no more than a 3.4% increase over DY 12 aggregate without HST PMPM expenditures).

50. **Return on Investment.** Annually, CMS will analyze the total return on investment in HST. The state must provide information (as part of the reporting requirements in paragraph 65) on total new federal funds claimed as DSHP as well as federal funds claimed using state funds repurposed as a result of DSHP relative to health savings achieved under the health transformation process. Elements in the analysis will include:
    a. New federal funds drawn as match against DSHP programs.
    b. New federal funds drawn as a result of DSHP. Under the state's proposal, this includes all federal funds drawn associated with state funds redirected from DSHP except DY1 rate stabilization.

c. Savings identified in the total cost of purchasing care in level 3 as described above (the total investment in HST).

51. **Evaluating Impact on Medicare and Medicaid Expenditures for Dual Eligibles.** In addition to expenditure estimates in paragraphs 47, 48, and 49, CMS and the state will examine total expenditures on individuals who are dually eligible for Medicaid and Medicare who are enrolled in CCOs.

52. **Measurement of Quality and Access Under the Demonstration.** The state will also monitor and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 65. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.

    Within 120 days of approval of the demonstration, the state will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's Medicaid population as a whole. The state's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). state quality and access reporting will take place on the same timeframes as the state's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

53. **Deliverables to be Negotiated Within 120 Days Post Approval:** Within 120 days of approval of the demonstration, CMS and the state will:

    a. Finalize the benefit package for the global payment Level 1 analysis during the demonstration period (Attachment F).
    b. Finalize the parameters of the total cost of care for levels 2 and 3 by identifying all payments and costs subject to inclusion in the costs of care calculation.
    c. Finalize the annual per capita amount for the baseline period.
    d. Finalize safe harbor language to limit risk to the state for increases in FQHC wrap-around payments for reasons that are not within the state's control for the purposes of Level 1 calculations. Valid reasons would include an increase in FQHCs in the state relative to the base year or changes in scope of service that actually effect the PPS rate.
    e. Finalize a methodology for the treatment of long term care services and supports (LTSS) expenditures.

f. Finalize the return on investment formula template and the per capita reporting templates.
g. Finalize the calculation of cost shifting using Medicaid uncompensated care (shortfall) using DSH audit information.
h. Finalize the timing of and reporting format of the annual expenditure and savings calculations.
i. A plan for specific quality and access measures that the state and CMS will use to monitor access and quality during the demonstration, as well as methods for such measurement and reporting timeframes.
j. CMS will review, discuss with the state, and approve all of the above deliverables within 30 days after the 120 day period.

54. **Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets**

This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. **Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates**. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 49, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Table 3: Per Capita Expenditure Growth Reduction Targets and Associated DSHP Expenditure Authority Reductions for Failure to Meet Targets

Demonstration Year	Per Capita Expenditure Growth Reduction Target (measure following DY close)	Reduction in DSHP Expenditure Authority (reduce succeeding DY's DSHP expenditure authority)
DY11	NA	NA
DY12	1 percentage point	$54 million
DY13	2 percentage points	$68 million
DY14	2 percentage points	$68 million
DY15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the state in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the state has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. **Earn Back Option.** For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:
    i. If the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year *and* significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.
    ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.
    iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

IX. DESIGNATED STATE HEALTH PROGRAMS

55. **Designated State Health Programs (DSHP).** To support the goals of health system transformation, the state may claim FFP for the following state programs subject to the annual limits and restrictions described below through June 30, 2017, unless otherwise specified. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment G. Subject to approval by the federal Office of Management and Budget, these expenditures can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of paragraph 54.

56. **Aggregate DSHP Annual Limits** – Expenditure authority for DSHP is limited to $704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by year as follows:

Table 4: Aggregate DSHP Annual Limits

Demonstration Year	Time Period	Annual Limit on FFP
DY 11	07/1/12-06/30/13	$230 M
DY 12	07/1/13-06/30/14	$230 M
DY 13	07/1/14-06/30/15	$108 M
DY 14	07/1/15-06/30/16	$ 68 M
DY 15	07/1/16-06/30/17	$ 68 M

57. **Restrictions on DSHP Programs.** Approved Designated State Health Programs for which FFP can be claimed are outlined below subject to the following funding limits by the four categories listed below. Prior to claiming funding for these programs, the state will submit and CMS will approve a DSHP claiming protocol. The state is not eligible to receive FFP until the protocol is approved. Upon CMS approval of the claiming protocol, state is eligible to receive FFP for the approved DSHP program expenditures beginning July 5, 2012.

Table 5. Limits on Allowable Designated State Health Programs

Expenditures by Type of Designated State Health Programs:	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**Total**
Oregon Medical Insurance Program	93	93	0	0	0	186
Workforce Training	69	69	40	0	0	178
Gero-Neuro	8	8	8	8	8	40
Other CMS Approved*	60	60	60	60	60	300
Total	**230**	**230**	**108**	**68**	**68**	**704**

*See Table 6 for all approved programs.

a. **Oregon Medical Insurance Program.** The state may claim FFP for expenditures related to the Oregon Medical Insurance Program only for DYs 11 and 12.

b. **Workforce Training.** To promote improved access and quality of care for Medicaid beneficiaries in the state by supporting the development of the health care workforce in the state and to the extent that such education promotes the rate of Medicaid participation among Oregon providers, the state may claim FFP for health workforce training programs and related supports at Oregon Health and Science University (OHSU), Oregon University System (OUS), and community colleges as follows; Blue Mountain, Clatsop, Linn Benton, Rogue, Umpqua, Central Oregon, Columbia Gorge, Mt

Hood, Southwestern, Chemeketa, Klamath, Oregon Coast, Tillamook Bay, Clackamas, Lane, Portland, Treasure Valley. The state may only claim FFP for workforce training DSHP programs in DYs 11-13. The annual limit the state may claim FFP for workforce training programs is limited to direct and indirect costs and shall not exceed $69 million in each of DYs 11 and 12 and $40 million in DY 13.

i. **Loan Repayment:** To ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the State shall commit to funding a primary care provider loan repayment program, with the following conditions:

By July 1, 2013, the state shall establish an annual funding level of $2,000,000 to provide assistance to providers who make written commitments to serving Medicaid populations in rural and underserved areas. If the state is unable to establish funding for this program at the amount specified in this term, the state's Workforce Development state designated health program expenditure authority must be reduced. The DSHP Workforce Development funding must be reduced by 25 percent of the difference between the $2,000,000 and the amount that the state is able to reinstate for the loan repayment program for Demonstration Years 12 and 13.

ii. **Training for Community Health Workers:** The state, through its Community Colleges, shall establish Community Health Worker curriculum that meets the core training elements established by the Oregon Health Policy Board. The state shall train 300 additional Community Health Workers by December 2015.

iii. **Increased Workforce/Provider Capacity.** The state must track the number of Medicaid primary care providers (including nurse practitioners, etc.). The state must submit to CMS within 180 days of the date of the demonstration amendment approval letter, a report detailing the number and types of primary care providers that are currently seeing Medicaid beneficiaries in the state of Oregon. In addition, the state must track where the graduates of these Educational Institutions are working and whether they become Medicaid providers beginning with DY 12 Quarterly and Annual Reports.

c. **Gero-Neuro.** The state may not begin claiming FFP for the Gero-Neuro program until the state begins the process to recertify the facility as an IMD meeting the inpatient hospital requirements as set forth in 42 CFR section 440.140 which include by reference requirements for the hospital conditions of participation at 42 CFR 482. Medicaid and CHIP citizenship rules apply as a condition for receiving FFP.

d. **Other CMS Approved DSHP.** For DYs 11-15, the state may claim FFP for expenditures related to state health programs specified in the "other" category of Table 6 in paragraph 58, subject to a 4.2% reduction on an annual basis. To the extent that the state identifies other programs in this category that support the health care needs of low-income, uninsured Oregonians, the state may submit to CMS for review and approval additional program expenditures for which expenditure authority may be provided. In the event of a shortfall in the "other" category, CMS will consider additional expenditures for OMIP if the state is able to document such expenditures. Additionally, subject to the aggregate annual DSHP limit, the state may exceed the amounts listed in Table 5 for the "other" category only in the event there is a shortfall in the remaining categories. The state must notify CMS in advance of the anticipated shortfall amount by category and the amount of funds to be redirected to either "OMIP" or "other" category. Upon approval, the state may only prospectively claim additional expenditures over the individual limits for OMIP and the "other" category. The state must not exceed the annual aggregate limit. For any additional OMIP or other expenditures, the state must obtain prior CMS approval for the methodology used to claim any such additional expenditures, subject to the aggregate limit described in Table 5. Once all relevant approvals are obtained, CMS and the State will update the DSHP claiming protocol (Attachment G).

58. **Specified Designated State Health Programs (DSHP).** The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and limits described in section XIII of the STCs.

Table 6.

DSHP
OTHER
Non-Residential Adult (AMH1)
Child and Adolescent (AMH1)
Regional Acute Psychiatric Inpatient (AMH1)
Residential Treatment for Youth (AMH2)
Adult Foster Care (AMH2)
Older/Disabled Adult (AMH2)
Special Projects
Community Crisis
Support Employment (AMH1)
Homeless (AMH1)
Residential Treatment (AMH2)
Non-Residential Adult (Designated)

A & D-Special Projects (AMH3)
A & D Residential Treatment - Adult (AMH4)
Continuum of Care (AMH5)
System of Care (CAF1)
Community Based Sexual Assault (CAF2)
Community Based Domestic Violence (CAF3)
Family Based Services (CAF5)
Foster Care Prevention (CAF6)
nhanced Supervision (CAF8)
Nursing Assessments (CAF11)
Other Medical (CAF13)
IV-E Waiver (Demo Project for Parenting, mentoring, enhanced supervision)
Personal Care (CAF17)
Oregon Project Independence
SE #150 Family Support (SPD3)
SE #151 Children Long-Term Support (SPD4)
Licensing Fee
General Microbiology
Virology
Chlamydia (PHD4)
Other Test Fees (PHD5)
State Support for Public Health (PHD6)
(Newborn screening OF is used for match for the MCH block grant) (PHD11)
Prescription Drug Monitoring Program (PHD7)
HIV Community Services (PHD8)
General Funds - HST (PHD9)
Sexually Transmitted Diseases
Mental Health Treatment
Drug and Alcohol
Formerly Medically Needy (Organ Transplant) Clients
Workforce Training To Promote Medicaid Provider Participation
Undergraduate and graduate health professions education
OMIP
State Hospitals (OSH and BMRC)
Gero-Neuro

X. TRIBAL HEALTH FACILITY PAYMENT PROGRAM FOR UNCOMPENSATED CARE

Through a tribal health program for uncompensated care, the state shall make supplemental payments to IHS and tribal health facilities operating under ISDEAA 638 authority: 1) for uncompensated care costs of primary care services on the prioritized list which are no longer

funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) for uncompensated care costs of primary care services on the prioritized list provided to individuals who have no Medicare, Medicaid, CHIP or other coverage, with incomes up to 133 percent of the Federal Poverty Level (FPL)..

59. **Payments to IHS and tribal health facilities.** The state is authorized under expenditure authority of this demonstration to make payments to (IHS) and tribal health facilities subject to the following conditions:

    a. Individuals receiving care at these facilities would continue to receive acute care hospital and specialty care services as they do now through the IHS contract health service referral system. These services are not included for payment under this section.

    b. Services will continue to be provided in these tribal health facilities to non-IHS beneficiaries according to the eligibility policy currently set by the IHS or tribal health authorities in accordance with the Indian Health Care Improvement Act.

    c. Payment will be based on the approved methodology set forth in Attachment I, Tribal Health Facility Payment Program Claiming Protocol.

    d. These payments will expire after December 31, 2013.

XI. GENERAL REPORTING REQUIREMENTS

Effective January 1, 2014, reporting requirements will change to reflect the new eligibility and benefits structure. The state will submit timely requests for amendment of the demonstration, consistent with the Transition Plan required by demonstration paragraph 13, in order to implement the reporting requirement changes by January 1, 2014.

60. **General Financial Requirements.** The state shall comply with all general financial requirements under Title XIX and XXI set forth in these STCs.

61. **Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request, including revised budget and allotment neutrality spreadsheets consistent with these STCs.

62. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR Section 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

63. **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, CCO/MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the OHP Standard demonstration group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, CCO/MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

64. **Quarterly Progress Reports.** The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter. CMS will provide the format for these reports in consultation with the state. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. An updated CHIP allotment neutrality monitoring spreadsheet;

    c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the OHP demonstration; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative activities, litigation status and other operational issues;

    d. Action plans for addressing any policy, administrative, or budget issues identified;

    e. Quarterly enrollment reports required under paragraphs 69 and 72; and

    f. Evaluation activities and interim findings.

    g. FHIAP Reporting inclusive of:

        i. **Premium Costs (member share and state subsidy):** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

        ii. **Subsidy Costs:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iii. **Enrollee Premium Contributions:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iv. **Employer Contributions:** By subsidy level, with a weighted overall average.

v. **Overall Premium Cost:** For individual and group, with a weighted overall average.

vi. **Overall Subsidy Cost:** For individual and group, with a weighted overall average.

65. **Monitoring To Assure Progress in Meeting Demonstration Goals:** The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the state's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of demonstration goals.

a. **Interim Reporting Format.** The state and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;
ii. Quality Improvement Metrics: Section VII;
iii. Access to Care measures: Section VII;

b. **Timeframe for Reporting.** The state will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.

c. **Data Sources:**

i. Goal 1:
1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with state);
2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;
3. Total Medicaid service spending per beneficiary; and
4. CCO provider spending per beneficiary.

ii. Goal 2:
1. Benchmarked metrics tied to incentive payments, including patient experience surveys;
2. Data from the all payer-all claims database;
3. Process Improvement Projects (PIPs);
a. EQRO studies;
b. Complaints and grievances;

c. Health risk assessment data;
d. Public health data;
e. Health risk assessment data;
f. Meaningful use attestation data;
g. State CCO monitoring reports; and
h. Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the duals demonstration.

d. **Final Annual Report:** The state shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The state will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.

e. **Penalty for Late Reporting:**

i. If the state fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The state may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that prevents the state from reporting timely, the state can request an exception to these timeframes and penalties.

Percentage withheld of quarterly demonstration administrative funding	Days late
.2	15-30
.4	30-40
.8	41-50
1	51+

66. **Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration covering Medicaid and CHIP populations. The draft report is also to include, at a minimum, the following:

a. **FHIAP activity**: the names of all participating private individual insurance plans and carriers; any changes in participating individual insurance plans and carriers; the number of OHP eligible participants enrolled with each individual insurance plan or carrier; and the amount of premium subsidies paid each individual insurance plan and carrier.

b. **Premium Assistance Evaluation Related to Cost Effectiveness.** Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the state's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The state provides limited wrap around services.

   i. The state will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:

      1. FHIAP's (populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies); to

      2. OHA direct coverage (populations 1 through 11 in Attachment D) overall pm/pm costs.

   ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in populations 12, 14, 16, 17, and 18 in Attachment D are based on maximum plan out of pocket costs (excluding premium share) to:

      1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.[4]

   iii. OPHP will monitor program expenditures for HK ESI (population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.

   iv. OPHP will report average aggregate cost sharing for HK ESI plans (population 20 in Attachment D) based on maximum plan out of pocket costs (excluding premium share).

   v. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

c. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual

[4] OHP Plus applies co-pays on an extremely limited basis: none for children, pregnant women, OAA and AB/AD clients with long-term care services, and only limited co-payments for other groups. Thus, they are not likely to provide a fair comparison with FHIAP and ESI cost sharing.

report shall be submitted. The state shall also submit the title XXI annual state report for its FHIAP children in the demonstration.

67. **Beneficiary Survey.** The state shall conduct surveys, at least every other year, of OHP enrollees and providers that assess the following information: enrollee health status; satisfaction with provider communication; and access to routine and specialty care. The surveys will be designed to allow analyses based on CCOs/MCOs and benefit plans. The state will also monitor and report on disenrollment requests and the reasons for the requests.

68. **Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act, and as specified in Section XV of these STCs.

69. **Enrollment Reporting.**

    a. Through the end of the second quarter of FY 2014, each quarter the state will provide CMS with an enrollment report for the title XXI FHIAP population, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30-days after the end of each quarter. The data will be reported for the same groups, categories and in the same manner as the state reports enrollment data for CHIP state plan population as described in Section 457.740 of the CHIP Final Regulation. SEDS reporting is required for any title XXI-funded population, including populations, and is also required for title XIX Medicaid child enrollment.

    b. Enrollment reporting in the Quarterly and Annual Reports is required by Eligibility Group (EG) and Type for the title XIX and XXI state Plan and populations.

    c. Quarterly Enrollment Reports. Within 60-days of the end of the quarter, the state shall provide CMS with an enrollment report by population showing the end of quarter actual and unduplicated enrollment. The state shall also report on the percent change in each category from the previous quarter and from the same quarter of the previous year. The state shall also report the number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

XII. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

70. **Title XIX Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under section 1115 authority and subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIII of these Terms and Conditions.

71. **Reporting Title XIX Demonstration Expenditures.** The following describes the reporting of title XIX expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures**. In order to track expenditures under this demonstration, Oregon must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual.

i. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver.

ii. Year 1 (DY 1) is defined as the year beginning October 1, 2002, and ending September 30, 2003. DY 2 and subsequent DYs are defined accordingly, through DY 9. DY 10 is defined as beginning November 1, 2011 and ending June 30, 2012. Beginning with DY 11, the Year is defined as beginning July 1, 2012 and ending June 30, 2013. DY 12 and subsequent DYs are defined accordingly. To simplify reporting, expenditures from the original Oregon Health Plan demonstration (11-W-00046/0) paid on or after October 1, 2002, shall be considered expenditures under OHP 2, and must not be reported on any Form CMS-64.9 Waiver or 64.9P Waiver for the original Oregon Health Plan demonstration.

iii. Up to and including the July-September 2008, QER, demonstration expenditures are to be reported on Forms CMS-64.9 Waiver and 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) in which payments were made for services.

iv. At the end of the demonstration, expenditures for which payment was made after the last day of the demonstration, but were for services or coverage provided during the demonstration period, are subject to the budget neutrality expenditure limit. These expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the demonstration project number assigned by CMS, with a project number extension equal to the DY number of the last year of the demonstration plus one. For example, if the last year of the demonstration is DY 8, the Forms CMS-64.9 Waiver and/or 64.9 P Waiver discussed here will bear the project number extension 09. The use of the last DY plus one as a project number extension is a reporting convention only, and does not imply any extension of the budget neutrality expenditure limit beyond the last DY.

v. All title XIX service expenditures that are not demonstration expenditures should be reported on the appropriate Forms CMS-64.9 Waiver/64.9P Waiver for another demonstration or waiver, if applicable, or on Forms CMS-64.9 Base/64.9P Base.

b. **Premium and Cost-Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the Eligibility Groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost-settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver schedules, and allocated to forms named for the different EGs described in (e) below, as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to populations shall be offset against expenditures.

e. **Use of Waiver Forms.** The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

   i. "Current": Base 1 EG expenditures;
   ii. "New": Expansion EG expenditures;
   iii. "SSI": Base 2 EG expenditures.
   iv. DSHP Expenditures
   v. CCO Expenditures
   vi. Indian Health Service or tribal health facility expenditures

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to (1) all title XIX expenditures with dates of service between November 1, 2002 and the end of the OHP2 demonstration on behalf of individuals who are enrolled in this demonstration, net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse) and (2) expenditures with dates of service during the original Oregon Health Plan demonstration that are reported as OHP2 expenditures under paragraph 71.a.ii) above. However, certain Title XIX expenditures,

as identified in paragraph 18.e.viii), are not subject to the budget neutrality expenditure limit. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit. Nevertheless, the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10 P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) for which the costs were expended.

h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the later 2-year period, the state must continue to separately identify net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 Waiver forms, in order to account for these expenditures properly to determine budget neutrality.

i. **Review of Past Expenditure Reporting and Corrective Action.** The state will conduct a review of title XIX expenditures reported on Form CMS-64 during the approval period for the OHP demonstration to ensure that expenditures subject to the budget neutrality expenditure limit have been reported appropriately, according to the instructions contained in this paragraph. The review will seek to verify that all demonstration expenditures have been reported on Forms CMS-64.9 Waiver, as required by the STCs, and not on any other CMS-64 form, and that no non-demonstration expenditures have been reported on Forms CMS-64.9 Waiver for the demonstration. The review will also ascertain whether demonstration expenditures have been reported under the correct DY. By the end of the second month following the date of approval of this extension, the state will submit a draft plan to the Project Officer for conducting the review, and for taking action to correct past reporting, subject to CMS approval. All corrective actions must be completed by October 31, 2009. At a minimum, the corrective action must result in the expenditures pertaining to the DY ending September 30, 2003 being identified as DY 01 expenditures, and correspondingly for subsequent DY. The state completed this corrective action on November 30, 2009.

72. **Reporting Member Months:** The following describes the reporting of member months for demonstration eligibles from October 1, 2002, forward:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 64 of these STCs, the actual number of eligible member months for all

Medicaid and demonstration Member-Month Reporting Groups (MMRGs) defined in the table below. The state must submit a statement accompanying the quarterly report, which certifies the member-month totals are accurate to the best of the state's knowledge. These member month totals should include only persons for whose expenditures the state is receiving matching funds at the Title XIX FMAP rate. The state must also ensure that member-months reported as FHIAP member-months are also not simultaneously reported as direct coverage member-months. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

MMRG	Included Populations	Limitations
Base 1 - Direct Coverage		
AFDC	6	
PLM-A Pregnant Women	1, 2,	
PLM Children	3, 4	
BCC Population	21	
Expansion - Parents or Medicaid		
Expansion Parents up to and including 100% FPL	10	
FHIAP (Medicaid)	14	
Base II Direct Coverage		
OAA	7 (aged only), 8 (aged only)	
Blind/Disabled	7 (blind/disabled only), 8 (blind/disabled only)	
Foster Children	5	

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

c. For the purposes of this demonstration, the term "demonstration eligibles" refers to the eligibility categories described in paragraphs 19, 0(a), and 22.b).

73. **Standard Medicaid Funding Process.** The Standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

74. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section entitled "Monitoring Budget Neutrality For The demonstration" of these STCS.

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

    c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

    d. Tribal Health Program for Uncompensated Care to IHS and tribal health facility.

75. **Sources of Non-federal share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

    c. Should the state exhaust all available Title XXI funding, the state may submit amendments to the CHIP and Medicaid State Plans to create a title XXI funded Medicaid expansion program. This would allow the state the ability to revert to title XIX funds for those populations covered under the Medicaid expansion program. CMS will provide an expedited timeline and complete review of both amendments within 60 days of submittal.

    d. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related

taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XIII. GENERAL FINANCIAL REQUIREMENTS FOR TITLE XXI STATE PLAN AND TITLE XXI DEMONSTRATION

Starting November 1, 2007, no expenditures are authorized to be reported on the CMS-21 Waiver and/or 21P Waiver form for title XXI funded populations in this demonstration. The following paragraphs govern reporting of title XXI demonstration expenditures for the demonstration approval period ending October 31, 2007, including prior period adjustments.

76. **Title XXI Quarterly Expenditure Reports.** The state must report state plan and demonstration expenditures using the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outline in section 2115 of the State Medicaid manual. The state shall use Form CMS-21 to report total expenditures for services provided under the approved CHIP plan. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP only for allowable Oregon demonstration expenditures that do not exceed the state's available title XXI funding.

In order to track expenditures under this demonstration, the state will report demonstration expenditures through the MBES/CBES, as part of the routine quarterly CMS-21 Waiver/CMS-21P Waiver reporting process. Title XXI demonstration expenditures will be reported on separate CMS-21 waiver forms, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the dtate must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21 Waiver and/or 21P Waiver.

b. The standard CHIP funding process will be used during the demonstration. On a separate Form CMS-21B, the state shall provide updated estimates of expenditures for the population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-21 Waiver and/or 21P Waiver. CMS will reconcile expenditures reported on the Form CMS-21 waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

c. The state will certify state/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

77. Oregon will be subject to a limit on the amount of federal title XXI funding that the state may receive on demonstration expenditures during the waiver period. federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available.

78. Total federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the state plan population. Demonstration expenditures are limited to remaining funds.

79. Total expenditures for outreach and other reasonable costs to administer the title XXI state plan and the demonstration that are applied against the state's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

80. All federal rules shall continue to apply during the period of the demonstration that state or title XXI federal funds are not available. The state is not precluded from closing enrollment or instituting a waiting list with respect to the population. Before lowering the FPL used to determine eligibility, closing enrollment or instituting a waiting list, the state will provide 60-day notice to CMS.

XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

81. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in paragraph 71.

82. **Risk.** Oregon shall be at risk for the per capita cost (as determined by the method described below in this Section) for "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and "Expansion - Parents or Medicaid" population (as defined in paragraph 72(a) reporting of Member Months) enrollees under this budget neutrality agreement, but not for the number of such enrollees. By providing FFP for all "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and Expansion - Parents or Medicaid" enrollees, Oregon shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Oregon at risk for the per capita costs for these enrollees, CMS assures that the fderal demonstration expenditures will reflect Oregon's estimates of savings from managed

care, CCO implementation the priority list, and the use of OHP Standard and the FHIAP benefit packages. Oregon will be at full risk for both enrollment and per capita cost for "Expansion – Childless Adults/Other" eligibles (as defined in paragraph 72(a)). Effective with the implementation of the ACA, these Expansion populations will become mandatory, and Oregon will no longer be at full risk for either enrollment or per capita cost.

83. **Budget Neutrality Ceiling.** The following describes the calculation of the yearly targets mentioned in paragraph 81. This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP through the end of the approval period.

    a. The Base 1 Subtotal is calculated by multiplying the actual number of member-months for each "Base 1" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.
    b. The Expansion Upper Limit is equal to the total number of Base 1 member months times the Oregon Ratio, which is equal to 46.86 percent.

    c. Between October 2002, and October 2007, the following rules will govern calculation of the Expansion subtotal.

        i. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is less than the Expansion Upper Limit, then the Expansion Subtotal is calculated by multiplying the actual number of member-months for each Expansion MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

        ii. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is more than the Expansion Upper Limit, the Expansion MMRG totals are adjusted downward by multiplying them by the ratio calculated by dividing the Expansion Upper Limit by the actual total number of Expansion member-months. The adjusted member-month totals are then used in place of the unadjusted totals to calculate the Expansion Subtotal, following (c) above.

    d. Beginning November 2007, and thereafter, the Expansion subtotal will be calculated by multiplying the actual number of member-months for each "Expansion - Parents or Medicaid" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together. The Oregon Ratio calculation will no longer be used after October 31, 2007.

    e. The Base 2 Subtotal is calculated by multiplying the actual number of member-months for each Base 2 MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

f. The annual limit is calculated as the sum of the Base 1 Subtotal, Expansion Subtotal, and Base 2 Subtotal. The cumulative budget neutrality expenditure limit is equal to the sum of the annual limits over the entire period of the demonstration.

g. The following table gives the projected PMPM costs for the calculations described above.

i. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
AFDC	$420.74	6.2%	$446.83	$474.53	$504.08
PLM-A Pregnant Women	$1,605.08	6.1%	$1,702.99	$1,806.87	$1,917.16
PLM Children	$613.21	6.2%	$651.23	$691.61	$ 734.70
Individuals receiving treatment under the Breast and Cervical Cancer Medical (BCCTP) program		6.2%	$		$2504.78

ii. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Expansion Parents to 100% FPL	$326.31	6.1%	$346.21	$367.33	$391.86
FHIAP (Medicaid)	$294.48	6.2%	$312.74	$332.13	$352.72

iii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Old Age Assistance	$546.17	5.0%	$573.48	$602.15	$658.53
Blind/Disabled	$1,750.67	5.8%	$1,852.21	$1,959.64	$2179.61
Foster Children	$735.95	6.2%	$781.58	$830.04	$887.03

The following table gives the projected PMPM costs for demonstration years 12 through 15. For DY 12 (July 1, 2013 to June 30, 2014) a blended per member per month was created to account for 4 months of state historical rate and 8 months of 2013 President's budget trend rate.

a. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM 7/1/14-6/30/15	DY 14 PMPM 7/1/15-6/30/16	DY 15 PMPM 7/1/16-6/30/17
AFDC	$529.80	4.5%	$553.83	$578.95	$605.22
PLM-A Pregnant Women	$2018.86	4.9%	$2117.88	$2221.76	$2330.74

PLM Children	$768.80	3.8%	$798.32	$828.98	$860.81
BCCTP	$2631.69	4.5%	$2750.12	$2873.87	$3003.20

i. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Expansion Parents to 100% FPL	$658.53	4.9%			
FHIAP (Medicaid)	$352.72	4.9%			

ii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Old Age Assistance	$721.39	4.1%	$786.23	$855.19	$928.47
Blind/Disabled	$2419.85	5.1%	$2673.57	$2946.88	$3241.11
Foster Children	$934.56	3.8%	$977.06	$1021.43	$1067.77

Beginning 1/1/2014 MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
New mandatory adults	$522.00	7%	$559.88	$600.50	$644.07

84. **Future Adjustments to the Budget Neutrality Expenditure Limit.**

a. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under OHP. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903 (w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. Should the state submit a state plan amendment to expand coverage, the state must submit written notification to the Project Officer, including a proposal for how the new or expanded eligibility group will be incorporated into the budget neutrality test for OHP.

85. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the composite federal share. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process through an alternative mutually agreed to method.

86. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds shall be returned to CMS.

    a. To perform the budget neutrality test, actual cumulative FFP received by the state on OHP demonstration expenditures are compared to the federal share of the cumulative OHP budget neutrality expenditure limit. The federal Share of the cumulative budget neutrality expenditure limit is equal to the cumulative budget neutrality expenditure limit calculated above (on a total computable basis) times the composite federal share, which is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by total computable demonstration expenditures for the same period. Actual expenditures are those reported on Form CMS-64, as described in paragraph 71 above. The state may include budget neutrality savings from the original Oregon Health Plan demonstration (11-W-00046/0) in its application of the budget neutrality test for OHP.

    b. Should the demonstration be terminated prior to the end of the approval period (see paragraphs 9, 10, and 12, the budget neutrality test (including calculation of the Composite federal share) will be based on the period in which the demonstration was active.

    c. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite federal share may be used.

    d. Interim Checks/Corrective Action Plan. If the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
DY 9	Cumulative budget neutrality cap plus:	0.25 percent
DY 10	Cumulative budget neutrality cap plus:	0.25 percent
DY 11	Cumulative budget neutrality cap plus:	0 percent

DY	Cumulative Target Definition	Percentage
DY 12	Cumulative budget neutrality cap plus:	0.25 percent
DY 13	Cumulative budget neutrality cap plus:	0.25 percent
DY 14	Cumulative budget neutrality cap plus:	0.25 percent
DY 15	Cumulative budget neutrality cap plus:	0 percent

X. EVALUATION OF THE DEMONSTRATION

87. **Evaluation Design.** In the 120 days following the date of approval of this demonstration, the state shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the state will consider the Evaluation Guidance in Attachment B. The evaluation will include:

    a. A discussion of the demonstration hypotheses that will be tested, focusing on key areas of the state's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional demonstration outcome measures;
    b. An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.
    c. Any other information pertinent to the state's evaluative or formative research via the demonstration operations.
    d. Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;
    e. The draft plan shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation; and
    f. Any other information pertinent to the state's evaluative or formative research via the demonstration operations

88. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of Section 1115 (a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

89. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

90. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

Attachment A - Quarterly Report Guidelines

(updated December 18, 2012)

As written within these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. In particular, the reporting elements may change to take advantage of new reporting via automated data systems that will support the transmission of data through data portals and other electronic reporting channels.

A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided in Appendix D.

REPORT FORMAT

I. Introduction

A. Letter from the State Medicaid Director – overview of the report

B. Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

C. State Contact(s):

1. Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise concerning quarterly reports.

II. Title

Title Line One – Oregon Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 11 (7/1/2012 – 6/30/2013)

Federal Fiscal Quarter: 4/2012 (7/2012 – 9/2012)

III. Events affecting health care delivery during the current quarter

Table 1 – Overview of significant events across the state affecting health care delivery during the current quarter

Table 1 is a statewide overview of the effect, or impact, of changes – positive, negative or with neutral effect – happening in the current quarter that are noteworthy because they reflect trends, major policy modifications or planned or unforeseen occurrences that affect:

- **The demonstration goals** of better health, better care, and lower costs as reflected in measures of efficiency, value and health outcomes;
- **A substantial portion of the delivery system**; or
- **A substantial portion of beneficiaries**.

Each category identifies data sources and whether there is a documented impact on the delivery system or beneficiaries. This table also shows interventions, or actions, the state may take or require to remedy, sustain or improve an outcome, as appropriate.

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
A. Enrollment progress	Quarterly enrollment reports – Appendix A				
B. Benefits	Provider and member transmittals – online at: http://www.dhs.state.or.us/policy/healthplan/transmit/main.htm				
C. CCO Complaints and Grievances	Monthly/quarterly CCO logs submitted to OHA and presented with detail in Table 2				
D. Quality of care – CCO	CCO and Innovator agent reporting to OHA as reported in Table 3 and Appendix F				
D. Quality of care – MCO	MCO reporting to OHA as reported in QI monitoring reports				
D. Quality of care – FFS	OHA FFS reporting				

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
E. Access	CCO and Innovator agent reporting to OHA as reported in Appendix F				
F. Provider Workforce	OHA surveys, summarized in Table 4				
G. CCO networks	CCO and Innovator agent reporting to OHA as summarized in Table 5 and Appendix F				

Detail on impacts or interventions

C. Table 2 – Complaints and grievances – statewide report -- all categories of CCO complaints and grievances for the current quarter

See www.oregon.gov for quarterly reports of complaints and grievances for individual CCOs.

NOTE: Oregon defines a grievance as any written or verbal complaint by an enrollee or consumer, or the enrollee's representative, regarding the enrollee's quality and access of care, individual or system abuse or neglect, issues related to the health plan's compliance with the Medicaid Program rules, billing complaints related to rights and limitations as provided by 42 CFR §438 and complaints related to eligibility and/or enrollment.

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
ELIGIBILITY AND ENROLLMENT					
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.					
b) Plan unresponsive, not available or difficult to contact for appointment or information.					
c) Provider's office too far away, not convenient					
d) Unable to schedule appointment in a timely manner.					
e) Provider's office closed					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
to new patients.					
f) Referral or 2nd opinion denied/refused by provider.					
g) Unable to be seen in a timely manner for urgent/ emergent care					
h) Provider not available to give necessary care					
i) Eligibility issues					
j) Client fired by provider					
INTERACTION WITH PROVIDER OR PLAN					
a) Provider rude or inappropriate comments or behavior					
b) Plan rude or inappropriate comments or behavior					
c) Provider explanation/instruction inadequate/incomplete					
d) Plan explanation/instruction inadequate/incomplete					
e) Wait too long in office before receiving care					
f) Member dignity is not respected					
g) Provider's office or/and provider exhibits language					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
or cultural barriers or lack of cultural sensitivity.					
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity					
i) Lack of coordination among providers					
CONSUMER RIGHTS					
a) Provider's office has a physical barrier					
b) Abuse, physical, mental, psychological					
c) Concern over confidentiality					
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.					
e) No choice of clinician					
f) Fraud and abuse					
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)					
h) Plan bias barrier (age, race, religion, sexual rientation, mental/physical health					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
status)					
i) Differential treatment for Medicaid clients					
j) Lack of adequate or understandable NOA					
k) Not informed of consumer rights					
l) Complaint and appeal process not explained					
m) Denied member access to medical records					
CLINICAL CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.					
b) Testing/assessment insufficient, inadequate or omitted					
c) Medical record documentation issue					
d) Concern about prescriber or medication or medication management issues					
e) Unsanitary environment or equipment					
f) Lack of appropriate individualized setting in treatment					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
QUALITY OF SERVICE					
b) Delay, quality of materials and supplies (DME) or dental					
c) Lack of access to ENCC for intensive care coordination or case management services					
d) Benefits not covered (Right click on drop down for selection)					
CLIENT BILLING ISSUES					
a) Co-pays					
b) Premiums					
c) Billing OHP clients without a signed Agreement to Pay					

Trends related to Grievances and Complaints, to include:

- Rate of complaints and grievances per enrollee
- Rate of complaints and grievances per enrollee using services
- Trends across quarters, including year to date total complaints and grievances with percentages

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

NOTE: Appeals and Contested Case Hearings are based on "actions" or denials, limited authorization, reduction, termination or suspension of services; or when payment is denied for a service that has been provided or a CCO has failed to act within specified timeframes.

	CCO Appeals		Overturned at plan level		Decisions Pending		Contested Case Hearings from CCO Appeals		Overturned at hearing		Decisions Pending	
Category	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**
a) Denial or limited authorization of a requested service												
b) Single PHP service area, denial to obtain services outside the PHP panel												
c) Termination, suspension or reduction of previously authorized covered services												
d) Failure to act within the timeframes provided in § 438.408(b)												
e) Failure to provide services in a timely manner, as defined by the State												

f) Denial of payment for a service rendered												
TOTALS												

Trends (Narrative):

Interventions (Narrative):

D. Table 3 – Summary – Implementation of 1% withhold

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

Metric	Amount(s)	Quarterly	Annually
Encounter data analysis - **Spending in top 25 services by eligibility group and by CCO** - **To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well**		X	X

E. Table 4 – Statewide Workforce development – Non-Traditional Health Workers (NTHW)

	Total Number Certified Statewide* (current quarter & cumulative)	Number of approved training programs (current quarter & cumulative)
Community Health Workers		
Personal Health Navigators		
Peer wellness specialists		
Other NTHW		

* Statewide NTHW registry anticipated to launch in fall of 2013. Quarterly reporting would be reasonable after that point.

Narrative detail on regional distribution of certified NTHWs and NTHW training programs; news about relevant recruitment efforts or challenges

Health professional graduates participating in Medicaid

Tracking method and reporting format in development. Current assumptions are that:

- Tracking and reporting will begin July 2013, per STC 57(b)(iii) and will continue through the period for which FFP is claimed.
- Tracking will include graduates of each health professional training program for which FFP is claimed, within Oregon Health & Science University, the Oregon University System, and select Community Colleges.
- Tracking and reporting will be done by program/professional type (e.g. reporting will distinguish between physicians, nurses, dentists, physical therapists, and so on) and by practitioner specialty to the extent possible.
- These data will be presented in a detailed annual report. Updates will be provided quarterly, as available.

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

Type of Change	Specific change	Effect on delivery system	Effect on members	Number of CCOs affected	Number of CCO members affected
Approval and contracting with new plans					
Changes in CCO/MCO networks					
Rate certifications					
Enrollment/disen-rollment					
CCO/MCO contract compliance					
Relevant financial performance					
Other					

G. Table 6 – Transformation center

Innovator Agents – Summary of promising practices statewide during current quarter

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
Innovator agent training				
Learning Collaborative activities				
Assisting and supporting CCOs with Transformation Plans				
Assist CCOs with target areas of local focus for improvement				
Communications with OHA				
Communications with other Innovator Agents				
Community Advisory Committee activities				
Rapid-cycle Stakeholder feedback to identify and solve barriers; to assist with adapting innovations; to simplify and/or improve rate of adoption and to increase stakeholder engagement				
Data base implementation – Tracking of CCO				

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
questions, issues and resolutions in order to identify systemic issues				
Information sharing with public				
Other				

G. Table 7 – Innovator Agents – – Measures of effectiveness

Measure	Data published for current quarter? Type?	Web link to Innovator Agent quality data
1. Surveys rating IA performance		
2. Data elements (questions, meetings, events) tracked		
3. Innovations adopted		
4. Progress in adopting innovations *		
5. Progress in making improvement based on innovations *		
6. CCO transformation plan implementation		
7. Learning Collaborative effectiveness		
8. Performance on Metrics and Scoring Committee metrics		

* These items will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

H. Legislative activities during current quarter

I. Litigation status

J. 2 percent trend data are reported in Appendix D: This table shows expenditures, including services inside and outside capitation rates for all populations served by CCOs, as well as administrative expenditures and indicates progress in meeting spending growth reduction targets.

K. DSHP terms and status are reported in Appendix E: This table shows new federal funds drawn as match against DSHP programs; new federal funds drawn as a result of DSHP and savings identified in the total cost of purchasing care (as described in STC 48).

IV. Status of Corrective Action Plans (CAP) that address any policy, administrative, or budget issues identified by CMS, the State, or a regulatory entity that impacts the demonstration.

Table 8 – Status of Corrective Action Plans (CAP)

Entity (CCO or MCO)	Purpose and type of CAP	Start date of CAP	Action sought	Progress during current quarter	End date of CAP	Comments

V. Evaluation activities and interim findings

Primarily narrative section focusing on the levers that are expected to drive quality improvement and cost trend reduction under the waiver, and results available to date regarding progress toward demonstration goals.

Reporting and discussion will include both OHA and CCO actions and may make reference to data presented in other sections of the quarterly report or in other documents (e.g. Section III of quarterly report, 2% trend reporting etc.)

Table 9 – Evaluation activities and interim findings

Lever	Report and Discussion
Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient- centered primary care homes (PCPCH)	*Discussion to include any rapid-cycle improvement activities planned as a result of findings, and reports on previous improvement efforts.*
Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes	
Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of	

Lever	Report and Discussion
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 Transformation Center	

Discussion of progress to date on waiver goals: reducing per-member cost growth, and improving quality, access, member experience and health outcomes.

VI. Public Forums – For any public forums held during the quarter**,** include public comment and summary report

VII. Transition Plan, Related to Implementation of the Affordable Care Act (ACA) – Effective 4-1-13 and ongoing, submit state's transition plan on 4-1-13, report and update on changes to or implementation of the plan quarterly, as necessary. The plan will include how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible.

VIII. Appendices

A. Quarterly enrollment reports that report:

1. SEDS
2. State reported enrollment tables
3. Actual and unduplicated enrollment, showing:
   a) The percent change in each category from the previous quarter and from the same quarter of the previous year
   b) The number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

B. Complaints and Grievance reports by sub-categories

C. Neutrality reports:

1. Budget monitoring spreadsheet
2. CHIP allotment neutrality monitoring spreadsheet
3. Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

D. Two percent trend reduction tracking

E. DSHP tracking

F. Oregon Measures Matrix for Quarterly Reporting

IX. Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

The state may also add additional program headings as applicable.

Appendix F: Oregon Measures Matrix

NOTE: Measures with an asterisk (*) are those that are reported quarterly. All others are reported annually.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
Improving behavioral and physical health coordina-tion	*Alcohol or other substance misuse (SBIRT)	√	√			√	MN method** Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplishe d 44% initial screen after 2 years of focused, evidence-based intervention).	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based intervention).			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from predecessor	TBD			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
									organization.				
	*Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available by April 2013.	90% (Note: Benchmark based on Metrics & Scoring Committee consensus).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	90%			
	*Follow-up care for children prescribed ADHD meds	√			√	√	Oregon Medicaid baseline 2011: Initiation:	Medicaid 2012 NCQA National 90th percentile: Initiation:	Individual CCO baselines will be determined with 2011	Medicaid NCQA National 90th percentile:			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	(NQF 0108)						50% C&M: 57%	51% C&M: 63%	data from predecessor organization.	Initiation: 51% C&M: 63%			
Improving perinatal and maternity care	*Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 89%			
	*Prenatal and postpartum care: postpartum			√		√	TBD (baseline data available in	2012 National Medicaid benchmark 75th	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	care rate (NQF 1517)						Feb 2013)	percentile: 90th percentile: 74.7%					
	*PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could also use the 16% rate publically available	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could also use the	5% or below.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
							from Joint Commission - Diane Waldo)		16% rate publically available from Joint Commission - Diane Waldo)				
Reducing preventable re-hospitaliza-tions	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			
	*Ambulatory	√	√		√	√	TBD (baseline	TBD	MN method	2011 National Medicaid 90th			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	Care: Outpatient and ED utilization						data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	percentile (ED utilization): 44.4/1,000mm			
	*All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a			
Ensuring appropriate care is delivered in appropriate	*Ambulatory Care: Outpatient and	√	√		√	√	TBD (baseline data available in	TBD 2011 National Medicaid 90th	MN method with 3% floor. Individual CCO	2011 National Medicaid 90th percentile (ED utilization):			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
settings	ED utilization						Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	percentile (ED utilization): 44.1 / 1,000 mm	baselines will be determined with 2011 data from predecessor organization.	44.4/1,000mm			
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5 year period based on trends in Medicare and Commercial data).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor	2012 National commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile:			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
									organization.	61.34 (Based on Metrics & Scoring Committee consensus)			
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	*Developmen-tal screening in the first 36 months of life (NQF 1448)	√	√		√	√	Oregon baseline: 19.6% using admin data only.	50% (Metrics & Scoring Committee consensus)	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	50% (Metrics & Scoring Committee consensus)			
	*Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								77.3%					
	*Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile: 56.9%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 75th percentile: 56.9%			
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								90th percentile: 27.5%					
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a			
	Appropriate testing for children with pharyngitis (NQF 0002)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
								90th percentile: 83.9%					
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed or recommen	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
							ded medication s with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)						
Deploying care teams to improve care and reduce	*Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013)	TBD 2011 National Medicaid 90th percentile	MN method with 3% floor. Individual CCO baselines will	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
preventable of unnecessarily costly utilization by super users							ED utilization baseline (2011): 56 / 1,000 mm	(ED utilization): 44.1 / 1,000 mm	be determined with 2011 data from predecessor organization.				
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%			
	*Comprehen-sive diabetes care: LDL-C			√		√	TBD (baseline data	2012 National Medicaid	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
coordinating a broad set of resources, including CHW.	Screening (NQF 0063)						available in Feb 2013)	benchmark 75th percentile: 90th percentile: 83.5%					
	*Comprehen-sive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 91.1%	n/a	n/a			
	Diabetes: HbA1c Poor Control (NQF	√				√	TBD (baseline data	Pick percentile	MN method. Individual	Pick percentile NCQA National			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	0059)						available in Feb 2013)	NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile: 28% 75th percentile: 34%			
	*PQI 01: Diabetes, short term complication admission rate (NQF 0272)		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
	*PQI 05:		√	√		√	416.9	10% reduction	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	Chronic obstructive pulmonary disease admission (NQF 0275)						(2011)	from baseline Benchmark set based on Oregon's data (2002-2011)					
	*PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
	*PQI 15: Adult asthma admission rate		√	√		√	178.7 (2011)	10% reduction from baseline	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	(NQF 0283)							Benchmark set based on Oregon's data (2002-2011)					
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	**Access to Care** OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentil	**Access to Care** OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%			
	CAHPS 4.0H (child version including Medicaid and children with	√	√		√	√							

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	chronic conditions supplemental items).							e: 90.31% National average: 86.97%					
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 72.7%	n/a	n/a			
	*Cervical cancer			√		√	TBD (baseline data	2012 National Medicaid	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	screening (NQF 0032)						available in Feb 2013)	benchmark 75th percentile: 90th percentile: 78.5%					
	*Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a			
	Provider Access Questions from the Physician Workforce Survey:					√	In 2009: 52.4% of Oregon's physicians accepted	TBD	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	1) To what extent is your primary practice accepting new Medicaid/ OHP patients? (include: completely closed, open with limitations, and no limitations) . 2) Do you						new Medicaid patients without limitations; 29.7% accepted with some limitations; and 17.9% were completely closed. 84% of physicians have Medicaid patients. The						

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	currently have Medicaid/ OHP patients under your care? 3) What is the current payer mix at your primary practice?						statewide payer mix for Medicaid is 15%.						
	Screening for depression and follow up plan (see above)												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	*SBIRT (see above)												
	*Mental and physical health assessment for children in DHS custody (see above)												
	*Follow-up care for children on ADHD medication (see above)												
	*Timeliness of												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
	prenatal care (see above)												
	Colorectal cancer screening (see above)												
	PCPCH enrollment (see above)												
	*Developmen-tal screening by 36 months (see above)												
	*Adolescent well child visits (see above)												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	statewide Variation	Activities
Meaningful Use	EHR adoption (Meaningful Use 3 question composite)	√				√	TBD (Baseline data available in April 2013)	TBD	TBD (Baseline data available in April 2013)	TBD			

* These measures are reported quarterly

**The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Attachment B – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS requires states with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; states, federal government, and individuals benefit from state conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to state and federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should states have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and
    - Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
    - Hypothesis or research questions to be investigated;
    - Goals, such as:
        - Increase Access
        - Impact of title XXI cost sharing waiver for children in premium assistance
        - Cost Effectiveness
        - Improve Care Coordination
        - Increase Family Satisfaction and Stability
    - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
    - The type of research design(s) to be included -
        - Pre/Post Methodology
        - Quasi-Experimental
        - Experimental
    - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
    - Enrollment and outreach records;
    - Medicaid claims data;
    - Vital statistics data;
    - Provide record reviews;
    - School record reviews; and
    - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
    - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
    - How findings will be incorporated into outreach, enrollment and education activities;
    - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
    - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the state and/or relevance to nuances of the demonstration intervention.

ATTACHMENT C
Glossary of Terms Related to title XIX and XXI funded Children

Effective with the implementation of the ACA, changes to the demonstration will require revision of the Glossary.

Exhibit 1: Glossary of Terms Related to title XIX and XXI funded Children

- **Healthy Kids*:*** Created by House Bill 2116 during Oregon's 2009 Legislative Session, *Healthy Kids* provides coverage for all uninsured children up to age 19 in the state. The plan offers comprehensive health care coverage that includes dental, vision, mental health and physical health care. The objective of *Healthy Kids* is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. *Healthy Kids* includes three different program components:

    1. Existing CHIP and Medicaid direct coverage (OHP Plus);

    2. Premium assistance administered by the Office of Private Health Partnerships (family coverage under FHIAP for children up to and including 200 percent of FPL, and Healthy Kids ESI child only premium assistance for kids up to and including 300 percent of FPL;

    3. A private insurance component, Healthy KidsConnect, which is provided under the CHIP state plan.

  The federal government will provide match for children up to and including 300 percent of the FPL. The state will also permit uninsured children above 300 percent of the FPL to purchase the plan under Healthy KidsConnect without state or federal match.

- **Family Health Insurance Assistance Program (FHIAP) for Families Enrolled in ESI or Individual Market:** The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA) administers FHIAP. The premium assistance program provides subsidies to help families and individuals pay for health insurance offered either through employer-sponsored insurance (ESI) or private health insurance carriers. Coverage provided by the insurance plans must meet or exceed the FHIAP benchmark criteria, which is approved at a level actuarially equivalent to federally mandated Medicaid benefits.

As of January 1, 2014: 1) Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP or Healthy Kids ESI components of this demonstration rather than enroll in the Medicaid or CHIP state plan, and 2) Parents and childless adults enrolled in FHIAP with income from 0 up to 133 percent of the FPL, will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP state plans. Individuals currently receiving premium assistance who, based on an initial screening evaluation, do not appear to be eligible under

the approved Medicaid or CHIP state plans will be afforded a full eligibility determination prior to termination. Individuals denied continued benefits will be offered the opportunity to have their information electronically transmitted to the state Affordable Insurance Exchange (Exchange) to be treated as an application for coverage and benefits through the Exchange.

- **Premium Assistance for children and families with incomes from zero up to and including 200 percent of FPL:** Subsidies are available to children in this income category through FHIAP or Healthy Kids ESI. Children determined eligible by DHS or OHA are referred to OPHP for enrollment and subsidy payment or go directly to OPHP and on the FHIAP reservation list. FHIAP pays premium subsidies ranging from 50 to 95 percent for adults. Both FHIAP and Healthy Kids ESI pay100 percent of the premium for children in this income group. Individuals (adults and children) who enroll in this program are subject to all other cost sharing provisions of the insurance plan. The children in this income group have the option of enrolling in FHIAP, Healthy Kids ESI, or CHIP direct coverage (OHP Plus), and children who choose FHIAP or Healthy Kids ESI can move back to state plan direct coverage at any time.

- **Healthy Kids ESI/Child Only Premium Assistance and Healthy KidsConnect for children in families with incomes above 200 up to and including 300 percent of FPL who have access to ESI:** Subsidies are available to children in this income category through ESI or the state's private insurance option, Healthy KidsConnect. Children in families with incomes above 200 percent FPL are not eligible for CHIP direct coverage (OHP Plus). Sliding scale subsidies are available for children who are able to enroll in the family's ESI.
    - Families with incomes above 200 up to and including 250 percent of FPL will receive state subsidies equaling about 90 percent of the child's monthly premium.
    - Families with incomes above 250 up to and including 300 percent of the FPL will receive state subsidies equaling about 80 percent of the child's monthly premium.
    - All other cost-sharing is subject to the cost of the employer plan.

- **Healthy KidsConnect:** This is a CHIP state plan direct coverage option provided under the state's separate child health program. Sliding scale subsidies are available to children who enroll in state-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP direct coverage (OHP Plus) benefit package.

- Families with incomes above 200 percent up to and including 250 percent of FPL will receive state subsidies equaling about 90 percent of the child's monthly premium; and
- Families with incomes above 250 percent up to and including 300 percent of the FPL will receive state subsidies equaling about 80 percent of the child's monthly premium.
- Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.

- **Oregon Health Plan (OHP) Plus:** OHP Plus is a CHIP state plan direct coverage option provided under the state's separate child health program. The state provides Secretary-approved coverage that is the same as coverage offered under the state's Medicaid program. The state's benefit package is based on the OHP Prioritized List of Health Services, which is a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration for its entire Medicaid population. Medically necessary services are defined in the Prioritized List. The benefit package includes mandatory services for children, including well-baby and well-child visits, immunizations and dental services. There are no premiums, co-payments, or deductibles for children in direct coverage.

- **FHIAP Reservation List:** Oregon uses reservation lists to manage enrollment in the premium assistance program. Only FHIAP-eligible families with income from 0 up to and including 200 percent of the FPL are subject to the reservation list.

  As of January 1, 2014 the FHIAP reservation list will no longer be applicable. Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP component of this demonstration rather than enroll in the Medicaid or CHIP state plan, and parents and childless adults enrolled in FHIAP with income below 133 percent of the FPL will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP state plans.

  - **The individual reservation list** is for applicants who do not have access to ESI.
    - Once approved, individuals may select an individual health plan from a list of approved FHIAP insurers.
    - Only plans that meet FHIAP's benchmark are offered to individual members.

  - **The group reservation list** is for applicants who have access to ESI.
    - ESI plans must meet FHIAP's benchmark.

Attachment D - Summary Chart of Populations Affected by or Eligible Under the Demonstration through December 31, 2013

ACA Implementation. As set forth in paragraph 13 and upon implementation of the ACA on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII) of the Act and the collapsing of certain eligibility groups will revert to the Medicaid state plan.

I. Mandatory Medicaid Populations*							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
1	Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL	None	OHP Plus	Base 1
3	Children 0 through 5	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL**	None	OHP Plus	Base 1
4	Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	0% up to 100% FPL	None	OHP Plus	Base 1
5	Foster Care/Substitute Care Children	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus	Base 2
6	AFDC low-income families (parents /caretaker relatives and their children)	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX	Title XIX State Plan	SSI Level	$2,000 for a single	OHP Plus	Base 2
21	Uninsured or underinsured	Title XIX	Title XIX	0% up to 250% FPL	None	Limited – case-by-	Base 1

II. Optional Medicaid Populations***							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
8	Aged, Blind, & Disabled	Title XIX	Section 1115 and Title XIX State Plan	Above SSI Level	$2,000 single individual; $3,000 for a	OHP Plus	Base 2

					couple		
2	Pregnant Women	Title XIX	Section 1115 and Title XIX State Plan	From 133% up to 185% FPL	None	OHP Plus	Base 1
13	Pregnant Women	Title XIX	Section 1115 and Title XIX State Plan	From 133% up to 185% FPL	None	OHP Plus	Base 1
III. Expansion Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
9	General Assistance adults (ages 18 and older)	Title XIX	Section 1115	$314 for need group of one; $628 for a need group of two	$2,000 single individual; $3,000 for a couple	OHP Plus	Expansion
10	Uninsured Parents, ages 19 through 64	Title XIX	Section 1115	0% up to 100% FPL	$2,000	OHP Standard	Expansion
11	Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	0% up to 100% FPL	$2,000	OHP Standard	Expansion

IV. Optional and Expansion Medicaid /CHIP Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
12	Participants in FHIAP as of 9/30/02; prior state-funded FHIAP parents and childless adults who already have insurance; FHIAP children	Title XIX	Section 1115	From 0 % up to 170% FPL	None	FHIAP	Expansion

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
14	Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	From 0% up to 185% FPL	None	FHIAP	Expansion
16	Until January 1, 2014: Uninsured targeted low income children ages 0 through 5, and Uninsured targeted low income children ages 6 through 18 These children choose voluntary enrollment in FHIAP.	Title XXI	Section 1115 and Title XXI	From 133% up to and including 200% FPL From 100% up to and including 200% FPL	None	FHIAP, including dental, well-baby, well-child, immunizat-ions and emergency services.	Optional
17	Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	From 0% up to and including 200% FPL	None	FHIAP	Expansion
18	Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	From 0% up to and including 200% FPL	None	FHIAP	Expansion

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
20	Until January 1, 2014, Uninsured children ages 0 through 18 with incomes above 200 up to and including 300 percent of the FPL, who meet the title XXI	Title XXI	Section 1115 and Title XXI CHIP state plan	Above 200% up to and including 300% FPL	None	Healthy Kids ESI child only premium assistance, including well-baby, well-child, immunizat-ions, dental	Optional

	definition of a targeted low-income child and choose voluntary enrollment in premium assistance under Healthy Kids ESI.					and emergency services	
22	Uninsured targeted low income children ages 0 through 5, and eligible for direct services under the CHIP state plan Uninsured targeted low income children ages 6 through 18 and eligible for direct services under the CHIP state plan Targeted low income children ages 0 through 18 who are eligible under the CHIP state plan (under Healthy KidsConnect). Uninsured target low income children ages conception to birth who reside in specific participating counties and are eligible for the unborn option.	Title XXI	Section 1115 and Title XXI CHIP state plan	From 133% up to and including 200% FPL From 100% up to and including 200% FPL Above 200% up to and including 300% FPL From 0% to 185% of the FPL	None	OHP direct services; Healthy KidsConnect private product under contract with OHA; OHP direct services as limited for unborn population **	Optional

* Mandatory populations have the option of choosing FHIAP, in which case they would be in Population 14.

**Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the state also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by federal regulations, since the state has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL.

***Optional Medicaid (OHP Plus) populations have the option of choosing FHIAP, in which case they would be in Population 14.

**** Unborn population is precluded from receiving the following services: abortion, death with dignity, sterilization, hospice services and postpartum services beyond the global rate

Attachment E: Menu Set of Quality Improvement in Focus Areas

The measures in bold would be the core measures for each focus area and would be required of any CCO selecting that focus area.[5] The purpose for these focus areas is to reduce costly, inappropriate, and unnecessary care where possible without decreasing the quality of care. The state may wish to add to this menu to account for how they will measure access and quality for individuals receiving care FFS—this should include populations receiving costly long term care and supportive services.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
1) Reducing rehospitalizations	**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 rehospitalizations and/or incentives for low rates (must remove the financial incentive to rehospitalize through incentives and penalties), care transition programs. Also see "super-utilizers" interventions
2) Addressing discrete 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	These will vary depending on issue identified, but could include disease specific measures such as Diabetes Care measure, pediatric asthma hospitalization	Ideally these would include a wide range of activities by multiple entities such as pediatric community based asthma initiatives, enhanced by coordinated public health interventions to target tobacco cessation. Clinical diabetes care initiatives can dovetail with public health interventions such as outreach programs and community based obesity reduction programs
Reducing utilization by "super-utilizers"	Cost of care measures (total cost of care per patient over	Community-based outreach programs to better address

[5] The rest of the measurement strategy will be determined later but sample additional measures are included for discussion purposes.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	specific time period), and the **readmissions measures mentioned above, rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; and outpatient and ED utilization**	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 superutilizers. Oregon's proposal includes pieces of these, including community health workers to help beneficiaries navigate the system and access resources; coordination with long-term care case workers and providers for individuals receiving long-term care and/or developmental disabilities supports and services; CCO efforts to integrate information flow across providers. It is critical these services are appropriately targeted
Integrating primary care and 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 health assessment for children in DHS custody, mean cost for outpatient mental health and medications per patient; mean cost for inpatient	Global budget and single point of accountability for behavioral and physical 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

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	mental health and substance abuse care per patient	
Ensuring appropriate care is delivered in appropriate settings	**Rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization,** Hospital readmissions (across age groups); Plan all-cause readmissions, primary care access measures	Narcotics registries, programs to address "super-utilizers", targeted case management for frequent ED users, connect vulnerable patients with appropriate behavioral health and social services
Improving perinatal and maternity care	**Early elective delivery before 39 weeks**, 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
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, BMI recorded (and appropriate counseling), drug-to-drug and drug allergy checks, and maintain active	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 EHR adoption and meaningful use; PCMH participation incentives; shared incentives across primary, specialty, long-term, and acute care; improved access (e.g., after-hours physician availability, 24/7 access to an NP or doctor); PHRs; open-access scheduling and sick hours.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
	medication list (including allergies)	

Attachment F: CCO Services Inventory
(updated December 18, 2012)

This attachment provides the schedule for inclusion of new services into CCO global budgets and reflects OHA's planning as of December 2012. Oregon will notify CMS if contract amendment schedule is revised.

Pursuant to STC 36b, the inclusion of additional services in the global budget will be mutually agreed upon by the state and CMS and phased in over the course of the demonstration. Oregon will submit proposed changes to the Regional Office as part of draft CCO contracts or contract amendments at least 45 days in advance of their effective date. Services outlined in Attachment F will generally be included in CCO global budgets as capitated services. For any services not paid as capitation, the state will identify the rate (referencing the state plan methodology or describing the rate methodology to CMS) and the rates will be subject to CMS review and approval.

	Program Area	**Program/Service/Function**	**Per Capita Trend Monitoring**					**Per Capita Trend Monitoring**	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
1	Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	X					Yes	Yes
2	Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities)	X					Yes	Yes
3	Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	X					Yes	Yes
4	Mental Health	Children's Statewide Wraparound Projects	X					Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
5	Mental Health	Exceptional Needs Care Coordinators	X					Yes	Yes
6	Mental Health	Non-forensic intensive treatment services for children(Inpatient Psychiatric Facility Services for Individuals Under age 21)	X					Yes	Yes
7	Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	X					Yes	Yes
8	Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	X					Yes	Yes
9	Mental Health	Supported Employment and Assertive Community Treatment		X				Yes	Yes
10	Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating	X			Yes	Yes
11	Addictions	Youth residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X			Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
12	Addictions	Adult residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X			Yes	Yes
13	Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating	X			Yes	Yes
14	Targeted Case Management	HIV/AIDS Targeted Case Management			X			Yes	Yes
15	Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon			X			Yes	Yes
16	Maternity Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)		Optional where currently operating	X			Yes	Yes
17	Transportation	Non-Emergent Medical Transportation			X			Yes	Yes
18	Mental Health	Adult Residential Mental Health Services			X			Yes	Yes
19	Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)				X		Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
20	Dental	OHP dental coverage	Optional	Optional	Optional	X		Yes	Yes
21	Mental Health	Young Adults in Transition Mental Health Residential			X			Yes	Yes
22	Mental Health	Personal Care 20 Client Employed Provider					X	Yes	Yes
23	Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)					X	No	Yes
24	Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)					X	No	Yes
25	Long Term Care	Long term care institutional and community supports					X	No	Yes
26	Mental Health	State Hospital Care - Forensic					X	No	Yes
27	Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations				X		No	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
28	Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)					X	No	Yes
29	Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB					X	No	Yes
30	Mental Health	OHP-covered mental health drugs					X	No	Yes
31	Other	Hospital Leverages: GME, Pro-Share, and UMG					X	No	Yes
32	Other	FQHC Full-Cost Settlements				X		No	Yes
33	Other	A & B Hospital Facilities Settlements					X	No	Yes
34	Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)					X	No	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
35	Targeted Case Management	Child Welfare Youth (Targeted Case Management)					X	No	Yes
36	Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)					X	No	Yes
37	Targeted Case Management	Tribal Targeted Case Management					X	No	Yes
38	Other	DSH					X	No	Yes
	Note: All services are state plan services with the overlay of the Section 1915(b) waiver for transportation and the Section 1115 demonstration that includes application of the Prioritized List of Health Services.								

Attachment G

Reimbursement and Claiming Protocol for Oregon Designated State Health Programs
Determination of Allowable DSHP Costs Per Waivers 21-W-00013/10 and 11-W-00160/10

Acronyms:

A & D – Alcohol and Drug
APD – Adults and People with Disabilities (formerly SPD)
AMH – Addictions & Mental Health
CAF – Children, Adults, and Families
CPMS – Client Process Monitoring System
DMAP – Division of Medical Assistance Programs
DSHP – Designated State Health Programs
eXPRS – Express Payment and Reporting System
OSPHL – Oregon State Public Health Lab
OMIP – Oregon Medical Insurance Pool
PHD – Public Health Division
SFMA – Statewide Financial Management System
SPD – Seniors and People with Disabilities

To support the goals of health system transformation, the state may claim federal Financial Participation (FFP) for the following state programs subject to the annual limits and restrictions described in the Standard Terms and Conditions (STCs) # 55 -58 of Oregon's Health Transformation Waivers 21-W-00013/10 and 11-W-00160/10 through June 30, 2017. This attachment contains the protocol for such determination of cost.

Office of Management and Budget (OMB) Circular A-87 (2 CFR Part 225), Cost Principles for state, Local and Indian Tribal Governments, section C.4. requires federal grants be provided net of any applicable credits. The state is required to offset all revenues received relating to eligible expenditures identified under this attachment.

For purposes of this protocol, CMS will recognize as allowable costs under this demonstration the total amounts expended by the state without reduction to FFP to reflect revenues in the form of premiums and tuition paid by program enrollees that might be otherwise treated as applicable credits. This exception is only available for approved expenditures associated with the Oregon Medical Insurance Pool through June 30, 2014, and for approved education expenditures associated with for Workforce Training at the State of Oregon's public colleges and universities through June 30, 2015.

All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval. CMS may review at any time the sources of the non-federal share of funding for the emonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding. For purposes of expenditures claimed under this protocol, the state cannot utilize provider-related donations as a source of the non-federal share.

Below are descriptions of each DSHP program that was approved under waivers 21-W-00013/10 and 11-W-00160/10. The following programs have been arranged based on program groups.

PROGRAM GROUP: AMH—Addictions and Mental Health

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the AMH non-contract program group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the tate in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure.

For each program in this group that involves contractual services, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual services delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the AMH Contractual Services Program Group is R-Base.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the AMH R-Base data base system (R-Base), a contract database subsidiary system for accounting data to the SMFA accounting system, the official 'book-of-record' for the state. The R-Base system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state Funds only will be so identified. Coding tables in R-Base are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. Data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

<u>Program: Mental Health (MH) Non-Residential Adult Services</u>

- **Brief Description:** MH services delivered to persons diagnosed with serious mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. The following services are provided via this program:

  - Vocational and social services
  - Medication and medication monitoring
  - Counseling for emotional support
  - Individual/family and group counseling and therapy
  - Support to locate and obtain housing
  - Coordination of care services

  Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Adults 18 years or older with serious mental illness who do not qualify for Medicaid.

<u>Program: MH Children and Adolescent</u>

- **Brief Description:** Mental health services for children and adolescents with primary mental, emotional or behavioral conditions. The following services are provided via this program:

  - Provision of screening
  - Assessment and Level of Service Intensity
  - Referral and care coordination services
  - Skills training

- Crisis planning
- Respite care
- In-home support.

Services may be delivered, as appropriate, in a clinic, home, school or other settings familiar and comfortable for the individual receiving such services. Other settings may be aftercare/daycare, county case manager office, mental health clinic, and primary care clinic.

Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Individuals under age 18 who have primary mental, emotional or behavioral conditions and are not eligible for Medicaid.

Program: MH Regional Acute Psychiatric Inpatient

- **Brief Description:** Stabilize, control or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the individual to a less restrictive environment. The following services are provided via this program:

  - Ancillary services such as regional coordination and enhancements to County, Community Mental Health Program (CMHP) ; treatment plan development that include identification of goals, strengths, target behaviors, methods for change; coordination of care, evidence-based interventions with families, advocates, representatives of community agencies; and medication management; individual and group therapy that addresses issues identified in the treatment plan.
  - Services that serve to expedite the movement (including secure transportation) of individuals into and out of facilities where inpatient psychiatric services are delivered and to divert persons from acute care services, collaboration with families, parenting support, crisis planning, skills training for client and family members, continuum of care plan to move client to less restrictive settings.

- **Eligible Populations:** Individuals in need of inpatient psychiatric services who are uninsured and/or indigent and are not eligible for Medicaid. These are individuals who suffer from an acute mental illness, or other mental or emotional disturbance posing a danger to the health and safety of the individual or others.

Program: MH Residential Treatment for Youth

- **Brief Description:** Services for individuals needing continued long-term services to avoid hospitalization. The following treatment services are provided via this program:

  - Medication and Medication monitoring supervision)
  - Vocational and social services
  - Individual and family group counseling
  - Counseling emotional support
  - Coordination of care services
  - Services delivered on a 24-hour basis.

Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Residential Treatment for Youth: Young adults through age 25 who are eligible, under ongoing review of the jurisdiction of the Juvenile Psychiatric Review Board or in the Youth and Young Adult in Transition Program, with mental or emotional disorders who

have been hospitalized or are at immediate risk of hospitalization, who need continuing services to avoid hospitalization or who are a danger to themselves or others or who otherwise require long-term care to remain in the community. These individuals are not eligible for Medicaid.

Program: MH Adult Foster Care

- **Brief Description:** This program includes continuing services, including ongoing supervision, which are provided to adults to avoid higher level services or hospitalization. The following services are provided via this program:

  - Clinical assessment
  - Develop individual plan of care that addresses clients MH diagnosis
  - In-home case management
  - Counseling (individual and family group)
  - Coordination of care services
  - Skill training
  - Transition support to move to the next step to independent living.
  - These services are delivered in family home or facility.

- **Eligible Population:** Adults 18 years old or older who are in need of continuing services to avoid hospitalization, or who have been hospitalized, or who pose a danger to the health and safety of themselves or others, and who are unable to live by themselves without supervision. These individuals are not eligible for Medicaid.

Program: MH Older and Disabled Adults

- **Brief Description:** This program includes specialized geriatric mental health services delivered to older and disabled adults with mental illness. The following services are provided via this program:

  - MH services
  - Medication management
  - Follow-up services.
  - Medical condition follow-up (many of these clients have ongoing medical conditions).
  - Coordination of care

- **Eligible Populations:** Older and disabled adults with mental illness needing mental health services. These individuals are not eligible for Medicaid.

Program: MH Special Projects

- **Brief Description:** These are projects that provide enhanced services, services to enable service delivery expansion, peer delivered services, and, educational and employment support services. The following services are provided via this program:

  - Peer delivered services (PDS): is the social, emotional and instrumental support offered or provided by persons with a mental health condition, to others who share a similar mental health condition in order to bring about a desired social or personal change. This overall service includes an array of agency or community-based services and supports provided by peers and peer support specialists.

Included is assistance for people with Serious Mental Illness (SEMI) to meet their education and/or recovery goals and/or become gainfully employed through the education and training acquired during postsecondary education.
    - Skill training
    - Counseling for emotional support
    - Community integration
    - Crisis support

- **Eligible Population:** Adults and Children with mental illness in unique condition situations who need special mental health services. These individuals are not eligible for Medicaid.

Program: MH Community Crisis

- **Brief Description:** This program provides immediate MH crisis intervention (24/7) and assessment; triage and intervention services (psychological treatment services and crisis counseling services) delivered to individuals experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. This program also includes the following psych services which can be rendered at a hospital or a non-hospital facility. Services are of limited duration and are intended to stabilize the individual and prevent further serious deterioration in the individual's mental status or mental health condition.

- **Eligible Population:** Adults and Children in a crisis situation who are not eligible for Medicaid.

Program: MH Support Employment

- **Brief Description:** This program includes the following services which are delivered to individuals to enable them to obtain and maintain employment:

    - Supervision and job training
    - On-the-job visitation
    - Consultation with the employer
    - Job coaching
    - Counseling
    - Skills training
    - Transportation
    - Transitional employment services: On-the-job skills development for the next level—to obtain a better job, job counseling.

- **Eligible Population:** Individuals 18 years or older with chronic mental illness needing to obtain and maintain employment. These individuals receive non-residential adult services and need evidence-based supported employment services. These individuals are not eligible for Medicaid.

Program: MH & Alcohol and Drug (A & D) Homeless

- **Brief Description:** This program provides transitional services to a supported environment, i.e., treatments services, housing/living environments that maintain and reinforce the client's recovery efforts. This program provides a broad range of transition services that include:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation and rehabilitation services
- Community MH services, A&D treatment services
- Staff training
- Case management services
- supportive and supervisory services in residential settings
- Referrals for primary health services
- Job training
- Educational services
- relevant housing assistance services (locating and securing housing)

Room and board is not considered in the amounts that will be claimed for this program

- **Eligible Population:** Individuals with serious mental illness that may have co-occurring substance abuse use disorders and who are homeless or at risk of being homeless. These individuals are not eligible for Medicaid.

Program: MH Residential Treatment for Adults

- **Brief Description:** This program includes crisis stabilization and intervention services, including:

  - Behavior management
  - Daily living activity coordination
  - Crisis stabilization services
  - Crisis intervention services
  - Residential treatment services determined upon individualized assessment of treatment needs and development of plan of care
  - Management of personal money and expenses
  - Supervision of daily living activities
  - Life skills training
  - Administration and supervision of medication
  - Provision or arrangement of transportation
  - Management of behavior
  - Diet management.

- Services are delivered on a 24-hour basis to individuals who need continuing services to remain in the community and to avoid higher levels of services or hospitalization or who are a danger to themselves or others or who otherwise require continuing care to remain in the community.

  Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Adults 18 years or older who are determined unable to live independently without supervised intervention, training or support, and who do not qualify for Medicaid.

Program: MH Non-Residential, Designated

- **Brief Description:** These individuals in this program have low frequency, high intensity needs above the standard non-residential structure. Services include:

    - Vocational and social services
    - Support to obtain and maintain housing (locating and securing housing)
    - Medication and medication monitoring
    - Emotional support
    - Individual, family and group counseling and therapy
    - Case management services

- **Eligible Population:** Adults 18 years old or older, who are uninsured needing mental health services delivered to designated persons (adults) diagnosed with serious, chronic mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. These individuals are not eligible for Medicaid.

Program: A & D Special Projects

- **Brief Description: This program includes the following** treatment enhancement activities:

    - Early screening and assessment for alcohol and drug problems
    - Facilitation of collaboration between schools and partner agencies in developing and maintaining screening and referral processes
    - Outreach
    - Case management

- **Eligible Population:** Youth at high risk of problems with alcohol and drugs and their families. These are Non-Oregon Health Plan individuals or may pay for services not provided by OHP. This program is specifically designed for families at risk of Temporary Assistance for Needy Families (TANF) involvement or in the TANF program.

Program: A & D Residential Treatment, Adults

- **Brief Description:** This service is to support, stabilize and rehabilitate individuals and to permit them to return to independent community living. Services provide a structured environment for an individual on a 24-hour basis consistent with chemical dependency placement, continued stay and discharge criteria Level III-services (twenty-four hour supervision is needed using a structured 7-day-a-week therapeutic environment to achieve rehabilitation). The services within this program address the needs of diverse population groups within the community. This program helps people stabilize physically and mentally so they are able to transition to a lower level of care including self-directed recovery management.

- **Eligible Population:** Individuals 18 years of age or older who are unable to live independently in the community and cannot maintain even a short period of abstinence and are in need of 24-hour supervision, treatment and care. These individuals are for non-OHP eligible and must be indigent status with income at 100 percent or lower of the federal Poverty Level (FPL). These individuals are not eligible for Medicaid.

Program: A & D Continuum of Care

- **Brief Description:** This program provides outpatient substance abuse disorder treatment including medication-assisted treatment (primarily methadone). This program also includes non-hospital detoxification, case management and wrap around services such as:

    - Peer mentoring
    - Child care
    - Transportation
    - Relapse prevention
    - Healthy eating and wellness counseling
    - Connection to social support groups

    Services build upon resilience, assisting individuals to make healthier lifestyle choices and to promote recovery from substance use disorders. Services consist of case management, clinical care and continuing care delivered when therapeutically necessary and consistent with the developmental and clinical needs of the individual, Level I (Outpatient), Level II (Intensive Outpatient), Level III (Non-medical Detoxification, and Intensive Treatment and Recovery Services).

- **Eligible Population:** Services delivered to youth and adults with substance use disorders. These are individuals who are indigent with no OHP or insurance coverage. These individual are not eligible for Medicaid.

PROGRAM GROUP: Children, Adults and Families (CAF)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the states' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

<u>Any combination of the above codes can identify the DSHP allowable expenditure.</u>

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the CAF program group is Oregon Kids System (OR-KIDS).
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the OR-KIDS, an interface sub-system for accounting data to the state accounting system official 'book-of-record' SFMA. The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the OR-KIDS system as they are then authorized for service payments to providers providing the designated client care services. The system checks the client eligibility status then matches to the appropriate fund source based on the client eligibility status. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state funds only will be so identified. Only those services funded with state funds only are allowable for DSHP match. Coding tables in OR-KIDS, are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: System of Care

- **Brief Description:** This program consists of purchased services provided to meet the individualized needs of children and parents involved with Child Welfare. This program is only applicable to services not rendered by any other state program. The following services are provided via this program:
    - Wrap-around planning services
    - Healthcare services for uninsured parents

- **Eligible Population:** Children and families being served by Child Welfare where caseworkers have identified needs for supports and services unmet by any other state resource.

Program: Community Based Sexual Assault

- **Brief Description:** This program consists of contracted services for Sexual Assault Counselors to provide counseling and support services to victims of sexual assault.
- **Eligible Population:** Victims of sexual assault who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Community-based Domestic Violence

- **Brief Description:** This program consists of contracted services for Domestic Violence Advocates to provide support and treatment services to victims of Domestic Violence.
- **Eligible Population:** Victims of domestic violence brought to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Family Based Services

- **Brief Description:** This program consists of services to provide in-home safety and reunification services. As a result of this program, families remain together while safety supervision and parenting support/coaching are provided. Services include:
    - Parent training
    - Therapeutic support
    - Supportive remedial day care.
- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Foster Care Prevention

- **Brief Description:** This program consists of Child Welfare services for families with children at risk of out-of-home placement. The following services are provided via this program:
    - Therapeutic supports
    - In-home case management
    - Counselling
    - Referrals to families to help them transform their lives.
- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Enhanced Supervision

- **Brief Description: This program consists of** one-on-one supervision services to children in out-of-home care to assure their safety or the safety of those around them. These are children that have emotional, behavioral or medical issues. This program involves assessment services to identify services needed, and the supervision of the process by which the client receives those services.

- **Eligible Population:** Children placed in out-of-home care due to allegations of abuse and/or neglect requiring additional supervision to assure safety.

Program: Nursing Assessments

- **Brief Description:** This program involves Individualized assessments provided by a Registered Nurse to determine the need for Personal Care services to be provided to a child in an out-of-home care setting.
- El**igible Population:** Children placed in out-of-home care that may have medical needs requiring ongoing care in a home setting.

Program: Other Medical

- **Brief Description:** This program consists of contracted services for assessments and evaluations deemed necessary for the comprehensive and coordinated care planning needed for children and families involved with Child Welfare.
- **Eligible Population:** Parents and children who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: IV-E Waiver Demonstration Project

- **Brief Description:** This program consists of additional supports in the form of Peer Mentoring or Relationship Based Visitation for parents and children being served by Child Welfare. These supports are in addition to traditional child welfare programs that provide services for prevention and reunification (of families). Traditional services and community supports include mental health counseling, parenting training, and assistance navigating the process (e.g., court processes) for victims of domestic violence.
- **Eligible Population:** Parents and children served by Child Welfare, not receiving Medicaid or services via any other federal program.

Program: Personal Care:

- **Brief Description:** This program consists of the provision of medical services including skilled services delegated by a Registered Nurse under Oregon's Nurse Practice Act, identified in an individual care plan and provided to eligible children in a family foster care setting. Services provided in this program can include: medication supervision and monitoring assistance, assistance with activities of daily living, specific medical procedures (e.g. trachea support), and incontinence management procedures.
- **Eligible Population:** Children served by Child Welfare that must be in out-of-home care due to allegations of abuse and/or neglect, and have medical needs requiring an individualized care plan approved by the state.

PROGRAM GROUP: Adults and People with Disabilities (APD) (formerly SPD—Seniors and People with Disabilities)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> > **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-systems for the APD (formerly SPD) Program Group are the House Keeper System for Oregon Project Independence, and the CPMS and eXPRS interface sub-systems for Family Support and the Children's Long-Term Support programs.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The tate further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- **House Keeper System :** The process of the determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients, and entry of the data into the House Keeper system as they are then authorized for service payments to providers providing the designated client care services. In the Housekeeper system, the status identifies the client for Oregon Project Independence (OPI) services and the system generates provider payments. The system assigns SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) that identify the clients' services and related costs attributable for DSHP. Payment data is interfaced to the state SFMA system from which payment (expense) reports are produced. The accounting reports pull data directly from the SFMA system, and/or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **eXPRS System:** Payment source data is from the eXPRS system, an interface sub-system for accounting data to the SFMA accounting system, the 'book-of-record' for the state. The eXPRS system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state funds only will be so identified. Coding tables in eXPRS are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **CPMS System:** The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the CPMS system. A report is pulled from CPMS source data and reconciled on a quarterly basis with the payment as authorized by the eXPRS System and paid by SFMA. Only those services funded with state funds only are allowable for DSHP match.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Project Independence (OPI)

- **Brief Description:** OPI provides in-home services to seniors who require the same level of care as people in nursing homes, but who do not qualify for Medicaid. Services can be received in their own homes, and include personal assistance, nursing tasks and help with housekeeping. Services may also include help with activities of daily living, memory and confusion, mobility and transfers, housekeeping and laundry, meal preparation or delivery, shopping and transportation, medical equipment, assistance with medications.

- **Eligible Population:** Eligibility for OPI is age (60 years of age or older or under 60 with a diagnosis of Alzheimer or related dementia) and a Client Assessment & Planning System assessment evidencing a service priority level (SPL) of 1-18. These services are provided statewide through Area Agencies on Aging local offices. Clients with net incomes between 100 percent and 200 percent of federal Poverty Level (FPL) are expected to pay a fee toward their service, based on a sliding fee schedule. Families with net incomes above 200 percent FPL pay the full hourly rate of the service provided.

Program: Family Support

- **Brief Description:** Services are provided for eligible children with developmental disabilities, in their parents' or relatives' home. Through this program, families determine what they need most. Families have the flexibility to choose services and providers. Families and service coordinators work to develop a plan revolving around the child and family needs. In some cases, a family may access family support for a brief time while other families may need an on-going family support plan. The program strives to help children and families remain independent, healthy and safe. The service coordinator and family work to identify all available resources from the family and community. These might include people, support-groups, public and private programs, private insurance, and many other resources. Services include assistance in determining needed supports, respite care, purchase of adaptive equipment; services are proactive, and are intended to help prevent families from going into crisis.

- **Eligible Population:** Families who have children with developmental disabilities. It is a capped program ($1,200 per eligible child per year) with a current caseload of approximately 500. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and have tried to get access to funds to cover their needs prior to submitting request for Family Support. These individuals are not eligible for Medicaid.

Program: Children Long-Term Support

- **Brief Description:** This program provides supports to a child with a developmental disability at risk of out-of-home placement (foster care, residential, etc.). Children are assessed for level of service by the local Community Developmental Disability Program Service Coordinator. With the family, the Service Coordinator assists in plan development that identifies supports needed for the child to stay in the home. Supports include:

  - In-Home Supports
  - Respite
  - Behavior Consultation
  - Family Training
  - Environmental Adaptations
  - Specialized Medical Equipment and Supplies.

- **Eligible Population:** Families who have children with developmental disabilities who are at risk for out of home placement. This is a capped program with a current caseload of approximately 180. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and meet a crisis criteria of risk of out of home placement. These individuals are not eligible for Medicaid.

PROGRAM GROUP: Public Health Division (PHD)

- **Funding Sources:** State General Funds, Other Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Public Health Division Program Group is the Oregon Statewide Payroll (OSPS) system.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service that is eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with state funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All PHD expenditures are processed directly in the SFMA system.

- **Payroll System**: Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses

(OPE) directly to the PHD programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination is entered to ensure their time is properly allocated to DSHP. Coding tables in OSPS are accessed that assign an SFMA coding structure and are interfaced to SFMA system.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

Program: PHD Licensing Fee (Health Care Regulation and Quality-HCRQI)

- **Brief Description:** The Health Care Regulatory & Quality Improvement Section (HCRQI) is statutorily mandated to regulate, inspect, license and provide certification approval for the following entities and individuals: Ambulatory Surgical Centers, Birthing Centers, Dialysis Facilities, Hemodialysis Technicians, Home Health Agencies, Hospice Agencies, Hospitals, In-Home Care Agencies, Special Inpatient Care Facilities, Trauma Hospital designations.
  HCQRI is responsible for the entire licensure and certification processes for each of the above-listed individuals or entities. HCRQI also provides licensing information to the public and other agencies. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

- **Eligibility:** HCRQI does not provide direct care to Oregonians so there are no eligibility criteria. However, the ultimate beneficiaries are Oregonians who are able to find access to safe, high-quality and patient-centered health care because of HCRQI's efforts. All Oregonians benefit from having a wide access to health care. The program ensures that the health care will be safe, of high quality, and meet or exceeds and federal standards.

Program: PHD, Oregon State Public Health Lab (OSPHL) General Microbiology Testing Program

- **Brief Description:** The OSPHL General Microbiology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitters. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: PHD OSPHL Virology/Immunology Testing Program

- **Brief Description:** The OSPHL Virology/Immunology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitter. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: State Support for Public Health

- **Brief Description:** This program consists of services rendered by Local Public Health Departments (LPHA) to operate a Communicable Disease control program This program includes the following components: (i) epidemiological investigations that report, monitor and control Communicable Disease, (ii) diagnostic and consultative Communicable Disease services, (iii) early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases, (iv) appropriate immunizations for human and animal target populations to control and reduce the incidence of Communicable Diseases, and (v) collection and analysis of Communicable Disease and other health hazard data for program planning and management. LPHAs must operate its Communicable Disease program in accordance with the Coalition of Local Health Officials (CLHO) Standards for Communicable Disease Control and the requirements and standards for the Control of communicable disease set forth in Oregon Revised Statutes (ORS) Chapters 431, 432, 433 and 437 and Oregon Administrative Rule (OAR) Chapter 333, Divisions 12, 17, 18, 19 and 24, as such statutes and rules may be amended from time to time. As part of its Communicable Disease control program, LPHAs must, within its service area, investigate the outbreak of Communicable Diseases, institute appropriate Communicable Disease control measures, and submit to the Oregon Health Authority as prescribed in the Oregon Health Authority Communicable Disease Investigative Guidelines.

- **Eligibility:** All Oregonians benefit from the communicable disease control program provided to Local Health Departments. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: PHD Laboratory Northwest Regional Newborn Screening (NBS) Program

- **Brief Description:** The Northwest Regional Newborn Screening Program conducts screening of all newborn infants to prevent mental retardation and premature death in children through early detection and treatment of congenital disorders by: screening and testing for selected diseases and conditions; serving as the regional center for newborn screening; contracting for the medical consultation needed for the initial clinical follow-up; and maintaining a data base of all screened infants for use in follow-up, tracking, and monitoring disease incidence. Oregon designates practitioners as being responsible for specimen collection. The definition of "practitioner" includes physicians, nurses, and midwives who deliver or care for infants in hospitals, birth centers or homes. Also, parents are responsible to ensure that their infants are tested.

- **Eligibility:** Newborn screening activity is not divided among specific eligibility groups within Oregon newborn infants. It is a population-based service applicable to all newborn infants in the state. Oregon statutes require that every infant be tested. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees and driven by volume or amount of tests received by the Lab for which they receive test fee revenues.

Program: Prescription Drug Monitoring Programs (PDMP)

- **Brief Description:** Oregon-licensed pharmacies are required to report to the Oregon Health Authority PDMP system all Schedule II – IV controlled substances dispensed to patients. The system must be accessible by healthcare providers and pharmacists 24/7. The intent behind the PDMP is to help improve patient management particularly among pain patients. Health improvements include pain care, addictions treatment and reduced overdose.

- **Eligibility:** Services are provided to any Oregonian who requests a copy of their own patient record. Services are provided to any authorized PDMP system user that can include any Oregon-licensed healthcare provider who prescribes controlled substances or any Oregon-licensed pharmacist who dispenses controlled substances. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: HIV Community Services

- **Brief Description:** The HIV program provides case management and support services (case managed, treatment and support plan) for people already tested and living with an HIV diagnosis.

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: General Funds – HIV, Sexually Transmitted Disease, Tuberculosis (HST)

- **Brief Description:** The HST program works with local health authorities and community based organizations to provide guidance on the delivery of services to the populations impacted by HIV, STD, and TB. This program is administered by local health authorities that primarily screen, treat or control the transmission of those diseases. As well, this program provides support administration, prevention, TB case management and medications for STD's and TB

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable STD's TB or HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: Sexually Transmitted Disease

- **Brief Description:** The program provides Clinician Training for the clinician workforce in Oregon. The training is a two-day didactic training designed for clinicians. Training is intended to provide an update on HIV, HPV, Cervicitis, Chlamydia, Gonorrhea, Syphilis and other STD's.

- **Eligibility:** Clinicians workforce in Oregon to provide training on reducing and detecting STD's.

PROGRAM GROUP: Oregon Youth Authority (OYA)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the OYA Program Group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services. The Waiver approval for DSHP included mental health and A & D treatment services funded through state funds only. The Protocol identifies the allowable state fund only funding stream(s) for these DSHP allowable services and expenditures for non-Medicaid eligible youth. The youth receiving and benefiting from these services (mental health and A & D) may be placed in the custody of the OYA, but are not incarcerated in a close custody setting. DSHP does not allow nor include expenditures for services

rendered to youth in a close custody setting, in other words, for incarcerated youth. Expenditures for which DSHP is claimed are community based, delivered in the youth's place of residence or in a licensed professional provider's office or clinic. Youth are living at home or in an out-of-home non-secure placement (not a residential treatment facility), where youth are free to leave the premise. The youth are not incarcerated, not associated with the prison system, not in secure facilities operated by OYA and are not in the physical custody of OYA. The youth may be in the custody of OYA, e.g. adjudicated youth served by county probation or diversion programs, are not Medicaid eligible, and are receiving mental health and A & D treatment funded by state funds only.

- Source data is from the state SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with state Funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OYA contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the R*STARS accounting database. Code and expenditures will be displayed.

Program: Alcohol & Drug Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Alcohol and drug abuse treatment provided to youth in community settings occurs through community service contracts for non-Medicaid eligible youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: alcohol and drug abuse treatment services in the community include: assessment, group treatment, individual treatment, individual care coordination, recovery, maintenance and relapse prevention.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for alcohol and drug treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

Program: Mental Health Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Mental health services provided to youth in community settings occurs through community service contracts for non-Medicaid eligible

youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: mental health treatment services in the community include: assessment of mental health needs, psychotropic medication management, group treatment, individual treatment, individual care coordination, crisis intervention and family therapy.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for mental health treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

10.

PROGRAM GROUP: DMAP – Division of Medical Assistance Programs

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 - Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the DMAP Program Group is MMIS.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. Thes further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the MMIS data base system that contains the requirements (i.e., edits) for processing claims for this population. MMIS is a subsidiary system for accounting data to the state SFMA accounting system, the 'book-of-record' for the state. From client and related payment data entered in MMIS, payments to providers are produced. The payment/expenditure data is interfaced to SFMA from which provider payments and expense reports are produced that identify the relevant category in which the DSHP allowable expenditure is incurred. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly. The SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) identifies the program, funding, and client are entered with the MMIS data. The coding is mapped to specific service tables that include each service funding source, thereby isolating the claims and associated payments for this population. The coding generated by the MMIS interfaces to SFMA. For this program, those services that match to state Funds only, will be allowable for FFP. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Formerly Medically Needy (Organ Transplant) Clients

- **Brief Description:** The program provides limited drug coverage for individuals receiving post-transplant services, formerly eligible for the Medically Needy program, which ended in 2003. Oregon Administrative Rule (OAR) 461-13-120-1195, chapter 461 filed with the Secretary of State, 9-30-2011, defines the population and covered services. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds and limited to 22 identified individuals.

- **Eligible Population:** This program provides services for 22 identified individuals receiving post-transplant services who were participating in the formerly Medically Needy program, as of January 31, 2003.

PROGRAM GROUP: Workforce Development and Education

- **Funding Sources:** State General Funds, Tuition and Fees

Expenditures for DSHP allowable Workforce Development Training expenditures are defined in the Waiver agreement, as those incurred by universities, colleges, and community colleges in the course of workforce training of health professionals in fields likely to benefit Medicaid beneficiaries. Source data elements are used to support the expenditures and payments of DSHP allowable Workforce Development Training and for the certification of DSHP allowable expenditures. The source data elements are:

- **Audited Financial Statements**
- **Invoices**
- **Payroll data**
- **Funding Source (ensures restriction to state only funds through the accounting elements and structure)**

Each university/college entity uses an integrated accounting system. Though they are not all the same system, they accumulate, process, and employ coding structures in similar formats for reporting and audit processes. These systems are the 'book of record' for each entity. They are complete systems with modules devoted to accounting, purchasing, accounts payable, fixed assets, grants, and budget development. The charts of accounts structures have these primary coding structure elements: Fund, Organization, Account, and Program. Transactions in the systems require these coding structures to store, process, and report out expenditures for all programs, including DSHP. The coding structure elements are hierarchical and roll up from lower data entry levels to higher summary levels. The DSHP expenditures roll into the regular monthly and annual final statements. Typically these types of expenses are tracked at a lower level of the accounting system coding structure and while they are not visually displayed in annual financial reports, they are included in the respective Instruction line displays in the financial statements.

For each Workforce Development Training program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #57(b). The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – Original source data is identified where data from the source documents is reviewed, and approved for coding and entry into the appropriate financial accounting sub-system for each Workforce Development Training program (e.g., accounts payable, payroll-personnel).

Step 2 – The financial data accumulation begins with initial entry into source data systems for the following:

- Invoices received for services and set up in the accounting system accounts payable module: invoices reviewed, services received verified, payment amounts approved, specific coding verified for programs and unique projects (e.g., DSHP - Instruction)

- Employee data set-up in the payroll system: Personnel payment data, pay rates, default cost center to be charged, etc.. Specific coding identified for additional programs/projects to where employee work time should be charged. Time sheet data, for time and effort recording, including proper employee and supervisory verifications/authorizations.

Step 3 – Source data systems access internal data and coding tables, and based on entry data, assigns to expenses the accounting coding element structures (i.e., codes: Fund, Organization, Account, Mission, Object). ***See Table 1,*** below.

TABLE 1 – Coding Elements

Oregon Health Sciences University

- *Fund code:* University General Fund 0151
- *Organization code:* Identifies the Schools: Medicine 54000-54999, Nursing 58000-58999, Dentistry 60000-69999.
- *Mission code:* Non-Sponsored Instruction & Training 11; Student Admin and Services
- *Object code:* Functional description of expenditures, Wages 5100-5199; Supplies 5300-5399; Cost of goods 5400-5499; Purchased services 5500-5599

A combination of the above codes identifies DSHP allowable expenses.

Oregon University System

- *Fund code:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Department of Community Colleges and Workforce Development

- *Fund Type:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code/Account Type:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Step 4 – Source data systems compile data during the system scheduled maintenance runs for interface to the financial accounting system, the 'book-of-record', source for all financial audits (e.g. general; A-133; other audits).

Step 5 – Accounting system processes are compiled, interfaced data configured according to the system processing design and the internally established chart of accounts. It matches the coded expense data to the internal chart of accounts (See ***Table 3 – OUS Example*** below). At period end close, the Overhead Cost Allocation module is run, charging indirect cost expenses (e.g. Administration and General (A & G)) to revenue producing cost centers, based on standard, approved cost allocation principles **(See *Table 2 – Cost Allocation***, below**)**. Closed period end financial data is downloaded to a database system (e.g., a financial services 'datamart') that can be queried using specific general ledger established accounting coding elements to pull out DSHP expenditure data (see ***Table 1 –Coding Elements above***).

TABLE 2 – Cost Allocation

DSHP approved program expenditures can include direct charged costs as well as indirect costs (i.e., a cost necessary for the functioning of the organization as a whole, but which cannot be directly assigned to one service or product, and therefore must be allocated). Very similar to the Medicare cost finding principles, cost allocation is a process, to identify common costs (e.g., A & G—executive staff, accounting, legal, human resources, etc.) to the courses of health care

professionals in fields likely to benefit Medicaid recipients. The entity can determine those costs that can be accurately direct charged, or charge them to an allocation cost center for charging via the allocation process. --Medicare Reimbursement Manual form 2552-10, 40-93

Step 6 – Report queries are run against the financial services datamart using the coding element structures unique to the DSHP program/project. (***See Table 1***, ***Coding Elements above***)

Step 7 – Expense Reports for DSHP expenditures are run after the accounting period end close. Accounting period close may be monthly, quarterly or annually.

Step 8 – Certification of Public Expenditures (CPE) form, certifying allowable DSHP expenditures per STCs #55 – 58 are represented in the expense reporting, will be sign by the appropriate and authorized college or university authority and provided to the State.

If an expenditure made under DSHP Workforce Training Program Group is found, in a future audit or financial review requiring corrective action, the prior period transaction(s) will be reconciled in the current DSHP claiming period using CMS 64 established guidelines. The CMS 64 reporting will reflect this reconciliation.

Accounting System, DSHP Expense Report Crosswalk to Financial Statements: DSHP Workforce Training expenditures, processed through the respective accounts payable and/or payroll systems are coded with organization department and instruction program coding elements (described in the preceding individual protocol narratives) that will identify DHSP allowable expenditures, per STCs # 55-58.

DSHP expenditures are a small subset of the overall individual operation of each university, college and community college. Expenditures to be claimed as DSHP, per STCs #55-58, are included in the annual year end audited statements as specific amounts at a lower level than displayed on the Instruction report line. These expenditures can be audited down to individual transactions for which original source documents can be pulled. Table 3 below illustrates this process.

Agreements will be in place between OHA and workforce entities to include allowance for audit by OHA of DSHP allowed expenditures. DSHP Expense Reports will be certified, and the amounts on the DSHP expense reports can be directly tied to the individual university, college and community college audited financial statements.

The total computable amount to be claimed to the federal government begins with the amount recorded for Instruction within the university, college or community college's audited financial statement. The financial statements may include the amount applicable to Instruction for one institution, or multiple institutions, depending on the structure of the university/college system.

In support of the total computable amount to be claimed under DSHP, supporting documentation will include the university's/college's expenditure report/account detail. The expenditure report classifies expenditures (as detailed in Table 1 – Coding Elements) by code, including fund code, organizational code, mission code and object or program code. The organization and fund type level codes will be primarily used to distinguish between aggregate expenditures applicable to Instructions and expenditures applicable to Instruction eligible under DSHP, per STCs #55-58.

Categorical Examples of Workforce Development Training DSHP allowable programs
School of Medicine
School of Nursing
School of Dentistry
Clinical Laboratory Science
Radiologic Technology/Diagnostic Imaging

Respiratory Care
Clinical Care
Medical Assistant
Dental Assistant/Dental Hygienist
EMT/Paramedic
Nursing Education/Certified Nursing Assistant
Pharmacy Technician

The examples above are not intended to be an exhaustive list of each course offered by the individual college or university. Rather, they an example by category of the type of DSHP allowable graduate and undergraduate workforce training programs available at the colleges and universities.

Upon receipt of the specific college and university expenditure report, OHA will verify the expenses reported are for health-care and health-care related fields of education and training. The specific listing of the DSHP allowable health-care and health-care related course offerings will be made available to OHA by each college or university, and will become a part of the DSHP report to CMS Region X for purposes of claiming via the CMS 64 Report. By keeping the specific list(s) apart from, yet referenced herein Attachment G, as a college or university changes, adds or deletes a DSHP allowable course, it would not be necessary to amend Attachment G.

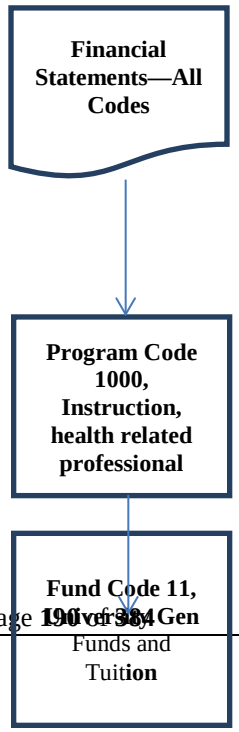
Verification of the DSHP allowable course may be accomplished in a three-fold manner using the 1) published course offering/calendar of the college or university; 2) through enrollment information, and; 3) through the college and university expenditure reports.

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for Workforce Training will be computed without taking into account program revenues from tuition. However, to the extent the above universities and colleges receive funds that are directly used to support Workforce Training applicable offsets will be made to the amount claimed to the federal government as an allowable DSHP expenditure per the above referenced STCs.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the Workforce entities accounting systems databases. Codes and expenditures will be displayed

Table 3 – OUS Example

Highest Level -- Financial Statements: Includes all accounting data codes. To reconcile to financial statements, the report query would not restrict to specific codes; all would be pulled.
Program Codes: Report query, restrict codes to program code 1000 for Instruction Courses of health care professionals in fields likely to benefit Medicaid recipients.
Funds: Further restrict report query to fund code 11, university general funds (incl tuition).



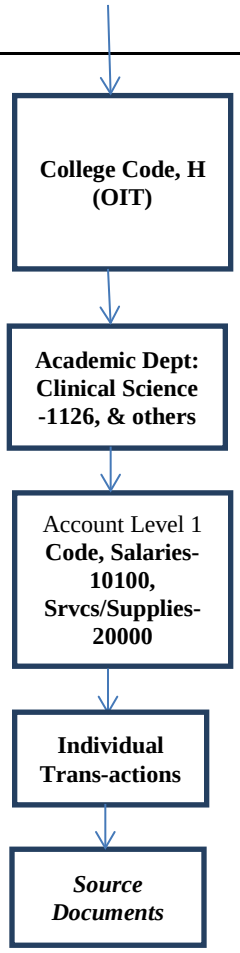
College Codes: Further restrict report query to college code H for OIT

Organization Codes: Further restrict report query to academic codes, 1126 & others.

Functional Codes: Further restrict report query to account level one codes for personnel, materials & supplies, etc.

Lowest Level -- Transactions: Further restrict to the lowest level Transactions that identify vendor/payee and personnel/ staff payee.

Documents Level **--** Based on the transaction list pulled (i.e., showing the amounts entered, vendor, other identifying data; payroll time & effort data) supporting documents can be pulled.



PROGRAM GROUP: Oregon Medical Insurance Pool (OMIP)

- **Funding Sources:** State General Funds

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for the Oregon Medical Insurance Program will be made without considerations for high risk pool healthcare premiums.

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the OMIP Program Group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OMIP contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Medical Insurance Pool

- **Brief Description:** The Oregon Medical Insurance Pool (OMIP), administered by the state Office of Private Health Partnerships (OPHP), is the high-risk health insurance pool for the state established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions. OMIP also enables continuance of insurance coverage for those who exhaust COBRA benefits and have no other options. The funding for OMIP comes from two sources. Premiums paid by enrollees currently cover about 52% of program costs. Statutory requirements for establishing premiums limit them to no more than 125% of average market premiums for comparable benefits. The remaining 48% of the costs are funded from assessments the OMIP Board charges the licensed Oregon commercial health insurers on a per covered life basis.
-
- **Eligibility:** Enrollees must be residents of Oregon when they enroll and, once enrolled, they must demonstrate that they have lived in Oregon for at least 180 days during each benefit year. It does have a six-month pre-existing condition waiting period for which enrollees can get credits if they have had prior comparable coverage. To be eligible for portability coverage, they must not have access to a commercial portability insurance plan.

PROGRAM GROUP: Oregon State Hospital (Gero-Neuro)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Oregon State Hospital Program Group is the Oregon Statewide Payroll (OSPS) system.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All Hospital expenditures are processed directly within the SFMA system.
- **Payroll System:** Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses (OPE) directly to the various Hospital programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination can be entered to ensure their time is properly allocated to DSHP.
    - The Hospital is accounted for as an enterprise fund where all costs for the program are recorded as one fund source. However, any resources from insurances (e.g., Medicaid, Medicare, Private pay) are identified to the various wards and are subtracted to record the State Only Fund expenditures that are allowable under the DSHP Waiver amendment. Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Coding and expenditures will be displayed.
-

Program: Gero-Neuro Wards at the Oregon State Hospital (MH, Psychiatric)

- **Brief Description:** This program is for patients who require a hospital level of care for dementia, organic brain injury or mental illness. Patients in this program require physically secure, 24-hour care that is not available through community programs. These patients often have significant medical issues. Some are either civilly committed or voluntarily committed by

a guardian because they are a danger to themselves or others, or are unable to provide for their own health and safety needs. Some patients who require significant medical care come through the criminal court system. Those admitted under criminal commitments are excluded, are not approved for DSHP federal Funds Claiming. The program's goal is for everyone to return to a community-care setting. From the day of admission, the treatment team works with the patient toward this goal. The program uses the following treatments:

- Sensory and behavioral therapy
- Recreation
- Coping and problem-solving skills learned through group and individual therapy in the treatment mall setting.

- Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.

- **Eligibility:** Elderly persons with a mental health diagnosis that requires hospital level of care, or all ages with special needs due to related neurological impairment. Inpatient services are available to older adults who have major psychiatric disorders and adults older than 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive community care nursing home system environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical-surgical hospital.

Attachment H: Calculating the Impact of Health Systems Transformation
(updated December 18, 2012)

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State of Oregon

Attachment H: Calculating the Impact of Health Systems Transformation -

Oregon's Accountability Plan and Expenditure Trend Review

December 18, 2012

Attachment H: Calculating the Impact of Health Systems Transformation

Table of Contents

Executive Summary

Section A - Oregon Accountability Plan

Part I: Quality Strategy

I. Introduction 208

II. Improvement Strategies 210

III. Oregon's Goals 224

- A. Lower Costs 224
- B. Better Care: Quality of Care 227
- C. Better Care: Access to Care 230
- D. Better Care: Experience of Care 232
- E. Better Health 233

IV. Assessment 237

- Performance Monitoring 237
- Data Sources 239
- Credentialing 240
- Health Information Technology 240

V. Contract Compliance 242

- Standards for Managed Care Contracts 242
- Delivery Services Performance Monitoring 242
- Enforcement 244

VI. Review of Quality Strategy 244

VII. Achievements and Opportunities 245

Appendix 1.A: Coordinated Care Organization Service Area Density 246

Appendix 1.B: Theory of Action Model 247

Appendix 1.C: Quality Pool Structure 248
Appendix 1.D: Innovator Agent Plan 256
Appendix 1.E: Contract Compliance 260
Appendix 1.F: List of Conditions that can result in Sanctions 264

Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluation

Preface 268
Oregon Special Terms and Conditions 52, 54, 64, 86 and 88 268
Introduction 274
Statewide Quality and Access Test 277
Evaluation 283
Evaluation Objectives 283
Contextual Considerations 284
Research Questions, Data Sources, and Analytic Approach 287
Table 1 – Formative Evaluation 288
Table 2 – Summative Assessment 292
Timeline 298

Part III: Oregon's Measurement Strategy

Introduction 300
OHA Measurement Framework 300
Incentive Measures 301
Ensuring Continuous Quality Improvement 302
Data Collection 303
Measurement Year 303
Data Analysis 304
Data Reporting 304
Appendix 3.A: Measure Sets by Population and Domain 306
Appendix 3.B: Oregon Measures Matrix 310
Appendix 3.C: CCO Incentive Measure Specifications 328

Appendix 3.D: Rationale for Incentive Measures 351

Appendix 3.E: Measures for Consideration in Demonstration Year 3 360

Section B - Draft Expenditure Trend Review

Description of Costs 326
Treatment of Populations within the Workbook 329
Description of Elements in the Workbook 332
Expenditure Trend Review Workbook 333

Executive Summary

Oregon has a long history of choosing innovative means of managing its Medicaid program. Yet, Oregon has faced a number of challenges in recent years familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and government (both state and federal); cost growth that far outpaces the state's general fund revenue; and a system focused on volume, not value. For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical.

Instead of responding to these challenges with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon chose a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon developed a coordinated care model for this transformation built on the three-part aim of better health, better care and lower costs. In alignment with that aim, the two overarching goals of Oregon's 2012-2017 demonstration are to reduce the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

This document contains Oregon's Accountability Plan, a multi-pronged strategy to achieve the three-part aim and methodology for the two percent trend reduction test. The document represents a shift toward a new model of care encouraging continuous learning and transformation, increased transparency, and clear expectations and incentives for improvement along with a significant investment in measurement, analytics, and evaluation.

Attachment H is divided into two sections: Oregon's Accountability Plan (Section A) and the Expenditure Trend Review (Section B).

Section A: Oregon's Accountability Plan is divided into three parts:

Part I: Coordinated Care Organization Quality Strategy

Part I of the Accountability Plan (pages 9-66) contains Oregon's Coordinated Care Organization (CCO) quality strategy, which describes the process by which the CCOs will work towards the three-part aim. The CCOs will be held accountable for spending through a comprehensive capitated per-member-per-month payment (PMPM). Under this capitated arrangement, beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures.

CCOs will also be rewarded for improving quality. At the start of the demonstration, two percent of the PMPM budget will form a quality incentive pool and will be available to CCOs that achieve specific quality goals. The percent assigned to this pool will increase over the course of the demonstration, subject to approval from CMS where necessary. By holding CCOs responsible for spending as well as quality, and by shifting incentives towards outcomes over time, the CCO model will increasingly reward value and outcomes rather than utilization.

A key part of the strategy is changing the way care is delivered in key focus areas. Each focus area was chosen because of prior evidence suggesting that improvement in these areas can achieve the three-part aim. Each CCO will address four of seven quality improvement areas:

- Reducing preventable re-hospitalizations;
- 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 federal and state programs;

- Deploying care teams to improve care and reduce preventable, unnecessary and costly utilization by frequent utilizers;
- Integrating primary care and behavioral health;
- Ensuring appropriate care is delivered in appropriate settings;
- Improving perinatal and maternity care; and
- Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness.

The state will support CCO efforts with a wide array of resources and supports:

- **The Oregon Transformation Center:** Once launched in 2013, the Oregon Transformation Center will act as the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state. The center will provide support mechanisms that include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a range of topics including health equity. A patient-centered primary care home (PCPCH) technical assistance institute, that is already operational, will coordinate with the Oregon Transformation Center's learning collaboratives once launched.
- **Innovator agents:** Innovator agents will be assigned to each CCO. They will be a single, constant point of contact between the CCO and OHA and will help champion and share innovation ideas in support of transformation, within either the CCOs or the state agency. The state's innovator agent plan is included in this master document.
- **Non-Traditional Healthcare Workers:** These workers include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems
- **Patient-Centered Primary Care Homes:** The adoption of patient-centered primary care homes (PCPCH) is integral to transforming the health system. The primary care home model of care is defined by Oregon's statewide PCPCH standards and measures. These measures call for a patient-and-family-centered approach to all aspects of care, wellness and prevention. This includes culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner.

- **Evidence-based clinical decision tools:** Disseminated through the Oregon Transformation Center, these tools, based on extensive research and expertise on treatment effectiveness in achieving meaningful clinical outcomes, will provide guidance to providers and CCO clinical advisory panels in delivering clinically and cost-effective care.

- **Transparency:** Quarterly public reporting on a wide range of quality, access, and beneficiary experience measures, via CCO dashboards, will synthesize performance data to make it clear and understandable to all stakeholders, most importantly Medicaid beneficiaries.

- **Timely feedback:** Feedback will be presented to CCOs about progress, opportunities, and areas for improvement through a robust measurement strategy and analytics infrastructure.

Part II: Statewide Quality and Access Tests and Evaluations

Part II of the document (pages 67-97) provides information about statewide activities to support and incent quality and access, including an annual statewide test of quality and access required by CMS to assure that the demonstration's cost control goal is not being achieved at the expense of quality. The tests are structured to encourage improvement in quality, but if quality and access significantly diminish, a Designated State Health Programs (DSHP) penalty specified in the demonstration special terms and conditions (STCs) will apply. Part II of the Accountability Plan also includes demonstration evaluation plans to support continuous quality improvement as well as a summative evaluation as required by the STCs.

The goal for these tests and evaluations is to create a new paradigm of accountability between CMS and the state. The key elements of this are:

- **Structured access and quality test:** Not only is the state required to meet the expenditure test outlined in Section B of this document, but in years where it meets that test, it is also required to meet a structured access and quality test to ensure that cost containment goals are not achieved at the expense of access or quality. The quality and access test consists of two parts: a relatively simple initial comparison of annual performance on a broad set of metrics against a baseline; and a more complex analysis of the associated between transformation activities and performance on access on quality, to be conducted only if the state fails part one of the test.

- **Formative, midpoint, and summative impact evaluations:** Building on the measurement strategy described in the first part of this document, the state will track and report regularly on OHA and CCO actions, the "levers" for health system transformation described in the STCs, and progress toward the goals of the three-part aim. The formative evaluation will provide timely and actionable feedback to CCOs, the state, and CMS. The midpoint and summative evaluations will be conducted by external, independent contractors and will employ more sophisticated analytic methods in order to determine whether changes in quality and outcomes resulted from the state's transformation activities.

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. The expansions and delivery reforms under this demonstration are intended in part to bridge the transition to implementation of the ACA, making monitoring the changes in 2014 an essential part of the state's efforts. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the quality and access tests will apply no differently in 2014 than in other demonstration years, except that the midpoint assessment is designed to provide analytical insight into progress as of 2014.

Part III: Measurement Strategy

Part III of the document (pages 98-170) describes the measurement strategies to support both CCO level quality activities in Part I as well as statewide quality activities in Part II.

Performance for all of these metrics will be made transparent, and will be reported by race, ethnicity and language to the extent possible, to ensure improved outcomes for all communities. CCO level dashboards will also be created to assist in rapid cycle improvement.

Metric groups:

- **Oregon CCO Incentive Measures:** The state's Metrics and Scoring Committee is responsible for identifying and adopting metrics for a program that establishes CCO financial incentives for improved outcomes. The Committee has identified an initial set of 17 metrics.
- **Oregon Demonstration Core Performance Measures:** Oregon's 1115 demonstration also includes ten additional measures that represent a broad snapshot of the Medicaid program.
- **CMS Adult Core Set for Medicaid**: These are the core set of measures recommended by an expert panel and established by CMS to track quality of care for the adult Medicaid population.
- **CMS Child Core Set for Medicaid and the Children's Health Insurance Program**: These are the core set of measures established by CMS for the pediatric population, also recommended by an expert panel. Both core sets will be part of the reporting format to the extent feasible, even as the sets evolve.

There is considerable overlap among these metric groups. The CCO incentive measures will determine the disbursement of the CCO-level quality pool and will serve as a strong incentive for quality improvement. The other measure sets, to the degree they are not included in the incentive measures, will serve as a broad snapshot of the Medicaid program in order to ensure that there is no degradation in some areas as the CCOs focus on the quality improvement areas represented by the incentive measures.

The statewide tests for quality and access that can trigger DSHP penalties include a very broad set of measures from all of these metric groups.

Section B: Expenditure Trend Review (pages 168- 188)

The expenditure trend review provides the methodology and template for measuring the required two-percentage point reduction in the rate of growth of Oregon Health Plan per capita expenditures. The test consists of three levels that capture growth in: 1) CCO global budget services; 2) total Medicaid expenditures for CCO enrollees; and 3) new administrative costs that may accrue to Medicaid in order to provide care under health system transformation in Oregon.

Along with submitting the expenditure trend review data quarterly, the state has agree to conduct an exploratory stakeholder process regarding opportunities, barriers, and strategies to integrate long term care into CCO global budgets. The state will also augment the expenditure review test reporting in March of each year with trends on hospital uncompensated care in the state for monitoring purposes.

Conclusion

The overall purpose of this demonstration is to help support fundamental changes in the delivery system. These changes can in turn help not only achieve the three-part aim, but also to prepare the state for the transition to 2014 when more of its population will be enrolled in CCOs.

Oregon's Accountability Plan and Expenditure Trend Review memorialize agreements negotiated between the state and CMS to ensure robust monitoring of the state's innovative health system transformation activities. Through regular reporting and rapid cycle improvement activities, both CMS and Oregon hope to learn lessons that can be applied to other payers and perhaps in other states.

Part I

Coordinated Care Organization (CCO)

Quality Strategy for the Oregon Health Plan 2012

CCO Quality Strategy Table of Contents

I. Introduction 208
II. Improvement Strategies 210
III. Oregon's Goals 224
A. Lower Costs 224
B. Better Care: Quality of Care 227
C. Better Care: Access to Care 230
D.Better Care: Experience of Care 232
E. Better Health 233
IV. Assessment 237
Performance Monitoring 237
Data Sources 239
Credentialing 240
Health Information Technology 240
V. Contract Compliance 242
Standards for Managed Care Contracts 242
Delivery Services Performance Monitoring 242
Enforcement 244
VI. Review of Quality Strategy 244
VII. Achievements and Opportunities 245
Appendix 1.A: Coordinated Care Organization Service Area Density 246
Appendix 1.B: Theory of Action Model 247
Appendix 1.C: Quality Pool Structure 248
Appendix 1.D: Innovator Agent Plan 256
Appendix 1.E: Contract Compliance 260
Appendix 1.F: List of Conditions that can result in Sanctions 264

I. Introduction

Oregon has a long history of choosing innovative means of managing its Medicaid program. Almost all of the state's Medicaid population is in managed care, and most of its long-term care program is in-home and community based services. When faced with the need to curb costs, the state developed the Prioritized List of Health Care Services to ensure that there was a rational, open process for selecting services to be covered based on their impact on population health. Even with this history as background, Oregon has faced a number of challenges in recent years familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and for the state and federal government; cost growth that far outpaces the growth in state general fund revenue and personal income; and a system focused on volume, not value.

For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical. Nationally, it is estimated that about 30 percent of care provided is either unnecessary or does not lead to patient health. For racial and ethnic minorities, access to care and health status are worse than for the general population. For example, 35 percent of minority women in Oregon have no regular care provider, compared to 18 percent for Caucasian women, and the life expectancy for African Americans and American Indians/Alaska Natives in Oregon is two years less than for Caucasians. People of color disproportionately represent one in four covered lives in the Medicaid population. Native Americans have lower utilization rates of preventive services for children (birth through 10 years old), when compared to Caucasians, Latinos, and Asian Americans. African Americans and Native Americans have high rates of ambulatory care sensitive condition hospitalizations than Caucasians, Latinos and Asian Americans. Oregon's Action Plan for Health issues a call for action to address racial and ethnic health disparities. Addressing these disparities will go a long way toward improving Oregon's health system.

Instead of responding to trends over the last several years with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon has chosen a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon has developed a coordinated care model for this transformation that is built on the three-part aim of better health, better care and lower costs, and is being implemented in Oregon's Medicaid program through Coordinated Care Organizations (CCOs).

The coordinated care model was the logical next step for Oregon's health reform efforts that began in 1994 with the creation of the Oregon Health Plan (OHP). The coordinated care model grew out of recognition that the services people need are not integrated, leading to poorer health and higher costs. Physical health, mental health, substance abuse, and oral health, services are fragmented and are insufficiently tailored to meet the diverse needs of Oregon's

population. There is a sense of urgency in the state to rein in these costs or they will continue to overwhelm state, business and personal budgets.

Coordinated Care Organizations are community-based organizations governed by a partnership among those sharing in financial risk, providers of care, and community members. CCOs are and will be the single point of accountability for the health quality and outcomes for their members. They have the flexibility, within model parameters, to institute their own payment and delivery reforms that achieve the best possible outcomes for their membership.

Oregon's first eight Coordinated Care Organizations were certified to begin enrolling new members as of August 1, 2012. As of December 2012, there are 15 CCOs extending across every county in the state and approximately 90 percent of the Medicaid enrollees *(See attached map in Appendix 1.A)*.

As in the past, Oregon will continue to develop and maintain a quality strategy to assess and improve the quality of CCO services and to ensure compliance with standards. Section A, Part 1 of this Accountability Plan (the current section) satisfies both STC 45 and 42 CFR Part 438, subpart D requirement for a state quality strategy. Oregon will continue its robust monitoring of system performance and will continue to assure that standards of access, program operation, and quality are met. Although many oversight mechanisms used today will continue in the future, the transition from managed physical and mental health care to CCOs has greater implications for quality assurance and performance improvement focus areas than for methods of oversight.

CCO accountability measures and related incentives will be core elements of the state's quality strategy. These measures will allow the Oregon Health Authority (OHA) to set clear expectations for care delivery and health systems transformation and to monitor CCOs' performance against those expectations. OHA will institute a system of progressive shared accountability that maximizes the opportunity to succeed but also protects the public interest.

OHA will perform periodic reviews of the quality strategy to determine the need for revision and to assure CCOs are in contract compliance and have committed adequate resources to perform internal monitoring and ongoing quality improvement activities.

II. Improvement Strategies

To meet the goals of the three-part aim, Oregon's coordinated care model and FFS delivery systems 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 will take in the form of the stimuli and supports described below, 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 alternative payment methodologies 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

OHA will employ a variety of stimuli to promote the action of the levers and supports to enhance their effectiveness. *See the theory-of-action visual in Appendix 1.B for more details on the interaction between these levers and supports.*

STIMULI

Contractual requirements

One of the hallmarks of Oregon's health system transformation is local governance and flexibility, which requires a unique approach to a quality strategy in that it must recognize that each organization is unique in its approach to a model of care that meets the three-part aim. To that end, the state has included in its contracts a requirement that each CCO submit a draft transformation plan for approval by OHA by January 15, 2013. These plans must incorporate all

the contractual requirements of transformation, including milestones and benchmarks in each of the following areas:

- The model of care that the CCO will adopt;
- Their strategies for integrating behavioral, physical and oral health;
- The use of flexible services;
- How they will coordinate care;
- How they will adopt alternative payment methodologies for compensating providers;
- How they will work with diverse community partners and their Community Advisory Council;
- How they will reduce health disparities and advance health equity for culturally and socially diverse communities;
- How they will employ non-traditional healthcare workers and health care interpreters; and
- How they will address four of the seven focus areas in the STCs, three of which will be addressed as performance improvement products (PIPs). See below for a detailed discussion.

OHA will negotiate the content of the transformation plans with the CCOs and the final plans will become part of the CCO contracts as addenda. *See also section V of the Quality Strategy for further discussion of contract compliance and the repercussions for CCOs of non-compliance*.

Global budgets for CCOs (STC 36b)

CCO global budgets integrate previously separated funding streams – physical, mental and, beginning in 2013, oral health – and represent the total cost of care for all services a CCO is responsible. CCOs are held accountable for managing the total array of services, either through a capitated per-member-per-month (PMPM) payment or though payment for outcomes. In addition to reducing administrative overhead and promoting administrative simplification by combining the infrastructure and function of previously separate organizations, global budgets require coordination of care across all services and promote accountability. By shifting some services away from capitation and toward payment for outcomes (subject to CMS approval where necessary), Oregon is moving toward a system that increasingly pays for value rather than utilization.

This global budget is neither a per-capita cap nor a global cap. Beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures. Per person spending trends will be measured to assure the demonstration is on track to save state and federal funds, but do not in any way serve as a cap on federal funding for medical assistance provided to Oregon's Medicaid beneficiaries.

Transparency

Beginning in January 2013, data supporting measures of cost, quality, access, experience of care, and health status will be collected by OHA over all delivery settings and populations. These measures include the core performance measures listed in the Oregon demonstration; others will be drawn from the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measures, the Medicaid adult core set, and a set of measures specifically addressing the needs of the severely and persistently mentally ill (SPMI) population. (*See Oregon's Measurement Strategy in Part III for the complete listing of metrics*). Data to track these measures will also be collected by race, ethnicity and language, to ensure improved outcomes for all communities. These measures will be reported publicly beginning June 2014 and will be updated either quarterly or annually depending on the measure. In addition, CCO dashboards will be created that will synthesize performance data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries.

Financial Incentives

A legislatively mandated stakeholder group, the Metrics and Scoring Committee, identifies metrics for financial incentives and makes recommendations to OHA about the design of the incentive structure. Incentive payments linked to metrics recommended by the Committee will form the basis of a fully-at-risk quality pool. The quality pool is a bridge strategy to move CCO payments from utilization to value. Over time, the proportion of a CCO's global budget based on capitation is expected to decrease as the proportion based on incentives tied to improvements in outcomes and efficiency increases, with prior CMS approval as needed.

The Oregon Metrics and Scoring Committee has worked with national experts to create the appropriate metrics and incentives that are aligned with the state's Medicaid quality strategy. Beginning July 2014, incentives will be linked to each CCO's performance on quality, cost and access measures as well as electronic health record adoption. In addition, in order to maximize the potential for achieving quality goals, CCOs will be required to align their provider incentives with the quality pool incentives; that requirement is reflected in CCO contracts. Timelines and milestones for implementation of alternative payment methodologies that further align CCOs and their providers with health system transformation objectives are addressed as part of CCO

transformation plans (drafts due January 15, 2013). *See Oregon's Measurement Strategy in Part III and the Quality Pool Structure in Appendix 1.C for a fuller description of financial incentives*.

One Percent Administrative Withhold

In accordance with STC 37b.i., OHA will withhold one percent of capitation revenue from CCOs in each year of the demonstration in order to ensure timely and accurate data submission. CCOs will forfeit up to the full one percent if they do not meet Oregon's standards for timely and accurate submission of encounter data. The specific contractual requirements are reflected in Oregon's January 2013 CCO contract amendments.

Quality Improvement Focus Areas

As required by contract and STC 25b.i., each CCO must address four of the quality improvement focus area 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 problem identified,
- Implement the action plan,
- Study its effects, and
- Refine the intervention.

Three of the focus areas will be conducted as performance improvement projects (PIPs). In Demonstration Year 11 (DY11), one of the three required PIPs will focus on integrating primary care and 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. Integrating primary care and behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care; and

7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. Finally, Attachment E of the demonstration's STCs outlines example measures that would be required of any CCO selecting specific focus areas.

SUPPORTS

The Oregon Health Transformation Center

In 2008 the Oregon Health Fund Board recognized the need for an infrastructure to stimulate system innovation and improvement. The Oregon Health Policy Board directed OHA in creating "Oregon's Action Plan for Health" to provide necessary supports for success of the model of coordinated care. As an important support, Oregon is forming a Transformation Center in the winter of 2013 to support the rapid learning and improvement necessary to implement the coordinated care model and to make any required mid-course corrections quickly. In Oregon's vision, the Oregon Transformation Center is the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state.

The activities of the Transformation Center will be aimed at creating the optimal conditions for the rapid spread of the key elements of the coordinated care model. Everett Roger's Diffusion of Innovation theory suggests that there are eight critical components in the successful spread of innovation.[6] In accordance with this work, the Transformation Center will conduct activities aimed at identifying or achieving:

- **Change leaders:** respected individuals who can serve as key messengers for the innovations;
- **Active learning networks:** peer-to-peer networks, collaboratives and other communication channels that enable stakeholders (CCOs and other payers, their providers, communities and consumers) to engage in learning and sharing information about the innovations;
- **Relative advantage:** stakeholders believe that the innovations are an improvement over current practice and their benefits outweigh the risks;

[6]Everett M. Rogers, *Diffusion of Innovations*, Fifth Edition 2003, Free Press, New York

- **Compatibility:** stakeholders understand how the innovations fit in with their current system and community needs;
- **Simplicity:** innovations are as easy as possible to implement;
- **Trialability:** stakeholders are able to try out an innovation with minimal investment before moving to full implementation;
- **Observability:** stakeholders see demonstrated evidence that an innovation works; and
- **Reinvention:** stakeholders can appropriately adapt innovations to serve local community needs.

The specific tools and support mechanisms to be provided by the Transformation Center include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a variety of topics including advancing health equity. Timely data and targeted analytic tools are among the most important supports that the Transformation Center will provide. In order to make sustainable progress towards integrating and coordinating care, CCOs and other health system partners will need better tools and stronger incentives to improve performance.

In cooperation with OHA's Office of Health Analytics, the Transformation Center will provide, both through Innovator Agents (described below) and directly to CCOs:

- Timely, reliable information and analysis to improve the targeting and delivery of services and to improve health equity;
- Data to drive accountability mechanisms, such as alternative payment methodologies aligned with performance measures and health outcomes; and
- Clear communication of analyses of performance, progress, and opportunities for improvement to help develop consensus around priorities and improve decision-making.

See Part III for descriptions of data sources and measurement details.

Learning Collaboratives

The Oregon Health Authority will establish a CCO learning collaborative as required by STC 25d within the Transformation Center, the purpose of which is to promote innovations and activities that will contribute to the objectives of health system transformation and accountability for achievement of the three-part aim of better health, better health care and

lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. In addition to learning collaborative areas of focus to be defined by OHA, CCO learning collaborative members will work together to decide upon additional focus area(s) of the collaborative and work with OHA to develop appropriate performance measures.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract. Also established by contract is a requirement 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.

Innovator Agents

STC 25d. and Senate Bill 1580 require OHA to provide CCOs with "innovator agents" who will act as a single point of contact between the CCO and OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation's three-part aim: better health, better care, lower cost. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight. (*See section V for additional details on contract monitoring and oversight*).

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication and allowing streamlined reporting, reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports.
- Assist the CCO in managing and using data to accelerate quality improvement.

- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The innovator agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other innovator agents, CCOs, community stakeholders and/or OHA.

Innovator agent performance will be assessed annually through a "360" review process that includes input from the Community Advisory Councils, CCO management, OHA partners and other relevant stakeholders.

For more details on innovator agents and the Transformation Center, see the innovator agent plan, Appendix 1.D.

Community Advisory Councils (STC 25a)

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 council must:

- Include representatives of the community and of each county government served by the coordinated care organization, 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 coordinated care organization; and
- Annually publishing a report on the progress of the community health improvement plan.

Community Advisory Council members will be surveyed annually to assess their satisfaction with the level and quality of their engagement with the functions of the CCO board.

Community Health Assessments and Community Health Improvement Plan (STC 25a)
Community health assessments and the resulting community health improvement plan are required annually of each CCO. 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.

Non-Traditional Healthcare Workers (STC 18j)
Non-Traditional Healthcare Workers (NTHW) include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems, including reaching fee-for-service members. NTHWs take health care beyond the four walls of clinics and hospitals, out into homes and the community, supporting healthcare transformation in a variety of ways.

By focusing on culturally sensitive and linguistically appropriate approaches, NTHWs support adherence to treatment and care plans, coordinate care and support system navigation and transitions, promote chronic disease self-management, and foster community-based prevention. In order to build a health care workforce for the future, Oregon will:

- Establish systems for certifying NTHWs and certify 300 new community health workers by December 2015;
- Establish infrastructure to accelerate the certification of health care interpreters and certify 100 interpreters by June 2016; and
- Establish a curriculum within the Transformation Center learning collaboratives that supports best practices in using this new workforce to improve access and outcomes.

Patient-Centered Primary Care Home (PCPCH) Adoption (STC 18k, 25, 40c.viii, ix)
The Patient-Centered Primary Care Home (PCPCH) is integral to health systems transformation, and is defined by Oregon's statewide PCPCH standards and measures[7], developed through a public process to advance the three-part aim. These PCPCH standards call for a focus on patient-and-family-centered approach to all aspects of care, wellness and prevention, culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner. PCPCHs are available for both CCO and FFS members alike.

Practices are recognized to meet the criteria for one of three tiers, with tier one being the basic level, tier two an intermediate level, and tier three a more advanced level of practice. There is a crosswalk so that practices that are NCQA-certified medical homes can use that as a portion of their requirement for designation. Health plans and other payers can then use the tiers to determine payment to incent and support the model.

Through a state plan amendment, OHA is currently providing tiered payments to recognized clinics for care to Medicaid enrollees with specific chronic diseases using federal funding through the Affordable Care Act's Section 2703. Several private payers are also paying an incentive payment to certified clinics based on the Oregon PCPCH standards, including those in partnership with the state and Medicare through the Centers for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care Initiative to 70 Oregon clinics.

House Bill 3650 (the enabling legislation for health system transformation) calls for CCOs to provide access to services through PCPCHs to the greatest extent possible. Through its contracts with CCOs, Oregon will encourage CCOs to use alternative payment methodologies that support PCPCH functions. Oregon will assess the implementation of PCPCHs through the

[7]See:http://www.oregon.gov/oha/OHPR/pages/HEALTHREFORM/PCPCH/standards.aspx

statewide PCPCH recognition process, CCO performance monitoring, and by assessing the percentage spent on primary care services and numbers of enrollees attributed to PCPCHs over time.

CCOs will demonstrate how they will use PCPCH capacity to:

- Partner with and/or implement a network of PCPCHs to the maximum extent feasible;
- Require other contracting health and services providers to communicate and coordinate care with PCPCHs in a timely manner using HIT/HIE technologies;
- Incent and monitor for comprehensive transitional care;
- Assure that beneficiaries receive integrated, person-centered care and are fully informed partners in transitioning to this new model of care;
- Assure that beneficiaries are informed about access to non-traditional providers as they are available through the CCO. Non-traditional providers may include personal health navigators, peer wellness specialists, and community health workers; and
- Assure that the primary care team provides culturally and linguistically appropriate assistance to beneficiaries in accessing needed services.

To further support the development of PCPCH capacity in Oregon, with funding from the Northwest Health Foundation and the Health Resources and Services Administration (HRSA) State Health Access Program, OHA awarded a $1.3 million contract to the Oregon Health Care Quality Corporation (Quality Corp) to establish a public-private partnership focused on supporting primary care transformation. The PCPCH Institute will provide technical assistance to Oregon clinics looking to improve care and gain recognition as patient-centered primary care homes.

Quality Corp will facilitate a collaborative and open process to establish the PCPCH Institute, beginning with the appointment of an expert oversight panel. The panel will include practicing providers with PCPCH knowledge and experience, experts in PCPCH learning techniques, behavioral health experts, public and private health system representatives, Independent Physicians Association representatives, and OHA staff. The Institute will invite proposals from interested technical assistance providers and organizations and the expert panel will oversee the selection process.

Once organizations are selected for providing specific services, a broad array of technical assistance will dramatically expand the quality and capacity of resources available to primary care clinics in Oregon including:

- The PCPCH learning collaborative

- A comprehensive, interactive learning system website
- Online learning modules and webinars
- Practice facilitation or "coaching" services
- Quality improvement training via a train-the-trainer model.

The Oregon Health Authority, Northwest Health Foundation, and Quality Corp will also be working to sustain the PCPCH Institute as an ongoing vehicle to support the patient-centered care model that will result in significant improvements in health care quality and outcomes in Oregon.

The Public Health Division (PHD) and the Office for Oregon Health Policy and Research are collaborating on the implementation and oversight for the PCPCH Program evaluation site visits in order to maintain the integrity and outcomes of the Program. PHD will train site evaluators that will conduct site visits in order to assist PCPCHs in identifying areas of strength and improvement.

In addition to these supports, the quality pool for CCOs will include an incentive for member enrollment in PCPCHs. *See Part III and Appendix 1.C for more details on Oregon's Measurement Strategy and Quality Pool Structure.*

Health Information Technology (HIT) is another tool that will support transformation; see the discussion of HIT initiatives at the end of Section IV, under the heading Health Information Technology.

Coordination with Other State Agencies

Public Health Division

Many of the factors that lead to chronic disease and disability, including unhealthy behaviors, 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 systemic barriers and root causes of poor health outcomes as well as corresponding risk factors such as tobacco use, poor nutrition and physical inactivity. Oregon's healthcare transformation initiative specifically delineates expectations that CCOs will address these root causes through the community needs assessment, community health improvement plan, the Community Advisory Council and collaboration with state and local public health agencies and community partners.

Through the Transformation Center, the state's Public Health Division will work with local health departments to collaborate in developing training and technical assistance for CCOs that

includes webinars, group training, individual coaching, and sharing of best practices, related to health promotion and disease prevention. This would include topics such as:

- The development and implementation of evidence-based cessation services, including benefits, referral systems, tobacco use as a vital sign, and integrating cessation support into electronic health records.
- The development of tobacco-free campus/worksite policies.
- The development of nutrition standards for hospital campuses, worksites and health care settings.
- USPSTF clinical preventive services recommendations for colorectal, breast, and cervical cancer screening, with specific emphasis on the importance of evidence-based colorectal cancer screening.
- The development and implementation of evidence-based chronic disease self-management programs, including referrals through electronic health records.

OHA will also be establishing a prevention policy committee that spans its operating divisions, including mental health, Medicaid, and public health to ensure that the OHA's policies support prevention in healthcare settings, extend prevention linkages between healthcare settings and communities, and integrate a variety of programmatic and professional approaches. This policy committee will consider issues related to supporting the CCOs, including operational policy issues and payment policy issues to support the three-part aim through prevention, and will review and make recommendations upon the request of the OHA Director. Issues the committee might consider include facilitating payment mechanisms for evidence-based chronic disease self-management programs such as Living Well with Chronic Conditions that are known to reduce the burden and costs associated with chronic diseases.

Office of Equity and Inclusion (OEI)

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.

Through the Transformation Center, the Office of Equity and Inclusion (OEI) will assist in developing a curriculum for CCOs and Medicaid providers that will include webinars, group training, individual coaching, information sharing, and technical assistance related to health equity. This would include topics such as:

- Language access services such as interpretation, translation, signage, web sites.
- Job descriptions, training, recruitment and retention of community health workers and other non-traditional health workers.
- Diversifying the health care workforce.
- Diversity and inclusion best practices.
- Diversifying community advisory boards.
- Including equity and diversity in CCO community health assessments and improvement plans.
- Cultural competence continuing education for all staff.
- Race, ethnicity, and language data collection, analysis, and reporting for quality improvement, and
- Community outreach and partnership with trusted culturally competent community and faith based organizations.

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. 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. OHA is coordinating with the ELC to ensure that a broad view of early learning is adopted, one that 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 ELC and OHA are seeking shared opportunities for coordination of services, workforce training, data sharing, quality measurement, and accountability for child outcomes.

Oregon Patient Safety Commission

OHA will partner with the Patient Safety Commission to make the Commission's Breakthrough Series Collaboratives available to CCOs, and to bring learnings from the work of the commission to improving patient safety throughout the Medicaid population.

III. Oregon's Goals

Oregon is engaged in multiple efforts to achieve the three-part aim. Through specific objectives, ideal behaviors, supportive stimuli, and through an infrastructure of learning systems to support rapid cycle improvement, the state can achieve lower costs, improve quality of care and improve the patient experience.

A. Lower Costs

In the past two decades, Oregon's health care expenditures have been increasing exponentially. It is one of the sectors of Oregon's economy with the highest growth rate, averaging 7.6 percent annually. Medicaid served 14 percent of the Oregon population in 2010. Its expenditures, at $3.3 billion, represented 12 percent of the total healthcare spending in 2010, and per capita Medicaid expenditures were $6,049.[8]

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as $10 billion in the FY 2017-2019 biennium with more than 900,000 individuals enrolled in the program. This figure includes approximately over 200,000 newly eligible under federal health reform expansion provisions that take effect in 2014.

With healthcare costs increasing unsustainably, a key goal of healthcare transformation in Oregon is to reduce the growth in statewide PMPM Medicaid spending by one percentage

[8]Sources: Population counts: Portland State University; 2010 expenditures by payer type from 1990-2004 National Health Expenditure (NHE) Data, Center for Medicare & Medicaid Services (CMS).

point in demonstration year two and by two percentage points over demonstration years three, four, and five.

Specific objectives:

1. Decrease trend rate by two percentage points as evidenced by total cost PMPM.
2. Meet or exceed 90th percentile national Medicaid benchmark for ED visit rates.
3. Meet or exceed national Medicaid benchmark for all cause readmissions

LOWER COST			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	Align provider financial incentives to achieve the Three-part aim Take meaningful action to reduce administrative waste Be creative with deploying flexible services Be creative with deploying caregivers directly when appropriate	Global budget creates incentive to coordinate care and eliminate redundant organizational structures Transparency: o Avoidable ED visits o ED utilization o PQI o Re-admissions to hospital o % of service dollars for enabling services for SPMI populations o Length of stay in various care settings for SPMI population Incentives: o Follow-up after hospitalization for mental illness o EHR adoption	• Analytic support: quarterly analysis of: o PQI o Avoidable ED visits o Expenditures per CCO o High utilizers • Innovator agents work with CCO to use results of analysis to determine most efficacious interventions in rapid cycle improvement (RCI) • Innovator agents recommend and provide information regarding best practices, innovative models, to address issues in RCI, e.g.: o Financial models, including alternative payment methodologies o Financial tools, such as groupers o Models for administrative simplification

LOWER COST			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
		o ED utilization Contract requirements for: • Flexible services • NTHWs • APMs	• Transformation center provides TA and tools related to the "starter set" of promising alternative payment models (APMs) including: o Bundled payments o Risk and gain sharing arrangements o Global payments o Service agreements aligning primary and specialty care incentives
Providers:	• Coordinate care with other providers • Coordinate care with community resources and services • Offer after-hours help and alternatives to the emergency department • Avoid duplicative and unnecessary services	Alternative payment methodologies Flexible services	• PCPCH adoption • Case managers and NTHWs • Support with community health solutions • Innovator agents work with CCO to share data analyses with PCPs • Transformation Center supports innovative strategies such as community health workers to address needs of high utilizers; use of flexible services

B. Better Care: Quality of Care

An in-depth examination of Oregon managed care organizations' (MCOs) historical performance on a number of measures of quality of care reveals significant areas where performance should improve to equal the national Medicaid average. In other measures, Oregon performs at the national average. In either case, it is important to maintain the level of quality and strive to improve it. Thus, Oregon set objectives to meet or exceed national Medicaid averages where they are available, focusing on areas that are closely aligned with the overall goals of health system transformation. For some measures, an Oregon baseline has not yet been calculated, but it is believed that the measure is critically important to evaluating the quality of care provided.

Specific objectives:

1. Improve developmental screening by 36 months to align with Oregon Early Learning Council objectives (no national baseline available).
2. Meet or exceed the 75th percentile of the national Medicaid average on HEDIS timeliness of prenatal care visits.
3. Meet or exceed the March of Dimes goal of <5% rate of elective deliveries before 39 weeks. Establish baseline in DY11.
4. Meet or exceed the 75th percentile national Medicaid benchmarks for diabetes care (HbA1C poor control).
5. Meet or exceed the 75th percentile national Medicaid average for controlling hypertension (HEDIS). Establish baseline in DY11.
6. Maintain or improve colorectal cancer screening. Set target at 49% (based on improvement across Oregon's Medicaid plans since 2002).
7. Improve substance abuse screening (SBIRT): Establish baseline in DY11 and set benchmark for DY12.
8. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.
9. Maintain or improve to meet or exceed the 90th percentile of the national Medicaid average for follow up after hospitalization for mental illness.
10. Improve mental health and physical health assessment in children in DHS custody. Establish baseline in DY11 and set benchmark for DY12.

11. Improve screening for clinical depression and follow up plan. Establish baseline in DY11 and set benchmark for DY12.

12. Meet or exceed the 90th percentile national Medicaid benchmarks for follow up care for children on ADHD medication

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to improve care coordination, including behavioral health • Encourage providers to exceed benchmarks for meaningful use and participate in HIE • Engage meaningfully with community, including culturally and linguistically diverse communities, to address its health needs • Encourage members to take an active role in their care	Global budgets provide stimulus for integrating and coordinating care Financial incentives: • Screening for addiction, brief intervention and referral to treatment (SBIRT) • Follow up after hospitalization for mental illness • Diabetes control • Colorectal cancer screening • Hypertension control • Elective delivery before 39 weeks • Timeliness of prenatal care visits • Developmental screening by 36 months • Mental health and physical health assessment for children in DHS custody • EHR adoption	• Learning collaboratives that target areas of concern • Provide TA as needed on PIPs • Innovator agents champion and share ideas • Transformation Center supports analysis of data by race, ethnicity and language to assure equitable quality of care • Support and encourage employment of NTHWs through registry of workers, establishment of certification criteria, and partnerships with community colleges • Transformation Center shares best practices, evidence-based interventions, and care models across communities • Public health supports through evidence-based interventions to improve population health • Work with Oregon Patient Safety Commission to bring information about best practices and evidence-based

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
		Transparency: Quality measures will be tracked and posted on the OHA website. See Part III for the complete listing. Contract requirements for: • Focus areas (PIPs) • Community needs assessment • Community Advisory Council • Transformation plan	interventions to improve patient safety to CCOs
Providers:	• Strive for tier 3 PCPCH status • Coordinate care with other providers • Coordinate care with community resources and services • Help patients navigate the healthcare system • Encourage patients activation • Show respect to patients and families • Adhere to clinical guidelines • Use data to ensure timely follow up, prevention, and interventions • Increase healthcare workforce diversity, including non-traditional	• Incentives for PCPCH status • Incentives for EHR adoption • Payment methodologies that incentivize performance	• Community support through public health • Utilization of NTHWs • Transformation Center and Innovator agents share best practices and resources • Feedback on performance measures

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
	health care workers • Access cultural competency continuing education		

C. Better Care: Access to Care

Oregon exceeds national Medicaid benchmarks in some measures of access, particularly for access to primary care and ambulatory care visits. For Consumer Assessment of Healthcare Providers and Services (CAHPS) measures, Oregon is often just below national Medicaid CAHPS measures of access. For adolescent well care visits, Oregon is below national Medicaid average and our goal is to improve it to meet that standard.

Specific objectives:

1. 100% of beneficiaries will have access to a certified PCPCH.
2. 75% of PCPCH sites will be certified as tier 3.
3. Rates for primary care sensitive admissions (PQI) will be reduced 10% from Oregon's baseline.
4. Rates for avoidable ED visits will meet or exceed (i.e., be lower than) national Medicaid averages.
5. Dental visits for children (after 2014) will meet or exceed national Medicaid averages.
6. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.

ACCESS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to meet level 3 PCPCH certification • Care about and take action to increase access • Encourage use of NTHWs • Support culturally and linguistically specific outreach and engagement to promote access • Support availability and use of culturally and linguistically appropriate materials	Transparency: Access measures will be tracked and reported on the OHA website. See Part III for additional details. Contractual requirements for: • Transformation plan must incorporate model of care that addresses access issues • Community needs assessment must address access • Community Advisory Council provides ongoing feedback on access to CCO Financial incentives: • CAHPS survey questions about access • ED utilization • Access to PCPCH • Adolescent well visits	• Support for NTHW, who help increase access by helping members navigate the healthcare system and advocating for them as needed • Data analytic support on measures of access • Innovator agents bring resources on best practices and innovations to increase access • Learning collaboratives focus on improving access • Support from Office of Equity and Inclusion to promote culturally competent care that is welcoming to all and increases access
Providers:	• Offer after-hours help and alternatives to the emergency room • Help patients navigate the healthcare system • Diversify the workforce	PCPCH financial incentives	• Learning collaboratives • NTHWs and HCIs

D. Better Care: Experience of Care

Patient-centeredness is the key component of the care Oregon aspires to provide to Medicaid beneficiaries. By encouraging feedback from patients about their experience of care, OHA learns how to make significant improvements in the quality of the care provided and build a model of care that meets their needs. In Oregon, CAHPS scores for patient experience of care measures for individuals are slightly lower than the national Medicaid average for adult members reporting getting needed care and positive communication with a doctor, but slightly higher for getting care quickly.

Specific goal:
Meet or exceed the 75th percentile of the national average for Medicaid CAHPS (for both adults and children) experience of care tools for specified composite measures that focus on areas critical to Oregon's goals for health system transformation:

- Access to care composite, for both children and adults

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
CCOs:	• Adopt value-based purchasing • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care	Transparency: OHA will post on its website: • CAHPS survey results • Performance metrics by race and ethnicity. Financial incentives: CAHPS survey questions are included in quality pool metrics: ▪ Composite: Health plan's customer service gave information or help you needed ▪ Composite: Getting care quickly Contract requirements include quarterly reporting of grievances and appeals by CCOs (*see section IV)*	• Data from CAHPS and other surveys used to identify learning needs • Innovator agents : o support improvement with learning collaboratives, peer-to-peer learning o Collaborate with the OHA Ombudsman to monitor emerging trends in complaints and appeals assigned CCOs. o Provide feedback to assigned CCOs and identify needs for peer-to-peer and learning collaboratives to address problems as they arise. • Community Advisory Council monitors patient experience and works with CCO to improve in identified areas • Office of Equity and Inclusion

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
			supports provision of culturally competent care which will improve the patient experience
Providers:	• Help patients navigate the healthcare system • Are accessible • Put patients first • Encourage patients to play an active role in their care • Show respect to patients and their families	Value-based purchasing and provider incentives encourage providers to address needs of patients	• Community support through public health • NTHWs support members in navigating healthcare system and getting needed services • Best practices and sharing of resources (e.g. Quit Line)

E. Better Health

The ultimate test of the effectiveness of a healthcare system is the health of the people who use it. While pursuing the goals of lower cost and better experience of care, it must be assured that at the very least health and healthcare are not degraded, and aim to improve them.

To improve population health and lower costs, Coordinated Care Organizations must address the increasing burden of chronic diseases. Chronic diseases account for 75 cents of every health care dollar spent. Eighty percent of health care resources are spent on 20 percent of members,[9] most of whom have multiple chronic conditions that are complex to manage. Chronic diseases that remain undetected untreated and poorly managed result in increased hospitalizations, costly medical interventions, lower productivity and, most importantly, lower quality of life for Oregonians.

Health status: Oregon's baseline data for Medicaid, taken from the 2011 Medicaid Adult CAHPS survey, reveals health status responses that are below national averages as well as health status of Oregon's general population as reported on the 2010 BRFSS:

[9] Agency for Healthcare Research and Quality

	Oregon CAHPS (Medicaid)	National Average CAHPS (Medicaid)	Oregon BRFSS Adult General Population
Excellent	7%	11%	19%
Very good	16%	22%	33%
Good	33%	32%	30%
Fair	29%	24%	13%
Poor	14%	10%	5%

Obesity: Oregon's 2010 BRFSS data reveal an adult Medicaid obesity rate of 38.3 percent, compared to 27.7 percent of the general population in Oregon. *(Note: the Medicaid data are not age adjusted, while the general population data are)*.

Tobacco: The current adult Medicaid rate of tobacco use is 31 percent (CAHPS 2011), compared to 23 percent in the general population in Oregon (BRFSS 2010). Oregon Medicaid is below the national average of 37 percent (Medicaid CAHPS), but tobacco use is a major driver of long-term health risks.

Specific objectives:

1. Reduce the proportion of beneficiaries who report their health status to be poor to 10 percent by 2017**.** Oregon will initially assess health status through the use of the CAHPS survey. It is expected that health status will be evaluated through a self-assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

2. Obesity as calculated from self-reported height and weight will not exceed 41 percent over course of the demonstration. Oregon will initially assess obesity through the use of the CAHPS survey. It is expected that a self-assessment tool will be available as part of a new online enrollment system projected to come on line in 2014. Enrollees will be asked to state their height and weight, from which a BMI can be calculated.

3. Decrease tobacco use in the Medicaid population to 25 percent over the course of the demonstration. Oregon will initially assess tobacco use through the use of the CAHPS survey. It is expected that tobacco use status will be determined through a self-assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

4. Reduce ethnic and racial disparities over the course of the demonstration. Establish baseline in first year of the demonstration. Use enrollment data, which identifies race,

ethnicity, and foster child status to compare these groups for health status, obesity and tobacco use. In the first year of the demonstration, develop strategy to identify disabled and Serious and Persistent Mental Illness (SPMI) populations, and establish baseline for disparities among all groups.

HEALTH STATUS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Care about and take actions to guarantee strong member outcomes • Use value-based purchasing to improve outcomes • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care • Focus on health equity	Contract requirements: • CCOs must perform a community health assessment in the first year • CCO's transformation plan must reflect the community health assessment • Community Advisory Council (CAC) will guide the development of the community health assessment, connect the CCO with the community, and hold it accountable to improving the health of beneficiaries enrolled Financial incentives for PCPCH adoption Transparency: publish health outcomes data by CCO on the OHA website. Relevant performance measures include: • Health and functional status among CCO	The Transformation Center will provide data and analytic support to CCOs for race/ethnicity composition of their population and inequities in performance metrics and the community health assessment Innovator agents work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work, champion and share ideas. Office of Equity and Inclusion will support CCOs in designing culturally appropriate strategies to improve health

		enrollees; • Rate of tobacco use among CCO enrollees; • Obesity rate among CCO enrollees • Reduction of disparities: differences in these metrics among race and ethnicity categories Community Advisory Council Community Needs Assessment PCPCH incentives	
Providers:	• Encourage patients to play an active role in their care	PCPCH incentives	• The Public Health Division will work with local health departments to support the implementation of evidence-based community interventions • Support for the employment of NTHWs through a registry of workers, establishment of certification criteria, and partnerships with community colleges

IV. Assessment

To monitor how well Oregon's coordinated care model is achieving its goals of access and quality improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have a robust measurement and reporting strategy and mechanisms to monitor and assess all Medicaid delivery systems (including Coordinated Care Organizations and Fee-for-Service). Full details on how the Oregon Health Authority will measure quality of and access to care for the Oregon Health Plan population are available in Part III: Oregon's Measurement Strategy. The format for the state's required quarterly reporting to CMS on quality, access, and many other elements of the demonstration can be found in STC Attachment A, Quarterly Report Guidelines. This section describes Oregon's assessment program, available data sources, requirements for credentialing, and an overview of health information technology.

Performance Monitoring

As required by CFR 438.202(d), the state assesses how well the Coordinated Care Organizations 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. Oregon's evaluation plans, described in Part II, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries.

In addition, OHA monitors plans activities on an ongoing or periodic basis for the level of contract compliance. Assessment program components are described below:

On-site operational reviews – Operational reviews are conducted on a regular basis. These reviews are designed to supplement other state monitoring activities by focusing on those aspects of CCO performance that cannot be fully monitored from reported data or documentation. These reviews focus on validating reports and data previously submitted by the CCO through a series of review techniques that include an assessment of supporting documentation and conducting a more in-depth review of the CCO's quality assurance activities.

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 the 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 reviews – 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.

Complaint, grievance and appeals reports – 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.

Fraud and abuse reports – 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 committee 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.

Data Sources

Oregon assesses the quality and appropriateness of care through the collection and analysis of data from many sources. The state has developed many systems to collect data from plans and plans are required to have information systems capable of collecting, analyzing, and submitting the required data and reports. Data sources include:

Administrative Data – All CCOs, managed care plans, 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.

In the MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Ethnicity is currently defined as Hispanic/non-Hispanic. Oregon does not have data on multiple races. Oregon only has data on preferred household language, not language spoken by an individual client.

Community Health Assessment – CCOs are contractually required to submit the community health needs assessment to OHA. For additional detail on the community health assessment, see section II, above.

Enrollment Data – Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

As the state moves to an online enrollment system in 2014, data collection on race, ethnicity, and language will be improved and additional data will be collected through this system, including tobacco use status and body mass index (BMI). All enrollment data is shared with the plans.

Member Satisfaction Surveys – Oregon, in conjunction with its external quality review agent (EQRO), conducts statewide-standardized surveys of patients' experience of care (satisfaction). These surveys allow for plan-to-plan comparisons. Plans are required to participate, as appropriate, in the performance of such surveys. Plans whose results are meaningfully and statistically below acceptable thresholds may be required to develop a corrective action plan that the state will review and monitor. The results of the surveys are made available to

Medicaid beneficiaries to assist them in the processes of selecting an appropriate plan. Survey results are shared with plans and reports are published on the OHA website.

Participating provider network reports – Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turn over.

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 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.

Credentialing

Managed care 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.

CCOs must also work with OHA through the Addictions and Mental Health Division and Public Health Division to assure proper credentialing of Mental Health Programs, associated providers and non-traditional health care workers. *See Appendix 1.E for a list of contractual elements and associated OARs.*

Health Information Technology

Adoption of Electronic Health Record Technology and Meaningful Use (STC 25c)

The Medicaid Electronic Health Record (EHR) Incentive Program provides incentives to certain providers who adopt and demonstrate meaningful use of certified electronic records. The program began in 2011 and concludes in 2021. Initial participation by eligible professionals (EPs) may begin any time until 2016. Oregon requires that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The Metrics and Scoring Committee is developing measures and benchmarks that will demonstrate CCO commitment to exceed the federal standards for EHR adoption. *See Part III for details on measures and benchmarks.*

Information Sharing

Health information exchange activities are critical for central elements of this demonstration, including reporting of quality metrics, progress with meaningful use of electronic health

records, meaningful care coordination, and real-time data assessments. CMS has made funds available, at state request, for the Medicaid portions of the health information exchange infrastructure. These funds could help support the HIE provisions outlined in STC 25(c).

The Health Information Technology Oversight Council (HITOC), created legislatively in HB 2009, has guided the development of Health Information Exchange (HIE) work in Oregon. HIE is not a single technical solution, but rather includes any solutions that allow health information to be made available to the provider at the right time and in the right place to meet patient needs. For Oregon's first phase of HIE, HITOC selected the standards for secure, HIPAA-compliant electronic messaging developed by the Direct Project through the Office of the National Coordinator for Health Information Technology (ONC). Using these standards, statewide Direct Secure Messaging was developed through the Oregon Office of Health Information Technology (OHIT) and launched in May 2012 under the brand CareAccord™. OHIT is tracking the number of Direct addresses in use and number of Direct messages being sent through CareAccord™ as one way to measure growth in information exchange.

Direct Secure Messaging is not the totality of HIE, and currently Oregon is in the process of gathering stakeholder input from within the state, from CCOs, from patient groups, and others to determine the right path for the development of further HIE services.

Recommended measures start with those that ONC has published in a program information notice (PIN) for HIE which established that states report the following measures annually:

- Percent of pharmacies participating in e-prescribing
- Percent of clinical laboratories sending lab results electronically and in structured format
- Percent of providers and hospitals sharing patient care summaries electronically
- Percent of state health programs within the Oregon Department of Health electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results

In addition, each CCO is contractually obligated to meet standards in foundational areas of health IT. This includes facilitation of providers' adoption and meaningful use of EHRs and ensuring that every provider either is registered with a statewide or local Direct-enabled health information service provider (HISP), or is a member of a health information organization (HIO) that enables electronic sharing of information with other providers in the CCO's network. Also, each CCO must develop a transformation plan that demonstrates, among other elements, how it will develop EHRs, HIE and meaningful use. The Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) are also investigating the inclusion of measures for HIE in future contracts.

These developments in EHR adoption and HIE support better collection of timely, actionable data to enable quality measurement and improvement.

Trailblazer State Project

The HIT Trailblazer Project is a new technical assistance award from ONC and supported by the National Academy for State Health Policy (NASHP) for a small number of states that are leading the nation in health system transformation. An action plan will be developed by March 2013 for the technical infrastructure for statewide quality reporting and feedback. Part of the assistance that the federal partners will be providing Oregon is an understanding of the federal vision for quality measures and how those can be aligned with the state measures to reduce the burden on providers for reporting while providing metrics that are meaningful to Oregon's specific implementation of health system transformation.

V. Contract Compliance

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 1.E 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.

Delivery System Performance Monitoring

Oregon has developed a comprehensive program to assess all aspects of the delivery system. As described in section IV, above, 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.

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 described in section IV above.

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.

External Quality Review Organization Activities

OHA has contracted with Acumentra Health to serve as its external quality review organization (EQRO). In compliance with federal regulations, the scope of work includes all mandatory activities: compliance reviews every three years, validating health plan Performance Improvement Projects; 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.

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. These Quality Management Plans (QMPs) are reviewed, along

with documentation of the activities and studies undertaken as part of the QMP during both the certification process and ongoing EQRO reviews.

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. A list of conditions that may result in sanctions can be found in Appendix 1.F.

VI. Review of CCO Quality Strategy

The Quality Strategy shall be reviewed annually by OHA. This annual review and update will begin each August and shall be completed by December of each year. The Quality Strategy update will be provided to CMS in December of each year upon significant changes.

The OHA Quality Committee 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:

- AMH Planning and Management Advisory Council (PAMAC)*
- Medicaid Advisory Committee*
- DMAP/AMH Executive Team
- OHP Medical Directors
- OHP Contractors

- OHP Quality Management Coordinators
- Local Government Advisory Committee*
- DHS 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.

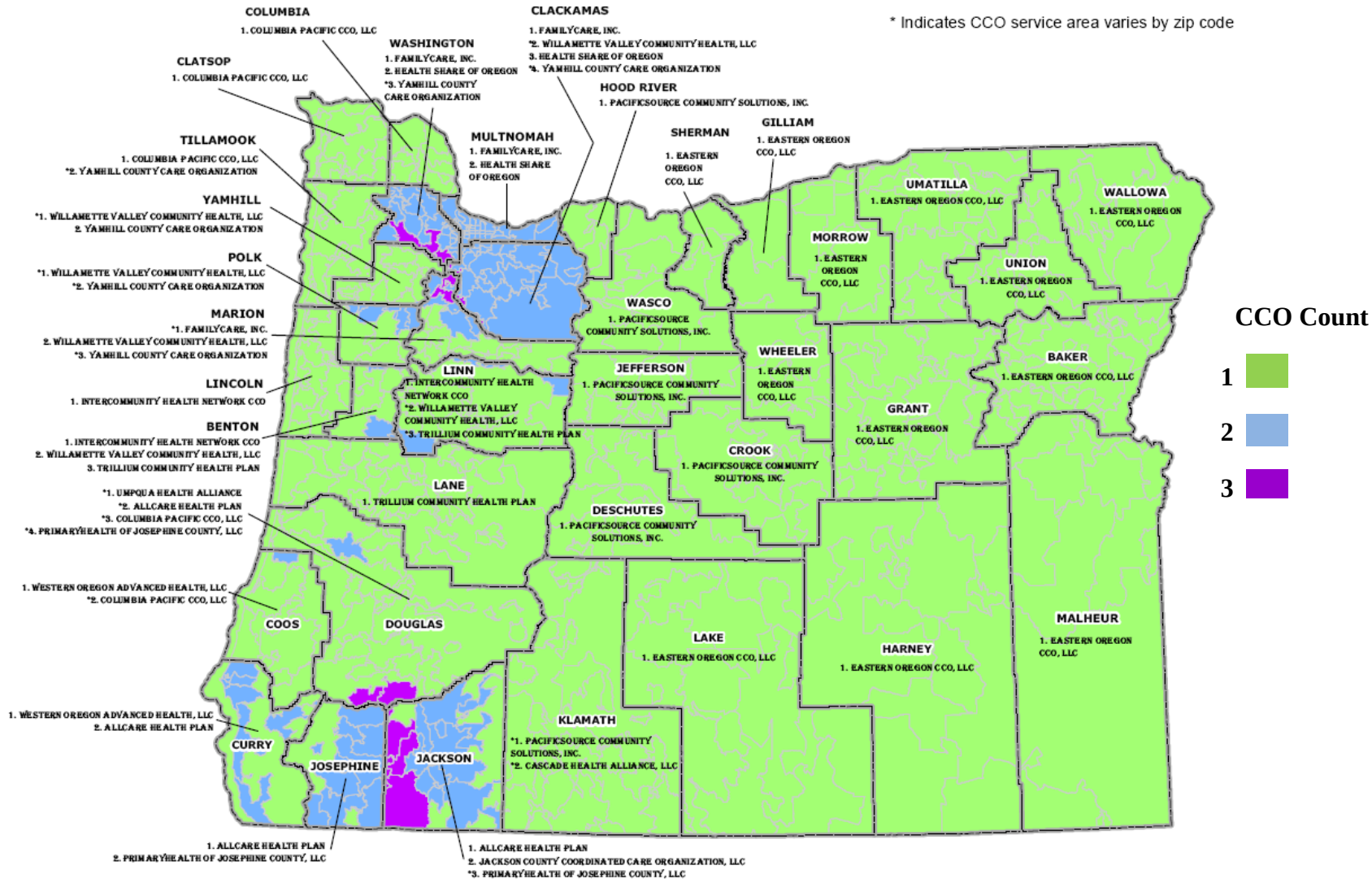
VII. Achievements and Opportunities

Passage of House Bill 2009 and HB 3650 are important achievements for the state and present a significant opportunity for Oregon to expand work already in progress to improve population health and increase access to high quality, efficient, and cost effective health care.

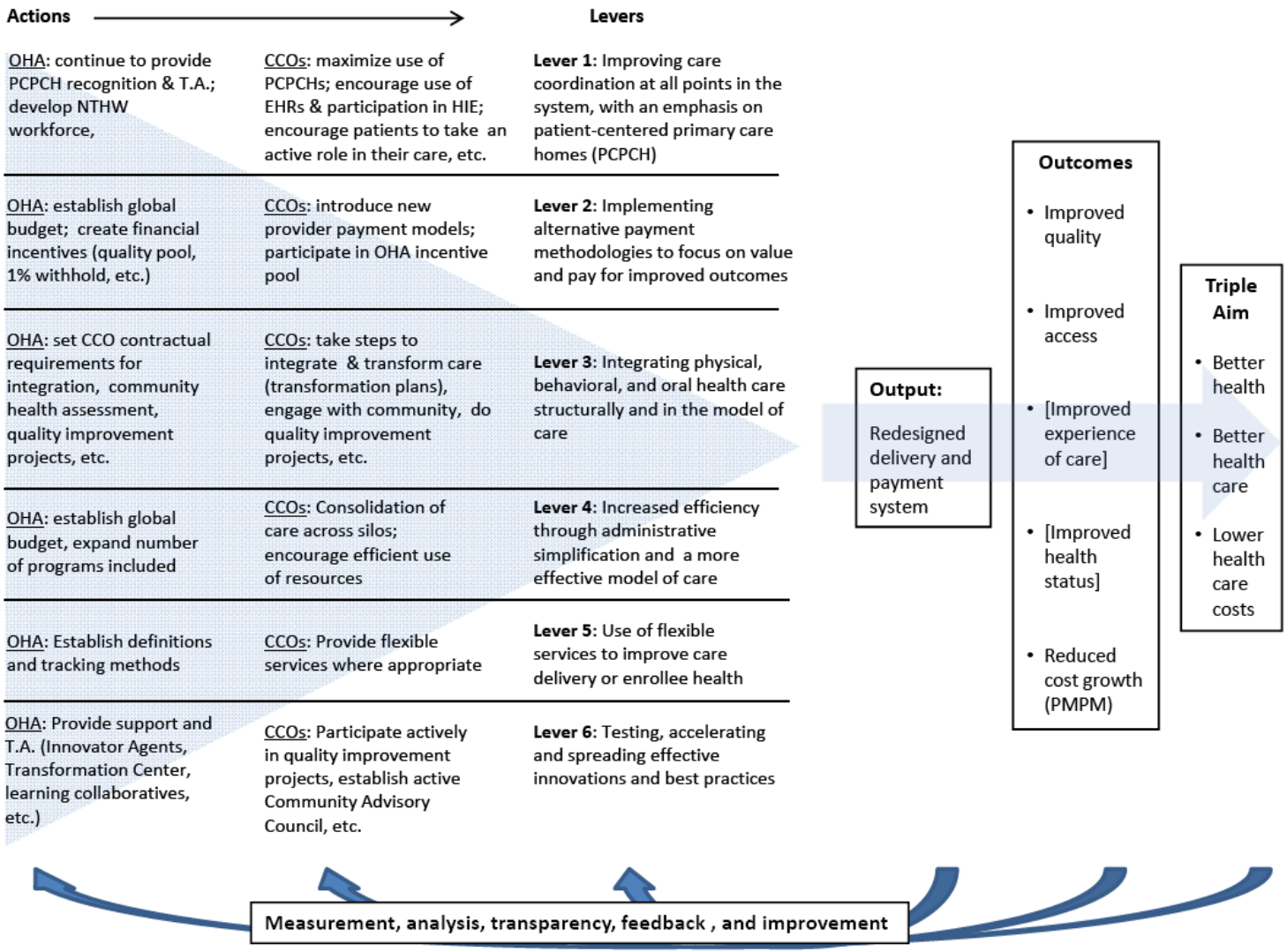
Oregon has a strong foundation for future health system transformation based upon the 20-year history of the Oregon Health Plan, and the extensive knowledge and experience developed during that time, including the unique use in Oregon of the Prioritized List of Health Services under the Health Services Resource Commission.

With the creation of the Oregon Health Authority consolidating all state health agencies in Oregon, there is further opportunity for increased focus and support for the Quality Strategy, including alignment with other quality and health improvement initiatives.

Appendix 1.A: Coordinated Care Organization Service Area Density



Appendix 1.B: Theory of Action Model



Appendix 1.C: Quality Pool Structure (STC 37b.ii)

Introduction

Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. By establishing a quality incentive pool as required by STC 37b.ii, the state is taking the first step in this process. It is expected that over time, savings accruing from the restructuring of 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.

OHA's Strategy for Annually Setting the Amount of CCO Payment at Risk for Performance

OHA's strategy is to annually increase the percentage of CCO payment at risk for performance over the term of the demonstration. OHA believes that unless CCOs have a meaningful percentage of their payment at risk for performance, they are unlikely to take the steps necessary to achieve significant performance improvement and affect transformative change in care delivery. OHA also believes that it must be careful to not make the at-risk amount so large as to threaten the financial viability of a CCO should it not perform well relative to the contractual targets.

Because performance-based contracting is new to both OHA and CCOs, OHA anticipates the need to annually assess experience, with CCO and Metrics and Scoring Committee input, and then determine both a) changes to the quality incentive pool methodology, and b) the desired level of CCO financial risk for the next contract year.

OHA recognizes that while a substantive incentive payment will provide meaningful motivation for CCOs, research has shown that fear of loss is a greater motivator than is the potential for gain.[10] For this reason, OHA intends to increase the at-risk amount by a percentage point each year of the demonstration—meaning poor performance could result in a loss of margin–although not a loss so large as to threaten the CCO's stability.

OHA's Planned Approach for Defining the At-Risk Amount for the DY12 Contract Year

OHA plans to finance the Quality Pool for the demonstration year 12 (DY12) contract year at two percent of the aggregate value of the per member per month (PMPM) CCO budget.

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[10]Kahneman, D. and Tversky, A. "Choices, Values, and Frames." American Psychologist39 (4): 341–350 (1984) and Kahneman, D., Knetsch, J., & Thaler, R. "Experimental Test of the endowment effect and the Coase Theorem" *Journal of Political Economy* 98(6), 1325-1348 (1990).

Specifically, OHA will make disbursement of these funds contingent on CCO performance relative to both absolute (benchmark) targets and improvement targets on selected measures. Using OHA's planned methodology, there will be two rounds of funding distributions. In Round One, each CCO will have a maximum amount of Round One dollars from the incentive pool for which it is eligible in any particular contract year. This pre-determined amount will be calculated by multiplying a common PMPM value by the CCOs' beneficiary average monthly member count for the contract year. OHA plans, however, to set a floor such that regardless of enrollment, each CCO shall be eligible to earn at least $1 million dollars, assuming maximal performance, through the incentive pool. OHA has adopted this strategy in order to ensure that small CCOs have sufficient grounds for making necessary investments in quality improvement.

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs in a second round of funding distribution called the "challenge" round. The challenge funds will be distributed to those CCOs that meet the performance targets on a subset of four incentive measures described in this document as "challenge measures." A complete description of the challenge measures and the distribution of challenge funds are provided below.

CCOs will only be rewarded for attaining performance targets ***or*** improving performance; there will be no penalties assessed related to performance in DY12.

OHA believes this strategy is appropriate for the first year for the following reasons:

- CCOs will view an incentive pool equivalent to the aggregate size of the rate increase to be sizeable, particularly given the large rate cuts experienced previously by the predecessor MCOs. The CCOs will be motivated to achieve this potential reward.
- This approach has been used by commercial health plans with providers with positive results.[11]
- Use of a challenge pool will allow CCOs to give special attention to those aspects of performance that are most important to OHA for DY12.
- The CCOs have never been measured or been held accountable for performance relative to many of the adopted measures. Neither OHA nor the CCOs can be absolutely certain regarding the feasibility of CCO target attainment. As CCOs develop experience with the measures and with implementing efforts to generate improvement to attain targets, they will be better prepared to accept higher levels of risk.

[11]Richard Weisblatt, Harvard Pilgrim Health Care, personal communications, March 8, 2011 and October 24, 2012.

For the above reasons, a first-year approach that offers a meaningful incentive appears appropriate as OHA and the CCOs transition to a new method of contracting and doing business.

Timeline for Distribution of Funding in DY12

The incentive funds will be distributed on an annual basis. The incentive period will run for one calendar year (January – December 2013); there will be an additional three-month period following the incentive period to account for the time lag to obtain complete claims data and conduct chart reviews, with the incentive payments to be made by June 2014.

The baseline measurement year for each of the incentive metrics will be 2011 and will be derived from combining the predecessor organizations (MCO + MHO) metrics in each service area. In areas where there is no predecessor MCO, the statewide average will be applied.[12]

The first measurement year and reporting period for the incentive measures will be 2013. Results will be available in early 2014, in time for the first quality pool distribution in the second quarter of 2014. The year two data measurement and reporting period for incentive measures will be 2014. Using this timeline, the final incentive payments of the demonstration program will not be paid until several months after the end of the demonstration period.

Process for Distributing Incentive Pool Dollars in Round One

The Metrics and Scoring Committee has selected an initial set of 17 measures, listed below. OHA will be collecting baseline data for these measures and conducting some statistical testing to determine if the selected measures and performance targets are feasible. Any revisions to the measure set will be made in coordination with the Metrics and Scoring Committee.

Measures selected by the Oregon Metrics and Scoring Committee as of Oct. 22, 2012 and negotiated with CMS as of December 12, 2012:

Prevention

1. Developmental Screening in the first 36 months of life (NQF 1448)
2. Assessment of Children in DHS Custody within 60 days (mental health and physical health)
3. Adolescent Well Care Visits
4. Colorectal Cancer Screening

[12] Most CCOs have predecessor MCO organizations. In every case, they have structurally and organizationally restructured to adopt the CCO business model as well as the coordinated care model.

Access and Patient Satisfaction and Access

5. Rate of Patient-Centered Primary Care Home enrollment (*Challenge Measure*)
6. CAHPs composite "Getting Care Quickly" (adult and child)
7. CAHPs composite "Health Plan Satisfaction" (adult and child)

Chronic Illness Management

8. Diabetes Control: HbA1c >9% (*Challenge Measure*) (NQF 0057)
9. Controlling High Blood Pressure (BP less than 140/90) (NQF 0018)

Behavioral Health

10. Screening for Clinical Depression and Follow-up Plan (*Challenge Measure*)
11. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT) (*Challenge Measure*)
12. Follow up for children prescribed ADHD medications (NQF 0108)
13. Follow-up after Hospitalization for Mental Illness (NQF 0576)

Maternal Care

14. Timeliness of Prenatal Care (NQF 1517)
15. Reducing Elective Delivery Before 39 weeks (NQF 0469)

Overuse

16. Ambulatory Care: Outpatient and Emergency Department Utilization

EHR Adoption and Use

17. EHR Composite (Implement drug-drug and drug-allergy interaction checks, e-prescribing, active medication list)

In order to access the incentive pool, CCOs will be measured against a specified benchmark for each measure. CCOs that don't meet the benchmark for a given measure will be assessed against an improvement from baseline target. The benchmark and improvement targets for each measure are described in detail in Part III. The target levels of performance and improvement are the same for all CCOs, regardless of geographic region and patient mix. All of these measures are independent from one another such that a CCO can receive an incentive payment if performance on a specific measure warrants it, regardless of overall performance.

All of the measures are valued equivalently in the algorithm. For all measures except for the Patient-Centered Primary Care Home (PCPCH) measure, performance is treated on a pass/fail basis. For example, if the benchmark is met or minimum improvement level achieved, the CCO

receives all of the credit available for that measure. If neither target is met, the CCO does not receive any credit for the measure.

For the PCPCH measure, performance is measured according to the following formula known as the "tiered formula." This formula multiplies the number of members enrolled in each tier (1, 2 and 3) with the level of the tier (if 100 people are enrolled in tier 3, multiply 100 by 3), adds the totals and divides by the total number of members enrolled in the CCO multiplied by 3. The goal is to have all members enrolled in a tier 3 PCPCH so the result of the tiered formula provides a sense of where the CCO is relative to the goal. The formula is below.

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

Once OHA has calculated how much incentive funding each CCO is eligible to receive and determined each CCO's level of performance against the measure targets, then it will calculate the amount of the incentive funds each CCO will receive based on its level of performance. For each measure (except for PCPCH), there are ten performance tiers with the incentive payment for each tier ranging from 10 percent to 100 percent. As the CCOs meet more benchmark or improvement targets, they receive a higher payment. If the CCO attains the benchmark or the improvement target on at least 75 percent of the measures (12.6 measures) and met or exceeded the benchmark or improvement target for the EHR measure, then the CCO will receive 100 percent of the incentive funds. If the EHR measure is not met, then the maximum incentive payment that the CCO can receive is equivalent to the second tier of incentive payment. If the CCO gets fewer than .6 measures, then the CCO does not receive any incentive funds. A detailed definition of the tiering methodology is provided in Table 1 below.

Table 1: Example of Initial Round Quality Pool Distribution

Tier	Percent of targets met (benchmark or improvement)	Number of targets met (benchmark or improvement)	Percent of total incentive payment for which the CCO is eligible
1	74.12-100% (with EHR)	At least 12.6 (with EHR)	100%
2	68.24%	At least 11.6 (does not require EHR)	90%
3	62.35%	At least 10.6	80%
4	50.5%	At least 8.6	70%
5	38.82%	At least 6.6	60%
6	27.06%	At least 4.6	50%
7	21.18%	At least 3.6	40%
8	15.29%	At least 2.6	30%
9	9.41%	At least 1.6	20%
10	3.53%	At least .6	10%
Nothing	Less than 3.53%	Fewer than .6	No incentive payment

Process for Distributing Incentive Pool Dollars in the Challenge Round

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs that met the benchmark or improvement target for one or more of the following measures:

1. Rate of Patient-Centered Primary Care Home Enrollment (PCPCH)
2. Screening for Clinical Depression and Follow-up Plan (Depression)
3. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT)
4. Diabetes Control: HbA1c > 9%

In the challenge round, OHA will determine the aggregate number of instances in which a CCO achieves either the benchmark or improvement target for each of the four challenge measures (Diabetes Control, Depression, PCPCH, SBIRT). Since the PCPCH measure does not have a benchmark, OHA will assume that all of the CCOs achieved the target. OHA will then calculate the base amount for achieving the target on this measure by dividing the challenge pool funds

into equal portion equivalent to the total number of challenge targets met (e.g. if all 16 CCOs met a PCPCH target, 5 CCOs met an SBIRT target, 6 met a Depression target, and 3 met a Diabetes Control target, then the incentive fund would be divided into 30 equal portions (the "base payment").

For the Diabetes, Depression, and SBIRT measures, OHA will calculate the payments for each CCO that achieved a target on each challenge measure by adjusting the "base payment" described above based on the CCO's enrollment relative to the mean for those CCOs that met a specific challenge measure's target. This calculation will be performed separately for each of the three measures. An example of this calculation is detailed in Table 2 below.

Table 2. Example of Challenge Fund Distribution for Standard Measures (Diabetes, depression, SBIRT)

CCO Name	Base Payment	Member Months (MM)	CCO's ratio of MMs to total MM	Adjusted Challenge Fund Payment
CCO A	$ 1,666.67	29,588	1.459	1,666.67*1.459= $ 2,432.26
CCO B	$ 1,666.67	23,343	1.151	1,666.67*1.151= $ 1,918.90
CCO C	$ 1,666.67	22,788	1.124	1,666.67*1.124= $ 1,873.27
CCO D	$ 1,666.67	18,014	0.889	1,666.67*.889= $ 1,480.83
CCO E	$ 1,666.67	16,394	0.808	1,666.67*.808= $ 1,347.66
CCO F	$ 1,666.67	11,521	0.568	1,666.67*.568= $ 947.08
	$10,000 (Total pool for measure #1)	121,648 (Total MM)		$ 10,000 (total)
		20274.67 (Mean MM)		

For the PCPCH measure, the funding will be distributed to the CCOs based on a combination of results of the tiered formula and overall enrollment. For each CCO, OHA will multiply the result of the tiered formula with the total number of member months for the CCO to get an adjusted number of member months. OHA will then multiply this adjusted enrollment with an adjustment factor (the adjusted member months relative to the mean) and multiply that by the "base payment" described above to determine the total incentive payment amount for PCPCH. An example of this calculation is detailed in Table 3 below.

Table 3: Example of Challenge Fund Distribution for PCPCH

	Base Payment	Result of Tiered formula	Member Months	Adjusted Member Months	Adjusted Member Months Relative to the Mean		Adjusted challenge fund payment (PCPCH)
CCO A	$ 1,666.67	0.4 *	29,588	=11,835.2	0.969	$ 1,666.67*.969=	$ 1,615.21
CCO B	$ 1,666.67	0.5 *	23,343	=11,671.5	0.956	$ 1,666.67*.956=	$ 1,592.87
CCO C	$ 1,666.67	0.6 *	22,788	=13,672.8	1.120	$ 1,666.67*1.120=	$ 1,866.00
CCO D	$ 1,666.67	0.7 *	18,014	=12,609.8	1.033	$ 1,666.67*1.033=	$ 1,720.92
CCO E	$ 1,666.67	0.8 *	16,394	=13,115.2	1.074	$ 1,666.67*1.074=	$ 1,789.90
CCO F	$ 1,666.67	0.9 *	11,521	=10,368.9	0.849	$ 1,666.67*.849=	$ 1,415.10
	$10,000 (Total pool for PCPCH measure)			73,273 (Total adjusted member months)			$ 10,000.00 (total)
				12,212 (mean adjusted member months)			

Appendix 1.D: Innovator Agent Plan

Innovator agents and Learning Collaboratives

Learning Collaboratives (STC 25d)

The Oregon Health Authority will establish a CCO learning collaborative, the purpose of which is to promote innovations and activities that will contribute to the goals of health system transformation and accountability for achievement of the three-part aim of better health, better health care and lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. CCO learning collaborative members will work together to decide upon the area(s) of focus of the collaborative and work with OHA to develop appropriate performance measures. OHA reserves the right to select some of the learning collaborative topics.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract as will a requirement that when a CCO is identified by OHA as underperforming in access, quality or cost against metrics established by the OHA Metrics and Scoring Committee, the CCO will be required to participate in an intensified innovator/learning collaborative intervention.

Role of the Innovator agents (STC 25d)

Senate Bill 1580 requires OHA to provide CCOs with “Innovator agents” who will act as a single point of contact between the CCO and the OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation’s three-part aim of better health, better care and lower cost.

The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability for achieving the three-part aim. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight.

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication; allowing streamlined reporting and reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports
- Assist the CCO in managing and using data to accelerate quality improvement.
- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other Innovator agents, CCOs, Community Stakeholders and/or OHA.

Tasks to be performed by innovator agents:

- Complete OHA innovator agent training (training will be developed in consultation with national experts and based on other national models, such as the CMMI Innovation Advisory program training).
- Assist and support the CCOs in developing and implementing their transformation plans.
- Assist the CCO with gathering and interpreting data to target areas of local focus for improvement.
- Gather input on CCO performance from other state agency staff working directly with the CCO, primarily the Quality Improvement Coordinator and Health Plan Coordinator.
- Communicate at least every other week with all other innovator agents (and meet in person at least once each quarter) to discuss ideas, projects and creative innovation planned or undertaken by their assigned CCO.
- Attend Community Advisory Committee meetings and provide input into Community Health Assessment process.
- Participate in innovator agent learning collaborative; Participate and/or convene in other learning collaboratives as appropriate (CCOs, providers, etc.).
- Ensure rapid-cycle stakeholder feedback to identify and solve barriers; to assist with adapting innovations to simplify and/or improve rate of adoption; and to increase stakeholder engagement.

- Track questions / issues from CCOs and the answers/resolution, establishing a database not only to serve as the basis for a FAQ and information sharing among innovator agents, but also to identify potential systemic issues.
- Participate in information sharing through an interactive website, sharing documents, communicate, collaborate, and developing resources to share with the team.

Innovator Agent Reporting Requirements:

- Monthly reports on CCO progress toward the implementation of the CCO's transformation plan.
- Monthly reports about CCO progress toward achieving "ideal behaviors".
- Quarterly reports on promising practices and/or innovations occurring within the CCO.

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.
- Secure website with a database into which the Innovator Agent will log all CCO/ Community Stakeholder questions and answers.
- Not less than once every calendar quarter, 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.

Measures of Effectiveness

The success and effectiveness of innovator agents will be measured in a variety of ways, but initially will focus on measures of the IAs level of engagement with the CCO and the community it serves as well as shared accountability for CCO outcomes, including:

- Survey rating innovator agent's performance to be completed by CCO leadership, Community Advisory Council members, and other relevant stakeholders.
- Number of questions answered (tracked in online database as outlined above) and number of meetings/ events an innovator agent has in the community.
- Number and success of innovations adopted by a CCO.
- Rate at which CCOs test new ideas and improve.
- Successful implementation of CCO's transformation plan, the measures for which will be developed upon completion of the CCO's transformation plan.
- The measures used to gauge the effectiveness of learning collaboratives (number of meetings, level of engagement, etc.) may also be used to measure efficacy of innovator agents.
- CCO performance on metrics as identified by the Metrics and Scoring Committee: improved access and quality, decreased per capita costs.

Appendix 1.E: Contract Compliance

The following 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, Subsection 3.a. • Exhibit G,1.b. • Exhibit B, Part 4, Subsection 2.m. • Exhibit B, Part 4, Subsection 3.a. (6) • Exhibit B, Part 4, subsection 3.b.(1) • Exhibit B, Part 4, subsection 3.a.(1)
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 3.a.(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	Model Contract: • Exhibit B, Part 4, 2.i. • Exhibit B, Part 4, 2.e.

Required Component	Contract Provision
with special health care needs. Special health care needs are defined as: 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 M, subsection 7
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, 3.b.
438.218 - Enrollee information • Plans must meet the requirements of 438.10	Model Contract: • Exhibit N
438.224 - Confidentiality • Plans must comply with state and federal confidentiality rules.	Model Contract: • Ex. B, Part 4, Section 5.b.(3)

Required Component	Contract Provision
438.226 - Enrollment and disenrollment • Plans must comply with the enrollment and disenrollment standards in 438.56.	Model Contract: • Ex. B, part 3, subsection 6
438.228 - Grievance systems • Plans must comply with grievance system requirements in the federal regulations.	Model Contract: • Ex. B, part 3, subsection 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: • Ex. M, subsection 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. • 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.	Model Contract: • Ex. B, Part 9

Required Component	Contract Provision
• 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

Appendix 1.F: List of Conditions that can 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.

Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluations

Attachment H

Evaluation Design and Quality and Access Tests

Table of Contents

Preface 268

Oregon Special Terms and Conditions 52, 54, 64, 86,and 88 268

Introduction 274

Demonstration Overview 275

Statewide Quality and Access Test 277

Evaluation 283

Evaluation Objectives 283

Contextual Considerations 284

Research Questions, Data Sources, and Analytic Approach 287

Table 1 – Formative Evaluation 288

Table 2 – Summative Assessment 292

Timeline 298

Preface

The prior part of this document describes the Oregon quality improvement strategy, and primarily addresses the interactions between the state and the CCOs as part of this demonstration.

Part II describes the efforts to monitor and assess quality and access at a statewide level to ensure that statewide quality and access are improving over the course of the demonstration.

The relevant special terms and conditions relating to evaluation, monitoring, and statewide tests are listed below.

Oregon Special Terms and Conditions 52, 54, 64, 86, and 88

Oregon's special terms and conditions (STCs) for the Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115(a) Medicaid demonstration extension ("demonstration"), contain the following provisions related to monitoring quality and access (STC 52) and standards of quality and access, including the standard that must be met for purposes of DSHP expenditure authority (STC 54):

52. ***Measurement of Quality and Access Under the Demonstration***. The state will also monitor *and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 64. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.*

Within 120 days of approval of the demonstration, the state will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's Medicaid population as a whole. The state's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). state quality and access reporting will take place on the same timeframes as the state's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

54. ***Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets.*** *This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration*

goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 49, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Demonstration Year	**Per Capita Expenditure Growth Reduction Target** (measure following DY close)	**Reduction in DSHP Expenditure Authority** (reduce succeeding DY's DSHP expenditure authority)
DY 11	NA	NA
DY 12	1 percentage point	$54 million
DY 13	2 percentage points	$68 million
DY 14	2 percentage points	$68 million
DY 15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the state in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the state has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. Earn Back Option. For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:

> *i. If the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year and significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.*

ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.

iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

Quarterly reporting requirements are outlined in STC 64 and are an integral part of monitoring the demonstration:

64. Monitoring To Assure Progress in Meeting Demonstration Goals: *The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the State's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of demonstration goals.*

a. ***Interim Reporting Format.*** *The state and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:*

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;

ii. Quality Improvement Metrics: Section VII;

iii. Access to Care measures: Section VII;

b. ***Timeframe for Reporting.*** *The state will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.*

c. ***Data Sources:***

i. Goal 1:

1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with state);

2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;

3. Total Medicaid service spending per beneficiary; and

4. *CCO provider spending per beneficiary.*

ii. *Goal 2:*

1. *Benchmarked metrics tied to incentive payments, including patient experience surveys;*
2. *Data from the all payer-all claims database;*
3. *Process Improvement Projects (PIPs);*
    a. *EQRO studies;*
    b. *Complaints and grievances;*
    c. *Health risk assessment data;*
    d. *Public health data;*
    e. *Health risk assessment data;*
    f. *Meaningful use attestation data;*
    g. *State CCO monitoring reports; and*
    h. *Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the Duals Demonstration.*

d. ***Final Annual Report:*** *The state shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The state will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.*

e. ***Penalty for Late Reporting:***

i. If the state fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The state may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that prevents the state from reporting timely, the state can request an exception to these timeframes and penalties.

Percentage withheld of quarterly demonstration administrative funding	***Days late***
.2	*15-30*
.4	*30-40*
.8	*41-50*
1	*51+*

The STCs also include the following language specific to Evaluation Design and Final Evaluation Design and Implementation:

86. ***Evaluation Design.*** *In the 120 days following the date of approval of this demonstration, the state shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the state will consider the Evaluation Guidance in Attachment B. The evaluation will include:*

a. A discussion of the demonstration hypothesis that will be tested, focusing on key areas of the State's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional demonstration outcome measures;

b. An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.

c. Any other information pertinent to the State's evaluative or formative research via the demonstration operations.

d. Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;

e. The draft plan shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation; and

f. Any other information pertinent to the State's evaluative or formative research via the demonstration operations.

88. ***Final Evaluation Design and Implementation.*** *CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the state shall submit its final design within 60 days after receipt of CMS comments. The state shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 after the expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after the receipt of CMS comments.*

Introduction

The statewide assessments of quality and access serve multiple functions for the demonstration.

First, the assessments help CMS determine the impact of the demonstration on quality and access, consistent with STCs 52 and 54. The state must pass these "tests" in order to avoid financial penalties as per STC 54. The first section of this Part II describes how these "tests" will function.

The second section of this Part II describes three types of evaluations. Each evaluation examines a specific set of questions. Although the analyses may be similar with regard to method, the demonstration evaluation is distinct from the quality and access “tests” associated with designated state health program (DSHP) expenditure authority under STC 54. The results of demonstration evaluation activities—including the midpoint assessment—have no bearing on the state’s DSHP authority.

Quarterly reports, as described here and as required by STC 64, will provide frequent feedback in order to inform ongoing operations. Elements of the quarterly reports are part of the "formative evaluations." These formative evaluations are intended to provide frequent feedback in order to ensure that course corrections are made, and that the results from those course corrections are understood in a timely fashion so as to continue the feedback cycle.

At the midpoint of the demonstration, a broader effort to learn from the demonstration will be conducted, called here the "midpoint assessment." This type of statewide assessment will provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

Finally, the state will conduct a "summative evaluation," which is required by STC 86 and 88 and is intended to summarize the experiences to ensure that this innovative demonstration is fully analyzed to determine whether it has been successful in achieving the stated goals.

As with the prior section, the measurement strategy is more fully described in Part III of this overall document.

Demonstration Overview

Demonstration Context

Health care costs are increasingly unaffordable. Despite the success of the Oregon Health Plan (OHP), which Oregon estimates has saved the state and federal government an estimated $16 billion since its inception in 1994, the growth in Medicaid expenditures in Oregon far outpaces the growth in General Fund revenue. And while health plan performance is generally strong, the growth in expenditures has not been matched by improvement in health outcomes. There are still significant opportunities to enhance access to care, improve care delivery, and advance health outcomes at the community level.

The structure of separate managed care organizations, mental health organizations and dental care organizations limits Oregon's ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. OHP clients face a sometimes dizzying array of plans and rules and the current payment system provides little incentive for the prevention or disease management actions that can improve health and lower costs.

Demonstration Goals

The July 2012 amendment and extension of Oregon's 1115 demonstration seeks 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 and access. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The current demonstration aims to accomplish two equally important and inter-related goals: reducing the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

These two goals form **the hypotheses to be tested as part of this demonstration**:

I. Oregon will reduce the growth in statewide PMPM Medicaid spending by 1 percentage point in demonstration year two and by 2 percentage points in demonstration years three and beyond; and

II. Over the course of the demonstration, Oregon will achieve control of PMPM cost growth while improving access to and quality of care for Oregon's Medicaid

beneficiaries.

Reflecting the state's commitment to the three-part aim, Oregon also proposes to evaluate the impact of Medicaid transformation on beneficiary experience of care and health outcomes.

Medicaid Transformation, Theory of Change

The Coordinated Care model, as implemented in Medicaid through Coordinated Care Organizations (CCOs), begins to address the health system shortcomings described above using several different approaches, or levers, to drive savings and quality improvement:

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on patient- centered primary care homes (PCPCHs)
- Lever 2: Implementing alternative payment methodologies 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 through administrative simplification and a more effective model of care
- Lever 5: Implementation of flexible services to improve care delivery or enrollee health
- Lever 6: Testing, accelerating and spreading effective innovations and best practices

These levers are described in more detail in Part I: Oregon's Quality Strategy, above, and are aligned with Oregon's quality improvement focus areas.

The OHA and CCO actions (including "ideal" behaviors) that power those levers are shown above in Appendix 1.B: theory of action model.

OHA and the CCOs will work toward improvement in specific focus areas (as outlined in Attachment E and elsewhere in this document) that can result in achievement of the three-part aim.

Statewide Quality and Access Test

Overview

The following section lays out the details of a "quality and access test" (the test), which will be applied each program year that the state achieves its cost control goal to determine whether Oregon's Health System Transformation (HST) has caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen. "Failing" the test results in reductions in a portion of DSHP funding to the state, as described in STC paragraph 54.

The quality and access test consists of two "parts," both described in detail below and in satisfaction of STCs 52 and 54. In brief, part 1 of the quality and access test is a relatively simple comparison of program period quality and access to historical baseline levels of quality and access; part 2 is a more complex comparison of program period quality and access to a counterfactual level of quality and access that would exist had HST not been undertaken. Part 2 of the quality and access test is required only if the state fails part 1, and Oregon fails the test for that year if and only if it fails both part 1 and part 2.

Seeking to balance the need for accurate and complete information against timeliness, CMS and the state have negotiated a streamlined reporting structure to monitor the goals of the demonstration while meeting the analytic requirements specified in STC 52 on an annual basis. This document memorializes CMS and the state's agreement to an annual test to assess whether unadjusted metrics for quality and access under the demonstration have stayed constant or, in later years, have improved. For the first two years, this first order test is passed if the score for the quality or access metrics remains constant or improves as compared to the historical baseline. After that, the first order test is passed only if the quality and access test shows improvement. If the State does not pass the first order test in any year to which it is applied, the state will undertake, and submit to CMS, a more detailed counterfactual analysis (as prescribed by STC 52 and conducted by an independent, third party evaluator) to determine whether quality and access have significantly diminished in a manner attributable to the state's efforts under the demonstration. If this counterfactual analysis indicates a significant diminishment in quality and access under the demonstration in a given year (or is not completed according to the timeframes specified below), CMS will apply the five percent DSHP reduction to the FFP claimed in the year immediately following the year for which the

determination was made as specified in STC 54. As described, after two demonstration years, Oregon will also undertake a robust midpoint analysis that will provide more detailed information about achievement of the demonstration's goals.

If the state has met its per capita expenditure growth target in any year, as described in Attachment H, Section B, but fails to achieve its quality and access goal as determined by the analysis conducted pursuant to STCs 52 and 54, beginning at the end of DY 12, the STCs give CMS the authority to prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year. Recognizing that data lags will prevent CMS from determining Oregon's satisfaction of yearly demonstration goals until several months after the close of the demonstration year, the prospective reduction will be applied at the beginning of the next succeeding demonstration year, as follows:

- Oregon may begin each new demonstration year claiming DSHP up to the full amount authorized in that year but will be at risk for a penalty of five percent of that year's DSHP allotment should CMS subsequently verify through the required reporting that, in the demonstration year in question, Oregon achieved a cost trend reduction at the expense of quality and access, or that the analyses were not submitted in accordance with the STCs.
- Once CMS has made such a determination and informed OHA of the rationale and the amount of expenditure reduction which it is subject to, Oregon must refund the funds identified as the agreed upon DSHP expenditure reduction in the quarter following the CMS determination.
- If the state does not voluntarily refund these funds, CMS may exercise the option of taking a deferral or disallowance for the amount.

Part 1 Quality and Access Test

A single "aggregate" indicator will be constructed using a number of "component" quality and access measures. A test result will be generated based on the difference between performance on this aggregate indicator in the current period (using the most recent full demonstration year) and a baseline period (calendar year 2011).

Component Measures

Oregon and CMS determined the component measures that will be used to construct the single quality and access aggregate indicator.

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 encourages broad-based improvement and tends to increase the precision of the aggregate. Measures included in the CCO incentive measure set are particularly attractive candidates, as the objectives of CCOs should be aligned with those of the state as much as possible. In general, measures for which the state is already planning to collect data should be included in the aggregate unless there is good reason to exclude that measure. Good reasons to exclude a measure are: no data are available for that measure in the baseline period; that measure would contribute so much uncertainty to the aggregate that judgments about the aggregate would be affected; it is not possible to establish a functional benchmark for the measure; or there is a lack of consensus at the state level about the value of the measure.

The component measures to be used in constructing the quality and access aggregate measure, as well as baseline and benchmark information for as many measures as possible are indicated on the *Oregon Measures Matrix* in Part III, below.

Aggregation of Component Measure Results

Because component measures may be in different units, on different scales, for different populations, and at different levels of performance compared to an ideal target, each component measure will be "translated" to a common scale, reflecting the fraction of the performance gap between baseline and ideal performance closed since the start of Medicaid system transformation. The algorithm for generating these translated measure values is as follows:

1. For each measure, Oregon and CMS will agree to a "target" level of performance, reflecting the best possible performance that Oregon would be able to achieve as a high performing program. Where possible, these targets are aligned with the CCO incentive benchmarks.

2. For each measure, the baseline (calendar year 2011 as described above) level of performance will be calculated.

3. For each measure, for each program period, the translated level of performance for the measure will be calculated as the difference between current and baseline performance divided by the difference between target and baseline performance. (Note that this formula applies whether or not the component measure has improved or worsened over time compared to a baseline.)

4. The translated value for each component measure takes the form of a percentage.

For each of the quality and access subtests, the aggregate measure is then constructed by taking the average of the component measures' translated values and rounding to the nearest first decimal place, i.e., to the nearest tenth of a percentage.

Metrics may be modified over time in the manner described in Part III of this document, regarding Oregon's Measurement Strategy.

Definition of Passing

Subject to CMS review and approval of reported findings and calculations, Oregon will be considered to have passed part one of the quality and access test for the DSHP performance periods of DYs 12 and 13 if the aggregate measure value for this test, rounded to the nearest tenth of a percentage, is greater than or equal to zero percent. In subsequent years (DYs 14 and 15), Oregon will be considered to pass a subtest only if the aggregate measure value, rounded to the nearest tenth of a percentage, is strictly greater than 0.

Timing and Deadlines

The statewide quality and access test applies only in years when the state meets its target for cost growth reduction. The first target is a one percentage point reduction for DY 12 (July 2013 – June 2014), so, allowing for data lag, the earliest point at which the test might be performed would be 6 months after the end of the end of the demonstration year in question, or early 2015. To align with quarterly reporting deadlines, the state will report test data and results to CMS in February 2015. However, the state will also calculate and report the aggregate measure to CMS in June 2013 on a practice basis only, using as much DY 11 performance data as is available at the time. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a report to CMS by the August following the end of the demonstration year in question (see Timeline).

The quality and access test for any year in which Oregon has met the cost growth reduction target will be based on measurements from the most recent full demonstration year, as follows:

DSHP Quality and Access Test Data Periods
DY 12 (7/1/13-6/30/14)
DY 13 (7/1/14-6/30/15)
DY 14 (7/1/15-6/30/16)
DY 15 (7/1/16-6/30/17)

2014

As described above, the period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the part 1 quality and access test will not be any different for 2014 in order to reflect the expectation that the demonstration will continue to provide high quality care and to preserve the simplicity of the part 1 quality and access test approach. Nevertheless, it would not be surprising if part 2 of the quality and access test were to be necessary for this year and the part 2 quality and access methodologies should specifically account for the particular circumstances in this year.

Subpopulation Subtests

Due to potential technical challenges, and the increased risk of false-negative test results associated with a substantial increase in the number of comparisons, CMS will not require Oregon to demonstrate any minimum level of quality and access performance for beneficiary subpopulations as part of part one quality and access test.

However, these analyses should be included in evaluation analyses, and performance of metrics for subpopulations should be made transparent in a similar fashion to the core performance metrics. See Part III: Oregon's Measurement Strategy below for additional details about planned subpopulation analysis and public reporting.

Part 2 Quality and Access Test

As described above, if Oregon fails to pass part one of the quality and access test, a more complex analysis will be undertaken to determine whether the performance decline compared to baseline was attributable to the state's transformation efforts. Methodologically, part 2 of the quality and access test will largely follow the rigorous independent analysis of the association between state transformation activities and changes in access and quality (controlling for external forces) that is described under Midpoint Assessment. (There is one exception: part two of the quality and access test will not include any subgroup specific analysis.) Practically, however, the part 2 test and any evaluation activities differ in both cause and consequence:

- Part 2 of the quality and access test is only triggered if the state does not pass part one of the test for a particular year. Formative, midpoint and summative evaluations will occur as planned, regardless of the state's performance related to cost growth reduction targets or part one of the test.

- Evaluation activities have no bearing on DSHP expenditure authority. In other words, if part 1 of the quality and access test is passed in a particular year, the state passes the test for that year and incurs none of the DSHP penalties described in STC 54, even if a concurrent rigorous analysis may be occurring as part of a formative, midpoint, or summative evaluation.

Definition of Passing

Oregon will be deemed to have passed the part 2 quality and access test if access and quality have not significantly diminished relative to changes in a comparison group or counterfactual scenario across the same time period. Thus, Oregon will pass as long as the difference between CCO members and the comparison group does not significantly change to the detriment of CCO members.

Responsibilities of Oregon

Oregon will issue a Request for Proposal for and contract with an independent evaluator or evaluators, which will be responsible for performing the part one and, if necessary, part two analyses in all required years. The state will convene a review group consisting of key state partners and independent scientific experts with appropriate expertise to review and score all proposals. The evaluator's responsibilities will include:

- Develop a detailed methodology for the execution of each part of the test, in advance of their use;
- For each required program year, review the relevant raw data, verify its accuracy, and, if necessary, clean the data;
- Produce the part one quality and access test —and, if necessary—part two quality and access test results described above.
- Deliver a package to CMS and Oregon containing (1) the cleaned datasets; (2) the detailed methodology; and (3) any results produced, by the required deadlines

Allowing for data lag, the state will submit the part one of the quality and access test to CMS in the February following the end of each demonstration year in which the test applies (see Timeline below). Failure to submit the required data also will result in application of the DSHP withhold specified in STC 54, as well as invoke the penalties for late reporting that are described in STC 64. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a report to CMS by the August following the end of the demonstration year in question (see Timeline).

Responsibilities of CMS

CMS will fully review the data, methods, and results produced for each year's test to ensure that calculations were made appropriately. Upon such a determination, CMS will notify the state that the DSHP penalty authorized by STC 54 shall not apply. If the state fails the test, the DSHP penalty described earlier will apply.

Evaluation

This section contains four parts: evaluation objectives; contextual considerations; research questions, data sources, and analytic approaches; and plan development.

Evaluation Objectives

This evaluation has three objectives:

(1) To perform a formative evaluation of Medicaid transformation that seeks to provide timely and actionable feedback on the initiative's progress, in terms of both outcomes and implementation activities. The formative evaluation will track and report regularly on OHA and CCO actions, progress toward achieving a health care system characterized by the key transformation levers; and progress toward achieving the primary goals of Medicaid transformation.

(2) To perform a midpoint assessment of Oregon's Medicaid transformation to provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

(3) To perform a summative assessment of Oregon's Medicaid transformation describing changes in Medicaid per capita expenditure trend and quality and access outcomes, as well as other outcomes of interest, and to identify the changes in outcomes resulting from transformation activities.

Note that there will be some overlap in the research questions, data sources, and measures used to fulfill these three objectives. In particular, early and medium-term results for certain questions will be addressed in a midpoint assessment in the third year of the demonstration, but may also be addressed in a formative or summative evaluation.

Contextual Considerations

Analytic challenges

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act will take effect. Expansion of Medicaid eligibility is expected to extend additional benefits to some adults already enrolled in the demonstration and bring more than 200,000 new individuals into the program and on to CCOs' membership rolls. These individuals, many of whom will have been uninsured previously, may need and utilize Medicaid services differently than the previously eligible group. In addition, all other large scale reforms—the individual mandate, guaranteed issue, tax subsidies for coverage through the Exchange etc.—are likely to have a significant impact on the capacity of the delivery system. The expansions and delivery reforms under this demonstration are intended to help bridge the transition to this new challenge, and so monitoring the changes in 2014 is an essential part of the efforts. The transitions in 2014 do create a few inter-related analytic challenges for assessing the impact of Oregon's Medicaid transformation, most notably:

- How to account for any effect the needs and experiences of the newly eligible group might have on aggregate trends of quality, access, and cost for Medicaid populations over the 5 years of the demonstration;
- How to account for any effect that the delivery system's response to health care reforms outside of Medicaid may have on measures of access, quality, and cost for Medicaid populations;
- How to isolate the impact of Oregon's Medicaid transformation activities from contemporaneous trends in quality, access, and cost.

Oregon will contract for independent analysis that includes a triangulated approach to addressing these analytic challenges including tracking outcomes for the expansion population separately, development of a sound comparison group, and in-depth or complex mixed methods analyses. On some questions, it will also be useful to compare Medicaid enrollees to those with other sources of coverage (via the state's All-Payer All-Claims data system or population surveys such as BRFSS), although there are likely to be some spill-over effects given that almost 85 percent of Oregon's health care providers serve Medicaid clients. A difference-in-differences design may also be helpful as part of this triangulated approach to compare changes over time among Medicaid CCO enrollees to an appropriate comparison population, at the mid- and end-points of the demonstration period. Together, these should provide a reasonable picture of the success of Oregon's Medicaid transformation against its stated goals.

External evaluations

Oregon has an active and engaged health services research community and a history of sophisticated, policy-relevant research on the Oregon Health Plan including the landmark Oregon Health Study (OHS). The Oregon Health Research & Evaluation Collaborative (OHREC) serves as a point of collaboration and connection between state staff researchers from a variety of organizations. Two OHREC-affiliated research projects have already received funding from a mix of foundation, government, scientific, and philanthropic sources:

- The Robert Wood Johnson Foundation-funded SHARE grant is a mixed-methods study building on the OHS to assess what CCOs in Oregon actually do, how they impact health care access, use, quality, costs, and health outcomes, and how each CCO's outcomes are associated with its individual design. The partners in the study are the Office for Oregon Health Policy and Research in the Oregon Health Authority, Portland State University, Oregon Health & Sciences University and the Center for Outcomes Research at Providence Health System.

- An NIH-funded economic study focuses on the impact of spending reductions implemented through the CCO global budgets and the financial integration of behavioral specialty care and primary health care. The study includes cross-state comparisons, and also includes a qualitative component. This study is being conducted by researchers at Oregon Health & Sciences University, Portland State University, and the University of Colorado Denver.

Other proposals are currently under review at different funding agencies.

The state will use results from these and future independent evaluations to supplement its own demonstration evaluation work and provide independent analysis on the demonstration hypotheses. In addition to taking advantage of related research, Oregon intends to issue a request for proposals (RFP) and to contract directly with independent evaluators for two products: a midpoint assessment of quality and access (described in more detail shortly); and a summative evaluation at the end of the demonstration that will address the major research questions described under Summative Assessment below, synthesizing and summarizing findings from earlier evaluation and research.

The demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. Among the characteristics of rigor that will be met for the midpoint and summative evaluations are use of best available data; controls for and reporting of the limitations of data and their effects on results and the generalizability of results. Treatment and control or comparison groups will be

used, except (in the common circumstance) where randomization is difficult, in which case appropriate methods will be used to account and control for confounding variables. The evaluation design and interpretation of findings will include triangulation of various analyses, wherein conclusions are informed by all results with full explanation of the analytic limitations and differences.

An independent third party, selected by some means other than sole source contracting, following applicable state procurement, selection and contracting procedures, will conduct the midpoint and summative evaluations. The third party selected for the evaluation shall be screened to assure independence and freedom from conflict of interest. The assurance of such independence will be a required condition by the state in awarding the evaluation effort to a third party.

STC 88 requires that the state will provide to CMS within 120 days after expiration of the demonstration a draft summative evaluation report. Recognizing data lags and complexity of the analyses that comprise the midpoint and summative evaluations, we have agreed that CMS will not hold the state to be out of compliance with the timing requirements of STC 88 if the state provides to CMS its draft summative evaluation report within 180 days after the end of demonstration Year 15. In addition, CMS will not hold the state to be out of compliance for the draft midpoint analysis if submitted to CMS 180 days after the close of the initial review period, July 1, 2012 through June 30, 2014.

For both reports, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the state or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the contractor.

Draft reports related to the midpoint and summative evaluations will not be routinely released except as required by state and federal law. Until the later of the following two dates – July 1, 2019 (two years after the end of the demonstration) or 12 months from the date that the final reports for these evaluations are provided to CMS, CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the contractor or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

In light of the flexibility that CMS has offered in enforcing these evaluation deadlines, Oregon has agreed that in each demonstration year, when draft and final midpoint and summative evaluation reports are due, it will reduce claimed DSHP expenditures by one half of one percent (0.5) for the year to follow if any of these reports are not provided or are found by CMS to be unacceptable because they do not represent adequate rigor and independence and do not adequately implement the final evaluation design. The claimed expenditures withheld by CMS would be authorized only if revised reports are provided and found by CMS to be acceptable within a year of their original due dates under STC 88. The penalties related to quarterly and annual reporting submission deadlines, as specified in STC 64(e), continue to apply as specified in the STCs.

Research Questions, Data Sources, and Analytic Approach

Formative Evaluation

The formative evaluation will track and report regularly on: (1) OHA actions; (2) CCO actions; (3) progress on the "levers" intended to drive savings and quality improvement; and (4) progress toward achieving the primary demonstration goals. (See the Quarterly Report Guidelines—Attachment A of the STCs—for details on who information from the formative evaluation will inform the state's quarterly reports.) The formative evaluation is designed both to provide actionable information for quality improvement and to help inform/explain the summative assessment and will therefore include analysis by individual CCO, as well as in the aggregate.

Data and findings resulting from all stages of the evaluation—formative, midpoint, or summative—will be shared widely as part of the state's commitment to feedback and continuous improvement. Key pathways for dissemination and use of evaluation findings beyond the required reporting to CMS include:

- The Oregon Transformation Center, which will act as the state's hub for innovation and improvement. The CCO learning collaboratives to be convened by the Transformation Center will be a primary venue for sharing evaluation information, posing additional analytic questions, and sharing best practices or potential solutions to problems;
- The state's innovator agents, who are expected to help CCOs review their own data and identify opportunities for improvement;
- Formal publications and presentations (primarily for midpoint or summative evaluations) aimed at a variety of different audiences, including service providers, beneficiaries, and communities and their members; and
- Internal reporting for OHA leadership and program personnel.

The data sources identified to address specific evaluation questions will provide relevant information on several important aspects of the demonstration operations, for example: measures of beneficiary experience of care and provider engagement with Medicaid will feed into monitoring and policy development for network adequacy; and assessments of CCOs' actions to improve care coordination and integration will inform interpretation and resolution of grievances or appeals.

Table 1 shows the relevant formative research questions for the four topics listed above, as well as proposed measures and data sources. Note: rows shaded in light grey indicate research questions to be addressed in both the formative assessment and the midpoint assessment, described later in this section.

Table 1 – Formative Evaluation (shaded rows will be addressed in midpoint as well as formative)

Topic Area	Related Research Question(s)	Measures or data source(s)
OHA actions	To what extent has OHA effectively taken action to support transformation? For example: • Set expectations and monitor for care management • Develop global budget and quality incentive pool • Establish robust quality measurement and improvement strategy • Provide technical assistance and support, including Innovator Agent program • Patient-centered primary care home recognition, certification system for non-traditional health workers • Tracking method for flexible services	OHA documentation is the data source for most of these questions. Specific measures might include: • Incorporation of CCO transformation plans into individual contracts • Amount paid to CCOs in the form of quality incentives, vs. capitation • Attendance/participation rate at learning collaboratives • Measures of effectiveness from innovator agents document
CCO actions	To what extent have CCOs – in aggregate and individually – taken action to transform care delivery & payment? For example: • Encourage use of EHRs and participation in HIE • Use alternative payment mechanisms with providers • Maximize use of PCPCHs • Support and encourage providers to improve care coordination • Use quality metrics • Take action to reduce administrative waste • Provide flexible services where	• CCO Transformation plan tracking • Innovator agent contact database and monthly reports (see Innovator Agent document) • Office of Health IT tracking of EHR adoption and HIE participation (surveys) • Data from CCO quality assurance and oversight processes (monthly accountability team reviews, on-site operational reviews, etc., see Quality Strategy) • Surveys of CCO leadership and CCO Community Advisory members (see

Topic Area	Related Research Question(s)	Measures or data source(s)
	appropriate • Engage meaningfully with communities	Innovator Agent document) • Tracking of flexible services • Qualitative information from independent evaluations – SHARE and McConnell NIH study
	• To the extent that some CCOs have not taken actions for transformation, what has prevented them from doing so? • To the extent that some CCOs have been successful in taking action, what have been their keys to their success?	As above
Levers for transformation	To what extent are CCO members experiencing improved care coordination, with emphasis on PCPCH?	• PCPCH enrollment by tier • Metrics from *Oregon Measures Matrix* related to integrating primary care and behavioral health, reducing preventable hospitalizations, and reducing preventable and costly utilization
	To what extent have OHA and CCOs implemented payment methods that focus on value not volume?	• Which CCOs do and which do not use alternative payment methods internally? • What is the distribution of available incentive funds across CCOs? (OHA admin data) • *Potentially:* measures from soon-to-Catalyst for Payment Reform scorecard
	To what extent have CCOs integrated physical, behavioral, and oral health services? Other services?	• CCO Transformation plan tracking • Metrics from *Oregon Measures Matrix* related to integration, e.g. SBIRT, follow-up after hospitalization for mental illness, etc.
	To what extent have CCOs achieved administrative efficiencies?	• CCO financial reporting requirements, including OHA-developed Exhibits (see CCO core contract) • Office of Health IT tracking of EHR adoption and HIE participation • CCO Transformation plan tracking • CCO participation in statewide administrative simplification efforts (e.g.

Topic Area	Related Research Question(s)	Measures or data source(s)
		common credentialing)
	To what extent are beneficiaries using flexible services?	• TBD – tracking method for flexible services is still in development • CCO Transformation plan tracking
	To what extent are best practices being tested and disseminated?	• CCO participation in learning collaboratives and other technical support opportunities • Innovator agent monthly reports; Number and success of innovations adopted by a CCO; rate at which CCOs test new ideas and improve (see Innovator Agent document) • Successful implementation of CCOs' transformation plans, the measures for which will be developed upon completion of the plans
Demonstration / Medicaid Transformation Goals	Have CCOs– in aggregate and individually • Improved quality of care for members? • Improved access to care? • Improved members' experience of care? • Improved members' health status?	See impact assessment table
	Has Oregon reduced per-member cost growth?	See summative assessment table

Midpoint Assessment

The midpoint assessment will analyze activity through the midpoint of calendar year 2014, with a report due to CMS no later than August 2015. In addition to summarizing findings to date on select research questions from the formative and summative evaluations (indicated by shaded rows in Table 1 and Table 2), the midpoint assessment will connect the two via an explicit examination of the coordinated care model on changes in access and quality. (Access and quality should be read here to include experience of care.) The report will also include a high-level summary of expenditure and cost data, based on 2 percent test reporting described in Attachment H, Section B. The state anticipates contracting with independent researchers (as described above) to perform a rigorous analysis of the association between state transformation activities and changes in access and quality, controlling for external forces.

For instance, a contractor could employ a difference-in-differences analysis, assessing the average changes in scores over time from the baseline year among CCO enrollees and

subtracting out the average changes among a comparison group of matched individuals from a non-CCO, fee-for-service comparison group in order to arrive at the "net" impact of transformation, as follows:

- **Measures**: Measures of access and quality (including care coordination and beneficiary experience of care) would be drawn from the *Oregon Measure Matrix* listed in Part III, below. Measures of access and quality for future consideration are also listed in Part III, below. Because this is an evaluative assessment rather than a "test," there is no need to create an aggregate access or quality measure. The results of the formative evaluation to date will provide contextual information about the extent to which the transformation "levers" have been implemented.

- **Study Groups**: Contractors will provide for an adequate comparison group. Potential contractors will describe a plan for specifying the control group and specify criteria for case-matching or other adjustments to account for potential changes in group composition over time, as well as plans for the treatment of individuals who disenroll during the study period.

- **Data Years**: The contractor's plan should also address the appropriate data years for both study and comparison groups to identify to the extent possible any underlying movement in the scores that was occurring prior to implementation.

- **Statistical Approach**: Contractors will describe a statistical plan that accounts for the distribution of the dependent variables and uses appropriate modeling techniques. The state will work with the contractor to insure that the model is appropriately pre-specified while being sensitive to model choices that must account for the distribution of the data.

- **Strategies to Account for Potential 2014 Expansion**: If the state expands its Medicaid program to 133 percent FPL in accordance with the Affordable Care Act in 2014, the contractors will describe specific strategies to account for the effects of this expansion on access and quality and separate them from the impacts of Medicaid system transformation. (A DiD design is robust against such changes provided the expansion impacts both groups in the same way, but if expansion impacts CCO and comparison group members differently, the model's ability to identify the specific impacts of Medicaid transformation will be compromised.) Contractors will propose methods to account for the impacts of the expansion (with respect to both expanded eligibility and the availability of more expansive coverage for some adults previously eligible for the demonstration) and extract those impacts from the estimates of CCO effects. Separate tracking of new eligibles, described in the analytic approach column of Table 1, will

produce information that may be of use to contractors in accounting for expansion effects.

- **Subgroup Analysis**: Contractors will describe a plan that provides results separately for vulnerable populations or subgroups of interest and compares those results to the overall trends to identify differences in effects by subgroup. Depending on the degree of variation across the state or among CCOs and the stability of enrollee populations, it may also be possible to compare trends in access and quality across beneficiaries experiencing "low-dose" and "high-dose" transformation.

The midpoint assessment will produce a more nuanced picture of trends than the summary scores of the DSHP quality and access "tests." It will also provide the state and CMS with a sophisticated assessment of the relationship between the state's actions and beneficiary outcomes well in advance of the end of the demonstration period.

Finally, the midpoint assessment will include a narrative section regarding the progress of Oregon towards streamlining its reporting processes, including whether there are reports and/or evaluations the state would recommend combining, and specifically regarding progress towards use of automated data systems that will support the transmission of data through data portals and other electronic reporting channels, and progress towards an HIE infrastructure.

Summative Assessment

The impact assessment focuses on the outcomes depicted in the theory of action: reduced PMPM cost growth (demonstration goal 1), improvement or maintenance of quality and access (demonstration goal 2), and improvement or maintenance of beneficiaries' experience of care and health status. Table 2 lists the research questions associated with each outcome, as well as proposed measures and data sources and analytic approaches for addressing the question. The research questions should be read as including both CCO enrollees and those beneficiaries for whom services will be provided on a fee-for-service basis even after January 2013. Note: rows shaded in light grey indicate research questions to be addressed in both the summative assessment and the midpoint assessment, described earlier in this section.

Table 2 – Summative Assessment (shaded rows will be addressed in midpoint as well as summative)

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
Per capita Medicaid spending	How does annual change in per-capita Medicaid spending during demonstration period compare to projected trend?	state Medicaid program expenditure data Presidents' budget for projected trend	Align with methodology for expenditures for 2% test (including adjustment for 2014).

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
	Which beneficiary subpopulations* deviate from the statewide trends?	state Medicaid program expenditure data	Subpopulation analysis of expenditures by demonstration year.
	How does spending change for behavioral health compare to overall trends and physical health spending changes?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.
	How does spending change for primary care services compare?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.
	Are "flexible services" deterring higher-cost care?	TBD – tracking method for flexible services is still in development.	Depending on tracking method, approach may include: Estimation of the value of flexible services provided, by category Estimation of costs deterred Case studies of variation by CCO in flexible services offered
Quality of care	Is quality of care for Medicaid beneficiaries improved or at least maintained over time?	Quality measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Is coordination of care for Medicaid beneficiaries improved or at least maintained over time?	Care coordination measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in the quality of care or care coordination for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
	Did Medicaid system transformation result in improved quality of care or care coordination?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g. PQIs using HCUP data) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation assessing changes in quality for those enrolled in CCOs vs. not enrolled. Incorporate results of independent McConnell NIH study of changes in "contracted" and "non-contracted" quality measures For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group
Access to care	Has access to care for Medicaid beneficiaries improved or at least maintained over time?	Access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Has the rate of change in access to behavioral health kept pace with physical health access improvements?	Behavioral health access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Comparison of change over time in access measures by service type
	Have there been variations in any of the access to care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved access to	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g.

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
	care?		care delayed due to cost) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation comparing changes in access for those enrolled in CCOs vs. not enrolled. Incorporate results of independent McConnell NIH study assessing impact to CCOs on probability of members accessing care, by provider type For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group and analysis of provider survey data on Medicaid acceptance by primary care v. subspecialty
Member experience of care	Has beneficiary experience of care improved or at least maintained over time?	Experience of care measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in experience of care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved experience of care?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of externally-

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
			conducted SHARE evaluation comparing changes in experience of care for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group
Health Status	Is beneficiary health status improved or at least maintained over time?	Health outcome or status measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in health status measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved health status?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures, BRFSS) Incorporate results of externally-conducted SHARE evaluation comparing changes in health status for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group

* Categories of interest for sub-population analysis include:

- Beneficiary race and ethnicity

- Beneficiary primary language
- Individuals eligible for Medicare and Medicaid
- Individuals with mental illness
- Disability status
- Rural vs. non-rural location

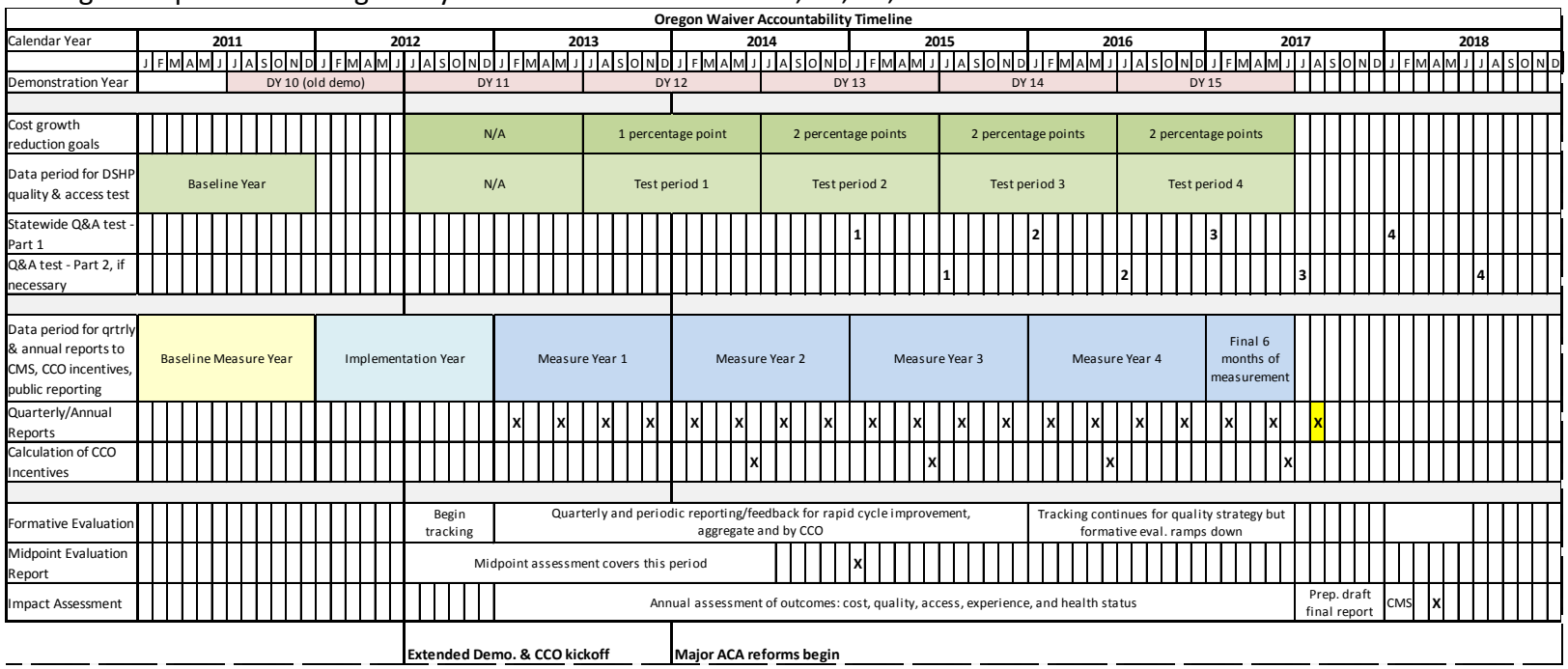
Ability to analyze outcomes by beneficiary sub-population will be dependent on the specific measure and data source. Provider measures for access will also be analyzed by subtype of provider.

Evaluation Plan Development

This plan was developed by a cross-division of OHA staff with experience in evaluation research and demonstration planning and reviewed by OHA leadership. External expertise and consultation was provided by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, as well as CMS staff. Because of the close connection between the formative evaluation plan described here and the state's Quality Strategy, the demonstration evaluation design will be reviewed annually along with the Quality Strategy.

Timeline

This figure depicts the timing of key deliverables under STCs 52, 54, 64, 86 and 88.



Part III: Oregon's Measurement Strategy 2012

Introduction

Oregon's Measurement Strategy (STCs 38, 39, 40, 42) outlines how the Oregon Health Authority will measure quality of care and access to care for individuals enrolled in Coordinated Care Organizations and for the Oregon Health Plan population as a whole. The metrics are also integral to the effort to monitor and correct pathways towards improvements in the quality of care and access to care for Medicaid beneficiaries under health system transformation efforts, as described in the Statewide Quality and Access Tests section above.

OHA Measurement Framework

Oregon has identified over 100 potential measures of cost, quality, access, patient experience, and health status that could be tracked over delivery settings and populations during the demonstration period. These measures come from several measure sets.

- Oregon CCO Incentive Measures
- Oregon Demonstration Core Performance Measures
- CMS Adult Core Set for Medicaid
- CMS Child Core Set for Medicaid and the Children's Health insurance Program

Oregon has committed to collecting and reporting on the CCO Incentive Measures and the Demonstration Core Performance Measures. Many of the CMS Adult Medicaid Quality Measures and CHIPRA Measures overlap with these measure sets, and Oregon has also committed to reporting on these two core sets even as they evolve to the extent feasible. *See Appendix 3.A for a listing of these measures by population and by domain.*

Oregon has submitted an application for an Adult Medicaid Quality Grant for the *Oregon CMS Adult Measures Project*, which would develop additional capacity for standardized collection and reporting of the CMS Adult Medicaid Quality Measures. Through this project, Oregon would test and evaluate methods for collection and reporting of the measures, improve measures so they are reliable, and develop capacity to report the data, analyze, and identify opportunities to improve health care quality for Medicaid beneficiaries. Work funded through this grant would inform the collection and reporting of the Demonstration Core Performance and CCO Incentive Measures.

Through participation in the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Program, Oregon has also collected all 24 CHIPRA measures and developed an understanding of standardization and comparability for these measures. Oregon will continue to participate in this program and collect and report on selected CHIPRA measures through 2015.

From these measure sets, Oregon has identified access measures, including CCO-level access improvement measures, and survey-based access measures. *These measures are also identified in the tables in Appendix 3.A.*

Incentive Measures

The Oregon Metrics and Scoring Committee have identified the year one incentive measures that will be tied to the quality pool as required by STC 37b.ii.[13] See Appendix 1.C: Quality Pool Structure above for a detailed description of the quality pool design and funding algorithm. Building on work completed by their predecessor committee, the Oregon Health Policy Board Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics[14], the Committee considered several core principles when selecting these measures. Among other principles, any selected measures should:

- Meet standard scientific criteria for reliability and face validity;
- Help drive system change;
- Successfully communicate to consumers what is expected of CCOs;
- Align with evidence-based or promising practices;
- Be nationally validated, a required reporting element in other health care quality initiatives, or align with national or other benchmarks for performance; and
- Usefully distinguish between different levels of CCO performance.

The majority of incentive measures selected overlap with Oregon's Demonstration Core Performance Measures, CMS Adult Medicaid Quality Measures, and CHIPRA Measures, ensuring that the incentive program is aligned with existing state and national quality measures. Selected incentive measures do strongly align with Oregon's quality improvement focus areas and all incentive measures have been included in the set of quality and access "test" measures. Specifications and data sources for the year one incentive measures can be found in Appendix 3.C and more detailed rationale for each of these incentive measures can be found in Appendix 3.D.

Through a public process, the Metrics and Scoring Committee established improvement and performance targets that a CCO must meet on the selected incentive metrics to be eligible for receiving funds from the quality pool. These targets are listed in Appendix 3.B.

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[13] http://www.oregon.gov/oha/pages/metrix.aspx

[14] http://www.oregon.gov/oha/OHPB/pages/health-reform/workgroups/outcomes-quality-efficiency.aspx

Oregon is also in the process of establishing benchmarks for the statewide quality and access test described below. Oregon's baseline data (2011) and those benchmarks that have already been identified are included in Appendix 3.B.

Ensuring Continuous Quality Improvement

Incentive Measures

The Metrics and Scoring Committee will likely consider additional measures, either as part of the Oregon Health Authority's overall measurement framework or as incentive metrics in future years. The Committee will be reviewing CCO performance data, improvement over baseline, and distribution of the quality pool to determine if the initial incentive metrics selected were the right combination of measures to improve quality and access for the Oregon Health Plan population. Incentive measures may be added in subsequent years and it is likely that other measures will be retired from the list, either due to measurement concerns or progress. CCO performance may improve significantly enough on select measures that the Committee refocuses efforts to different areas needing improvement.

The Committee is charged with revisiting not only the selected incentive measures, but also the performance and improvement targets. It is critical that these targets take future CCO improvement into account and continue to provide stretch goals that CCOs must meet to be eligible for the quality pool. CCOs will not be allowed to coast on early success, or demonstrate improvement in just one domain.

Specifically, the initial decision by the Metrics and Scoring Committee was to reward improvement in incentive metrics as compared to a historical baseline, rather than to the prior year's performance. This structure may not be adequate to provide ongoing incentives for continued improvement and may be reexamined by the Metrics and Scoring Committee in consultation with CMS and the state as part of the midpoint assessment.

Likewise, the Oregon Health Authority will be revisiting selected quality and access measures in future years of the demonstration to ensure that quality of care and access to care are being tracked appropriately. A subset of quality and access test measures has already been identified for consideration in demonstration year 3. These are listed in Appendix 3.E.

OHA will also be exploring National Quality Forum (NQF)-endorsed and other healthcare disparities and cultural competency measures for inclusion in the measurement framework. As new measures are identified, potentially through the CMS Adult Core Quality Measures Grant, or endorsed, through NQF or Meaningful Use Stage 2, OHA will add and retire measures from the overall measurement framework.

Modification of Metrics for Statewide Quality and Access Test

Consistent with the recognized need for flexibility to modify plans over time and take into account evidence and learning over time, as well as for unforeseen circumstances or other good cause, a CCO, CMS, or the state may request prospective changes to metrics or targets for any achievements that are well above or below the established targets based on progress to date through a modification process. CMS and the state must agree to modify the metrics; CMS retains the authority for final approval of such changes, which will be reflected in the quality strategy. Examples of when requests for changes may be appropriate are:

a. **Difficult metrics:** The CCO, CMS, or the state may suggest re-targeting of metrics in instances in which it appears that statewide targeted performance will not be achieved over the life of the demonstration.

b. **Topping out on metrics:** During any given year, the CCO, CMS, or the state may suggest re-targeting in instances in which targets have been achieved or surpassed. However, it appears that there is still substantial room for growth on selected projects (e.g., percentage improvement or volume metrics for subsequent years were already met because the original estimates were too low, but data suggest that more improvement could be done.)

c. **Mismatched metrics:** The CCO, CMS, or the state may suggest new metrics that better reflect local concerns when it is determined that the existing metrics are inadequate.

Data Collection

The Oregon Health Authority will be responsible for collecting data on all measures selected. Data sources for incentive measures are included in Appendix 3.B and descriptions of data sources are also included in section IV of the Quality Strategy. An external quality review organization (EQRO) will play a role in data collection and analysis where necessary, assisting with measures that require chart reviews and/or validation of information submitted by a CCO.

OHA will contract with the Oregon Health Care Quality Corporation (Quality Corp) for assistance in data cleaning and analysis, third party validation, and reporting. As a Robert Wood Johnson Foundation *Aligning Forces for Quality* grantee, Quality Corp is experienced in ensuring the production of transparent data and analytics that are highly valued and actionable.

Measurement Year

The first measurement year for the CCO incentive measures will be calendar year 2013. Results will be available in June 2014, in time for the first quality pool distribution by June 30, 2014. The

second measurement year for incentive measures will be 2014. Medicaid adult quality and CHIPRA measures will be calculated during the same period. A detailed timeline for the formative and summative assessments, and quarterly reporting as required by STC 64, is included in the Evaluation Plan above. Of note, the measurement period for the statewide quality and access tests will be the demonstration year, which runs from June to July, and so is offset from the measurement period for the CCO incentive measures by six months.

Data Analysis

OHA will also be responsible for conducting data analysis on these measures. Where possible, measures will be aggregated by the 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 vulnerable populations such as people experiencing homelessness and people with specific diagnoses (disabling conditions, SPMI, chronic conditions, addictions).

Where possible, measures will also be reported for the fee-for-service (FFS) population. For example, all measures from the Consumer Assessment of Health Plans and Systems (CAHPS) survey will be reported for the remaining FFS population.

Other subpopulations of interest for analysis include beneficiary primary language, individuals eligible for Medicare and Medicaid, and rural versus non-rural locations. OHA will involve data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders in clearly defining selected subpopulations for analysis before the measurement year begins in January 2013.

This 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 Part I (Oregon's CCO Quality Strategy). Data from selected measures will also be used to inform the evaluation questions described in Part II (Statewide Evaluations and Tests).

Data Reporting

The Oregon Health Authority has committed to transparency in health system transformation efforts: all selected measures will be reported publicly through reports made available on the Oregon Health Authority website. At a minimum, data will be reported publicly on an annual basis; however a subset of information will be reported more frequently to track patterns of utilization and highlight potential issues with performance. This will also allow OHA to work frequently with CCOs on metrics and possibly make course corrections prior to annual reports. Additional details on reporting are included in the Evaluation Plan timeline above.

Where possible and appropriate, measures will be reported by race and ethnicity, disability, and a where there is a diagnosis of serious and persistent mental illness (SPMI). Measures will be reported by CCO, and in aggregate. In addition, CCO dashboards will synthesize performance data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries. OHA will not disclose any information otherwise protected by law.

Appendix 3.A: Measure Sets by Population and Domain

Table I: CCO Incentive Measures	Population		Domain					
Measures	**Adult**	**Child**	**Access**	**Cost**	**Quality**	**Health Outcomes**	**Patient Experience**	**Systems**
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√			√	√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√	√	√			
Mental and physical health assessment within 60 days for children in DHS custody (state measure)		√	√		√			
Follow up care for children on ADHD medication (NQF 0108)		√	√		√			
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Elective delivery before 39 weeks (NQF 0469)	√				√			
ED utilization without an admission per 1,000 member months (HEDIS)	√	√		√				
Colorectal cancer screening (HEDIS)	√		√		√			
Patient-Centered Primary Care Home (PCPCH) (state enrollment (state measure)	√	√	√	√				
Developmental screening by 36 months (NQF 1448)		√	√		√			
Adolescent well child visits (HEDIS)		√	√		√			
Controlling hypertension (NQF 0018)	√		√	√		√		
HemoglobinA1c poor control (NQF 0059)	√			√		√		
Access to Care: Getting Care Quickly (CAHPS Composites)	√	√	√				√	
Health Plan Satisfaction: Customer Service (CAHPS Composites)	√	√					√	
EHR adoption (composite – 3 questions)	√							√

Attachment H

Table II: Oregon Core Performance Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Getting needed care and getting care quickly (CAHPS Composites)	√	√	√				√	
Member health status, adults (CAHPS health status)	√	√				√		
Rate of tobacco use among CCO enrollees (Medicaid BRFFS, CAHPS)	√					√		
Rate of obesity among CCO enrollees (state measure)	√					√		
Ambulatory Care: Outpatient and emergency department visits (HEDIS)	√	√	√					
Potentially avoidable ED visits (Medi-Cal approach)	√	√		√				
Ambulatory-care sensitive hospital admissions (PQI #1: NQF 272; PQI #14: NQF 638)	√		√		√			
Medication reconciliation post-discharge (NQF 0554)	√				√			
All-cause readmissions (NQF 1789)	√			√				
Alcohol or other substance misuse (SBIRT)	√				√			
Initiation and engagement in alcohol and drug treatment (NQF 0004)	√		√		√			
Mental health assessment for children in DHS custody		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Effective contraceptive use among women who do not desire pregnancy (BRFFS)	√		√		√			
Low birth weight (NQF 0278, PQI 9)					√	√		
Developmental screening by 36 months (NQF 1448)		√	√		√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√		√			

Attachment H

Table III: CHIPRA Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Frequency of Ongoing Prenatal Care (NQF 1391)	√	√	√		√			
Low birth weight (NQF 1382)		√			√	√		
Childhood immunization status (NQF 0038)		√	√		√			
Immunizations for adolescents (NQF 1407)		√	√		√			
Developmental screening by 36 months (NQF 1448)		√	√		√			
Chlamydia screening for women (NQF 0033)	√		√		√			
Well-child visits in the first 15 months of life (NQF 1392)		√	√		√			
Well-child visits in the 3rd, 4th, 5th and 6th years of life (NQF 1516)		√	√		√			
Adolescent Well-Care Visit (NCQA)		√	√		√			
Child and adolescent access to Primary Care Practitioner (NCQA)		√	√		√			
Appropriate testing for children with pharyngitis (NQF 0002)		√			√			
Ambulatory Care: ED Visits (NCQA)	√	√	√	√	√			
Annual % of Asthma Patients with 1 or more Asthma-related ED visits (ages 2-20)		√	√	√	√			
Follow up Care for Children prescribed ADHD medication (NQF 0108)		√	√		√			
Annual pediatric hemoglobin A1C testing		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Mental health assessment for children in DHS custody		√	√		√			
CAHPS Health Plan Survey (child version with chronic conditions supplemental items)	√	√	√	√	√			

Table IV: Medicaid Adult Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Cervical cancer screening (NQF 0032)	√		√		√			
Medical assistance with smoking and tobacco use cessation (NQF 0027)	√		√	√	√			
Screening for clinical depression and f/u (NQF 0418)	√		√		√			
Plan All-Cause Readmissions (NCQA)	√	√	√	√	√			
Diabetes short-term complications admission rate (NQF 0272; PQI 01)	√		√	√	√			
COPD Admission Rate (NQF 0275, PQI 05)	√		√	√	√			
CHF Admission Rate (NQF 0277, PQI 08)	√		√	√	√			
Adult Asthma Admission Rate (NQF 0283, PQI 0283)	√		√	√	√			
Chlamydia Screening in Women age 21-24 (NQF 0033)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√				√			
Elective delivery before 39 weeks (NQF 0469, PC-01)	√			√	√			
Controlling hypertension (NQF 0018)	√			√	√	√		
Comprehensive Diabetes Care: LDL-C Screening (NQF 0063)	√		√	√	√			
Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF 0057)	√		√	√	√			
Antidepressant Medication Management (NQF 0105)	√		√		√			
Adherence to antipsychotics for individuals with schizophrenia (CMS-QMHAG)	√			√	√			
Annual monitoring of patients on persistent medications (NQF 0021)	√		√		√			
CAHPS Adult Survey (including NCQA Supplemental) (NQF 0006 and 0007)	√		√		√			
Prenatal and Postpartum Care: Postpartum Care Rate (NQF 1391)	√		√		√			

Appendix 3.B: Oregon Measures Matrix

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
Improving behavioral and physical health coordination	Alcohol or other substance misuse (SBIRT)	√	√			√	MN method[15] Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based

[15] The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore, the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								intervention).		intervention).
	Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from predecessor organization.	TBD
	Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available	90% (Note: Benchmark based on Metrics & Scoring	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data	90%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							by April 2013.	Committee consensus).	from predecessor organization.	
	Follow-up care for children prescribed ADHD meds (NQF 0108)	√			√	√	Oregon Medicaid baseline 2011: Initiation: 50% C&M: 57%	Medicaid 2012 NCQA National 90th percentile: Initiation: 51% C&M: 63%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid NCQA National 90th percentile: Initiation: 51% C&M: 63%
Improving perinatal and maternity care	Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 89%
	Prenatal and postpartum care: postpartum care rate (NQF 1517)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 66%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								90th percentile: 71%		
	PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per Oregon Association of Hospitals and Health Systems (OAHHS), could also use the 16% rate publically available from Joint Commission)	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per OAHHS, could also use the 16% rate publically available from Joint Commission)	5% or below.
Reducing preventable re-hospitalizations	Follow-up after hospitalization for mental illness	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO	2012 National Medicaid 90th percentile: 68%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	(NQF 0576)								baselines will be determined with 2011 data from predecessor organization.	
	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm
	All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a
Ensuring appropriate care is delivered in appropriate settings	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1	MN method with 3% floor. Individual CCO baselines will be determined	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							baseline (2011): 56 / 1,000 mm	/ 1,000 mm	with 2011 data from predecessor organization.	
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5-year period based on trends in Medicare and Commercial data).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile: 61.34 (Based on Metrics & Scoring Committee consensus)
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to	The percentage of dollars available to each CCO for this measure will be tied to the

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
									the percentage of enrollees in PCPCH, based on measure formula.	percentage of enrollees in PCPCH, based on measure formula.
	Developmental screening in the first 36 months of life (NQF 1448)	√	√		√	√	Oregon baseline: 19.6% using admin data only.	50% (Metrics & Scoring Committee consensus)	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	50% (Metrics & Scoring Committee consensus)
	Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 77.3%	n/a	n/a
	Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile:	MN method with 3% floor. Individual CCO	2011 National Medicaid 75th percentile: 56.9%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								56.9%	baselines will be determined with 2011 data from predecessor organization.	
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 27.5%	n/a	n/a
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a
	Appropriate testing for children with pharyngitis (NQF				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 76%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0002)							90th percentile: 84%		
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed or recommended medications with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a
Deploying care teams to improve care and reduce	Ambulatory Care: Outpatient and	√	√		√	√	TBD (baseline data available in Feb	TBD 2011 National	MN method with 3% floor.	2011 National Medicaid 90th percentile (ED

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
preventable of unnecessarily costly utilization by super users	ED utilization						2013) ED utilization baseline (2011): 56 / 1,000 mm	Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	Individual CCO baselines will be determined with 2011 data from predecessor organization.	utilization): 44.4/1,000mm
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and coordinating a broad set of resources, including CHW.	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%
	Comprehensive diabetes care: LDL-C Screening (NQF 0063)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 80% 90th percentile: 84%	n/a	n/a
	Comprehensive diabetes care: Hemoglobin A1c testing (NQF			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0057)							percentile: 86% 90th percentile: 90%		
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	TBD (baseline data available in Feb 2013)	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%
	PQI 01: Diabetes, short term complication admission rate (NQF 0272)		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 05: Chronic obstructive pulmonary disease admission (NQF		√	√		√	416.9 (2011)	10% reduction from baseline Benchmark set based on	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0275)							Oregon's data (2002-2011)		
	PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 15: Adult asthma admission rate (NQF 0283)		√	√		√	178.7 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy	√	√	√		√	**Access to Care** OR adult baseline: 79% OR child	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63%	MN method with 2% floor Access to Care OR adult	Average of the 2012 Medicaid 75th percentile for the adult and child rates.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	modules).						baseline 88% OR average: 83.5%	2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%	baseline: 79% OR child baseline 88% OR average: 83.5%	Access to Care 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√				
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 63% 90th percentile: 69%	n/a	n/a
	Cervical cancer screening (NQF			√		√	TBD (baseline data available in Feb	2012 National Medicaid benchmark 75th	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0032)						2013)	percentile: 74% 90th percentile: 79%		
	Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a
	Provider Access Questions from the Physician Workforce Survey: 4) To what extent is your primary practice accepting new Medicaid/OHP patients? (include: completely					√	In 2009: 52.4% of Oregon's physicians accepted new Medicaid patients without limitations; 29.7% accepted with some limitations; and 17.9% were completely closed. 84% of	TBD	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	closed, open with limitations, and no limitations). 5) Do you currently have Medicaid/OHP patients under your care? 6) What is the current payer mix at your primary practice?						physicians have Medicaid patients. The statewide payer mix for Medicaid is 15%.			
	Screening for depression and follow up plan									

Attachment H

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	(see above)									
	SBIRT (see above)									
	Mental and physical health assessment for children in DHS custody (see above)									
	Follow-up care for children on ADHD medication (see above)									
	Timeliness of prenatal care (see above)									
	Colorectal cancer screening (see above)									
	PCPCH enrollment (see above)									

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Developmental screening by 36 months (see above)									
	Adolescent well child visits (see above)									
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules)- report on identified Access to Care and Satisfaction with Care composites for incentive, waiver and test.	√	√	√		√	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	MN method with 2% floor. Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average: 78%	Average of the 2012 Medicaid 75th percentile for the adult and child rates. Satisfaction with Care 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71%
	CAHPS 4.0H (child version including Medicaid and children with chronic	√	√		√	√				

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	conditions supplemental items)- report on identified Access to Care and Satisfaction with Care composites for incentive, waiver and test.									National average: 83.95%
Meaningful Use	EHR adoption (Meaningful Use 3 question composite)	√				√	TBD (Baseline data available in April 2013)	TBD	TBD (Baseline data available in April 2013)	TBD

Appendix 3.C: CCO Incentive Measure Specifications

Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) 329

Follow up after hospitalization for mental illness 330

Screening for depression and follow up plan 331

Mental and physical health assessment for children in DHS custody 333

Follow up care for children prescribed ADHD medication 334

Prenatal and Postpartum Care: Timeliness of prenatal care 336

Elective delivery before 39 weeks 337

Emergency Department Utilization 339

Colorectal cancer screening 340

Patient-Centered Primary Care Home (PCPCH) enrollment 342

Developmental screening in the first three years of life 343

Adolescent well child visits 345

Controlling high blood pressure 346

Diabetes: HbA1c Poor Control 347

Access to Care: Getting Care Quickly 348

Satisfaction with Care: Health plan information and customer service 348

Electronic Health Record (EHR) Adoption 349

Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)

This is a non-standard measure based on recommendations from SAMHSA and CMS. The measure is modeled after the screening for depression and follow up measure, without the chart review component.

Numerator

- Individuals screened using SBIRT as indicated by billing codes: 99408, 99409, and 99420

Denominator

- All individuals age 18+

Exclusions

- No exclusions noted.

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
A very low rate of claims submitted in a 12 month period (using CPT codes or H codes). Assume 0% baseline.	n/a	n/a

Follow up after hospitalization for mental illness

NQF Measure #0576. Measure Steward: National Committee for Quality Assurance.

This measure tracks the percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment (had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner) within seven days of discharge.

Numerator

- Clients seen for a non-inpatient visit for mental health services within seven days of discharge for a psychiatric hospitalization defined by relevant DRG codes.

Denominator

- Discharges for psychiatric hospitalization with principal mental health diagnosis.

Exclusions

- If discharge is followed up by another hospitalization for any cause within seven days of discharge, the discharge should be excluded from denominator.
- If it can be determined that the client was transferred to Oregon State Hospital or Blue Mountain Recovery Center, the discharge should be excluded from the denominator. This should be signified by disenrollment from OHP.

Notes

HEDIS specification also defines a metric for 30 day follow up. Continuous enrollment specifications in HEDIS metric take this longer follow up period into account. In addition, the clinics that qualify for follow up visits are too prescribed within HEDIS specifications. It is recommended that OHA adapts to include visits to any setting for mental health services. HEDIS calls for a mental health practitioner to see the person within 7 days. HEDIS definition for MH practitioner includes practically all practitioners allowed to encounter a mental health service in Oregon.

Data Source(s) Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
51%	68% (2012)	58% (2012)

Screening for depression and follow up plan

NQF Measure #0418. Measure Steward: Centers for Medicare and Medicaid Services

This measure tracks the percentage of clients age 18 and older screened for clinical depression using a standardized tool and with a documented follow-up plan

Numerator

- Individuals screened for clinical depression using an age appropriate tool with follow-up plan documented.

Denominator

- All individuals age 12+.

Exclusions

A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.

Notes

This is a metric that will have initial specifications for CMS Adult Quality Measures Grant. It is not currently defined in NQF, despite notation.

Data Source(s)

- Administrative data and chart review.

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
Assume 0% baseline.	n/a	n/a

Mental and physical health assessment for children in DHS custody

This is a non-standard measure that tracks the percentage of children in DHS custody who receive a mental and physical health assessment with 60 days of initial custody date

Numerator

- The number of children brought into DHS custody within a given quarter that received a mental health assessment within 60 days of custody date. Mental Health assessment is defined through the following procedure codes: H0031; H1011; 90801; 90802; 96101; and 96102.
- The number of children brought into DHS custody within a given quarter that received a physical health assessment (procedure codes to be defined) within 60 days of custody date.

Denominator

- The number of children age 4+ taken into custody within a given timeframe (month, quarter or year) who remained in DHS custody for 60 days.

Exclusions

- Children must be continuously enrolled for the 60 day follow up period.

Notes

Current agreed upon procedure codes (with predecessor Mental Health Organizations) may need to be updated with CCOs.

Committee proposed expanding this measure to include oral health screening in future years

Data Source(s)

- Administrative data and child welfare records (ORKids)

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
58% (Mental Health assessment)	n/a	n/a

Follow up care for children prescribed ADHD medication

NQF #0108. Measure Steward: NCQA

The measure tracks the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

2. *Continuation and Maintenance (C&M) Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Numerator

- Rate 1: Members from the denominator with one face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date.

- Rate 2: The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Denominator

- Members 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an attention deficit/hyperactivity disorder (ADHD) medication during the 12-month Intake Period.

Exclusions

- Initiation Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis or DRG for mental health or substance abuse during the 30 days after the IPSD.

- Continuation and Management Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis of mental health substance abuse during the 300 days after the IPSD.
- Patients diagnosed with narcolepsy (ICD-9-CM Code: 347) should be excluded from the denominators.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
2011 rate 1: 49.96%	2012 rate 1: 51%	2012 rate 1: 44%
2011 rate 2: 57.09%	2012 rate 2: 63%	2012 rate 2: 53%

Prenatal and Postpartum Care: Timeliness of prenatal care

NQF #1517. Measure Steward: NCQA

This measure tracks the percentage of deliveries of live births that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Numerator

- Number of live birth deliveries that received a prenatal care visit as a member of the CCO in the first trimester or within 42 days or enrollment.

Denominator

- Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Exclusions

- None.

Notes

Must be enrolled for 43 days prior to delivery with no gaps.

From July 1, 2009, managed care plans received global payments for prenatal, delivery, and postpartum services in addition to capitation rates: a significant portion of ambulatory services may not generate a claim. This could be addressed through chart review.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
30.4% (administrative data only)	92% (2012)	89% (2012)

Elective delivery before 39 weeks

NQF #0469. Measure Steward: The Joint Commission

This measure tracks the percentage of patients with elective vaginal deliveries or elective cesarean sections at >=37 and <39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).

Numerator

- Individuals with elective deliveries with ICD-9-CM principal procedure code or ICD-9-CM other procedure codes for one or more of the following: Medical induction of labor, Cesarean section while not in active labor or experiencing spontaneous rupture of membranes.
- Procedure codes are defined in Appendix A, Table 11.05 and 11.06 available online at http://manual.jointcommission.org

Denominator

- Patients delivering newborns with >= 37 and < 39 weeks of gestation completed.

Exclusions

- ICD-9-CM Principal Diagnosis Code of ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07.
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
0.8% (2012)		

Emergency Department Utilization

This measure summarizes emergency department utilization and is half of the HEDIS measure "outpatient and ED utilization."

Numerator

- Number of ED visits (multiple visits on one day are counted as one visit).

Denominator

- Per 1,000 member months.

Exclusions

- Emergency Department visits that result in hospital admission.
- HEDIS does not include mental health or chemical dependency if diagnoses are listed as primary.

Notes

Recommend OHA reports total utilization for all covered diagnoses per 1,000 member months, as well as grouping for physical health, mental health, and chemical dependency.

Each group should be reported by recommended race and ethnicity categories. Each group should also be broken out by the following age categories: 0-12; 13-17; 18-20; 21-64; 65-74; and 75+.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
56/1,000mm (2011)	44.4/1,000mm (2011)	55.2/1,000mm (2011)

Colorectal cancer screening

NQF #0034. Measure steward: NCQA

The measure tracks the percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Numerator

- Individual who had an appropriate screening if a submitted encounter / claim contains appropriate CPT code.

Codes used to identify (2012 HEDIS Specifications)

FOBT	CPT CODES: 82270, 82274 HCPCS: G0328 LOINC: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2
Flexible sigmoidoscopy	CPT CODES: 45330-45335, 45337-45342, 45345 HCPCS: G0104 ICD-9 CM PROCEDURE CODES: 45.24
Colonoscopy	CPT CODES: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 HCPCS: G0105, G0121 ICD-9 CM PROCEDURE CODES: 45.22, 45.23, 45.25, 45.42, 45.43

Denominator

- All eligible members meeting enrollment criteria and age 50-75 during measurement year.

Exclusions

- Continuous enrollment for measurement year and prior year. No more than one gap of up to 45 days.
- Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review.

Codes used to identify exclusions (2012 HEDIS specifications)

Colorectal cancer	HCPCS: G0213-G0215, G0231 ICD-9 CM DIAGNOSIS CODES: 153, 154.0, 154.1, 197.5, V10.0
Total colectomy	CPT CODES: 44150-44153, 44155-44158, 44210-44212 ICD-9 CM PROCEDURE CODE: 45.8

Notes

Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy. The diagnosis must have occurred by December 31 of the measurement year.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
30.5% (administrative data only)	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 90th percentile: 71.67.	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 75th percentile: 65.76
	Adjustment factor for Medicaid: 4.12	Adjustment factor for Medicaid: 4.42
	Adjusted 90th percentile: 67.55	Adjusted 75th percentile: 61.34

Patient-Centered Primary Care Home (PCPCH) enrollment

This measure identifies the number of members enrolled in patient-centered primary care homes by tier.

Numerator

- The number of PCPCH enrolled members by tier:
    - # of enrollees in tier 1 x 1
    - # of enrollees in tier 2 x2
    - # of enrollees in tier 3 x 3

Denominator

- All enrolled members x 3

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	n/a	n/a

Developmental screening in the first three years of life

NQF #1448. Measure Steward: Oregon Health & Sciences University

This measure tracks the percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Numerator

- Children in the relevant denominator who had a claim/encounter with CPT code 96110 (developmental testing, with interpretation and report) by their birthday.

Denominator

- The children in the eligible population who turned one during the measurement period
- The children in the eligible population who turned two during the measurement period
- The children in the eligible population who turned three during the measurement period

Children must be covered by Medicaid/CHIP program continuously for 12 months between last birthdate and this birthdate, regardless if they had a medical/clinic visit or not during the measurement period.

Exclusions

- Children with more than one 45 day gap in enrollment for 12 months prior to birthday are excluded.

Notes

Measure could be collapsed into one across described denominators.

If using hybrid methodology, OHA may need to accept other forms of evidence. This would need to be defined and standardized across plans. Hybrid methodology would lose comparison to national benchmarks.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
19.6% (administrative data only)		

Adolescent well child visits

This HEDIS measure tracks the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Numerator

- Members 12-21 years of age who received at least one comprehensive well-care visit during the measurement year.

Codes used to identify well-child visits (2012 HEDIS Specifications)

Well Child Visits	CPT CODES: 99381, 99382, 99391, 99392, 99432, 99461 HCPCS: G0438, G0439 ICD-9 CM DIAGNOSIS CODES: V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Denominator

- Members 12-21 years of age continuously enrolled in a specific health plan, FFS, or primary care management for the measurement year, with up to one 45-day gap in enrollment allowed.

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
26.7%	64.1% (2011)	56.9% (2011)

Controlling high blood pressure

NQF #0018. Measure Steward: NCQA

This measure tracks the percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator

- The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.

Denominator

- Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Exclusions

- Exclude from the eligible population all patients with evidence of end-stage renal disease (ESRD) (including dialysis or renal transplant), all patients who are pregnant, and all patients who had an admission to a non-acute inpatient setting on or prior to December 31 of the measurement year.
- Individual must be continuously enrolled during the measurement year with no more than one month gap in coverage.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	66% (2012)	60% (2012)

Diabetes: HbA1c Poor Control

NQF #0059. Measure Steward: NCQA

This measure tracks the percentage of adult patients with diabetes ages 18-75 years with most recent hemoglobin A1c level greater than 9.0% (poor control)

Numerator

- The number of patients in the denominator with HbA1c levels greater than 9.0% during the measurement year.

Denominator

- Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Exclusions

- Patients with a diagnosis of polycystic ovaries who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.
- Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
TBD	28% (2012)	34% (2012)

Access to Care: Getting Care Quickly

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: getting care quickly (adult) and getting care quickly (child).

The measure reports on the ease with which the members can access care quickly. The composite score is the overall percentage of members who responded "always" or "usually" to the following questions:

- In the last 6 months, when you needed care right away, how often did you get are as soon as you thought you needed? (Adult)
- In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? (Adult)
- In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed? (Child)
- In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 79%	Adult (2012):85.59%	Adult (2012): 83.63%
Child (2011): 88%	Child (2012):92.16%	Child (2012): 90.31%
Average (2011): 83.5%	Average (2012): 88.88%	Average (2012): 86.97%

Satisfaction with Care: Health plan information and customer service

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: health plan information and customer service (adult) and health plan information and customer service (child).

This measure reports members' customer service experiencing when contacting the health plan. The composite score is the percentage of members who responded "always" or "usually" to the following questions:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed? (Adult)
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? (Adult)
- In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed? (Child)
- In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 76%	Adult (2012):86.67%	Adult (2012): 83.19%
Child (2011): 80%	Child (2012): 88.99%	Child (2012): 84.71%
Average (2011): 78%	Average (2012): 87.83%	Average (2012): 83.95%

Electronic Health Record (EHR) Adoption

This measure is a composite of three Eligible Professional (EP) Meaningful Use Core Measures.

- #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)
- #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology).
- #5: Active Medicaid List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

Notes

Data Source(s)

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
TBD	n/a	n/a

Appendix 3.D: Rationale for Incentive Measures

Incentive Measures[16]	Brief Description	Rationale for Measure
Screening for clinical depression and follow-up plan	Percent of members age 12+ screened for clinical depression using an age-appropriate standardized tool and follow-up plan documented in chart.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Alcohol and Drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	Percentage of members age 18+ with routine visit in the measurement year screened for substance abuse and referred as necessary.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Bundled measure: mental health and physical health assessment for children in DHS custody	Percentage of children age 4+ who receive a mental health assessment and/or physical health assessment within 60 days of DHS custody date.	Oregon's baseline for mental health assessments for children in DHS custody is 58%. As this assessment is a requirement for the foster program, the rate should be much closer to 100%. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

[16] These measures will be publically reported by CCO, by race and ethnicity, and by other subpopulations where possible and appropriate, including people who are dually eligible, people with serious and persistent mental illness, people with disability, and people with special health care needs (e.g., chronic conditions, homelessness). Other analysis may include looking at beneficiary primary language, or rural versus non-rural locations.

Incentive Measures[16]	Brief Description	Rationale for Measure
Follow up care for children prescribed ADHD medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed	Oregon's baseline for follow-up care for children prescribed ADHD medication is 49.96% (rate 1) and 57.09% (rate 2). This is between the 2012 National Medicaid 75th and 90th percentiles. This measure addresses coordination of behavioral health and physical health care, as well as an emerging issue for children.
Follow-up after hospitalization for mental illness	Percentage of members age 6+ and mental health diagnosis with a follow-up visit within 7 days after hospitalization.	Oregon's baseline for follow-up after hospitalization for mental illness is 52%, between the 50th and 75th percentiles nationally (54% and 58%, respectively, 2012 Medicaid Benchmarks). Research has found patient access to follow-up care within 7 days of discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmissions.[17] In addition to potential cost savings from reducing readmissions, focusing on the integration between physical and behavioral health is a key component of Oregon's Health System Transformation. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

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

Incentive Measures[16]	Brief Description	Rationale for Measure
Prenatal care initiated in the first trimester	Percentage of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan.	Oregon's baseline for prenatal care is 30.4% based on administrative data, compared to the 25th percentile nationally of 77% (2012 Medicaid Benchmarks). However, ongoing measurement issues, including bundled payments for pre- and post-natal services, create an artificially low rate when just using administrative data. While Oregon's baseline is likely much higher than 30.4%, improving prenatal care is widely acknowledged as the most cost-effective way to improve the outcome of pregnancy for all women and infants.[18] As 43% of babies born in Oregon are covered by Medicaid (2009),[19]Oregon can achieve significant cost savings and better health outcomes by improving prenatal care. This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Reducing elective delivery before 39 weeks	Patients with elective vaginal deliveries or elective cesarean sections at >=37 and < 39 weeks of gestation completed.	The Leapfrog 2011 hospital survey indicates that rates of elective deliveries in Oregon range from 3.9 – 18.2%, compared to the recommended national benchmark of 5%. Complications for infants delivered by early cesareans include infections, five days or more of hospitalization, and the need for CPR. Additionally, babies born earlier average more visits during the first year of life compared to full-term babies (nine visits versus six, respectively). [20]

[18] A California Medi-Cal study found that women with no prenatal care were four times as likely to give birth to a baby of low birth weight and more than seven times as likely to give birth prematurely (2000). And a Missouri Medicaid study found a cost-savings of $1.49 for every $1 spent on prenatal care (1992).
[19] http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF
[20] http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Maternity_Care.pdf

Incentive Measures[16]	Brief Description	Rationale for Measure
		Total first year costs after initial hospitalization have been found on average to be three times higher for late preterm infants (>37weeks, <39 weeks) than for full-term infants. [21] This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Developmental screening by 36 months	The percentage of children with documentation that they were screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.	Oregon's baseline for developmental screening by 36 months is 19.6%. National survey for children's health indicates a range of 9% - 52% for developmental screening rates across the country. 52% was the highest performing state in the nation. Early developmental delays are often not identified until kindergarten entry or later – well beyond the period in which early intervention is most effective. Early identification and treatment of developmental delays leads to improved outcomes and reduced costs. This measure will help inform the quality improvement focus area: improving primary care for all populations.
Adolescent well care visits	The percentage of enrolled members age 12-21 who had at least on comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Oregon's baseline for adolescent well care visits is 26.3% (2010), well below the 25th percentile nationally of 39.7% (2011 Medicaid National Benchmark) and lower than the general population (in 2011, just over half of Oregon's 8th and 11th graders reported a well care visit in the past year – Oregon Healthy Teens). Youth who can easily access developmentally appropriate,

[21] McLaurin KK, Hall CB, Jackson EA, et al. Persistence of morbidity and cost differences between late-preterm and term infants during the first year of life. *Pediatrics*. 2009;123:653-659.

Incentive Measures[16]	Brief Description	Rationale for Measure
		evidenced-based preventive health services are more likely to be healthy.[22] This measure will help inform the quality improvement focus area: improving primary care for all populations.
Diabetes care: HemoglobinA1c poor control	Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control)	Addresses quality of care for a disease that impairs health and function in the individual and results in high costs due to complications and hospitalizations. By measuring HbA1c control, Oregon will assess the effectiveness of diabetes care. This measure will help inform the quality improvement focus area: Addressing discrete 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.
Controlling hypertension	Percentage of patients age 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year (2013).	According to 2010 BRFSS data, 39.4% of Oregon Health Plan adult enrollees have high blood pressure, compared to 31% of the general population. While baseline data for OHP members with controlled high blood pressure is not available, Oregon is likely below the 25th percentile nationally of 47% (2012 Medicaid Benchmarks) as studies indicate that as many as two thirds of those with hypertension are either undertreated or untreated.[23][24]

[22] Haas, S.A. & Fosse, N.E. (2008). Health and the educational attainment of adolescents: Evidence from the NLSY97.*Journal of Health and Social Behavior, 49,* (2), 178-92.
[23] *Trends in prevalence, awareness, treatment, and control of hypertension in the United States, 1988–2000.*JAMA.*2003; 290: 199–206*

Incentive Measures[16]	Brief Description	Rationale for Measure
		This measure will help inform the quality improvement focus area: Addressing discrete 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.
Colorectal cancer screening	Percentage of individuals age 50-75 who had appropriate screening for colorectal cancer, defined as: • Fecal occult blood test (FOBT) during the measurement year (2013); • Flexible sigmoidoscopy during the measurement year (2013) or the four years prior to the measurement year; or • Colonoscopy during the measurement year (2013) or the nine years prior to the measurement year.	Oregon's baseline for colorectal cancer screening is 30.5%, well below the 25th percentile of 51% (Regions 9 & 10, commercial population) and the overall screening rate in Oregon (63%)[25] Colorectal cancer is Oregon's second leading cause of cancer deaths.[26] Numerous studies have found that colorectal cancer screening is cost-effective or even cost-saving compared with no screening.[27] This measure will help inform the quality improvement focus area: improving primary care for all populations.
ED Utilization	Number of Emergency Department visits,	Oregon's baseline for Emergency Department utilization is 56 visits/1,000 member months (2011), close to the 75th

[24] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6135a3.htm?s_cid=mm6135a3_w
[25] 2008 BRFSS data. Screening is defined as fecal occult blood test within one year, sigmoidoscopy within 5 years, or colonoscopy within 10 years.
[26] www.oregon.gov/DHS/ph/oscar/arpt2006/colorectal06.pdf
[27] Cost-effectiveness of Colorectal Cancer Screening. *Epidemiol Rev (2011) doi: 10.1093/epirev/mxr004* First published online: June 1, 2011 http://epirev.oxfordjournals.org/content/early/2011/06/01/epirev.mxr004.full#abstract-1

Incentive Measures[16]	Brief Description	Rationale for Measure
	calculated per 1,000 member months	percentile nationally of 55.2/member months (2011 Medicaid Total Population National Benchmarks). Reducing ED utilization will result in cost savings.
Rate of PCPCH enrollment:	Percentage of members enrolled in patient-centered primary care homes, calculated by tier.	The Oregon Health Policy board estimates that up to $44 million in 3 years and up to $190 million in 10 years can be saved by implementing integrated health homes for Oregon Health Plan beneficiaries with chronic and/or comorbid conditions. Further savings will be possible when PCPCHs are expanded to public employees and other privately insured Oregonians.[28] This measure will help inform the quality improvement focus area: improving primary care for all populations.
CAHPS Composite: Getting Care Quickly Getting Needed Care	Percentage of members who responded "Always" or "Usually" to four CAHPS survey questions about getting needed care as soon as needed and getting appointments at a doctor's office or clinic as soon as needed. •	Improving access to effective and timely care has the potential to improve the overall quality of care and help reduce costs. [29] It is necessary to assess for the availability and proximity of providers, as well as barriers to access such as lack of transportation, or long waits to get an appointment.[30]Measuring access to care can also identify disparities based on race/ethnicity, gender, or geography.
CAHPS Composite:	Percentage of members who responded	Member satisfaction is a critical component of quality

[28]http://www.oregon.gov/OHA/OHPR/HFB/docs/Final_Report_12_2008.pdf

[29]Steinbrook R. Easing the shortage in adult primary care -- Is it all about money? N Engl J Med. 2009;360:2696-2699; Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff. April 7, 2004: w4.184-197.

[30] Hall A, Harris Lemak C, Steingraber H, et al. Expanding the definition of access: It isn't just about health insurance. J Health Care Poor Underserved. 2008;19:625-638

Incentive Measures[16]	Brief Description	Rationale for Measure
Health plan information and customer service	"Always" or "Usually" to four CAHPS survey questions about how often a health plan's customer service gave needed information or help and how often a health plan's customer service treated members with courtesy and respect.	analysis, from NCQA's HEDIS to the American Medical Association's Accreditation Program. Patient satisfaction is considered a key result of patient care. Healthier members tend to report better satisfaction with their health plan; although this has not been demonstrated conclusively, patient satisfaction could be used as a partial proxy for health status, particularly for managed care members.[31] Addressing patient satisfaction with health plans covers a number of variables, including patient interactions with individual providers, which may be less under the control of the health plan, but also the quality of communication of rules and benefits, and overall customer service provided by the plan.
EHR Composite (3Qs)	1. Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)	Creating a composite score from three Meaningful Use core measures will serve as a measure of EHR adoption across Oregon. The three MU measures selected address both quality and coordination of care, a critical component of the Coordinated Care model.

[31] http://www.dssresearch.com/Download/PSATwithHCHP_RG.pdf

Incentive Measures[16]	Brief Description	Rationale for Measure
	2. Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.) 3. Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	

Appendix 3.E: Measures for Consideration in Demonstration Year 3

Quality Improvement Focus Area	Measures
Reducing preventable rehospitalizations	• Pediatric central line associated bloodstream infections – Neonatal intensive care unit and pediatric intensive care unit
Addressing discrete health issues	
Reduce preventable and costly utilization	• Medication reconciliation post-discharge (NQF 0054) • Care transition – transition record transmitted to health care professional (NQF 0648)
Integrate primary care and behavioral health	• Antidepressant medication management (NQF 0105) • Behavioral health risk assessment for pregnant women (AMA PCPC1) • Depression remission at 12 months (NQF 710)
Improving access to timely and effective care	• Total eligible who received dental treatment services (ages 1-20) • Total eligible who received preventive dental services (ages 1-20) (NQF 1334)
Improving perinatal and maternity care	• Percentage of live births weighing less than 2500 grams (NQF 1382) • Prenatal and postpartum care: postpartum care rate (NQF 1391) • Behavioral health risk assessment for pregnant women (AMA PCPC1)
Improving primary care for all populations	• Annual monitoring of patients on persistent medications (NQF 0021)

Section B: Expenditure Tracking for Trend Reduction Test

Attachment H

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 46, 47, 48, and 49.

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 separately documented on the Tab entitled New FQHC/RHC and included in Level 2 tracking. In addition, any incremental increases in wrap payments associated with a change in scope after July 1, 2011 will also be tracked in this Tab and included as part of Level 2 tracking.

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.

Level 3: The per-member-per-month total expenditure to the state to provide care under Health System Transformation in Oregon.

On the tracking template, there are three administrative cost categories. For the first two on HIT and internal IT costs, specifically the costs funded by Medicaid AND undertaken exclusively to help make CCOs successful are included. The third, the transformation center and related supports, OHA will report the full budget and parse out the Medicaid funding share of that work. This will provide a full picture of the funds needed to support transformation directly. The following provides a more detailed description of the three administrative cost categories and what would be included:

1. **HIT/Interoperability Costs**

    - This category would include administrative expenditures by the state to implement and further statewide HIT/Interoperability *specific to CCOs*.
    - These expenditures would not include anything activities that are the responsibility of the CCOs and providers paid through the CCO global budget.
    - A couple examples of these state costs could include:
        - State monitoring and measuring the CCO progress in increasing EHR adoption rates within their networks
        - State evaluation of the HIT/HIE portions of the CCO Transformation Plans and measuring progress of those plans in those areas

2. **Internal IT system changes**

    - This category would include administrative costs to implement health system transformation that are above and beyond the intensity, frequency, or complexity of normal system changes and are undertaken for the sole purpose to successfully implement CCOs.
    - Examples would include:
        - Personal services focused on HST project direction, management, coordination.

- Hardware and software purchased to establish a new function or service (such as SharePoint for the CCO portal and collaboration)
- Contracted resources to assist with workload (such as documentation of business requirements, making system changes, implementation of new function/service, etc.)
- System changes needed to accommodate both transfer of pertinent data between the state and the CCOs, but also the changes required to support metrics, performance and quality measures and the payment processing attached to those requirements.

3. Transformation Center costs

- This would include the full cost of the transformation center, with Medicaid's share delineated.
- Medicaid's share could include analytic support, staff training, and other related administrative costs that are not funded by other grant funds.

Other Cost Treatment

- **Long-Term Care services**: Oregon has agreed to conduct an exploratory stakeholder process that would result in a report to CMS regarding the integration of DHS Medicaid-funded long-term care for the aged or people with disabilities into CCO global budgets. The report will identify opportunities, barriers, and strategies for integrating long term care, and address issues of scope, process and timeline for integration. The report will be submitted to CMS no later than December 31, 2013.
- **Uncompensated Care Costs:** CMS and OHA acknowledged that DSH audit reports have a significant lag between the review year and date of the actual audit report. State and CMS agree to use data from the most recently filed Medicare cost reports to evaluate the year-to-year trend in hospital uncompensated care. Most recently filed Medicare cost reports are available through the Healthcare Cost Report Information System (HCRIS) maintained by CMS. Six months following the end of the state fiscal year (beginning with SFY 2013), the state would extract HCRIS data for each of the two previous state fiscal years, calculate an aggregate year-to-year trend of uncompensated care and report it to CMS as a component of the quarterly report ending March 31 of each year.

To the extent uncompensated care is increasing more quickly than other health care costs, the state and CMS will attempt to identify underlying factors for the increase and to what extent the state and CMS have influence to affect such factors in the future.

Attachment H

Treatment of Populations Within the Workbook after January 1, 2014

The attached spending growth reduction template is now populated with actual expenditure data and caseload for CY 2011. Expenditure data is extracted from the OHA accounting system based on date of payment.

CMS has proposed a methodology for accounting for the influx of new enrollees in 2014 with the ACA Medicaid expansion. In discussions with the state, CMS has identified three particular populations that are identified in the waiver and subject to the two percent test for some portion of the expenditures for health care (also known as Level 1 service expenditures). The populations are:

A. State plan eligibles currently receiving the OHP Plus benefit package

B. Demonstration population that currently receives the OHP Standard benefit package but will move to the OHP Plus package on January 1, 2014 (approximately 60-70k enrolled individuals)

C. Newly covered individuals in the new section 1902(a)(10)(A)(i)(VIII) group (estimated at 220k individuals)

The current STCs require that the state begin achieving savings in state fiscal year 2014 (July 1, 2013 – June 30, 2014) for populations A and B based on calendar year 2011 base year expenditures for services identified as in the global budget. By June 30, 2014, the state is required to document a one percent savings for all groups covered in the demonstration. However, populations B and C will have major expenditure effects associated with mid-year changes attributable to implementation of ACA Medicaid expansions.

- Population A will not be affected as their benefit package will remain the same and the base year expenditures are still the relevant measure against which savings are determined.

- Population B will experience an increase in expenditures as of January 1, 2014, due to the expansion of their benefit package. CMS proposes that the state measure savings at the two percent level for the OHP Standard benefit package for the full 2014 period. The contracts in place with the CCOs would identify the capitated rate paid for the first half of the year. The state should document the proportion of the rate for the remainder of the demonstration year that is associated with the expanded (Plus) benefit package. The additional benefits available after January 1, 2014, are not subject to the spending growth reduction test for this demonstration year. For the subsequent demonstration year, the expenditures incurred over the final 6 months of the SFY 2014 demonstration year will be

used to develop a new SFY 2014 base (full expanded benefit package) against which SFY 2015 demonstration year (DY 13) will be measured.

- Population C will be new as of January 1, 2014 and therefore, expenditures from January 1 – June 30, 2014 will become the base against which SFY 2015 demonstration year (DY 13) expenditures are measured. The first year that the two percent will be applied is 2015 expenditures.

- If during demonstration year 2015 or 2016, the state is required to modify the rates for the expansion population based on actual experience of the CCOs due to a demonstrable difference in health status or a significant and identifiable increased pattern of utilization, the state will need to provide both of the following:

    1. Analyses that indicate population C has a higher case mix acuity requiring rates that are increased to reflect this higher "sicker population". The state will use the Chronic Illness and Disability Payment System Model (CDPS) to document this case mix and acuity differential and modify the base against which savings will be measured. The documentation must clearly demonstrate that the new population is clearly more expensive due to actual differences in population acuity (health) rather than simply increased utilization of services, poor management in CCOs, or other volume and care management issues.

    2. Analysis that population C has a significantly higher pattern of utilization when compared to the other Medicaid populations (rate groups). Significant increases in utilization that can be isolated to the expansion population are the result of either missed assumptions in the rate setting process or the result of untreated pent up demand. This state will demonstrate this discrepancy by documenting the base utilization assumptions used in setting the capitation rates for the expansion population and then compare those assumptions to the actual experienced utilization for specific services and activities identified prior to the population receiving services in 2014.

The state must provide the actual baseline service data, utilization assumptions, and health status indicators being targeted for review and analysis within the models employed under (1) and (2) for CMS approval prior to the population being enrolled in 2014. CMS understands that the contracts for this population will be negotiated between June and September of 2013 and would expect that the state would begin sharing this information during that period. If the detailed information described in this paragraph is not provided to CMS for review and approval, the state will not be able to request a change in the base for these populations.

Any modification to the base year would need to be agreed upon by CMS and Oregon through the underlying documentation and only for this specific population.

Return on Investment: The return on investment analysis focused on the federal investment represented by total federal financial participation (FFP) in DSHP claims plus additional FFP drawn by the state because it has additional state dollars in the same amount as the FFP drawn against the DSHP claims. This amount represents the total new federal investment into Oregon to support their delivery system transformation under the 1115 demonstration. This amount will be measured against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Attachment H

Description of Elements in the Work Book

Tab 1: PMPM Target – includes 2011 base year per member per month expenditures as developed using OHA expenditure information based on actual date of payment expenditure for 2011. 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. 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 2011 base year aggregate expenditures derived from Tab 8. CY 2011. Subsequent year expenditures for Tab 2 will be 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. Annual estimates will be updated quarterly based on the combination of actual and projections available each quarter.

Tab 4: Expenditure Actuals – includes actual aggregate expenditures derived from Tabs 8 through 13 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/Standard) for calculation of PMPMs.

Tab 6: New FQHC-RHC – provides a tracker of wrap payments made to FQHCs/RHCs established after 7/01/2011 and incremental increases in wrap payments due to increases in scope of service made after 7/01/2011. These calculations then feed into the FQHC/RHC wrap line items in Tabs 10-14.

Tab 7: ROI – includes calculations for the return on investment analysis outlined in STC 50 and above measuring the total DSHP investment against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Tabs 8-13: Yearly tabs that track actuals for the CY 2011 base year and 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. For each current demonstration year, the full year will be estimated, updated with actuals as they are available.

Attachment H

PMPM WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGET

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
	Without HST Baseline Growth (Per ST&Cs)	Base Year	5.40%	5.40%	5.40%	5.40%	5.40%
	Without HST Baseline Growth PMPM	$ 400	$ 421	$ 444	$ 468	$ 493	$ 520
	With HST Spending Reduction Growth Target	Base Year	5.40%	4.40%	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	$ 368					
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						
	Youth residential alcohol and drug treatment (OHP carve out)						
	Adult residential alcohol and drug treatment (OHP carve out)						
	Nurse Home Visiting program: Babies First! And CaCoon						
	Non-Emergent Medical Transportation						
	Adult Residential Mental Health Services						
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
	Young Adults in Transition Mental Health Residential						
	Targeted Case Management						
	Federally Qualified Health Center Wrap						
	Primary Care Case Management						
	Global Budget PMPM	$ 400	$ 421	$ 440	$ 459	$ 484	$ 510
Level 2: Total Expenditu	**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 Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system costs						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment H

TOTAL EXPENDITURES WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGETS

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget	**Capitation:**						
	Total Managed Care	$ 2,140,213,391					
	Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
	Incentive Payment Pool						
	Total Capitation	**$ 2,519,153,853**	**$ -**				
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030.00					
	Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
	Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
	Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
	Non-Emergent Medical Transportation	$ 43,416,273					
	Adult Residential Mental Health Services	$ 71,019,309					
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
	Young Adults in Transition Mental Health Residential	$ 376,116					
	Targeted Case Management	$ 9,846,177					
	Federally Qualified Health Center Wrap	$ 67,458,838					
	Primary Care Case Management	$ 153,133					
	Total Global Budget - No HST	**$ 2,733,284,427**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	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 Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system changes						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Total Administrative Expenses						

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment H

	PMPM ACTUALS UNDER HEALTH SYSTEM TRANSFORMATION					
	TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget						
Capitation:						
Total Managed Care						
Total Fee For Service (for equivalent CCO services)						
Incentive Payment Pool						
Total Capitation PMPM	$ 368.32					
Services Outside of Capitation + Subject to Evaluation						
ADDITIONAL SERVICES:						
Substance Abusing Pregnant Women and Substance Abusing						
Parents with Children under Age 18 (Targeted Case Management)						
Youth residential alcohol and drug treatment (OHP carve out)						
Adult residential alcohol and drug treatment (OHP carve out)						
Nurse Home Visiting program: Babies First! And CaCoon						
Non-Emergent Medical Transportation						
Adult Residential Mental Health Services						
Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
Young Adults in Transition Mental Health Residential						
Targeted Case Management						
Federally Qualified Health Center Wrap						
Primary Care Case Management						
Global Budget PMPM	$ 399.63					
Level 2: Total Expendit						
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 Wrap for new centers and change of scope after 7/01/2011						
Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin						
Administrative Expenses						
HIT/Interoperability costs						
Internal IT system changes						
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

3. PMPM Actuals 12/14/2012 3

TOTAL ACTUAL EXPENDITURES UNDER HEALTH SYSTEM TRANSFORMATION

	BASE TOTAL CY 2011	TOTAL SFY 2013	3.4% TOTAL SFY 2014	3.4% TOTAL SFY 2015	3.4% TOTAL SFY 2016	3.4% TOTAL SFY 2017
Level 1: Global Budget						
Capitation:						
Total Managed Care	$ 2,140,213,391					
Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
Incentive Payment Pool	$ -					
Total Capitation	**$ 2,519,153,853**					
Services Outside of Capitation + Subject to Evaluation						
ADDITIONAL SERVICES:						
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030					
Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
Non-Emergent Medical Transportation	$ 43,416,273					
Adult Residential Mental Health Services	$ 71,019,309					
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
Young Adults in Transition Mental Health Residential	$ 376,116					
Targeted Case Management	$ 9,846,177					
Federally Qualified Health Center Wrap	$ 67,458,838					
Primary Care Case Management	$ 153,133					
Total Global Budget	**$ 2,733,284,427**					
Level 2: Total Expendit						
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 Wrap for new centers and change of scope after 7/01/2011						
Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin						
Administrative Expenses						
HIT/Interoperability costs	$ -					
Internal IT system changes	$ -					
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Ar	$ -					
Total Administrative Expenses	**$ -**					

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

4. Expenditure Actuals 12/14/2012 4

Base Year Caseload and Projected Caseload								
	HST Population Groups	Base CY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Total PLUS		5,533,161						
Total Standard	ACA/OHP Standard	838,738						
Total ACA Expansion	ACA/OHP Standard							
Total CHIP	Child	816,558						
Total Plus, Standard, ACA and CHIP		**7,188,457**						
Cawem Prenatal	Non-disabled adult	16,324						
Breast and Cervical Cancer Program	Non-disabled adult	6,309						

Footnote for discussion:

[1]AB/AD w/o Medicare and AB/AD w/Medicare populations include disabled children

Less Duals Non-enrollees	**286,450**
Less TPL Caseload	**68,761**
Total Caseload not including Cawem Prenatal	**6,839,555**

TPL Caseload:	
kids	**9896**
Non-Dis	**4571**
Dis	**2842**
Duals	**50306**
Standard	**1146**
Total TPL	**68761**

Attachment H

FQHCs and RHCs who were either established after 7/01/2012 or have a change of scope since the CY 2011 baseyear

Note: these calculations will be fleshed out and linked to expenditure pages for FQHC payments lines.

Health Centers Established after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

DMAP Provider ID	FQHC/RHC Name	Type	Began	PPS Rate	CY 2011 Wrap	SFY 2012 Wrap	SFY 2013	SFY 2014
500637389	Women's Health Center	RHC	7/13/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637337	Ocean Medical Clinic	RHC	8/17/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637480	Naselle Clinic	RHC	8/17/2011	$86.32	$0.00	$0.00	$0.00	$0.00
544642552	MMoreCare	RHC	11/1/2011	$206.70	$0.00	$0.00	$0.00	$0.00
500640302	Centennial Medical Group	RHC	12/1/2011	$128.11	$0.00	$63,358.13	$0.00	$0.00
500642552	St. Charles Health Sys. Inc.	RHC	1/1/2012	$207.53	$0.00	$0.00	$0.00	$0.00
500646533	Firwood- Legacy Clinic	RHC	8/1/2012	$193.46	$0.00	$0.00	$0.00	$0.00
	Total				$0.00	$63,358.13	$0.00	$0.00

Incremental increases in wrap payments due to rate change effective after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

							SFY 2013		SFY 2014	
DMAP Provider ID	FQHC/RHC Name	Type	Pre-7/1/12 PPS Rate	New PPS Rate	Incremental Rate Change	Effective Date for New Rate	Total	Incremental Increase	Total	Incremental Increase
xxxxxxxxxxx	Example	FQHC	$ 200	$ 225	$ 25	1/1/2013	$ 2,250,000	$ 250,000		
	Total						$ 2,250,000	$ 250,000		

ROI Analysis

	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17
FFP DSHP Claimed (FMAP X TC)					
a. High Risk Pool					
b. Higher Education					
c. State identify Health Programs					
Total Claimed					
New FFP Available on Non-Federal Share {Total DSHP Claimed (line 7)/(1-FMAP)}-DSHP claimed					
Total Federal Investment (Line 7 + Line 9)					
Total Actual Savings (% reduction in Level I & 2 savings realized by the state X Level 1 & 2 spending)					
ROI (line 12/line 14)					

Attachment H

CY 2011 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care	$ 647,342,558	$ 489,607,766	$ 530,789,880	$ 105,277,560	$ 367,195,627		$ 2,140,213,391
Total Fee For Service (for CCO equivalent services)	$ 115,182,230	$ 48,275,516	$ 165,007,384		$ 50,475,332		$ 378,940,462
Incentive Payment Pool							$ -
Total Capitation	$ 762,524,788	$ 537,883,283	$ 695,797,264	$ 105,277,560	$ 417,670,958	$ -	$ 2,519,153,853
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						$ 1,206,030	$ 1,206,030
Youth residential alcohol and drug treatment (OHP carve out)						$ 3,010,303	$ 3,010,303
Adult residential alcohol and drug treatment (OHP carve out)						$ 9,982,229	$ 9,982,229
Nurse Home Visiting program: Babies First! And CaCoon						$ 227,973	$ 227,973
Non-Emergent Medical Transportation						$ 43,416,273	$ 43,416,273
Adult Residential Mental Health Services						$ 71,019,309	$ 71,019,309
Cost-sharing for Medicare skilled nursing facility care (day 21-100)						$ 7,434,193	$ 7,434,193
Young Adults in Transition Mental Health Residential						$ 376,116	$ 376,116
Taregeted Case Management						$ 9,846,177	$ 9,846,177
Federally Qualified Health Center Wrap						$ 67,458,838	$ 67,458,838
Primary Care Case Management						$ 153,133	$ 153,133
Total Global Expenditures	**$ 762,524,788**	**$ 537,883,283**	**$ 695,797,264**	**$ 105,277,560**	**$ 417,670,958**	**$ 214,130,575**	**$ 2,733,284,427**
Total Caseload	**4,146,385**	**858,410**	**603,435**	**393,733**	**837,592**		**6,839,555**
PMPM	**$ 183.90**	**$ 626.60**	**$ 1,153.06**	**$ 267.38**	**$ 498.66**		**$ 399.63**
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service	$ 13,891,529	$ 8,376,740	$ 61,414,236	$ 816,989	$ 10,748,475		$ 95,247,969
Long Term Care						$ 812,827,021	$ 812,827,021
School Based Health Services						$ 25,174,125	$ 25,174,125
Behavioral Rehabilitative Services (BRS)						$ 3,663,118	$ 3,663,118
Personal Care 20 Client Employed Provider						$ 988,176	$ 988,176
FQHC Wrap for new centers and change of scope after 7/01/2011						$ -	$ -
Total Services Outside of Capitation + NOT Subject to	**$ 13,891,529**	**$ 8,376,740**	**$ 61,414,236**	**$ 816,989**	**$ 10,748,475**	**$ 842,652,439**	**$ 937,900,408**
Administrative Expenses							
HIT/Interoperability costs							$ -
Internal IT system changes							$ -
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							$ -
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

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Attachment H

SFY 2013 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment H

SFY 2014 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment H

SFY 2015 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment H

SFY 2016 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment H

SFY 2017 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Global Budget							
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Attachment I
Tribal Health Facility Payment Program Claiming Protocol

The methodology outlined, as required by STC 59, below has been approved for structuring supplemental payments to IHS and tribal health facilities from the date of CMS approval of the amendment to this demonstration through December 31, 2013.

Using the methodology, the state shall make supplemental payments to IHS and tribal health facilities operating under ISDEAA 638 authority: 1) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, that were restricted or eliminated from the Medicaid state plan effective January 1, 2010 for non-pregnant adults enrolled in Medicaid (Oregon Health Plan); and 2) for uncompensated care costs of primary care services on the prioritized list which are no longer funded, provided to individuals who have no Medicare, Medicaid, CHIP or other coverage with incomes up to 133 percent of the Federal Poverty Level (FPL).

Provider Claiming Methodology

1. Participating IHS or tribal health facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The service provided;
    b. Whether the service was provided to an IHS eligible individual;
    c. Whether the service was provided to an individual who is later found to not meet the eligible criteria to receive care at the facility;
    d. Whether the service was provided to a OHP beneficiary that is IHS eligible; and
    e. The service date.
2. Qualifying encounters shall not include encounters for which any payment was made under OHP at the IHS published rate.
3. Participating IHS or tribal health facilities shall have procedures to determine if individuals are uninsured, and if so to determine their income level (which could include a protocol based on self-attestation).
4. Participating IHS and tribal health facilities shall maintain existing policies for pursuing third party liability, and shall have procedures to ensure that individuals who have a source of third party liability are not considered uninsured.
5. Participating IHS and tribal health facilities shall submit to Oregon Health Authority (OHA), on a quarterly basis, the number of qualifying uncompensated encounters, broken down by type of qualifying uncompensated service (primary care services above and below the funding line on the prioritized list), type of individual (OHP individual or non-OHP individual) and status of individual as IHS-eligible (Indian or Alaskan Native, or non-IHS).
6. Participating IHS and tribal health facilities shall submit to OHA, on a quarterly basis, the amount of third party payments received for OHP beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.

State Payment Process

7. OHA will process the reports from participating IHS and tribal health facilities and submit to CMS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1) specifying the number of qualifying

uncompensated encounters for each IHS/tribal health facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.

8. In support of the Quarterly Aggregate Encounter Rate, OHA shall submit a certification, signed by the Director of Medical Assistance Plan (DMAP) of OHA that the information contained therein is current, complete, and accurate.
9. The state shall make supplemental payments to each participating facility based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published encounter rate, offset by any third party payments received by each IHS or tribal health facility for uncompensated encounters involving OHP beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other OHP payments to the facility by the amount of such payments.
10. The state must maintain documentation sufficient to support the claims for supplemental payments and provide to CMS upon request.
11. The state may claim federal matching funding for supplemental payments to IHS and tribal health facilities at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated primary care services which fall below the funding line of the prioritized list to individuals who are both Medicaid-enrolled and status as IHS-eligible.

Attachment I
Tribal Health Facility Payment Program Claiming Protocol

Exhibit 1

Facility Name	IHS Eligible Individuals	
	Uninsured: non-OHP beneficiaries	OHP beneficiaries
Total Number of Encounters		
IHS Encounter rate		
Total Expenditures		
Less: Any other payments received		
Total Net Expenditures		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

June 21, 2013

Ms. Tina Edlund
Chief of Policy
Oregon Health Authority
500 Summer Street, NE
Salem, OR 97301-1097

Dear Ms. Edlund:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has made a technical correction to the special terms and conditions of your section 1115 demonstration project, entitled, Oregon Health Plan (21-W-0013/10 and 11-W-00160/10).

Specifically, CMS has made a technical correction in special term and condition 57 which clarifies restrictions to the aggregate Designated State Health Plan (DSHP) limits. This change is based on several discussions held prior to the July 2012 approval of the STCs. We have inserted language providing the intended DSHP flexibility to redirect funds in the event of a DSHP expenditure shortfall. The state may only redirect DSHP to the OMIP or "Other CMS Approved" category with advance state notification and CMS approval. The amount of the redirected DSHP is still subject to the annual aggregate DSHP limit. The changes are effective from the date of this approval letter and claiming is subject to the parameters outlined in Attachment G, Reimbursement and Claiming Protocol for Oregon Designated State Health Programs.

As always, CMS approvals are conditioned upon written acceptance from the state that it agrees with the amendments, expenditure authorities, and STCs. Please provide your written acceptance within 30 days of the date of this letter. Your correspondence should be directed to your project officer, Ms. Terri Fraser. She may be reached at the following:

Ms. Terri Fraser
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5573
Facsimile: (410) 786-8534
E-mail: terri.fraser@cms.hhs.gov

A copy of any correspondence should also be sent to the Seattle Associate Regional Administrator, Ms. Carol Peverly. She may be reached at:

Ms. Carol Peverly
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
2201 Sixth Avenue
MS RX-43
Seattle, WA 98121
Telephone: (206) 615-2515
Facsimile: (206) 615-2311
Email: carol.peverly@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Diane Geritts, Division Director, Division of State Demonstrations and Waivers, at (410) 786-5776.

Sincerely,

/s/

Jennifer Ryan,
Acting Director

Enclosures

cc: Ms. Carol Peverly, Associate Regional Administrator, Seattle
Ms. Diane Gerrits, Division Director, Division of State Demonstrations and Waivers
Ms. Terri Fraser, Project Officer

CENTERS FOR MEDICARE & MEDICAID SERVICES AMENDED WAIVER LIST AND EXPENDITURE AUTHORITY

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

All requirements expressed in Medicaid and CHIP laws, regulations and policies apply to this Demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Such deviations from Medicaid requirements are limited in scope to expenditures related to the following populations affected by the Demonstration:

Populations Affected by OHP

The following title XIX and title XXI State plan populations, and Demonstration-only Expansion Populations are affected by this Demonstration and are listed for purposes of references in the waiver list and expenditure authorities.

Title XIX State Plan Populations

Population 1: Medicaid mandatory pregnant women included in the State plan with income from 0 up to 133 percent of the Federal poverty level (FPL).

Population 2: Medicaid optional pregnant women included in the State plan with income from 133 up to 185 percent of the FPL.

Population 3: Medicaid children 0 through 5 included in the State plan with income from 0 up to 133 percent of the FPL and infants (age 0 to 1) born to women receiving Medicaid benefits at the time of birth with incomes up to 185 percent of the FPL.

Population 4: Medicaid children ages 6 through 18 included in the State plan with income from 0 up to 100 percent of the FPL, and beginning January 1, 2014, Medicaid children with income from 100 up to 133 percent of the FPL.

Population 5: Medicaid mandatory foster care and substitute care children (as defined in the STCs).

Population 6: Medicaid mandatory AFDC section 1931 low-income families (as defined in the STCs).

Population 7: Medicaid mandatory elderly, blind, and disabled individuals with incomes at the SSI level of the FPL (as defined in the STCs).

Population 8: Medicaid optional elderly, blind and disabled individuals with incomes above the Supplemental Security Income (SSI) level of the FPL (as defined in the STCs).

Population 21: Women under the age of 65 who have been screened and diagnosed through the State's National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast and cervical cancer, and are not otherwise covered under creditable coverage with respect to the needed treatment for breast and cervical cancer.

Demonstration Expansion Populations

On January 1, 2014 expenditure authority for many Demonstration Expansion populations will end. When the State amends its Medicaid or CHIP State plan to include some or all of these populations after that date, the State will submit an amendment to the Demonstration updating the populations that will be affected by the Demonstration.

Population 9: Until January 1, 2014, general assistance expansion individuals with income from 0 up to and including 43 percent of the FPL (as defined in the STCs).

Population 10: Until January 1, 2014, expansion parents ages 19 and older with income from 0 up to 100 percent of the FPL (as defined in the STCs).

Population 11: Until January 1, 2014, expansion childless adults age 19 and older with income from 0 up to 100 percent of the FPL (as defined in the STCs).

Population 14: Until January 1, 2014, participants who would have been eligible for Medicaid but choose FHIAP instead.

Population 16: Until January 1, 2014, uninsured children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL, and uninsured children ages 6 through 18 with income from 100 up to and including 200 percent of the FPL (as defined in the STCs) who meet the title XXI definition of a targeted low-income child, and who choose voluntary enrollment in premium assistance under FHIAP.

Population 17: Until January 1, 2014, uninsured parents of children who are eligible for Medicaid or CHIP, who are themselves ineligible for Medicaid/Medicare with income from 0 up to and including 200 percent of the FPL enrolled in FHIAP (as defined in the STCs).

Population 18: Until January 1, 2014, uninsured childless adults who are not eligible for Medicaid/Medicare with income from 0 up to and including 200 percent of the FPL enrolled in FIHAP (as defined in the STCs).

Population 20: Uninsured children ages 0 through 18 with income from above 200 up to and including 300 percent of the FPL, who meet the title XXI definition of a targeted low-income child and choose voluntary enrollment in premium assistance under Healthy Kids ESI.

Population 22: Children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL and uninsured children from ages 6 through 18 with income from 100 up to and including 200 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP State plan; title XXI children ages 0 through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP State plan (under Healthy KidsConnect); and targeted low-income children from conception to birth with income from 0 up to 185 percent of the FPL under the CHIP State Plan.

Population 12 is no longer applicable (in prior demonstration periods, this population included individuals with incomes from 0 up to 170 percent of the FPL who were enrolled in FHIAP as of September 30, 2002), but all such individuals would be otherwise covered in other populations in the current demonstration.

Population 13: is no longer applicable (in prior demonstration periods, this population included, pregnant women with incomes from 170 up to and including 185 percent of the FPL, but has been combined with Population 2, which now covers all pregnant women with incomes from 133 up to and including 185 percent of the FPL, under the title XIX State plan.)

Populations 15 and **19** are no longer applicable (under prior Demonstration periods, these were for individuals covered under the title XXI State plan as of November 1, 2007), and are no longer subject to this Demonstration.

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project. Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan beginning with the approval of this Demonstration renewal and amendment from through June 30, 2017. As specified below, on January 1, 2014 certain waiver authorities will end. When the State amends its Medicaid or CHIP State plan to include some or all of these populations after that date, the State will submit an amendment to the Demonstration updating the populations that will be affected by the Demonstration.

1. Statewideness/Uniformity **Section 1902(a)(1)**
42 CFR 431.50

To enable the State to provide benefits through contracts with managed care entities that operate only in certain geographical areas of the State. (Applies to all populations listed above except 14,16, 17, 18, 20 and the portion of population 22 with income from above 200 up to and including 300 percent of the FPL .)

2. Amount, Duration and Scope of Services **Section 1902(a)(10)(A)**
1902(a)(10)(B)
42 CFR 440.230-250

To enable the State to modify the Medicaid benefit package and to offer a different benefit package based on condition and treatments than would otherwise be required under the State Plan to mandatory Medicaid populations, and to enable the State to limit the scope of services for optional and expansion populations. (Applies to populations 1 -11, 21 and the direct coverage portion of population 22, with the exception of Population 3 for children 0 up to 1 year of age.)

3. Eligibility Standards **Section 1902(a)(17)**
42 CFR 435.100 and
435.602-435.823

Until January 1, 2014, to enable the State to waive income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming restrictions, and to base eligibility on household family unit (rather than individual income). (Applies to Populations 1, 2, 3, 4, 9, 10, 11, 14, 17, 18 and 22).

4. Eligibility Procedures **Section 1902(a)(10)(A) and**
1902(a)(34)
42 CFR 435.401 and
435.914

Until January 1, 2014, to enable the State to apply streamlined eligibility rules for individuals. The 3-month retroactive coverage will not apply, and income eligibility will be based only on gross income. (Applies to Populations 1, 2, 3, 4, 9, 10, 11, 14, 17, 18 and 22.)

5. Freedom of Choice **Section 1902(a)(23)(A)**
42 CFR 431.51

To enable the State to restrict freedom-of-choice of provider by offering benefits only through managed care entities (and other insurers) in a manner not authorized by section 1932 because beneficiaries may not have a choice of managed care entities. This does not authorize restricting freedom of choice of family planning providers. (Applies to all populations listed above.)

6. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) — **Section 1902(a)(10)(A) and 1902(a)(43)(C)**

To allow the State to restrict coverage of services required to treat a condition identified during an EPSDT screening to the extent that the services are beyond the scope of the benefit package available to the individual. The State must arrange for, and make available, all services within the scope of the benefit package available to the individual that are required for treatment of conditions identified as part of an EPSDT screening. (Applies to all Populations above.)

7. Disproportionate Share Hospital (DSH) Reimbursements — **Section 1902(a)(13)(A)**

To the extent necessary to allow the State to not pay DSH payments when hospital services are furnished to managed care enrollees. (Applies to populations 1-11, 13, 21 and for population 22, applies only to those in OHP direct services)

8. Prepaid Ambulatory Health Plan Enrollment — **Section 1902(a)(4) as implemented in 42 CFR 438.56(c)**

To enable managed care entities to permit enrollees a period of only 30 days after enrollment to disenroll without cause, instead of 90 days. (Applies to all populations 1-11, 21 and the direct service population of 22.)

9. Reasonable Promptness — **Section 1902(a)(8) 42 CFR 435.906, 435.911, 435.914, and 435.930(a)**

Until January 1, 2014, to permit the State to implement a reservation list as a tool to manage enrollment in OHP-Standard and FHIAP. (Applies to Populations 10, 11, 14, 17, and 18.)

10. Premiums — **Section 1902(a)(14) insofar as it incorporates 1916 and 1916(A)**

To enable Oregon to impose premiums and cost sharing in excess of statutory limits on demonstration eligible individuals enrolled in the FHIAP and Healthy Kids ESI programs through December 31, 2013.

Title XXI Waiver Authority

All requirements of the CHIP expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project. Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the CHIP State plan requirements contained in title XXI of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan beginning with the approval of this Demonstration renewal and amendment from through June 30, 2017. The following waivers apply to title XXI Demonstration Populations 16, 20 and 22.

1. Benefit Package Requirements **Section 2103**

To permit the State to offer a benefit package for Demonstration Populations 16, 20 and 22 that does not meet the requirements of section 2103 of the Act, as defined in Federal regulations at 42 CFR 457.410(b), but instead equals the private or ESI plan coverage that the beneficiary has elected.

Title XXI - Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A) of the Act, State expenditures for the provision and administration of child health assistance to the demonstration populations described below (which would not otherwise be included as matchable expenditures under title XXI), shall for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of the title XXI statute will be applicable to such expenditures, except as specified below as not applicable to these expenditure authorities.

a. **Population 16:** Until January 1, 2014, uninsured children ages 0 through 5 with incomes from 133 up to and including 200 percent of the FPL, and uninsured children ages 6 through 18 with incomes from 100 up to and including 200 percent of the FPL (as defined in the STCs) who meet the title XXI definition of a targeted low-income child, and who choose voluntary enrollment in premium assistance under FHIAP.

b. **Population 20:** Until January 1, 2014, uninsured children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL; and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI.

CHIP Requirements Not Applicable to the CHIP Expenditure Authorities:

1. Cost Sharing **Section 2103(e)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to Demonstration Populations 16 and 20 to the extent necessary to enable the State to subject beneficiaries to the cost sharing required under the private or ESI plan coverage that the individual has elected.

Title XIX - Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this Demonstration, be regarded as expenditures under the State's Medicaid title XIX State plan.

1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in an MCO.

2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.

3. Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.

4. Expenditures for costs for certain mandatory and optional Medicaid eligibles who have elected to receive coverage through a private or ESI plan. Such enrollment in a plan that offers a limited array of services or in a private or employer-sponsored plan is voluntary and the family may elect to switch, if eligible, to direct State coverage at any time, and families will be fully informed of the implications of choosing FHIAP rather than direct State coverage. (Applies to population 14.)

5. Until January 1, 2014, Expenditures for health care-related costs for Demonstration Populations 9, 10, 11, 14, 17, and 18.

6. Designated State Health Programs (DSHP). Subject to the conditions outlined in paragraph 54 and as described in Section IX, a limited amount of expenditures for approved designated state health programs (DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. This expenditure authority will not be renewed or extended after June 30, 2017.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan

AWARDEE: Oregon Health Authority

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115 (a) Medicaid Demonstration extension (hereinafter referred to as "Demonstration"). The parties to these STCs are the Oregon Health Authority (formerly Oregon Department of Human Services) (State) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. These amended STCs are effective July 1, 2012, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. The amended STCs are effective July 1, 2012, through June 30, 2017, unless otherwise specified.

The STCs have been arranged into the following areas:

I. Preface
II. Program Description, Objectives, Historical Context;
III. General Program Requirements;
IV. The Oregon Health Plan;
V. Delivery System Transformation;
VI. Capitation Rates and Performance Measures;
VII. Measurement of Quality of Care and Access to Care;
VIII. Calculating the Impact of Health Systems Transformation and Reductions in Designated State Health Program Funding;
IX. Designated State Health Programs;
X. General Reporting Requirements;
XI. General Financial Requirements for Title XIX;
XII. General Financial Requirements for Title XXI;
XIII. Monitoring Budget Neutrality for the Demonstration;
XIV. Evaluation of the Demonstration; and
XV. Additional attachments have been included to provide supplementary information and guidance for specific STCs.
1. Attachment A: Quarterly Report Guidelines
2. Attachment B: Evaluation Guidelines

3. Attachment C: Glossary of Terms
4. Attachment D: Summary Chart of Demonstration Populations
5. Attachment E: Menu Set of Quality Improvement in Focus Areas
6. Attachment F: CCO Services Inventory
7. Attachment G: DSHP Claiming and Documentation Protocols
8. Attachment H: Calculating the Impact of Health Systems Transformation

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

Oregon Health Plan (OHP) is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. OHP began in phases on February 1994. Phase I of the Medicaid Demonstration Project started on February 1, 1994. Originally, the Demonstration affected Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II added the aged, blind, disabled, and children in State custody/foster-care. Following the creation of title XXI of the Act by Congress in 1997, Oregon's Children's Health Insurance Program (CHIP) was incorporated into the OHP. From its inception, Oregon's CHIP provided eligibles with the same benefit package available to all OHP-Medicaid clients.

Objectives

Under the Demonstration, Oregon strives to promote the objectives of title XIX and title XXI by:

- Providing health care coverage for uninsured Oregonians;
- Providing a basic benefit package of effective services;
- Insuring broad participation by health care providers;
- Decreasing cost-shifting and charity care;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Making Medicaid available to people living in poverty regardless of age, disability or family status;
- Structuring benefits (what is covered), using a prioritized list of health care conditions and treatments.
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing the per capita costs of care for populations through such improvements.

Historical Context: Demonstration Extensions and Amendments

<u>1994 Initial Demonstration Approval</u>

CMS initially approved the Oregon Health Plan (OHP) section 1115 Demonstration for a 5-year period beginning February 1, 1994. Oregon sought to expand eligibility and manage costs by using managed care and a Prioritized List of Health Services. This list is updated every 2 (two) years, whereby services are added, deleted, or moved to a different ranking within the list.

1998 Demonstration Extension

The OHP was extended by CMS for a 3 (three) year period through 2001.

2002 Demonstration Extension and Amendment

CMS approved Oregon's application to extend and amend OHP to implement a new Health Insurance Flexibility and Accountability (HIFA) Demonstration for 5 (five) years through 2007. With this approval, Oregon was able to expand the Demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

2005 Demonstration Amendment

CMS approved a Demonstration amendment that changed coverage under the Demonstration which placed a new emphasis on preventive care and chronic disease management in the recognition that the utilization of these services can lead to a reduction in more expensive and often less effective treatments provided in the crises stages of a disease.

2007 Demonstration Extension

CMS revised the structure of the populations within the Demonstrations to reflect updated law and CMS policy. Uninsured adults not eligible for Medicaid or CHIP were removed from the title XXI expansion populations and moved into title XIX expansion populations. In addition, title XXI targeted low-income children (TLIC) in Oregon from ages 0 through 5 years with incomes from 133 percent to 185 percent of the FPL and ages 6 through 18 with incomes from 100 percent up to 185 percent of FPL, were made eligible under the CHIP state plan regardless of whether the child opts for CHIP direct state plan coverage (OHP Plus) or premium assistance (Family Health Insurance Assistance Program/FHIAP). In addition, it was clarified that mandatory pregnant women and children 0 to 1 year of age receive full Medicaid State Plan benefits, subject to necessary pre-authorizations.

2009 Demonstration Extension and Amendment

CMS approved an amendment to the Demonstration that restructured and expanded coverage for children through the "Healthy Kids," initiative. Healthy Kids provides coverage through its various components for otherwise uninsured children through age 18 in the State with family incomes from 0 up to and including 300 percent of FPL. The State also provides access to coverage for children above 300 percent of FPL, but does not receive FFP for this population. Healthy Kids includes four different program components: 1) Existing CHIP direct coverage (OHP Plus), 2) premium assistance through FHIAP, 3) Child-only premium assistance administered by the Office of Private Health Partnerships (Healthy Kids ESI), and 4) A private insurance component (Healthy KidsConnect). Through Healthy Kids, children from 0 up to and including 200 percent of the FPL have the choice between title XXI CHIP direct coverage, premium assistance through FHIAP, or Healthy Kids ESI. Children from above 200 up to and

including 300 percent of the FPL have the choice between Healthy Kids ESI or coverage under Healthy KidsConnect.

In addition, the last CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed the methodology for use of a 'reservation list" to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance program; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

2012 Demonstration Amendment

As reflected in these STCs, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and a reduction of other benefits (reflected in 13 lines of the Prioritized List of Health Services for FFY12-13). This amendment is effective January 1, 2012.

2012 Demonstration Extension and Amendment

In July 2012, CMS approved an amendment and extension related to Oregon's Health System Transformation

The amendment and extension of OHP seeks to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve a three-part aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The design and implementation of the Oregon demonstration will be driven locally; overall, the amended 1115 demonstration seeks to achieve two equally important and inter-related goals:

- **Goal 1: Medicaid Statewide Spending Growth Reduction.** The demonstration will bend the Medicaid cost curve to achieve a 2 percentage point reduction in Medicaid per capita trend by year 13 of the demonstration. Progress toward and ultimate achievement of this goal will be measured by reviewing the State and Federal cost of purchasing care for individuals enrolled in Coordinated Care Organizations (CCOs).

- **Goal 2: Improving Statewide Care Quality and Access.** Oregon Medicaid beneficiaries will experience improved access to care and quality of care over the five-year program period of July 2012 – June 2017, compared to a baseline level of performance.

The Demonstration authorizes expenditures on certain Designated State Health Programs (DSHP), and in order to align incentives and support progress, if Demonstration goals are not realized after interventions have been pursued to reorient progress, CMS will reduce DSHP funding as described in Section VIII.

Oregon seeks to achieve these goals without any diminution of eligibility or benefits. Instead, the State will pursue several different approaches, or "levers" to drive savings and quality improvement:

- Lever 1: Improved care management experienced by beneficiaries in CCOs
- Lever 2: Administrative efficiencies in CCOs
- Lever 3: Integration of physical and behavioral health for beneficiaries in CCOs
- Lever 4: Improved care coordination experienced by beneficiaries aligned with patient-centered primary care homes (PCPCH)
- Lever 5: Use of flexible services

Oregon plans to realize these goals through better care management, increased provider and community accountability, payment reform, administrative efficiencies, use of flexible services, promoting the provision of services by nontraditional health workers, and expanding access through improvements to the State's health care workforce.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The State must, within the timeframes specified in Federal law, regulation, or policy, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

b. If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the date such State legislation becomes effective, or the date such legislation was required to be in effect under Federal law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, reservation list, sources of non-Federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in the these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Consistent with Oregon's community-focused health systems transformation approach, the State shall undertake a robust public process to ensure community engagement in the development and submission of amendments to the Demonstration. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15, prior to submission of the requested amendment;

   b. A data analysis which identifies the specific impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**

a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the Demonstration. The chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

b. Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the Demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:

i. Historical Narrative Summary of the Demonstration Project: The State must provide a narrative summary of the Demonstration project, reiterate the objectives set forth at the time the Demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the Demonstration.

v. Financial Data: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the Demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the Demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Evaluation Report: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR section 431.408: The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

   a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in

accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

e. Post Award Forum: Within six months of the Demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the Demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the Demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraphs 63 and 64 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph 65.

10. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the

project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Submission of State plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA)**
Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for many Demonstration Expansion populations will end. To the extent that the State seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP State plan, the State will, by April 1, 2013, submit proposed State plan amendments for any such populations. Concurrently, the State will submit proposed amendments to the Demonstration to the extent that such populations will be subject to the Demonstration. In addition, the State will submit by April 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

    a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

        i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b. Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements,

c. Transition Plan Implementation:

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State.

In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the

consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

17. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the State for premiums paid by beneficiaries shall not be used as a source of State match for FFP.

IV. THE OREGON HEALTH PLAN

18. **Overview of the Oregon Health Plan (OHP).** OHP provides health care coverage to low-income Oregonians through programs administered by the Division of Medical Assistance Programs (DMAP). Four separate benefit packages are offered by OHP: OHP Standard benefits, OHP Plus benefits, FHIAP premium assistance, and HealthyKids ESI premium assistance. Beneficiaries enrolled in OHP also may receive services identified in subparagraph (e.viii) below, which are not included in the OHP or affected by this Demonstration. During the demonstration period, the State may not reduce eligibility or covered benefits.

    a. **ACA Implementation.** As set forth in paragraph 13 and upon implementation of the ACA on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII); benefits; and cost sharing will revert to the Medicaid State plan and comply with Medicaid regulatory and subregulatory guidance. Benefits under the Oregon Health Plan Demonstration will include the provision of Essential Health Benefits identified in the Medicaid/CHIP State plan.

    b. **Eligible Populations.** Within OHP, the State will provide health care coverage to Oregonians who have applied for and who have been determined eligible for the OHP programs defined within these special terms and conditions (STCs). This includes Medicaid mandatory and optional groups under the Oregon State plans, as well as Demonstration expansion groups as defined in the "**Summary Chart of Demonstration Populations"** (Attachment D). Over the course of this demonstration, the State will not make substantive or administrative changes to the Demonstration that would result in a

reduction in Demonstration eligibility for any of the Medicaid or CHIP state plan populations or expansion populations. CMS will provide guidance to the State regarding permissible changes to implement the Affordable Care Act Medicaid coverage expansion in 2014.

c. **Applicability of Medicaid and CHIP Laws and Regulations.** All requirements expressed in Medicaid and CHIP laws, regulations and policies apply to all the populations affected by this Demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration

d. **Screening for Medicaid, CHIP and other Health Insurance Products for Children**. Children (population 16 and 20 in Attachment D) seeking or obtaining coverage through OHP will be screened for Medicaid and CHIP eligibility at initial application at least every 12 months, and prior to enrollment in FHIAP or Healthy Kids ESI . Applicants will be offered an informed choice of voluntary enrollment in direct coverage under the Medicaid or CHIP HealthyKids program depending on the program for which they may be eligible. Should a child opt to enroll in premium assistance under FHIAP, or Healthy Kids ESI, and subsequently disenroll from any of these programs, eligible children will be notified of their potential eligibility in Medicaid or CHIP.

e. **Summary of OHP Benefit Structure.** The Oregon Health Plan Demonstration has four components, two offered directly through public sector programs (OHP Plus and OHP Standard) and two through a combination of public and private sector funds (premium assistance under FHIAP, or Healthy Kids ESI, both of which will be ending on December 31, 2013). Most beneficiaries under the public sector programs receive services through managed/coordinated care delivery systems.

   i. Mandatory Medicaid State Plan eligibles receive the OHP Plus benefit (populations 1, 3, 4, 5, 6, 7 and 21 in Attachment D) unless they are children who have elected direct Medicaid coverage outside of OHP, administered by Oregon Health Authority (OHA) (formerly Oregon Department of Human Services (DHS)). In addition, certain Optional and Demonstration Medicaid populations, including pregnant women up to 185 percent of the FPL, receive coverage under OHP Plus (populations 8, 2 and 9 in Attachment D).

   ii. Adults who are not eligible under the State plan are enrolled in OHP Standard (populations 10 and 11 in Attachment D) except if the condition in iii is met.

   iii. Until December 31, 2013, enrollment in FHIAP is required for adults eligible for OHP Standard (populations 10 and 11 in Attachment D) if ESI is available.

iv. All mandatory and optional Medicaid State Plan eligible children younger than 21 years old are entitled to elect to receive direct Medicaid coverage outside of OHP including all State Plan and EPSDT covered services (populations 3, 4, 5, 6 7, and 8 in Attachment D).

v. Through December 31, 2013, FHIAP is Oregon's primary premium assistance program. Through FHIAP, eligible uninsured Oregonians (adults and children in populations 12, 14, 16, 17 and 18, as set forth in Attachment D) can elect to receive premium subsidies for the purchase of private health insurance instead of direct coverage. This option applies to enrollment in both individual and employer-sponsored insurance. Both adults and children applying for FHIAP benefits are subject to the FHIAP reservation list.

vi. Children enrolled in CHIP in families with income from zero up to and including 200 percent of the FPL (Population 16 in Attachment D) can instead receive premium assistance through Healthy Kids ESI if employer-sponsored insurance is available and voluntarily chosen by the family. These children apply for coverage through OHA and are not subject to the FHIAP reservation list.

vii. Children in families with income above 200 up to and including 300 percent of the FPL can receive premium assistance through Healthy Kids ESI if employer-sponsored insurance is available and chosen by the family (population 20 in Attachment D) and coverage under Healthy KidsConnect.

viii. The following Medicaid services and expenditures are not affected by the OHP Demonstration, and are available as otherwise provided under the State plan:

1. Mental Health Facility – DSH Adjustment Payments;
2. Long Term Care Services;

    a. Nursing Facility Services
    b. Home- and Community-Based Services
    c. Community Supported Living Services
    d. Programs of All-Inclusive Care Elderly

3. ICF/MR Services;
4. Medicare Premium Payments;

f. **Prioritized List of Health Services.** One of the distinguishing features of the OHP Demonstration is that OHP benefits are based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services.

i. **Oversight**

1. **The Health Evidence Review Commission (HERC) -** The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Office for Oregon Health Policy and Research. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse. The Health Evidence Review Commission performs a biennial review of the Prioritized List and will amend the List as required.

ii. **Modifications to the Prioritized List**. Modifications to the Prioritized List require Federal approval through submission of an amendment, as described in paragraph 7 in order to ensure the Prioritized List is comprehensive enough to provide Medicaid beneficiaries with an appropriate benefit package. A current version of the prioritized list of health services is maintained by the State of Oregon at the following website: http://www.oregon.gov/OHA/OHPR/HERC/Current-Prioritized-List.shtml. During the demonstration period and as specified below the State will not reduce benefits.

iii. **Ordering of the Prioritized List. Th**e Prioritized List is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g. common colds); (b) are primarily cosmetic in nature (e.g. benign skin lesions); or (c) have no effective treatments available (e.g. metastatic cancers).

iv. **Updating the Prioritized List**. The Commission is charged with updating the list for every biennial legislative session. The Oregon State Legislature determines how much of the list to cover (subject to Federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.

v. **Non-covered Condition and Treatment Pairs**. In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

The State must adopt policies that will ensure that before denying coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the prioritized list of health services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, providers will be instructed to provide the specified treatment. The State shall provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

g. **Funding Line for the "2012-2013" Prioritized List of Health Services.**

   i. Beginning January 1, 2012, the 2012-2013 Prioritized List of Health Services contains 692 lines. Lines 1-498 are funded to provide the OHP Plus and Standard benefit packages.

   ii. The 2012-2013 Prioritized List will stay in effect until September 30, 2014 to allow time for a transition from the ICD-9 code system to the new, more extensive ICD-10 codes, which is currently underway.

   iii. Beginning October 1, 2014, the 2014-2015 Prioritized List of Health Services will go into effect and will change the line number, structure and composition as a result of the biennial review and the conversion to ICD-10-CM. The State will maintain the funding line at the same position relative to the 2012-2013 List (currently between Chronic Sinusitis and Keratoconjunctivitis and Corneal Neovascularization) on the 2014-2015 List and for the remainder of the Demonstration.

h. **Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

   i. The state will maintain the cutoff point for coverage at the same position on the List relative to the 2012-2013 List for the remainder of the Demonstration as noted above in subparagraph (g). For a legislatively directed line change to increase benefit coverage or a legislatively approved biennial list with substantive updating of benefits due to new evidence, an amendment request (in compliance with paragraph 7) will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in Section XIII.

ii. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.

iii. For a change to the list not defined above that meets the terms of paragraph 6, an amendment request.

i. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The EPSDT benefit under OHP Standard and OHP Plus is limited by the coverage under the applicable benefit package, but all other requirements of EPSDT, including the provision or arrangement of all covered services to treat a condition identified during an EPSDT screening that is within the scope of the benefit package available to the individual.

j. **Non Traditional Health Workers (NTHW).** NTHWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and doulas. NTHWs may serve individuals currently enrolled in Managed Care Entities (MCEs), and/or through the State's FFS delivery system.

k. **Patient Centered Primary Care Homes (PCPCH):** The State includes PCPCH services in the OHP Standard and Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement and obtaining agreement to participate. The State will work with CCOs to provide the enrollee with notice that s/he has been enrolled in a PCPCH. In addition this notice will provide the participant with information informing them of their right to opt out.

19. **Oregon Health Plan Standard (OHP Standard)**

a. **Eligibility and Enrollment.** Until January 1, 2014, the OHP Standard benefit package is provided to uninsured parents and childless adults ages 19 and older (Populations 10 and 11, in Attachment D respectively). These individuals are only eligible for benefits by virtue of Oregon's Section 1115 Medicaid Demonstration.

i. **Screening and Enrollment.** Parents and childless adults who are found eligible for OHP Standard (populations 10 and 11) and have employer-sponsored insurance available are *required* to pursue eligibility under FHIAP.

1. If a parent or childless adult is found eligible for FHIAP, OHP Standard eligibility ends. (The parent or childless adult would then be eligible as defined in Populations 17 and 18, in Attachment D respectively.)

2. If a parent or childless adult is found ineligible for FHIAP, the uninsured parent or childless adult will be enrolled in OHP-Standard as long as enrollment slots are available.

ii. **Reservation List**. Until January 1, 2014, the State may employ a reservation list as a method of adding clients to the OHP Standard program. (Applies to populations 10 and 11 in Attachment D)

1. Applications for OHP Standard will be provided to potential clients based on the projected budget limitations of the OHP Standard program.

2. The State may impose an enrollment cap upon the OHP Standard program in order to remain under the budget neutrality limit or to address projected budgetary limitations of the OHP Standard program. The State will be required to provide written notice to CMS at least 60 days prior to changing the budget-driven ceiling.

3. The State will be required to provide written notice to CMS at least 60 days prior to instituting any enrollment cap/ceiling or re-establishing program enrollment. The notice to CMS, at a minimum, must include:

i. Data on current enrollment levels in the program;
ii. An analysis of the current budget neutrality agreement; and
iii. The projected timeframe for the enrollment cap to be in effect or the period for enrollment into OHP Standard.

iii. **Managing enrollment and revising the Reservation List**.

1. For the OHP Standard population described in paragraph 19(a), the State may employ additional caseload management strategies to include: lowering the FPL used to determine eligibility; and/or suspending eligibility and/or intake into the program; or discontinuing coverage. No later than 60 days prior to the date of implementation, the State shall submit its plan to CMS. CMS shall complete a review of the plan for implementation and notify the State of a decision within 60 days of receiving the State's plan.

2. Beginning with the December 1, 2009 approval of this amendment to the Demonstration, the State will begin to use a new reservation list.

3. The State will perform targeted outreach to those individuals on the existing (2008) reservation list to afford those individuals the opportunity to sign up

for the new reservation list if they are still seeking coverage. Outreach materials will remind individuals they can apply for OHP Plus programs at any time.

4. Periodically, the State will send notices to those individuals on the reservation list, at a minimum of every 12 months asking if they want to remain on the reservation list. If so, these individuals will be given a chance to update their contact information. These notices will remind individuals that they can apply for OHP Plus programs at any time. These notices should be a vehicle for ensuring the OHP Standard reservation list is populated with individuals who are still seeking coverage. Based on the State's budgetary constraints, OHA will periodically select individuals from the reservation list, using a randomized sampling methodology. The State will:

    i. Send applications to selected individuals.
    ii. Determine eligibility for the selected individuals who submit applications.

iv. **Eligibility Redeterminations.** Parents and childless adults ages 19 and older (Populations 10 and 11, in Attachment D respectively) enrolled in the OHP Standard program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for any open OHP program. An enrollee may apply for any open OHP program at any time for any reason. The State will determine eligibility and enroll individuals in programs for which they are found eligible.

b. **Disenrollment.** Enrollees in OHP Standard may be disenrolled if they:

i. Are approved for and seeking enrollment in FHIAP or become eligible for OHP Plus;
ii. Exceed income limits allowed for the program at redetermination;
iii. Exceed resource limits allowed for the program at redetermination;
iv. Voluntarily withdraw from the program;
v. No longer reside in the State of Oregon;
vi. Become incarcerated or are institutionalized in an IMD;
vii. Obtain health insurance;
viii. Become eligible for Medicare; or
ix. Are no longer living.

c. **The OHP Standard Benefit Package** consists of a core set of fixed services and other add-on services. The complete set of covered services is overlaid by the Prioritized List of Health Care Services. The OHP Standard benefit package consists of the following core set of fixed services: physician services; ambulance; prescription drugs; laboratory and x-ray services; medical supplies; outpatient chemical dependency services; and emergency dental services. In addition to this fixed set of core services, OHP Standard

also includes a full inpatient hospital benefit and a hospice benefit as add-on services. This benefit package will be offered through December 31, 2013.

d. **Changes to the OHP Benefit Package.** Any increase in the OHP Standard benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in section XIII. Any increases to the approved OHP Standard core set of services shall not include abortion or Death with Dignity services.

COVERED SERVICES	OHP STANDARD
Acupuncture	Limited
Chemical Dependency Services	✓
Dental	Limited
Emergency/urgent hospital services	✓
Hearing aids an**d hearing aid exams**	**n/a**
Home Health	n/a
Hospice Care	✓
Hospital Care	✓
Immun**izations**	✓
Labor and Delivery	✓
Laboratory and X-ray	✓
Medical Equipment and Supplies	Limited
Medical Transportation	Limited
Mental Health Services	✓
Physical, Occupational, & Speech Therapies	n/a
Physician Services	✓
Prescription Drugs	✓
Private Duty Nursing	n/a
Vision	Limited

e. **Cost Sharing under OHP Standard through December 31, 2013:**

i. OHP Standard co-payments were discontinued on June 19, 2004.
ii. However, some OHP Standard clients pay premiums.
iii. For those who are required to pay premiums, the premium charge is between $9-20 a month.
iv. The State is permitted to require clients to be current on their premium payments to reapply for another 12-month eligibility period.
v. OHP Standard clients with household income 10 percent or less of the Federal poverty level at the time of enrollment do not pay premiums.
vi. Any increase in premiums or cost-sharing must be submitted to CMS for notification purposes and approval as a Demonstration amendment as per paragraph 7.

20. **Oregon Health Plan Plus (OHP Plus) through December 31, 2013**

a. **Eligibility -** Through December 31, 2013, the Medicaid State plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8, 9 and 21 in Attachment D) who have not elected benefits through FHIAP are served in the component known as OHP Plus.

b. **Eligibility Redeterminations.** Medicaid State plan, mandatory, optional and expansion groups (populations 1, 2, 3, 4, 5, 6, 7, 8, 9 and 21 in Attachment D) enrolled in the OHP Plus program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for any OHP program. Any enrollee may apply for any OHP program at any time for any reason. The State will determine eligibility and enroll individuals in programs for which they are found eligible. An enrollee found at redetermination to be ineligible on the basis of income for OHP Plus but eligible for OHP Standard will be transferred to OHP standard with no interruption in coverage.

c. **Benefits.** The OHP Plus benefit package is the Prioritized List of Heath Care Services through the line on the list funded by the Oregon State Legislature as of January 1, 2012.

   i. The benefits table in paragraph 0(d) provides a high-level summary of the services funded and covered on the prioritized list.

   ii. OHP Plus is the Medicaid State Plan Services Benefit Package for Mandatory pregnant women and children 0 up to 1 year of age (populations 1 and 3, in Attachment D respectively), subject to necessary pre-authorization.

d. **Benefits Table for OHP Plus.**

COVERED SERVICES	OHP PLUS[1]
Acupuncture	✓
Chemical Dependency Services	✓
Dental	Limited**
Emergency/urgent hospital services	✓
Hearing aids and hearing aid exams	✓
Home Health	✓
Hospice Care	✓
Hospital Care	✓
Immunizations	✓
Labor and Delivery	✓
Laboratory and X-ray	✓

[1] No benefit limitations apply to children under the age of 19 with Medicaid or CHIP direct coverage.

Medical Equipment and Supplies	✓
Medical Transportation	✓
Mental Health Services	✓
Physical, Occupational, & Speech Therapies	✓
Physician Services	✓
Prescription Drugs	✓ *
Private Duty Nursing	✓
Vision	Limited***

* For individuals with Medicare Part D, the OHP Plus benefit package does not cover drugs covered by Medicare Part D.
** Limited Dental coverage as described in the State Plan
***Limited Vision coverage as described in the State Plan

e. **Cost Sharing under OHP Plus**

i. For OHP Plus, individuals may be liable for nominal copayments. No copayment liability will be imposed on pregnant women or children under the age of 19.
ii. The approved copayments are included in the Title XIX State Plan.
iii. Oregon uses the State Plan Amendment process to make changes to its OHP Plus copayment policies.
iv. There are no premiums for OHP Plus enrollees.

f. **Disenrollment from OHP Plus.** Enrollees in OHP Plus may be disenrolled if they:

i. Are approved for and seeking enrollment in FHIAP;
ii. Exceed income limits allowed for the program at redetermination;
iii. Exceed resource limits allowed for the program at redetermination;
iv. Voluntarily withdraw from the program;
v. No longer reside in the State of Oregon;
vi. Become incarcerated or are institutionalized in an IMD;
vii. Are no longer pregnant;
viii. No longer have a qualifying disability; or
ix. Are no longer living.

21. **Breast and Cervical Cancer Treatment Program (BCCTP)**

a. The Breast and Cervical Cancer Treatment Program (BCCTP), formerly known as BCCM, provides medical assistance to women under the age of 65 who have been screened and diagnosed through the Breast and Cervical Cancer Treatment Program (BCCTP) and found to need treatment for breast or cervical cancer, or specific precancerous conditions, and are receiving such treatment. Such individuals are uninsured or underinsured with respect to necessary treatment.

b. Women determined to be eligible for BCCTP (Population 21 in Attachment D) will be enrolled on the Oregon Health Plan for the duration of their treatment.

c. BCCTP Presumptive Eligibility

   i. Any licensed health care provider qualified to diagnose cancer or pre-cancerous conditions can determine presumptive eligibility under the BCCTP
   ii. Presumptive eligibility provides immediate, temporary coverage for women who appear to meet basic eligibility criteria.
   iii. Presumptive coverage lasts approximately a month before full determination of coverage through OHP.

d. Eligible individuals remain eligible for a period of 12 months. At the end of the 12 months:

   i. A redetermination application is sent to the client;
   ii. The client's provider verifies if patient still requires treatment and submits verification to OHP;
   iii. If the client still needs treatment, coverage is extended for additional year;
   iv. Not have creditable health insurance to cover her treatment; and
   v. Be in need of treatment for breast or cervical cancer, including qualifying precancerous conditions.

22. **Premium Assistance.** As of January 1, 2014, individuals who are currently enrolled in premium assistance under FHIAP or Healthy Kids ESI (Demonstration Populations 14, 16, 17, 18 and 20), and remain eligible for the Medicaid or CHIP state plan will be seamlessly enrolled in coverage through Medicaid or CHIP and will be enrolled in a CCO. Individuals currently receiving premium assistance who do not appear to be eligible under the approved Medicaid or CHIP State plans based on an initial assessment will be afforded a full eligibility determination prior to termination. Individuals denied Medicaid or CHIP eligibility will have their information electronically transmitted to the State Affordable Insurance Exchange (or other insurance affordability program as appropriate) to be treated as an application for eligibility and benefits through the Exchange.

a. **Overview of Premium Assistance Options**

   i. **Family Health Insurance Assistance Program (FHIAP)** (Populations 12, 14, 16, 17, and 18 in Attachment D). The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA), administers FHIAP. This premium

assistance program provides subsidies to help families and individuals with income from 0 up to and including 200 percent of the FPL, including children and adults, pay for health insurance offered either through employer-sponsored insurance (ESI), or private health insurance carriers that provide coverage in the individual market. Children eligible for FHIAP have the choice between FHIAP and direct State Plan coverage.

ii. **Healthy Kids Employer Sponsored Insurance (ESI)** (populations 16 and 20 in attachment D). Healthy Kids ESI provides child only premium assistance for available employer sponsored insurance (ESI) for families with children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL; and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI.

iii. **Oregon Medical Insurance Pool (OMIP)** Oregon operates a high-risk medical insurance pool for individuals denied coverage for pre-existing medical conditions. Effective with the implementation of the ACA, and with the implementation of the Oregon Health Insurance Exchange (ORHIX), individuals eligible for OMIP will be transitioned to coverage under the ORHIX. Some individuals enrolled in OMIP are eligible for Medicaid or CHIP, and will be transitioned to coverage under those programs.

b. **Eligibility**

i. **FHIAP through December 31, 2013.** Premium assistance for children, adults and families from zero through 200 percent of the FPL who choose voluntary enrollment in FHIAP (populations 12, 14, 16, 17, and 18 in Attachment D). Premium assistance can be used for employer-sponsored insurance (ESI) or individual health insurance. Eligible participants include: 1) Families (including parents), 2) childless adults, and 3) children (populations 14 and 16 in Attachment D) in families with parents who apply for premium assistance directly through the FHIAP reservation list.

ii. **Healthy Kids ESI.** Healthy Kids ESI provides child only premium assistance for families with children ages 0 through 5 with income from 133 up to and including 200 percent of the FPL; children from 6 through 18 with income from 100 up to and including 200 percent of the FPL and children zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child and who voluntarily enroll in ESI. (Populations 16 and 20 in Attachment D). These children apply for coverage through DHS or OHA and voluntarily choose to receive subsidies for ESI. Children with income above 200 up to and including 300 percent of the FPL also have the option of electing coverage under the CHIP State plan through Healthy KidsConnect (population 22 in Attachment D).

c. **Enrollment for Children:**

i. **FHIAP.**

1. **Enrollment through FHIAP Reservation List Process.** Children from zero up to and including 200 percent FPL may elect to receive premium assistance for individual health insurance or ESI (populations 14 and 16 in Attachment D). These children can apply for subsidies through the FHIAP reservation list process. OPHP determines eligibility, enrolls them and pays subsidies. Children receive a 100 percent subsidy.

ii. **Healthy Kids.** Alternatively, children with family incomes from 0-200 percent of the FPL may receive direct coverage under the CHIP State plan by applying for Healthy Kids through OHA and DHS. At the time they request a FHIAP application and are put on the reservation list, families are provided with information about direct coverage through Healthy Kids, including the differences between Healthy Kids direct coverage and FHIAP benefits, cost-sharing and other provisions. They are also provided a Healthy Kids application and are encouraged to apply for immediate coverage rather than wait on the FHIAP reservation list. These children can switch between direct coverage and FHIAP at any time.

1. **Healthy Kids ESI.** Children who have been found eligible for Healthy Kids direct coverage may choose premium assistance under Healthy Kids ESI instead. These children must be informed about the difference in benefits, cost sharing and other provisions between direct coverage and Healthy Kids ESI and be provided with the choice to enroll in Healthy Kids direct coverage at any time. Subsidies are paid at 100 percent for children through age 18. If a child is determined eligible and the family chooses ESI, DHS or OHA refers the child to OPHP for enrollment and subsidy payment.

iii. **Healthy Kids Connect.** Children with family incomes above 200 and up to 300 percent of the FPL apply for coverage through OHA or DHS for eligibility for direct coverage under the CHIP State plan. The child may elect such coverage, or may elect Healthy Kids ESI premium assistance, if employer sponsored insurance is available, on a sliding scale based on family income. These children must also be informed of the differences in benefits, cost sharing and other provisions between Healthy Kids ESI and coverage under the CHIP State plan through Healthy KidsConnect. These children can switch between these two options at any time.

d. **Cost Effectiveness for Children and Adults**

i. **FHIAP and Healthy Kids ESI**. Oregon compares the aggregate per member per month subsidy costs for Demonstration Populations 12, 14, 16, 17 and 18 in Attachment D in FHIAP and Population 20 in Attachment D in Healthy Kids ESI

relative to OHA direct coverage costs for Demonstration Populations 1 through 11.

e. **Enrollment for Adults**

i. **FHIAP.** Parents and childless adults from zero up to and including 200 percent FPL (populations 14, 17 and 18 in Attachment D) apply for premium assistance through FHIAP by first getting on a FHIAP reservation list. As program openings occur, applications are mailed to families on the list, with priority for OMIP applicants, and then on a first come first served basis. Subsidies can be used for ESI or individual health insurance. Adult subsidies are paid on a sliding scale based on income.

f. **Enrollee Education and Notification**

i. **Adults.** Parents and childless adults eligible for OHP Plus benefits (population 14 in Attachment D) must be periodically notified that they may choose direct coverage under the State plan at any time. The State will provide information prior to enrollment in FHIAP explaining the differences in benefits, cost sharing and other provisions between State plan direct coverage and private insurance options.

ii. **Children.** Families with children from zero up to and including 200 percent FPL (populations 14 and 16 in Attachment D) applying for FHIAP will receive written information explaining the differences in benefits, cost sharing and other provisions between direct state plan coverage and private insurance options. Children will also be screened for Medicaid and CHIP eligibility prior to actual enrollment in FHIAP and enrolled in the appropriate program if the family selects Medicaid or CHIP state plan direct coverage. Children in families with income from above 200 up to and including 300 percent of the FPL are eligible for Healthy Kids ESI and under the CHIP State plan. These families can also contact choice counselors who can help explain their insurance options.

iii. **Application Assistance.** Subject to available funding, the State will provide community-based assistance to potential applicants for Healthy Kids programs, including Healthy Kids ESI and Healthy KidsConnect, in completing and submitting their application in a timely manner.

iv. **Children and Immunization.** In the case of children, families are to be informed that all age-appropriate immunizations (in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), well-baby, well-child services and emergency services for Title XXI eligible children will be covered, regardless of whether the health insurance coverage includes such coverage. The State shall provide information as to

where children may receive immunizations without charge and well-baby and well-child services and emergency services in the event these services are not covered in the employer-sponsored plan or private health plan in which they are enrolled.

v. **Provider Reimbursement for Immunizations.** In the case of Title XXI eligible participants, the State must have a mechanism in place to reimburse providers for the cost of immunizations, well-baby and well-child services and emergency services so that families will not be held responsible for the costs associated with these services.

vi. **Period of Uninsurance.** As used in the tables below, the term "uninsured" means an individual who is not covered by creditable private health insurance as defined in 45 CFR 146.113 for a specified period. OHP coverage is not considered insurance in determining FHIAP eligibility. In addition, individuals with FHIAP coverage or those on the FHIAP reservation list who have met the required period of uninsurance but have since obtained coverage are exempt from the uninsurance period in determining OHP Standard or CHIP eligibility. The following are FHIAP exceptions to the period of uninsurance. The member:

1. Is currently enrolled in the OHP;
2. Was enrolled in the OHP within the last 120 days;
3. Is a former FHIAP member;
4. Has enrolled in a creditable health insurance plan while on the reservation list.
    a. Must have met the two-month period of uninsurance immediately prior to enrolling in the creditable health insurance plan;
5. Has coverage through the Kaiser Child Health Program or any benefit plan authorized by ORS 735.700 - 735.714;
6. Has a military health insurance plan;
7. Has enrolled in group coverage within the 120 days prior to getting on the FHIAP reservation list;

a. Must have been without any creditable health insurance coverage for two consecutive months immediately prior to becoming insured under the group plan.

8. Has recently become unemployed and lost health insurance coverage as a result;

9. Has lost health insurance coverage while still employed (e.g. reduction in hours, employer stops providing coverage, etc); or

10. Is an OMIP member or an applicant to OMIP.

vii. The State must establish and maintain procedures that will:

1. Ensure that children who enroll in premium assistance are enrolled in creditable coverage;

2. Ensure the consent of the responsible adult family member to receiving premium assistance under FHIAP instead of coverage through Medicaid or CHIP;

3. Allow Medicaid or CHIP eligible participants to opt out of FHIAP and receive direct coverage at any time, with the exception of Medicaid eligible participants who would otherwise qualify for OHP Standard. OHP Standard direct coverage is governed by the reservation list. In addition, OHP Standard eligible participants with ESI would not be able to opt out of FHIAP and into direct coverage;

4. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in individual or ESI coverage with premium assistance (if appropriate) and the individual's/family's share of the premium is being paid;

5. Require eligible participants to immediately notify the State if they change or terminate their individual or ESI coverage under premium assistance (if appropriate);

6. Ensure that the total amount of premium subsidies provided to an individual or family does not exceed the amount of the individual or family's financial obligation toward their coverage (if appropriate);

7. Provide for recovery of payments made for months in which the individual or family did not receive individual or ESI coverage with premium assistance; and

8. Provide for a redetermination of eligibility at least once every 12 months.

g. **FHIAP and Healthy Kids ESI Benefits.** FHIAP and Healthy Kids ESI participants (including children and adults in populations 12, 14, 16, 17, 18 and 20 in Attachment D), as described in these STCs, receive the benchmark plan as defined below for FHIAP. The plan is approved at a level actuarially equivalent to mandated Medicaid services.

i. **Changes to the FHIAP and Healthy Kids ESI Benchmark.** Any reduction to the benchmark below the approved level will be submitted to CMS for review and approval as per paragraph 7. Any increase to the benchmark above the approved level will not require approval, but will be subject to the requirements of budget neutrality, as described in these STCs.

1. **Administration of changes to the FHIAP and Healthy Kids ESI benchmark** are through the Office of Private Health Partnerships (OPHP), which is within the Oregon Health Authority (OHA). OPHP may annually survey Oregon's small group health insurance market to determine the most common benefits and cost-sharing levels, and may adjust the benchmark accordingly. The FHIAP and Healthy Kids ESI benefit benchmark must be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

2. As directed by HB 2519 (2001 Oregon Laws), the benchmark reflects the benefits commonly offered in Oregon's small group health insurance market.

h. **Benchmark for FHIAP and Healthy Kids ESI.** The benchmark is based on the actuarial value of the member's out-of-pocket expense for the core benefit design (as listed in the benchmark chart.) The values in the chart reflect the actuarial equivalent of mandated Medicaid benefits. Actual benefit designs can vary slightly, but must meet the actuarial equivalency test and have all the required services to be eligible for Federal funding.

FHIAP General Provisions	
Lifetime Maximum	$1,000,000
Medical Cost Sharing	
Annual Deductible	$750 per individual
Member Coinsurance Level	20 percent
Stop Loss Level	$10,000 per individual

Out-of-pocket Maximum (Includes Deductible)	$4,000 per individual
Required Serves Prescription Medication Cost Sharing	
Member Coinsurance level	50 percent
Out of Pocket Maximum	No out-of-pocket maximum
Other Required Services	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks	Covered Benefit
Dental*	Covered Benefit
Women's Health Care Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Room	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency/Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

* The State must wrap-around dental coverage (as specified in 2103(c)(5) of the Act) for children in employer sponsored insurance plans that do not offer dental coverage in either FHIAP or Healthy Kids ESI.

i. **Premium Assistance Levels**

i. **Premium Assistance Levels.** FHIAP and Healthy Kids ESI premium assistance levels are based on a family's average monthly gross income and are a percentage of premium cost after any applicable employer contribution.

Percentage of FPL	Subsidy Level

Parents and Childless Adults	
0 percent up to 125 percent FPL	95 percent subsidy
125 percent up to 150 percent FPL	90 percent subsidy
150 percent up to 170 percent FPL	70 percent subsidy
170 percent up to and including 200 percent FPL	50 percent subsidy
Children	
0 percent up to and including 200 percent FPL (Medicaid and CHIP Children in populations 12, 14 and 16))	100 percent subsidy
Above 200 percent up to and including 250 percent FPL (populations 20)	Approximately 90 percent subsidy
Above 250 percent up to and including 300 percent FPL (populations 20)	Approximately 80 percent subsidy

j. **Enrollee Contribution Verification.** People enrolled in an employer sponsored insurance plan are reimbursed for the premium withheld from their paychecks (minus the enrollee's share of the premium), provided the enrollee submits verification, at least quarterly, that the premium is being withheld. Copies of paycheck stubs or other employer-generated documentation serve as verification.

k. **Enrollees in the Individual Market**. People in the individual market are billed by FHIAP each month for their portion of the premium. FHIAP combines the member's portion with the premium assistance amount and pays the insurance carrier. Individuals who fail to pay their premium will be disenrolled. Members are billed one month in advance of the date premiums are due to the carrier so that FHIAP can pay carriers in a timely manner. FHIAP does not pay carriers until the member's portion is received. Members are provided a premium grace period of at least 30 days from the billing date. Reminder notices are mailed mid-way through this grace period. Premium assistance cancellation notices outlining the program's intent to terminate, are mailed at the end of the grace period. These notices also provide information on the members' right to appeal termination. Individuals are given no less than an additional seven days to remit premium. Terminated individuals are able to re-enroll in the program after being disenrolled for failure to pay premiums. In order to do so, however, they must get back on the FHIAP reservation list. They are placed at the bottom of the list using the request date. If the children of families from zero up to and including 200 percent of the FPL do not pay their premiums, these children can either enroll in Medicaid or CHIP direct coverage or get back on the FHIAP reservation list.

l. **FHIAP and Healthy Kids ESI Contribution Level.** Generally, the employer pays a portion of the premium for FHIAP and Healthy Kids ESI coverage, although there is no State specified minimum employer contribution level.

m. **FHIAP and Healthy Kids ESI Cost Sharing Excluding Premiums.** Cost-sharing requirements or levels for FHIAP and Healthy Kids ESI members are determined by private-sector insurance carriers or employers, not by the Medicaid or CHIP program.

n. **FHIAP Reservation Lists.** The State may employ two reservation lists as a method of continuously adding clients to the FHIAP program (populations 12, 14, 16, 17, and 18 in Attachment D). Individuals eligible for Medicaid or CHIP must be provided with the option to enroll in direct coverage at any time while awaiting premium assistance for health insurance provided under an employer-sponsored or an individual market plan.

i. **ESI Premium Assistance reservation list.** A separate list may be employed for individuals interested in obtaining premium assistance for health insurance available through their employers.

ii. **Individual Health Insurance reservation list.** A separate list may be employed for individuals interested in obtaining premium assistance to buy individual health insurance plans when coverage is not available through their employers.

iii. **Outreach to children in families with income from zero through 200 percent of the FPL (Population 14 and 16 in Attachment D) currently on the FHIAP Reservation List:** The State will perform targeted outreach to families on the existing reservation list to ensure they are aware that children also have the option to receive direct state plan coverage at any time under Medicaid or CHIP. Families with children will be sent information about direct coverage through Healthy Kids, along with a Healthy Kids application, and a letter encouraging families to apply for immediate coverage rather than wait on FHIAP's reservation list. Families must either complete the application or actively decline direct coverage. All children that choose FHIAP at the point of application and choose to go on the reservation list will also receive information on direct coverage options and be informed that they can move from the FHIAP reservation list or decline CHIP or Medicaid coverage, but still be given the opportunity to choose to move to direct state plan coverage at any time.

iv. **Protections for Children on FHIAP Reservation List:** Families waiting for FHIAP assistance will not lose their place in line or experience any delay as a result of applying for Healthy Kids direct state plan coverage for their children. The State must also inform families that if circumstances change or they change their mind at a later date, they may move their child or children from FHIAP to direct Medicaid or CHIP coverage at any time.

v. **FHIAP Program Openings.** As program openings occur, applications are mailed to families on the FHIAP reservation list(s) on a first come first served basis. Subsidies can be used for ESI or individual health insurance.

vi. **Publication of Reservation List.** The reservation list must be well publicized. It is publicized on the State OHA website and the FHIAP website, and Oregon employers are informed of the reservation list on a regular basis through various state sources (e.g. Employment, Insurance).

vii. **Option for FHIAP Enrollment Cap.** The State may impose an enrollment cap upon the FHIAP program in order to remain under the budget neutrality limit or to address projected budgetary limitations of the FHIAP program.

viii. **Screening for Medicaid and CHIP Eligibility.** All children are screened for Medicaid and CHIP eligibility prior to enrollment in FHIAP. Children will also be screened for Medicaid and CHIP eligibility prior to actual enrollment in FHIAP and enrolled in the appropriate program if the family selects Medicaid or CHIP state plan direct coverage. These families can also receive assistance from choice counselors who can help explain their insurance options.

ix. **Management of FHIAP.** For FHIAP populations 12, 14, 16, 17, and 18 in Attachment D the State may lower the FPL used to determine eligibility; and/or suspend eligibility and/or intake into the program; or discontinue subsidies.

1. No later than 60 days prior to the date of implementation, the State shall submit to CMS its plan for any of these approved actions for review. CMS will complete a review of the plan for implementation, and notify the State of a decision within 60 days of receiving the State's plan.

2. FHIAP will limit the enrollment in the program to a number that can be served within the State and Federal resources allocated to the program, under the constraints of budget neutrality.

3. If sustained enrollment levels would cause FHIAP to exceed its biennial budget, enrollment levels will be allowed to fall either through natural attrition or by one of the caseload control mechanisms outlined above.

4. All children (including Medicaid and CHIP eligible children in demonstration populations 3, 4, 5, 6, 7, 8, and 16 in Attachment D) and certain adults (populations 1, 2, 6, 7 and 8 in Attachment D) who would be eligible for OHP Plus benefits always have the option of enrolling in OHP Plus, which includes Medicaid or CHIP state plan direct coverage children, at anytime and the State will keep families informed of this option.

x. **Limitations on the use of the Reservation List.** The FHIAP reservation list does not apply to children applying for Healthy Kids ESI with incomes from zero up to and including 300 percent of the FPL. Children from zero up to and including 200 percent of the FPL will be screened for Medicaid and CHIP enrollment under the Healthy Kids initiative prior to enrolling in Healthy Kids ESI.

o. **Healthy Kids Evaluation.** The Office for Oregon Health Policy and Research will analyze and evaluate the implementation of Healthy Kids, including premium assistance and coverage under the CHIP state plan. The Office will report on the following information using a variety of data sources including a statewide health insurance

survey, program administrative data and other quantitative and qualitative data sources. This information will be provided in the State's annual report as specified in paragraph 65.

i. Biennial estimates of the number of children who are eligible for but not enrolled in any of the three Healthy Kids options,

ii. The number of children enrolled in each type (Healthy Kids ESI, and direct state plan coverage options) of program,

iii. The number of children disenrolled from each type of program, and reasons for disenrollment,

iv. Enrollment trends (from the inception of Healthy Kids) related to the number of children remaining on the FHIAP reservation list who do not opt for CHIP direct coverage ,

v. A description of any identified barriers to enrolling or maintaining enrollment of children in any of the program types,

vi. The quality of care received using nationally accepted HEDIS measures for children,

vii. Biennial estimates of the number children voluntarily not enrolling in employer-sponsored health coverage who enroll in the program.

p. **Premium Assistance Evaluation Related to Cost Effectiveness.** Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the State's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The State provides limited wrap around services.

i. The State will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:

1. FHIAP's (Populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies);

2. OHA direct coverage (Populations 1 through 11 in Attachment D) overall pm/pm costs.

ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in Populations 12, 14, 16, 17, and 18 based on maximum plan out of pocket costs (excluding premium share) to:

1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.

iii. OPHP will monitor program expenditures for HK ESI (Population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.

1. OPHP will report average aggregate cost sharing for HK ESI plans (Population 20 in Attachment D) based on maximum plan out of pocket costs (excluding premium share).

2. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

3. This information will be provided in the State's annual report as specified in paragraph 65 as well as progress toward this goal in quarterly reports referenced in Attachment A.

V. DELIVERY SYSTEM TRANFORMATION

Description of the pre-Health System Transformation Managed Care Delivery System

23. **Pre-Health System Transformation Delivery Systems for OHP Plus and OHP Standard.** The majority of health care services under OHP Plus and OHP Standard are provided through a managed care delivery system. The managed care entities (MCEs) coordinate health care systems, including pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and comprehensive or targeted management of health services. The managed care services have been delivered through the entities in Table 1. Once the health system transformation has been fully implemented the current managed care providers will be replaced by the Coordinated Care Organizations.

Table 1. Existing Care Delivery Systems

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
Fully Capitated Health Plan (FCHP) (a managed care entity)	An organization contracted to provide physical health services and chemical dependency treatment services, including inpatient hospitalization. Oregon contracts with FCHPs throughout the State to provide health care services to Oregon Health Plan members.	FCHP contract ends if the FCHP reorganizes as a CCO in a particular service area.	No new FCHP contracts after July 1, 2014.
Physician Care Organization (PCOs) (a managed care entity)	An organization contracted to provide physical health services, excluding payment for inpatient hospitalization.	The two PCO contracts will end if they join a CCO in the PCO service areas.	No new PCO contracts after July 1, 2014.
Mental Health Organizations (MHOs) – (a managed care entity)	An organization contracted to provide outpatient and acute inpatient mental health services. Mental Health services are provided by stand-alone organizations that specialize in such services and are paid on a capitated rate basis	MHO contract ends if the MHO reorganizes as, or joins, a CCO in a particular service area. MHOs will continue to serve enrollees currently FFS for physical health care until 11/1/12. After that	No new MHO contracts after July 1, 2014.

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
		date, MHO contracts will end.	
Dental Care Organizations (DCOs) – (a managed care entity)	An organization contracted to provide dental services, including preventive care, restoration of fillings, and repair of dentures. Dental services are contracted on a stand-alone basis through a DCO and are paid on a capitated rate basis to provide services to OHP members	CCOs will contract with DCOs in the CCO service area, but DCOs must be integrated into CCOs by July 1, 2014.	CCO/DCO contracts will be executed by July 1, 2014.
Primary Care Manager (PCM)	A physician or other OHP approved medical provider responsible for providing primary care and maintaining the continuity of care, supervising and coordinating care to patients, initiating referrals to consultants and specialist care. PCMs are not under contract with a managed care organization; they provide health care services through a FFS system, and receive a nominal management fee on a per member per month basis. Compensation to PCMs for direct services is non-risk based and in accordance with the State Plan.	Some PCMs will continue to exist for the small FFS population remaining. The state will be working with PCMs to meet PCPCH requirements.	Ongoing and parallel to CCO timelines.
Fee-For-Service/ Open Card	The OHP participants may also receive services through the fee-for-services delivery system. The OHP participant that receives service through FFS may be served through a PCPCH.	FFS open card will be maintained only for small number of exempted or excluded populations or those outside CCO service areas.	Ongoing
Patient Centered Primary Care Homes (PCPCH)	The PCPCHs provide comprehensive care management, care coordination,	The PCPCHs are optional and will be available to	Ongoing Transition over 3-5 years

Type of delivery system entity	Description	Relationship with future CCO structure	Timeline
	health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services.	OHP participants whether they are enrolled with a CCO or served through the FFS delivery system.	as more PCPCHs become certified

Health System Transformation Transition

24. The State will transform its delivery system through a shift to the delivery of care from current specialized MCEs to Coordinated Care Organizations (CCOs) beginning in August 2012. Initially, CCOs will be required to provide both medical and behavioral health services (formerly provided under different MCEs). Dental services must be merged into the CCO by July 2014. The State's contracting with the CCO will result in the phase out of new Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), and Mental Health Organization (MHO) contracts by July 1, 2014 and CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. The CCOs initially will be phased into the delivery system over four monthly cycles (or "waves") beginning in August 2012 and ending in November 2012.

    a. Transition of OHP Populations to CCOs

        i. Existing enrollees of an MCE that has transitioned to a CCO will be given a 30 day notice and transitioned (rolled over) to the new CCO when certification and contracting is complete. This roll over will include currently enrolled tribal members and dual eligibles, who will be able to opt-out if they wish. Existing members who are receiving services from out-of-area or non-participating providers will be moved to a CCO when their MCE transitions. For these members, the CCO will be expected to cover out-of-network or non-participating provider services authorized by the member's care team, Medical Director of the MCO or the Medical Director of the Division of Medical Assistance Programs, for a transitional period until the CCO establishes a relationship with the member and is able to develop a medically appropriate care plan.
            1. An MCO transitioning to become a CCO in any of the four initial contracting waves will retain its existing enrollees and those enrollees will be transitioned (rolled over) to the new CCO when certification and contracting is complete.

            2. For an MCO not transitioning to become a CCO in any one of the four waves, enrollment of existing members will continue in the plan until the

member chooses another plan as described below, or until the OHA determines on a case-by-case basis that members should be transitioned to other plans serving the geographic area.

ii. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.

1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.

2. All existing MCEs from Table 1 in paragraph 23 will be closed to new enrollment once sufficient capacity is determined to exist in the CCO(s) serving the area. If CCOs do not have sufficient capacity, new members may be enrolled only in MCOs on the path to becoming a CCO in one of the four waves until capacity in those plans is reached, then can be enrolled in any remaining MCOs.

iii. Individuals who are currently in FFS for physical health, other than dual eligibles and tribal members, will receive a 30 day notice and be required to enroll in CCOs by November 1, 2012 where sufficient capacity exists, and will be given their choice of plan.

1. Members not choosing a plan will be auto-assigned to a plan through an auto-enrollment process.

2. For members who are enrolled in an MHO for mental health services but otherwise receive physical health services through fee for service, if a CCO becomes operational in their area prior to November 1st, their mental health coverage will be through that CCO until they are enrolled in a CCO for both physical and mental health services in November.

iv. Tribal members and dually eligible individuals are both populations that must make an affirmative voluntary choice for CCO (and existing MCE) enrollment (i.e., cannot be auto-enrolled).

v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.

vi. OHA is planning member transition strategies for FFS members with special considerations:

1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage

Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:

- Care management requirements based on the beneficiary's medical condition
- Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations
- Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services)
- Availability of medically appropriate medications under the CCO formulary
- Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team

2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.

Description of Delivery System Transformation

25. **Definition and Role of Coordinated Care Organizations**. CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the State. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR Part 438 unless a requirement has been specifically identified in the waiver authorities for this Demonstration. CCOs will provide a governance structure to align the specialized MCE services under one managed care organization. CCOs will partner with OHA to further the State's implementation of PCPCH and utilization of Non-Traditional Health Workers (NTHWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

a. **CCO Criteria**. The CCOs are required to meet the following criteria:

i. **Governance and Organizational Relationships.**

1. Governance. Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see 2 below); and at least

two members from the community at large to ensure that the organizations decision making is consistent with the community members' values. .

2. Community Advisory Council (CAC). The CCOs are required to convene a CAC that include representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be ongoing bodies and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.

3. Clinical Advisory Panel. The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.

4. Partnerships. The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees and with county health departments and other publicly funded providers for certain point-of-contact services.

5. Community Health Needs Assessment. Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The State encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

b. **CCO quality and access measurement.** CCOs will be accountable for metrics for quality and access as described in Section VII and Attachment E, including measures to track progress in the quality improvement focus areas, measures to track quality broadly, and measures to track access. Specific measures, timeframes, and CCO reporting requirements will be determined by the state and approved by CMS during the supplemental 120-day planning period.

   i. **Menu-set of CCO quality improvement focus areas.** OHA will ensure that each CCO will commit to improving care in at least 4 of the following 7 focus areas, which have the significant potential for achieving the demonstration's goals of improving the patient experience of care, improving population health, and reducing per capita Medicaid expenditure trend. Three of these four projects

may serve as a CCO's Performance Improvement Projects in accordance with 42 CFR 438.358 and 438.240. Attachment E provides further details on each of these focus areas. The State and CCOs may add to this menu of focus areas but should review Attachment E and provide a similar level of detail for anything not on the list below. The State will incorporate the PIP requirements into its CCO/MCE contracts within 120 days of the approval of the demonstration

1. Reducing preventable rehospitalizations.
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, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by "super-utilizers".
4. Integrating primary care and 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 model of care throughout the CCO network.

c. **Health Information Technology (Health IT).** The CCOs are directed to use HIT to link services and core providers across the continuum of care to the greatest extent possible. The CCOs are expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

i. Health IT:

1. CCOs must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State's health information exchanges. If providers 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.

2. In order for CCOs to fully realize years 2-3 performance incentives, the State must require that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The related incentives must take into account the costs incurred in order to facilitate

adoption and meaningful use of EHRs, as well as the existing incentives available to eligible providers.

3. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. The State must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

4. All requirements must also align with Oregon's State Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

d. **Innovator Agents and Learning Collaboratives**. State shall utilize innovator agents to act as a single point of contact between the CCO and the Oregon Health Authority. Innovator agents will be assigned to each contracted CCO by January 15, 2013. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the Demonstration's goals of improving quality and access while managing costs, within 120 days from the approval of the Demonstration amendment the State will:

i. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.

ii. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as underperforming (as described above), the State will plan and execute intensified innovator/learning collaborative interventions.

iii. The information in (a) and (b) above will be incorporated into the CCO contracts by amendment.

26. **Alternate Delivery System**. The FFS delivery system applicable to some Demonstration populations will continue under the health system transformation.

27. **Patient Rights and Responsibilities, Engagement and Choice.** The CCO is responsible for ensuring that its enrollee receives integrated person-centered care and services designed to provide choice, independence and dignity.

28. **Compliance with Managed Care Requirements.** The State must meet the requirements of 42 CFR Part 438 unless a requirement of part 438 has been identified in the waiver authorities for this Demonstration.

29. **Managed Care Enrollment, Disenrollment, Opt Out and Transitions**

a. **Mandatory Enrollment.** The State may mandatorily enroll individuals served through this Demonstration in managed care programs to receive benefits pursuant to Sections – IV and V of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to 12 months. The Table below illustrates the mandatory and affirmative choice (i.e., "opt-in") populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given[2]
1-11	Individuals of the identified populations other than those footnoted. [3]	Mandatory; current FFS enrollees not transitioned for physical health until November 2012	Other CCO if available; MCO if no CCO in area; FFS with cause
21	Breast and Cervical Cancer Treatment Program Income: Up to 250% FPL Resource Limit: None	Not enrolled until November 2012, then Mandatory	Other CCO if available; MCO if no CCO in area; FFS with cause
22	Targeted low income children up to 200 percent of the FPL who are eligible for direct services under the CHIP State Plan.	Mandatory	Other CCO if available; MCO if no CCO in area; FFS with cause

[2] See (b) below for more information on disenrollment/plan change options and timelines.
[3] Exceptions include individuals who are: dually eligible for Medicare and Medicaid, American Indian or Alaska Native who are permitted to enroll, but not mandatory. Current MCO enrollees will be rolled over to a CCO in November 2012, others may opt in. FFS populations who require special consideration (e.g., HIV/AIDs) will be transitioned in November 2012, after receiving individualized transition planning.

	Description	In/Out of CCOs	
	Title XXI children ages zero through 18 with income above 200 up to and including 300 percent of the FPL who meet the title XXI definition of a targeted low-income child under the CHIP State plan (under Healthy KidsConnect)	Out	
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
22	Targeted low-income children from conception to birth with income from 0 up to 185 percent of the FPL who are eligible under the CHIP State Plan.	Optional	N/A
12, 14, 16-18, and 20	Individuals in FHIAP and Healthy Kids ESI	Out	N/A
1-11, 21 and 22	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid State Plan	Individuals who are receiving non-OHP Medicare (QMB, SLMB, QI)	Out	N/A
Medicaid State Plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A
Medicaid State Plan	Individuals who are Transplant Rx only	Out	N/A

b. **Disenrollment.** The information in the table is applicable to all managed care enrollees.

Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR Part 438.
Eligibility redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

30. **Network Adequacy and Access Requirements.** The State must ensure that any MCE and CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and services, considering the urgency of the service. Detailed standards for various levels of care (e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the State's quality strategy required by 42 CFR 438.204.

31. **Required Notice for Change in CCO Network.** The State must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

32. **Contingency Planning.** In the event that a CCO contract is amended to significantly reduce its service area or the contract is terminated, the State will implement contingency planning in consultation with CMS to assure enrollee continuity of care.

33. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10(f)(4), 42 CFR 438.6(i) and 42 CFR 431.20, the State may allow the use of electronic methods for the beneficiary and provider communications as required by:

- 42 CFR 438.10(b) – Special rule for mandatory enrollment states – timeframes for providing information;
- 42 CFR 438.10(e) - Information for potential enrollees;
- 42 CFR 438.10(f)(2), (3) and (6) - Right of enrollee to request and obtain information;
- 42 CFR 438.10 (g)(2) and (3) – Other plan information, including PIPs;
- 42 CFR 438.10(h)(2) and (3) - For PAHPs only - Other plan information, including PIPs;
- 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
- 42 CFR 438.102(b)(1)(ii) – state policies on excluded services.

a. The State may allow the use of such electronic communications only if:

   i. The recipient has requested or approved electronic transmittal;
   ii. The identical information is available in written form upon request;
   iii. The information does not constitute a direct beneficiary notice related to an adverse action or any portion of the grievance, appeals, hearings or any other beneficiary rights or beneficiary protection process; and
   iv. Language and alternative format accommodations are available.
   v. Please note: All HIPAA requirements apply with respect to personal health information.

34. **Transparency/Public Reporting.**

a. The State must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).

b. The state shall publish data regarding CCOs' performance on State-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the State's progress toward achieving the two primary goals of this demonstration.

35. **State Oversight of the CCOs.** The State Agency must have in effect procedures for monitoring the CCO operations, including, at a minimum operations related to the

following: recipient enrollment and disenrollment; processing of grievance and appeals; violations subject to immediate sanctions, as set forth in sub part I of 42 CFR 438; violations of the conditions for FFP, as set forth in subpart J; and all other provisions of the contract.

VI. CAPITATION RATES AND PERFORMANCE MEASURES

36. **Principles for Payment Methods that Support the Three-Part Aim.** The State will employ the following concepts in its payment methods to CCOs:

    a. The State will transition to a payment system that rewards health outcomes improvement and not volume of services.

    b. The State will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services. The global budget will be phased in, but will eventually consist of two parts: 1) a capitated per member per month (PMPM) payment; and 2) a separate PMPM payment for services not included under the capitation rate.

    Until January 2013, the global budget will include only capitated services (i.e., the first part above). After January 2013, the State will begin including additional services to the global budget (see Attachment F). These services may be included in the capitated portion of the global budget or in the separate PMPM payment methodology. The methodology for inclusion of additional services in the global budget will be mutually agreed upon by the State and CMS and phased in over the course of the Demonstration. The State and CMS will finalize the methodology for inclusion of additional services within 120 days of this agreement.

    No payment will be made for CCO enrollees to FCHPs, MHOs and, if dental services are included in the CCO benefit package, DCOs.

        i. Attachment F provides a proposed schedule of inclusion of additional services into the CCO global budgets. Initial CCOs approved August through December 2012 will be at risk for Lines 1-8 through a PMPM global budget. The state intends to add service lines 9-22 to CCO global budgets over the course the demonstration. While the intent is to include as many services as possible within the PMPM payment methodology, the state will work in collaboration with CMS to determine the most

appropriate methodology for adding these services to the global budget. Until services are added to the global budget either through the PMPM or another methodology, CCOs are not at risk for services other than 1-8 in Attachment F. If the state wishes to add any services included in lines 23-38 in Attachment F, the state will work with CMS to determine the most appropriate methodology for inclusion of the additional services within the CCO global budgets and amend the Section 1115 waiver if necessary.

c. The CCO contract language will require the CCOs to consider alternative non-State Plan services (the constellation of these services includes services known as "in-lieu of services," "substitute services," "flexible services," and "non-encounterable services" and hereafter referred to as "flexible services" in order to capture the array of potential services). CCOs are always at liberty to offer any *additional* health-related services at their discretion, as allowed under 42 CFR 438.6(e). Since enrollees may need additional services that are not substitutes for State Plan services, which could ultimately improve the enrollee's health, the CCOs should use this option as necessary.

   i. The contract must not require specific, discrete service substitutions, but may require that the principle of "flexible services" (i.e., that CCOs look for more cost-effective services to replace or supplant the need for State plan services, as appropriate) be applied under the following circumstances:

      1. An enrollee's request to have a State Plan service rather than a flexible service must be honored when medically necessary.

      2. All flexible services will be health related however the CCO will have broad flexibility in creating the array of services to improve care delivery and enrollee health. The State will report on the non-State plan services provided through the CCO contracts, including the effectiveness of the services in deterring higher cost care.

      3. Flexible services will be accounted for in the administrative expenses part of the capitation rate. Although flexible service will not be included in the medical expenses portion of the capitation rate, utilization assumptions may be applied.

   ii. The CCO contracts may levy performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. I.e.,

the more creative the CCOs are with flexible service delivery, health outcomes will improve and growth in per capita expenditures will decrease.

1. As CCOs provide health care services that are more cost-effective than State Plan services (which is what the capitation rate is based on), the capitation per capita growth rate should gradually decrease over the waiver period. The State will offset the decrease in capitation per capita rate growth with additional incentives outside of the capitation rate.

2. Over time, the per capita expenditure trend should be lower through decreased use of unnecessary and costly services. This will happen when: 1) Decreased utilization of unnecessary and costly services; 2) Financial reward of CCOs and their contracted providers for quality improvement, not volume of services; and 3) the health status of enrollees improves through coordination of care.

3. Success will be measured by and incentives paid based upon: 1) decreased rate of per capita Medicaid expenditure growth; 2) increased patient satisfaction with, and involvement in, care planning and quality of care; and 3) overall population health improvement.

d. In each year, the State and CCOs must track discrete services whether it is a State Plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate.

37. **Structure.** Capitation rates and incentives for the Coordinated Care Organizations (CCOs) for each demonstration year (DY) will be structured as follows:

a. Demonstration Year 11:

i. Capitation rates. There will be no major changes in the currently approved rate-setting methodology for DY11.

ii. Incentives and Withholds. There will be no incentive payments made to CCOs or amount withheld from the CCOs.

iii. Special performance Standards. The State will apply special performance standards of timely and accurate data reporting in the first year.

b. Demonstration Years 12 through 15:

i. Capitation Rate Withhold. The first quarter of DY 12 will include a 1-percent capitation rate withhold that will be returned to CCOs successful in DY 11 performance metrics which reward timely and accurate data reporting A CCO that successfully meets the performance metrics of timely and accurate data reporting in DY 11 will receive the full capitation rate in this quarter. A CCO that does not meet the DY 11 performance metrics will not have the withhold restored, resulting in a 1-percent rate reduction. The state will determine the parameters for the special performance standards of timely and accurate data reporting within 120 days of this agreement.

ii. The State will have an additional 120 days after the agreement is in effect to address the details of DYs 12-15 so long as it is within the following parameters and subject to CMS approval:

1. Bonus Incentive Pool. The State will establish a separate bonus/incentive pool outside of the capitation rates (i.e., in addition to any capitation rate withholds). Incentives must be designed to reduce costs and improve health care outcomes. When developing the bonus pool, the State will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing.

a. The State will alert the CCOs that the bonus incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole bonus incentive pool amount will be at risk. The State will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark, and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance. Within 120 days of the Demonstration approval, the State will submit and CMS will approve the specific requirements. The State will amend its CCO contracts to incorporate the changes immediately following the 120-day period.

2. CCO Provider Agreements. Incentives must be correlatively reflected in the CCO/provider agreements to insure that the incentives are passed through to providers to reflect the arrangement with the State-CCO contract.

iii. Each subsequent DY rates and incentives will be set in the DY preceding the implementation in order to apply program experience as the program matures (e.g., DY 13 rates and incentives will be set in DY 12). The State will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

VII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

38. **Overview.** Improving access and quality is a key component of the State health system transformation and measurement is necessary to determine whether the demonstration's goal of advancing the triple aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required.

39. **Metrics and Scoring Committee.** The State's strategy for a robust measurement includes the newly established Metrics and Scoring Committee. The Committee will review data and the relevant literature, determine which measures will be included in the CCO incentive program, and establish the performance benchmarks and targets to be used in this incentive program. The Committee will endorse/develop specifications for each measure. In future years, the Committee will review earlier decisions and make adjustments as needed. A transitional Metrics and Scoring Committee recommended a set of metrics for the first program year, which were described in CCO RFA contracts. Going forward, the permanent Metrics and Scoring Committee will recommend metrics that will be used to determine financial incentives for CCOs.

40. **Additional Quality Measures and Reporting at the CCO Level.** CMS developed an additional list of requirements for the Metrics and Scoring Committee that should be incorporated into the measurement planning and financial incentive determinations. This should not supplant the work of this committee, but rather provide some strategic direction to reach the two goals of this Demonstration. The CCOs will be required to collect and validate data and report to the State on the metrics listed in this section, which may be revised or added to over time as the demonstration matures, but these metrics will remain constant for the first 2 years of the demonstration. CMS also encourages the CCOs to report on the core set of performance measures for children and adults in Medicaid and CHIP.

a. **Metrics to track quality improvement focus areas:** Pursuant to paragraph 25.b.i), the State and CMS will ensure the collection and validation of measures to track progress in the quality improvement focus areas. (See Attachment E)

b. **Core set of quality improvement measures**. The initial core measures will track the following:

   i. Member/patient experience of care (CAHPS tool or similar);
   ii. Health and functional status among CCO enrollees;
   iii. Rate of tobacco use among CCO enrollees;
   iv. Obesity rate among CCO enrollees
   v. Outpatient and emergency department utilization;
   vi. Potentially avoidable emergency department visits;
   vii. Ambulatory care sensitive hospital admissions;
   viii. Medication reconciliation post discharge;
   ix. All-cause readmissions;
   x. Alcohol misuse-screening, brief intervention, and referral for treatment;
   xi. Initiation & engagement in alcohol and drug treatment;
   xii. Mental health assessment for children in DHS custody;
   xiii. Follow-up after hospitalization for mental illness;
   xiv. Effective contraceptive use among women who do not desire pregnancy;
   xv. Low birth weight;
   xvi. Developmental screening by 36 months; and
   xvii. Difference in these metrics between race and ethnicity categories;

c. **Access improvement measures based on CCO data.** The State and CMS will identify and agree to additional access measures by 120 days after the approval of this demonstration planning period. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.

   i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
   ii. Percentage of adults with any outpatient visit.
   iii. Percentage of adults with a chronic disease w/any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
   iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.

v. Percentage of children with at least one dental visit.
vi. Fraction of physicians (by specialty) 'participating' in the Medicaid program.
vii. Change in the number of physicians (by specialty) participating in Medicaid
viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
ix. Percentage of CCO enrollees with access to a PCPCH.

d. **Access improvement measures based on state survey data.** The State will identify and CMS will approve additional access measures, particularly measures based on survey data, by 120 days after the approval of this demonstration planning period. Additional survey-based measures could include:

i. Percent of beneficiaries with a usual source of care.
ii. Percent of beneficiaries with a preventive visit in past year.
iii. Percent of beneficiaries with a dental visit in past year.
iv. Percent of beneficiaries with any unmet needs.
v. Percent of beneficiaries delaying/deferring care due to cost.
vi. Percent of beneficiaries delaying/deferring care due to lack of available provider.
vii. Percent of beneficiaries delaying/deferring care due to provider office being. closed at time of illness.
viii. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

41. **Utilization of new services.** The State and CCOs must track discrete services whether it is a State Plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement.

42. **Quality and Access Data Reporting from the State to CMS.** In accordance with paragraph 7864, "Monitoring to Assure Progress in Meeting Demonstration Goals," the State will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the State will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 120 days of the Demonstration approval, the State will submit and CMS will approve a reporting format.

43. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**

a. **Statewide quality, access, and expenditure monitoring and analysis.** The State, working with the CCO Innovator agents, shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The State must report to CMS any CCO issues impacting the CCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights

b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the State shall intervene promptly within 30 days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to focused learning collaboratives and/or innovator agents, targeting underlying issues affecting outcomes, performance, access and cost.

c. **Additional actions taken if goals are not achieved**. If the interventions undertaken pursuant to paragraph 43.b do not result in improved performance in identified areas of concern within 90 days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the State placing the CCO on a corrective action plan. The State must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the learning collaboratives and peer-support to the extent practicable.

44. **EQRO.** The State is required to meet all requirements found in 42 CFR 438, subpart E. The State will need to amend its current EQRO contract to require the reporting of outcomes information in the annual technical report related to performance measures and performance improvement projects. The State should generally have available its final EQR Technical Reports to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)]. In the first year of the

transition to the CCO system and to a modified EQRO contract, CMS will use the quality and access data from the quarterly reports as identified in paragraph 42 to satisfy regulatory requirements.

45. **State Quality Strategy**. In accordance with CMS regulations, the State is required to submit a written strategy for assessing and improving the quality of managed care service offered by all managed care entities. This written strategy (also referred to as the "quality strategy") must meet all of the requirements found in 42 CFR 438, subpart D. Before implementing a final, approved quality strategy, the State is required to submit a draft quality strategy to CMS for approval within 120 days of the approval date of the Demonstration. The State will submit a revised strategy to CMS within 60 days, whenever significant changes are made. The State will submit annual reports to CMS on the implementation and success of the strategy, by means of the annual EQRO technical report or a separate annual report that assesses the implementation and effectiveness of the quality strategy.

VIII. CALCULATING THE IMPACT OF HEALTH SYSTEMS TRANSFORMATION AND REDUCTIONS IN DESIGNATED STATE HEALTH PROGRAM FUNDING

This section establishes the parameters by which the State and CMS will annually measure the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved. Data specified in this section shall be reported on a quarterly and annual basis as specified in paragraph 64.

There are three levels of baseline and actual expenditures that the State must calculate and provide to CMS that will be measured and monitored annually under this demonstration. These levels are:

- 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,
- 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, and
- Level 3: The per member per month total expenditure to the State to *provide* care under Health System Transformation in Oregon.

46. The following section summarizes the specific populations, expenditures, and other variables that will be included in calculations of each of the expenditure levels described above.

a. **Level 1: Global Budget Expenditures**.

These expenditures are for services identified in Attachment F for all individuals enrolled in eligibility categories that are required to enroll in CCOs (mandatory populations) and for individuals that voluntarily enroll in CCOs that are in non-mandatory enrollment populations (voluntary populations). Expenditures would also include any incentive payments, shared savings payments made to CCOs as well as wrap-around or supplemental payments for services identified in the global budget and provided to these populations. This expenditure level is the level against which the health care cost trend targets and the associated funding consequences described in paragraph 54 will be based.

b. **Level 2: Medicaid Program Service Expenditures**

These expenditures are for all Medicaid services provided to all individuals enrolled in mandatory eligibility categories as well as those individuals enrolled in voluntary populations who voluntarily enroll in CCOs. This expenditure level includes all payments described in level 1 plus all other Medicaid payments for services provided under the demonstration or the State plan to individuals described in level 1 during a demonstration year. These additional expenditures would include services such as long term care services that are not included in the global budget service package but are provided to individuals described in level 1.

c. **Level 3: Medicaid Program Costs for Health System Transformation**

This expenditure measure will capture total costs to support Health System Transformation (HST) and will include all costs in level 1 plus all costs that the State incurs for supporting HST including activities such as learning collaboratives, innovation agents, and other activities performed or contracted by the State to implement and operate HST.

47. **Calculating Baseline Expenditures.** The baseline expenditures to the State without Health Systems Transformation of these services will be developed using expenditure information from 2011 for the full calendar year. The costs will be developed for each level of spending for each eligibility group. These baseline costs will be transformed into aggregate per member per month costs based on total member months in 2011. The groups are:

Population	**Enrollment**
Children	Mandatory

Non-disabled Adults	Mandatory
Disabled Adults	Mandatory
Dual Eligibles	Voluntary

The baseline PMPMs for each level will be developed as follows:

a. Level 1: The actual baseline PMPM will include all costs for global budget services plus all wrap-around payments for all populations whose enrollment is mandatory or voluntary (as defined in Table 2 in paragraph 29). The base costs for global budget services will be divided by the total applicable member months to create an aggregate PMPM.

   The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the State and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

b. Level 2: The actual baseline PMPM will include all level 1 costs plus all other Medicaid service expenditures attributable to 2011 for all individuals in both mandatory and voluntary populations. The total base costs for global budget services will be divided by the total applicable member months.

   The actual dollar value of the base line PMPM for each eligibility group and the aggregate baseline will be submitted by the State and approved by CMS in the 120 days following approval of the demonstration and will be included as Attachment H.

c. Level 3: The actual baseline PMPM will include all level 1 costs by eligibility group and for the base year, should not differ from Level 1 expenditures as the additional costs in this category is expenditures supporting health system transformation.

The baseline PMPM in Level 1 will be the without Health System Transformation (HST) costs. The trend rate applied to the aggregate PMPM, which is based on the President's Budget estimates of the national rate of growth in Medicaid expenditures on a per member per month basis, is 5.4% for each year in the demonstration. If within the 120 day period following approval of the demonstration, the State provides analysis and data demonstrating that Oregon's trend differs substantially from this national average, and the Chief Actuary of CMS determines the difference to be valid and calculated reasonably and in accordance with general actuarial standards of practice, CMS will adjust this trend rate.

The PMPM calculation will be performed for each level (1, 2, and 3) described above in the aggregate.

48. **Calculating Actual Expenditures under Health System Transformation.** This measurement is based on actual DY expenditures for services and supports under HST. Actual HST PMPM expenditures will be calculated as follows:

a. Level 1: The actual HST expenditure PMPM will include all costs for global budget services plus all wrap-around payments.

For the mandatory populations, costs for global budget services will be included regardless of whether the CCO directly provided the services or not and whether or not individuals were enrolled in a CCO.

For voluntary populations, the costs for global budget services will be included regardless of whether the CCO directly provided the services or not. Expenditures and member months for individuals in the voluntary group will be included in this calculation only if they were enrolled in a CCO.

The State will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory populations and voluntary populations if they were enrolled in a CCO.

b. Level 2: The actual HST PMPM will include all Level 1 costs plus all other Medicaid service expenditures during the DY. For the mandatory populations, the total level costs will include both global budget services and all other Medicaid services provided to individuals in the mandatory eligibility groups.

For voluntary populations, costs will include all Level 1 costs plus all other Medicaid service expenditures during the DY only for individuals actually voluntarily enrolled in CCOs. Individuals in the voluntary group will contribute their expenditures only if they were enrolled in a CCO.

The State will develop an aggregate PMPM by dividing total HST costs by total eligible member months for mandatory and voluntary populations.

c. Level 3: The HST PMPM will include all Level 1 costs by eligibility group and all costs incurred by the State for expenditures to support HST. The costs will include activities such as learning collaboratives, innovator agents, the quality and access metrics committee, and other administrative support the State may provide to facilitate the implementation and operation of CCOs and HST. The State will submit and CMS will approve within 120 days after the date of approval of the demonstration the activities and costs that will be included in the HST support expenditure category.

For mandatory and voluntary populations, the HST calculation will include Level 1 aggregate expenditures plus aggregate, identified HST support expenditures divided by total Level 1 mandatory and voluntary member months.

49. **Calculation of Trend Reduction Targets:** The State must beginning immediately following DY 12 to annually demonstrate the savings achieved under HST using the without HST PMPM and the HST PMPM for Level 1 expenditures each DY. The savings requirements and penalties are described in paragraph 54.

    The PMPM savings percentages will be reported for each eligibility group and in the aggregate, although the savings reduction requirement will be applied only to the aggregate with and without HST expenditures. The aggregate HST PMPM must be below:

    a. the 5.4% without HST trend rate by 1 percentage point in DY 12 (i.e. aggregate PMPM expenditures in DY 12 must be no more than a 4.4% increase over DY 11 aggregate without HST PMPM expenditures).

    b. the 5.4% without HST trend rate by 2 percentage points in DY 13, 14 and 15 (i.e. aggregate PMPM expenditures in DY 13 must be no more than a 3.4% increase over DY 12 aggregate without HST PMPM expenditures).

50. **Return on Investment.** Annually, CMS will analyze the total return on investment in HST. The State must provide information (as part of the reporting requirements in paragraph 64) on total new federal funds claimed as DSHP as well as federal funds claimed using State funds repurposed as a result of DSHP relative to health savings achieved under the health transformation process. Elements in the analysis will include:
    a. New federal funds drawn as match against DSHP programs.
    b. New federal funds drawn as a result of DSHP. Under the State's proposal, this includes all federal funds drawn associated with State funds redirected from DSHP except DY1 rate stabilization.
    c. Savings identified in the total cost of purchasing care in level 3 as described above (the total investment in HST).

51. **Evaluating Impact on Medicare and Medicaid Expenditures for Dual Eligibles.** In addition to expenditure estimates in paragraphs 47, 48, and 49, CMS and the State will examine total expenditures on individuals who are dually eligible for Medicaid and Medicare who are enrolled in CCOs.

52. **Measurement of Quality and Access Under the Demonstration.** The State will also monitor and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as

required by paragraph 64. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.

Within 120 days of approval of the demonstration, the State will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the State will use to monitor quality of and access to care for individuals enrolled in CCOs and for the State's Medicaid population as a whole. The State's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). State quality and access reporting will take place on the same timeframes as the State's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

53. **Deliverables to be Negotiated Within 120 Days Post Approval:** Within 120 days of approval of the demonstration, CMS and the State will:

a. Finalize the benefit package for the global payment Level 1 analysis during the demonstration period (Attachment F).
b. Finalize the parameters of the total cost of care for levels 2 and 3 by identifying all payments and costs subject to inclusion in the costs of care calculation.
c. Finalize the annual per capita amount for the baseline period.
d. Finalize safe harbor language to limit risk to the state for increases in FQHC wrap-around payments for reasons that are not within the state's control for the purposes of Level 1 calculations. Valid reasons would include an increase in FQHCs in the state relative to the base year or changes in scope of service that actually effect the PPS rate.
e. Finalize a methodology for the treatment of long term care services and supports (LTSS) expenditures.
f. Finalize the return on investment formula template and the per capita reporting templates.
g. Finalize the calculation of cost shifting using Medicaid uncompensated care (shortfall) using DSH audit information.
h. Finalize the timing of and reporting format of the annual expenditure and savings calculations.
i. A plan for specific quality and access measures that the State and CMS will use to monitor access and quality during the demonstration, as well as methods for such measurement and reporting timeframes.
j. CMS will review, discuss with the State, and approve all of the above deliverables within 30 days after the 120 day period.

54. **Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets**

This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. **Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates**. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 49, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Table 3: Per Capita Expenditure Growth Reduction Targets and Associated DSHP Expenditure Authority Reductions for Failure to Meet Targets

Demonstration Year	**Per Capita Expenditure Growth Reduction Target** (measure following DY close)	**Reduction in DSHP Expenditure Authority** (reduce succeeding DY's DSHP expenditure authority)
DY11	NA	NA
DY12	1 percentage point	$54 million
DY13	2 percentage points	$68 million
DY14	2 percentage points	$68 million
DY15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the State in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the State has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. **Earn Back Option.** For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:

i. If the State undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure

growth reduction target in the following year *and* significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.

ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the State undertakes a corrective action plan to achieve improvement and CMS determines that the State has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.

iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

IX. DESIGNATED STATE HEALTH PROGRAMS

55. **Designated State Health Programs (DSHP).** To support the goals of health system transformation, the State may claim FFP for the following State programs subject to the annual limits and restrictions described below through June 30, 2017, unless otherwise specified. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment G. Subject to approval by the federal Office of Management and Budget, these expenditures can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of paragraph 54.

56. **Aggregate DSHP Annual Limits** – Expenditure authority for DSHP is limited to $704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by year as follows:

Table 4: Aggregate DSHP Annual Limits

Demonstration Year	Time Period	Annual Limit on FFP
DY 11	07/1/12-06/30/13	$230 M
DY 12	07/1/13-06/30/14	$230 M
DY 13	07/1/14-06/30/15	$108 M
DY 14	07/1/15-06/30/16	$ 68 M
DY 15	07/1/16-06/30/17	$ 68 M

57. **Restrictions on DSHP Programs.** Approved Designated State Health Programs for which FFP can be claimed are outlined below subject to the following funding limits by the four categories listed below. Prior to claiming funding for these programs, the State will submit

and CMS will approve a DSHP claiming protocol. The State is not eligible to receive FFP until the protocol is approved. Upon CMS approval of the claiming protocol, state is eligible to receive FFP for the approved DSHP program expenditures beginning July 5, 2012.

Table 5. Limits on Allowable Designated State Health Programs

Expenditures by Type of Designated State Health Programs:	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**Total**
Oregon Medical Insurance Program	93	93	0	0	0	186
Workforce Training	69	69	40	0	0	178
Gero-Neuro	8	8	8	8	8	40
Other CMS Approved*	60	60	60	60	60	300
Total	**230**	**230**	**108**	**68**	**68**	**704**

*See Table 6 for all approved programs.

a. **Oregon Medical Insurance Program.** The State may claim FFP for expenditures related to the Oregon Medical Insurance Program only for DYs 11 and 12.

b. **Workforce Training.** To promote improved access and quality of care for Medicaid beneficiaries in the State by supporting the development of the health care workforce in the State and to the extent that such education promotes the rate of Medicaid participation among Oregon providers, the State may claim FFP for health workforce training programs and related supports at Oregon Health and Science University (OHSU), Oregon University System (OUS), and community colleges as follows; Blue Mountain, Clatsop, Linn Benton, Rogue, Umpqua, Central Oregon, Columbia Gorge, Mt Hood, Southwestern, Chemeketa, Klamath, Oregon Coast, Tillamook Bay, Clackamas, Lane, Portland, Treasure Valley. The State may only claim FFP for workforce training DSHP programs in DYs 11-13. The annual limit the state may claim FFP for workforce training programs is limited to direct and indirect costs and shall not exceed $69 million in each of DYs 11 and 12 and $40 million in DY 13.

   i. **Loan Repayment:** To ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the

State shall commit to funding a primary care provider loan repayment program, with the following conditions:

By July 1, 2013, the State shall establish an annual funding level of $2,000,000 to provide assistance to providers who make written commitments to serving Medicaid populations in rural and underserved areas. If the State is unable to establish funding for this program at the amount specified in this term, the State's Workforce Development state designated health program expenditure authority must be reduced. The DSHP Workforce Development funding must be reduced by 25 percent of the difference between the $2,000,000 and the amount that the State is able to reinstate for the loan repayment program for Demonstration Years 12 and 13.

ii. **Training for Community Health Workers:** The State, through its Community Colleges, shall establish Community Health Worker curriculum that meets the core training elements established by the Oregon Health Policy Board. The State shall train 300 additional Community Health Workers by December 2015.

iii. **Increased Workforce/Provider Capacity.** The State must track the number of Medicaid primary care providers (including nurse practitioners, etc.). The State must submit to CMS within 180 days of the date of the demonstration amendment approval letter, a report detailing the number and types of primary care providers that are currently seeing Medicaid beneficiaries in the State of Oregon. In addition, the State must track where the graduates of these Educational Institutions are working and whether they become Medicaid providers beginning with DY 12 Quarterly and Annual Reports.

c. **Gero-Neuro.** The State may not begin claiming FFP for the Gero-Neuro program until the State begins the process to recertify the facility as an IMD meeting the inpatient hospital requirements as set forth in 42 CFR section 440.140 which include by reference requirements for the hospital conditions of participation at 42 CFR 482. Medicaid and CHIP citizenship rules apply as a condition for receiving FFP.

d. **Other CMS Approved DSHP.** For DYs 11-15, the State may claim FFP for expenditures related to state health programs specified in the "other" category of Table 6 in paragraph 58, subject to a 4.2% reduction on an annual basis. To the extent that the State identifies other programs in this category that support the health care needs of low-income, uninsured Oregonians, the State may submit to CMS for review and approval additional program expenditures for which expenditure authority may be provided. In the event of a shortfall in the "other" category, CMS will consider additional expenditures for OMIP if the State is able to document such expenditures. Additionally,

subject to the aggregate annual DSHP limit, the state may exceed the amounts listed in Table 5 for the "other" category only in the event there is a shortfall in the remaining categories. The state must notify CMS in advance of the anticipated shortfall amount by category and the amount of funds to be redirected to either "OMIP" or "other" category. Upon approval, the state may only prospectively claim additional expenditures over the individual limits for OMIP and the "other" category. The state must not exceed the annual aggregate limit. For any additional OMIP or other expenditures, the State must obtain prior CMS approval for the methodology used to claim any such additional expenditures, subject to the aggregate limit described in Table 5. Once all relevant approvals are obtained, CMS and the State will update the DSHP claiming protocol (Attachment G).

58. **Specified Designated State Health Programs (DSHP).** The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and limits described in section XIII of the STCs.

Table 6.

DSHP
OTHER
Non-Residential Adult (AMH1)
Child and Adolescent (AMH1)
Regional Acute Psychiatric Inpatient (AMH1)
Residential Treatment for Youth (AMH2)
Adult Foster Care (AMH2)
Older/Disabled Adult (AMH2)
Special Projects
Community Crisis
Support Employment (AMH1)
Homeless (AMH1)
Residential Treatment (AMH2)
Non-Residential Adult (Designated)
A & D-Special Projects (AMH3)
A & D Residential Treatment - Adult (AMH4)
Continuum of Care (AMH5)
System of Care (CAF1)
Community Based Sexual Assault (CAF2)
Community Based Domestic Violence (CAF3)
Family Based Services (CAF5)
Foster Care Prevention (CAF6)
Enhanced Supervision (CAF8)

Nursing Assessments (CAF11)
Other Medical (CAF13)
IV-E Waiver (Demo Project for Parenting, mentoring, enhanced supervision)
Personal Care (CAF17)
Oregon Project Independence
SE #150 Family Support (SPD3)
SE #151 Children Long-Term Support (SPD4)
Licensing Fee
General Microbiology
Virology
Chlamydia (PHD4)
Other Test Fees (PHD5)
State Support for Public Health (PHD6)
(Newborn screening OF is used for match for the MCH block grant) (PHD11)
Prescription Drug Monitoring Program (PHD7)
HIV Community Services (PHD8)
General Funds - HST (PHD9)
Sexually Transmitted Diseases
Mental Health Treatment
Drug and Alcohol
Formerly Medically Needy (Organ Transplant) Clients
Workforce Training To Promote Medicaid Provider Participation
Undergraduate and graduate health professions education
OMIP
State Hospitals (OSH and BMRC)
Gero-Neuro

X. GENERAL REPORTING REQUIREMENTS

Effective January 1, 2014, reporting requirements will change to reflect the new eligibility and benefits structure. The State will submit timely requests for amendment of the Demonstration, consistent with the Transition Plan required by Demonstration paragraph 13, in order to implement the reporting requirement changes by January 1, 2014.

59. **General Financial Requirements.** The State shall comply with all general financial requirements under Title XIX and XXI set forth in these STCs.

60. **Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The State must

submit any corrected budget and/or allotment neutrality data upon request, including revised budget and allotment neutrality spreadsheets consistent with these STCs.

61. **Compliance with Managed Care Reporting Requirements.** The State shall comply with all managed care reporting regulations at 42 CFR Section 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

62. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, CCO/MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the State's progress on enrolling individuals into the OHP Standard Demonstration group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, CCO/MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

63. **Quarterly Progress Reports.** The State must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter. CMS will provide the format for these reports in consultation with the State. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. An updated CHIP allotment neutrality monitoring spreadsheet;

    c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the OHP Demonstration; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the Demonstration; pertinent legislative activities, litigation status and other operational issues;

    d. Action plans for addressing any policy, administrative, or budget issues identified;

    e. Quarterly enrollment reports required under paragraphs 68 and 71; and

    f. Evaluation activities and interim findings.

    g. FHIAP Reporting inclusive of:

i. **Premium Costs (member share and State subsidy):** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

ii. **Subsidy Costs:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iii. **Enrollee Premium Contributions:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.

iv. **Employer Contributions:** By subsidy level, with a weighted overall average.

v. **Overall Premium Cost:** For individual and group, with a weighted overall average.

vi. **Overall Subsidy Cost:** For individual and group, with a weighted overall average.

64. **Monitoring To Assure Progress in Meeting Demonstration Goals:** The State will submit to CMS a quarterly monitoring report to enable CMS to monitor the State's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of Demonstration goals.

a. **Interim Reporting Format.** The State and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;
ii. Quality Improvement Metrics: Section VII;
iii. Access to Care measures: Section VII;

b. **Timeframe for Reporting.** The State will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.

c. **Data Sources:**
   i. Goal 1:
      1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with State);
      2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;
      3. Total Medicaid service spending per beneficiary; and
      4. CCO provider spending per beneficiary.

ii. Goal 2:
   1. Benchmarked metrics tied to incentive payments, including patient experience surveys;
   2. Data from the all payer-all claims database;
   3. Process Improvement Projects (PIPs);
      a. EQRO studies;
      b. Complaints and grievances;
      c. Health risk assessment data;
      d. Public health data;
      e. Health risk assessment data;
      f. Meaningful use attestation data;
      g. State CCO monitoring reports; and
      h. Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the Duals Demonstration.

d. **Final Annual Report:** The State shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The State will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.

e. **Penalty for Late Reporting:**

i. If the State fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the Demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The State may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that prevents the State from reporting timely, the State can request an exception to these timeframes and penalties.

Percentage withheld of quarterly demonstration administrative funding	Days late
.2	15-30
.4	30-40
.8	41-50
1	51+

65. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration covering Medicaid and CHIP populations. The draft report is also to include, at a minimum, the following:

a. **FHIAP activity**: the names of all participating private individual insurance plans and carriers; any changes in participating individual insurance plans and carriers; the number of OHP eligible participants enrolled with each individual insurance plan or carrier; and the amount of premium subsidies paid each individual insurance plan and carrier.

b. **Premium Assistance Evaluation Related to Cost Effectiveness.** Eligible FHIAP ESI and Individual plans and Healthy Kids ESI plans must meet the State's benchmark. The benchmark reflects benefits commonly offered in Oregon's small group health insurance market. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. The State provides limited wrap around services.

i. The State will monitor program expenditures for FHIAP and compare these expenditures against costs for direct coverage. Specifically, OPHP will compare:

1. FHIAP's (Populations 12, 14, 16, 17, and 18 in Attachment D) overall (Individual and ESI) per member per month (pm/pm) subsidized costs (premium subsidies); to

2. OHA direct coverage (Populations 1 through 11 in Attachment D) overall pm/pm costs.

ii. OPHP will also compare average aggregate cost sharing for FHIAP Individual and ESI plans in Populations 12, 14, 16, 17, and 18 in Attachment D are based on maximum plan out of pocket costs (excluding premium share) to:

1. Out of pocket costs (co-payments) for OHP Plus fee-for-service enrollees.[4]

iii. OPHP will monitor program expenditures for HK ESI (Population 20 in Attachment D) and compare overall pm/pm subsidized costs to OHA direct coverage (children in populations 3, 4, 5, 6, 7 and 8 in Attachment D) overall pm/pm costs. Since there is no direct coverage option available to individuals above 200% FPL, however, these results may be distorted.

[4] OHP Plus applies co-pays on an extremely limited basis: none for children, pregnant women, OAA and AB/AD clients with long-term care services, and only limited co-payments for other groups. Thus, they are not likely to provide a fair comparison with FHIAP and ESI cost sharing.

iv. OPHP will report average aggregate cost sharing for HK ESI plans (Population 20 in Attachment D) based on maximum plan out of pocket costs (excluding premium share).

v. OPHP may survey enrollees participating in premium assistance to determine how well it meets the enrollees' needs.

c. The State shall submit the draft annual report no later than 120 days after the end of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The State shall also submit the title XXI annual State report for its FHIAP children in the Demonstration.

66. **Beneficiary Survey.** The State shall conduct surveys, at least every other year, of OHP enrollees and providers that assess the following information: enrollee health status; satisfaction with provider communication; and access to routine and specialty care. The surveys will be designed to allow analyses based on CCOs/MCOs and benefit plans. The State will also monitor and report on disenrollment requests and the reasons for the requests.

67. **Final Evaluation Report.** The State shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act, and as specified in Section XIV of these STCs.

68. **Enrollment Reporting.**

a. Through the end of the second quarter of FY 2014, each quarter the State will provide CMS with an enrollment report for the title XXI FHIAP population, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the State into the Statistical Enrollment Data System (SEDS) within 30-days after the end of each quarter. The data will be reported for the same groups, categories and in the same manner as the State reports enrollment data for CHIP State Plan population as described in Section 457.740 of the CHIP Final Regulation. SEDS reporting is required for any title XXI-funded population, including populations, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports is required by Eligibility Group (EG) and Type for the title XIX and XXI State Plan and populations.

c. Quarterly Enrollment Reports. Within 60-days of the end of the quarter, the State shall provide CMS with an enrollment report by population showing the end of quarter actual and unduplicated enrollment. The State shall also report on the percent change in each category from the previous quarter and from the same quarter of the previous year. The State shall also report the number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

XI. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

69. **Title XIX Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the Demonstration under section 1115 authority and subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period and pool payments and certified public expenditures made for the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIII of these Terms and Conditions.

70. **Reporting Title XIX Demonstration Expenditures.** The following describes the reporting of title XIX expenditures subject to the budget neutrality expenditure limit:

    a. **Tracking Expenditures**. In order to track expenditures under this Demonstration, Oregon must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual.

        i. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver.

        ii. Year 1 (DY 1) is defined as the year beginning October 1, 2002, and ending September 30, 2003. DY 2 and subsequent DYs are defined accordingly, through DY 9. DY 10 is defined as beginning November 1, 2011 and ending June 30, 2012. Beginning with DY 11, the Year is defined as beginning July 1, 2012 and ending June 30, 2013. DY 12 and subsequent DYs are defined accordingly. To simplify reporting, expenditures from the original Oregon Health Plan Demonstration (11-W-00046/0) paid on or after October 1, 2002, shall be considered expenditures under OHP 2, and must not be reported on any Form CMS-64.9 Waiver or 64.9P Waiver for the original Oregon Health Plan Demonstration.

        iii. Up to and including the July-September 2008, QER, Demonstration expenditures are to be reported on Forms CMS-64.9 Waiver and 64.9P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) in which payments were made for services.

        iv. At the end of the Demonstration, expenditures for which payment was made after the last day of the Demonstration, but were for services or coverage provided during the Demonstration period, are subject to the budget neutrality expenditure limit. These expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the Demonstration project number assigned by CMS, with a project number extension equal to the DY

number of the last year of the Demonstration plus one. For example, if the last year of the Demonstration is DY 8, the Forms CMS-64.9 Waiver and/or 64.9 P Waiver discussed here will bear the project number extension 09. The use of the last DY plus one as a project number extension is a reporting convention only, and does not imply any extension of the budget neutrality expenditure limit beyond the last DY.

v. All title XIX service expenditures that are not Demonstration expenditures should be reported on the appropriate Forms CMS-64.9 Waiver/64.9P Waiver for another Demonstration or waiver, if applicable, or on Forms CMS-64.9 Base/64.9P Base.

b. **Premium and Cost-Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by Demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the Eligibility Groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost-settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver schedules, and allocated to forms named for the different EGs described in (e) below, as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to populations shall be offset against expenditures.

e. **Use of Waiver Forms.** The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. "Current": Base 1 EG expenditures;
ii. "New": Expansion EG expenditures;
iii. "SSI": Base 2 EG expenditures.

iv. DSHP Expenditures
v. CCO Expenditures

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to (1) all title XIX expenditures with dates of service between November 1, 2002 and the end of the OHP2 Demonstration on behalf of individuals who are enrolled in this Demonstration, net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse) and (2) expenditures with dates of service during the original Oregon Health Plan Demonstration that are reported as OHP2 expenditures under paragraph 70.a.ii) above. However, certain Title XIX expenditures, as identified in paragraph 18.e.viii), are not subject to the budget neutrality expenditure limit. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit. Nevertheless, the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10 P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) for which the costs were expended.

h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the later 2-year period, the State must continue to separately identify net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 Waiver forms, in order to account for these expenditures properly to determine budget neutrality.

i. **Review of Past Expenditure Reporting and Corrective Action.** The State will conduct a review of title XIX expenditures reported on Form CMS-64 during the approval period for the OHP Demonstration to ensure that expenditures subject to the budget neutrality expenditure limit have been reported appropriately, according to the instructions contained in this paragraph. The review will seek to verify that all Demonstration expenditures have been reported on Forms CMS-64.9 Waiver, as required by the STCs, and not on any other CMS-64 form, and that no non-Demonstration expenditures have been reported on Forms CMS-64.9 Waiver for the Demonstration. The review will also ascertain whether Demonstration expenditures have been reported under the correct DY. By the end of the second month following the date of approval of this extension, the State will submit a draft plan to the Project

Officer for conducting the review, and for taking action to correct past reporting, subject to CMS approval. All corrective actions must be completed by October 31, 2009. At a minimum, the corrective action must result in the expenditures pertaining to the DY ending September 30, 2003 being identified as DY 01 expenditures, and correspondingly for subsequent DY. The State completed this corrective action on November 30, 2009.

71. **Reporting Member Months:** The following describes the reporting of member months for Demonstration eligibles from October 1, 2002, forward:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 63 of these STCs, the actual number of eligible member months for all Medicaid and Demonstration Member-Month Reporting Groups (MMRGs) defined in the table below. The State must submit a statement accompanying the quarterly report, which certifies the member-month totals are accurate to the best of the State's knowledge. These member month totals should include only persons for whose expenditures the State is receiving matching funds at the Title XIX FMAP rate. The State must also ensure that member-months reported as FHIAP member-months are also not simultaneously reported as direct coverage member-months. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

MMRG	Included Populations	Limitations
Base 1 - Direct Coverage		
AFDC	6	
PLM-A Pregnant Women	1, 2,	
PLM Children	3, 4	
BCC Population	21	
Expansion - Parents or Medicaid		
Expansion Parents up to and including 100% FPL	10	
FHIAP (Medicaid)	14	
Base II Direct Coverage		
OAA	7 (aged only), 8 (aged only)	
Blind/Disabled	7 (blind/disabled only), 8 (blind/disabled only)	
Foster Children	5	

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

c. For the purposes of this Demonstration, the term "Demonstration eligibles" refers to the eligibility categories described in paragraphs 19, 0(a), and 22.b).

72. **Standard Medicaid Funding Process.** The Standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

73. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section entitled "Monitoring Budget Neutrality For The Demonstration" of these STCS.

    a. Administrative costs, including those associated with the administration of the Demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities.

    c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

74. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/Local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Should the State exhaust all available Title XXI funding, the State may submit amendments to the CHIP and Medicaid State Plans to create a title XXI funded Medicaid expansion program. This would allow the State the ability to revert to title XIX funds for those populations covered under the Medicaid expansion program. CMS will provide an expedited timeline and complete review of both amendments within 60 days of submittal.

d. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XII. GENERAL FINANCIAL REQUIREMENTS FOR TITLE XXI STATE PLAN AND TITLE XXI DEMONSTRATION

Starting November 1, 2007, no expenditures are authorized to be reported on the CMS-21 Waiver and/or 21P Waiver form for title XXI funded populations in this demonstration. The following paragraphs govern reporting of title XXI Demonstration expenditures for the Demonstration approval period ending October 31, 2007, including prior period adjustments.

75. **Title XXI Quarterly Expenditure Reports.** The State must report State Plan and Demonstration expenditures using the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outline in section 2115 of the State Medicaid manual. The State shall use Form CMS-21 to report total expenditures for services provided under the approved CHIP plan. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Oregon Demonstration expenditures that do not exceed the State's available title XXI funding.

In order to track expenditures under this Demonstration, the State will report Demonstration expenditures through the MBES/CBES, as part of the routine quarterly CMS-21 Waiver/CMS-21P Waiver reporting process. Title XXI Demonstration expenditures will be reported on separate CMS-21 waiver forms, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made).

a. All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the

expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-21 Waiver and/or 21P Waiver.

b. The standard CHIP funding process will be used during the Demonstration. On a separate Form CMS-21B, the State shall provide updated estimates of expenditures for the population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 Waiver and/or 21P Waiver. CMS will reconcile expenditures reported on the Form CMS-21 waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c. The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

76. Oregon will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the waiver period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the separate child health program or Demonstration until the next allotment becomes available.

77. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this Demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

78. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the Demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

79. All Federal rules shall continue to apply during the period of the Demonstration that State or title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Population. Before lowering the FPL used to determine eligibility, closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

80. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in paragraph 70.

81. **Risk.** Oregon shall be at risk for the per capita cost (as determined by the method described below in this Section) for "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and "Expansion - Parents or Medicaid" population (as defined in paragraph 71(a) reporting of Member Months) enrollees under this budget neutrality agreement, but not for the number of such enrollees. By providing FFP for all "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and Expansion - Parents or Medicaid" enrollees, Oregon shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Oregon at risk for the per capita costs for these enrollees, CMS assures that the Federal Demonstration expenditures will reflect Oregon's estimates of savings from managed care, CCO implementation the priority list, and the use of OHP Standard and the FHIAP benefit packages. Oregon will be at full risk for both enrollment and per capita cost for "Expansion – Childless Adults/Other" eligibles (as defined in paragraph 71(a)). Effective with the implementation of the ACA, these Expansion populations will become mandatory, and Oregon will no longer be at full risk for either enrollment or per capita cost.

82. **Budget Neutrality Ceiling.** The following describes the calculation of the yearly targets mentioned in paragraph 80This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP through the end of the approval period.

    a. The Base 1 Subtotal is calculated by multiplying the actual number of member-months for each "Base 1" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.
    b. The Expansion Upper Limit is equal to the total number of Base 1 member months times the Oregon Ratio, which is equal to 46.86 percent.

    c. Between October 2002, and October 2007, the following rules will govern calculation of the Expansion subtotal.

        i. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is less than the Expansion Upper Limit, then the Expansion Subtotal is calculated by multiplying the actual number of member-months for each Expansion MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

        ii. If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless

Adults/Other") is more than the Expansion Upper Limit, the Expansion MMRG totals are adjusted downward by multiplying them by the ratio calculated by dividing the Expansion Upper Limit by the actual total number of Expansion member-months. The adjusted member-month totals are then used in place of the unadjusted totals to calculate the Expansion Subtotal, following (c) above.

d. Beginning November 2007, and thereafter, the Expansion subtotal will be calculated by multiplying the actual number of member-months for each "Expansion - Parents or Medicaid" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together. The Oregon Ratio calculation will no longer be used after October 31, 2007.

e. The Base 2 Subtotal is calculated by multiplying the actual number of member-months for each Base 2 MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

f. The annual limit is calculated as the sum of the Base 1 Subtotal, Expansion Subtotal, and Base 2 Subtotal. The cumulative budget neutrality expenditure limit is equal to the sum of the annual limits over the entire period of the Demonstration.

g. The following table gives the projected PMPM costs for the calculations described above.

i. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
AFDC	$420.74	6.2%	$446.83	$474.53	$504.08
PLM-A Pregnant Women	$1,605.08	6.1%	$1,702.99	$1,806.87	$1,917.16
PLM Children	$613.21	6.2%	$651.23	$691.61	$ 734.70
Individuals receiving treatment under the Breast and Cervical Cancer Medical (BCCTP) program		6.2%	$		$2504.78

ii. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM
Expansion Parents to 100% FPL	$326.31	6.1%	$346.21	$367.33	$391.86
FHIAP (Medicaid)	$294.48	6.2%	$312.74	$332.13	$352.72

iii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 8 PMPM	Trend	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM

Old Age Assistance	$546.17	5.0%	$573.48	$602.15	$658.53
Blind/Disabled	$1,750.67	5.8%	$1,852.21	$1,959.64	$2179.61
Foster Children	$735.95	6.2%	$781.58	$830.04	$887.03

The following table gives the projected PMPM costs for demonstration years 12 through 15. For DY 12 (July 1, 2013 to June 30, 2014) a blended per member per month was created to account for 4 months of State historical rate and 8 months of 2013 President's budget trend rate.

a. Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM 7/1/14-6/30/15	DY 14 PMPM 7/1/15-6/30/16	DY 15 PMPM 7/1/16-6/30/17
AFDC	$529.80	4.5%	$553.83	$578.95	$605.22
PLM-A Pregnant Women	$2018.86	4.9%	$2117.88	$2221.76	$2330.74
PLM Children	$768.80	3.8%	$798.32	$828.98	$860.81
BCCTP	$2631.69	4.5%	$2750.12	$2873.87	$3003.20

i. Expansion Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM PMPM 7/1/13-6/30/14	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Expansion Parents to 100% FPL	$658.53	4.9%			
FHIAP (Medicaid)	$352.72	4.9%			

ii. The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
Old Age Assistance	$721.39	4.1%	$786.23	$855.19	$928.47
Blind/Disabled	$2419.85	5.1%	$2673.57	$2946.88	$3241.11
Foster Children	$934.56	3.8%	$977.06	$1021.43	$1067.77

Beginning 1/1/2014 MMRG	DY 12 PMPM	Trend	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM
New mandatory adults	$522.00	7%	$559.88	$600.50	$644.07

83. **Future Adjustments to the Budget Neutrality Expenditure Limit.**

a. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under OHP. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903 (w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. Should the State submit a State Plan Amendment to expand coverage, the State must submit written notification to the Project Officer, including a proposal for how the new or expanded eligibility group will be incorporated into the budget neutrality test for OHP.

84. **Composite Federal Share Ratio.** The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the composite federal share. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process through an alternative mutually agreed to method.

85. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. If the budget neutrality expenditure limit has been exceeded at the end of the Demonstration period, the excess Federal funds shall be returned to CMS.

a. To perform the budget neutrality test, actual cumulative FFP received by the State on OHP Demonstration expenditures are compared to the Federal Share of the cumulative OHP budget neutrality expenditure limit. The Federal Share of the cumulative budget neutrality expenditure limit is equal to the cumulative budget neutrality expenditure limit calculated above (on a total computable basis) times the Composite Federal Share, which is the ratio calculated by dividing the sum total of FFP received by the State on actual Demonstration expenditures during the approval period, by total computable Demonstration expenditures for the same period. Actual expenditures are those reported on Form CMS-64, as described in paragraph 70 above. The State may include budget neutrality savings from the original Oregon Health Plan Demonstration (11-W-00046/0) in its application of the budget neutrality test for OHP.

b. Should the Demonstration be terminated prior to the end of the approval period (see paragraphs 9, 10, and 12, the budget neutrality test (including calculation of the Composite Federal Share) will be based on the period in which the Demonstration was active.

c. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

d. Interim Checks/Corrective Action Plan. If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
DY 9	Cumulative budget neutrality cap plus:	0.25 percent
DY 10	Cumulative budget neutrality cap plus:	0.25 percent
DY 11	Cumulative budget neutrality cap plus:	0 percent
DY 12	Cumulative budget neutrality cap plus:	0.25 percent
DY 13	Cumulative budget neutrality cap plus:	0.25 percent
DY 14	Cumulative budget neutrality cap plus:	0.25 percent
DY 15	Cumulative budget neutrality cap plus:	0 percent

XIV. EVALUATION OF THE DEMONSTRATION

86. **Evaluation Design.** In the 120 days following the date of approval of this Demonstration, the State shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the State will consider the Evaluation Guidance in Attachment B. The evaluation will include:

a. A discussion of the Demonstration hypotheses that will be tested, focusing on key areas of the State's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional Demonstration outcome measures;
b. An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.
c. Any other information pertinent to the State's evaluative or formative research via the Demonstration operations.
d. Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;
e. The draft plan shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation; and

f. Any other information pertinent to the State's evaluative or formative research via the Demonstration operations

87. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of Section 1115 (a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

88. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The State shall submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

89. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

Attachment A - Quarterly Report Guidelines

(updated December 18, 2012)

As written within these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. In particular, the reporting elements may change to take advantage of new reporting via automated data systems that will support the transmission of data through data portals and other electronic reporting channels.

A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided in Appendix D.

REPORT FORMAT

I. Introduction

A. Letter from the State Medicaid Director – overview of the report

B. Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

C. State Contact(s):

1. Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise concerning quarterly reports.

II. Title

Title Line One – Oregon Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 11 (7/1/2012 – 6/30/2013)

Federal Fiscal Quarter: 4/2012 (7/2012 – 9/2012)

III. Events affecting health care delivery during the current quarter

Table 1 – Overview of significant events across the state affecting health care delivery during the current quarter

Table 1 is a statewide overview of the effect, or impact, of changes – positive, negative or with neutral effect – happening in the current quarter that are noteworthy because they reflect trends, major policy modifications or planned or unforeseen occurrences that affect:

- **The demonstration goals** of better health, better care, and lower costs as reflected in measures of efficiency, value and health outcomes;
- **A substantial portion of the delivery system**; or
- **A substantial portion of beneficiaries**.

Each category identifies data sources and whether there is a documented impact on the delivery system or beneficiaries. This table also shows interventions, or actions, the state may take or require to remedy, sustain or improve an outcome, as appropriate.

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
A. Enrollment progress	Quarterly enrollment reports – Appendix A				
B. Benefits	Provider and member transmittals – online at: http://www.dhs.state.or.us/policy/healthplan/transmit/main.htm				
C. CCO Complaints and Grievances	Monthly/quarterly CCO logs submitted to OHA and presented with detail in Table 2				
D. Quality of care – CCO	CCO and Innovator agent reporting to OHA as reported in Table 3 and Appendix F				
D. Quality of care – MCO	MCO reporting to OHA as reported in QI monitoring reports				
D. Quality of care – FFS	OHA FFS reporting				

Category of event	Data source/citation	Impact on Demon-stration goals Yes /No	Impact on bene-ficiaries Yes /No	Impact on delivery system Yes /No	Interven-tions or actions taken Yes /No
E. Access	CCO and Innovator agent reporting to OHA as reported in Appendix F				
F. Provider Workforce	OHA surveys, summarized in Table 4				
G. CCO networks	CCO and Innovator agent reporting to OHA as summarized in Table 5 and Appendix F				

Detail on impacts or interventions

C. Table 2 – Complaints and grievances – statewide report -- all categories of CCO complaints and grievances for the current quarter

See www.oregon.gov for quarterly reports of complaints and grievances for individual CCOs.

NOTE: Oregon defines a grievance as any written or verbal complaint by an enrollee or consumer, or the enrollee's representative, regarding the enrollee's quality and access of care, individual or system abuse or neglect, issues related to the health plan's compliance with the Medicaid Program rules, billing complaints related to rights and limitations as provided by 42 CFR §438 and complaints related to eligibility and/or enrollment.

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
ELIGIBILITY AND ENROLLMENT					
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.					
b) Plan unresponsive, not available or difficult to contact for appointment or information.					
c) Provider's office too far away, not convenient					
d) Unable to schedule appointment in a timely manner.					
e) Provider's office closed					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
to new patients.					
f) Referral or 2nd opinion denied/refused by provider.					
g) Unable to be seen in a timely manner for urgent/ emergent care					
h) Provider not available to give necessary care					
i) Eligibility issues					
j) Client fired by provider					
INTERACTION WITH PROVIDER OR PLAN					
a) Provider rude or inappropriate comments or behavior					
b) Plan rude or inappropriate comments or behavior					
c) Provider explanation/instruction inadequate/incomplete					
d) Plan explanation/instruction inadequate/incomplete					
e) Wait too long in office before receiving care					
f) Member dignity is not respected					
g) Provider's office or/and provider exhibits language					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
or cultural barriers or lack of cultural sensitivity.					
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity					
i) Lack of coordination among providers					
CONSUMER RIGHTS					
a) Provider's office has a physical barrier					
b) Abuse, physical, mental, psychological					
c) Concern over confidentiality					
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.					
e) No choice of clinician					
f) Fraud and abuse					
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)					
h) Plan bias barrier (age, race, religion, sexual rientation, mental/physical health					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
status)					
i) Differential treatment for Medicaid clients					
j) Lack of adequate or understandable NOA					
k) Not informed of consumer rights					
l) Complaint and appeal process not explained					
m) Denied member access to medical records					
CLINICAL CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.					
b) Testing/assessment insufficient, inadequate or omitted					
c) Medical record documentation issue					
d) Concern about prescriber or medication or medication management issues					
e) Unsanitary environment or equipment					
f) Lack of appropriate individualized setting in treatment					

Complaint or grievance type	Number of complaints and grievances in current quarter	Trend(s) identified? Yes/No	Number resolved in current quarter	Actions to prevent recurrence Yes/No	Range of CCO number of complaints and grievances in current quarter
QUALITY OF SERVICE					
b) Delay, quality of materials and supplies (DME) or dental					
c) Lack of access to ENCC for intensive care coordination or case management services					
d) Benefits not covered (Right click on drop down for selection)					
CLIENT BILLING ISSUES					
a) Co-pays					
b) Premiums					
c) Billing OHP clients without a signed Agreement to Pay					

Trends related to Grievances and Complaints, to include:

- Rate of complaints and grievances per enrollee
- Rate of complaints and grievances per enrollee using services
- Trends across quarters, including year to date total complaints and grievances with percentages

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

NOTE: Appeals and Contested Case Hearings are based on "actions" or denials, limited authorization, reduction, termination or suspension of services; or when payment is denied for a service that has been provided or a CCO has failed to act within specified timeframes.

	CCO Appeals		Overturned at plan level		Decisions Pending		Contested Case Hearings from CCO Appeals		Overturned at hearing		Decisions Pending	
Category	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**	**#**	**Range**
a) Denial or limited authorization of a requested service												
b) Single PHP service area, denial to obtain services outside the PHP panel												
c) Termination, suspension or reduction of previously authorized covered services												
d) Failure to act within the timeframes provided in § 438.408(b)												
e) Failure to provide services in a timely manner, as defined by the State												

f) Denial of payment for a service rendered												
TOTALS												

Trends (Narrative):

Interventions (Narrative):

D. Table 3 – Summary – Implementation of 1% withhold

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

Metric	Amount(s)	Quarterly	Annually
Encounter data analysis - **Spending in top 25 services by eligibility group and by CCO** - **To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well**		X	X

E. Table 4 – Statewide Workforce development – Non-Traditional Health Workers (NTHW)

	Total Number Certified Statewide* (current quarter & cumulative)	Number of approved training programs (current quarter & cumulative)
Community Health Workers		
Personal Health Navigators		
Peer wellness specialists		
Other NTHW		

* Statewide NTHW registry anticipated to launch in fall of 2013. Quarterly reporting would be reasonable after that point.

Narrative detail on regional distribution of certified NTHWs and NTHW training programs; news about relevant recruitment efforts or challenges

Health professional graduates participating in Medicaid

Tracking method and reporting format in development. Current assumptions are that:

- Tracking and reporting will begin July 2013, per STC 57(b)(iii) and will continue through the period for which FFP is claimed.
- Tracking will include graduates of each health professional training program for which FFP is claimed, within Oregon Health & Science University, the Oregon University System, and select Community Colleges.
- Tracking and reporting will be done by program/professional type (e.g. reporting will distinguish between physicians, nurses, dentists, physical therapists, and so on) and by practitioner specialty to the extent possible.
- These data will be presented in a detailed annual report. Updates will be provided quarterly, as available.

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

Type of Change	Specific change	Effect on delivery system	Effect on members	Number of CCOs affected	Number of CCO members affected
Approval and contracting with new plans					
Changes in CCO/MCO networks					
Rate certifications					
Enrollment/disen-rollment					
CCO/MCO contract compliance					
Relevant financial performance					
Other					

G. Table 6 – Transformation center

Innovator Agents – Summary of promising practices statewide during current quarter

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
Innovator agent training				
Learning Collaborative activities				
Assisting and supporting CCOs with Transformation Plans				
Assist CCOs with target areas of local focus for improvement				
Communications with OHA				
Communications with other Innovator Agents				
Community Advisory Committee activities				
Rapid-cycle Stakeholder feedback to identify and solve barriers; to assist with adapting innovations; to simplify and/or improve rate of adoption and to increase stakeholder engagement				
Data base implementation – Tracking of CCO				

Task	Summary of activities during current quarter	Promising practices identified during current quarter	Number of participating CCOs	Number of participating Innovator Agents
questions, issues and resolutions in order to identify systemic issues				
Information sharing with public				
Other				

G. Table 7 – Innovator Agents – – Measures of effectiveness

Measure	Data published for current quarter? Type?	Web link to Innovator Agent quality data
1. Surveys rating IA performance		
2. Data elements (questions, meetings, events) tracked		
3. Innovations adopted		
4. Progress in adopting innovations *		
5. Progress in making improvement based on innovations *		
6. CCO transformation plan implementation		
7. Learning Collaborative effectiveness		
8. Performance on Metrics and Scoring Committee metrics		

* These items will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

H. Legislative activities during current quarter

I. Litigation status

J. 2 percent trend data are reported in Appendix D: This table shows expenditures, including services inside and outside capitation rates for all populations served by CCOs, as well as administrative expenditures and indicates progress in meeting spending growth reduction targets.

K. DSHP terms and status are reported in Appendix E: This table shows new federal funds drawn as match against DSHP programs; new federal funds drawn as a result of DSHP and savings identified in the total cost of purchasing care (as described in STC 48).

IV. Status of Corrective Action Plans (CAP) that address any policy, administrative, or budget issues identified by CMS, the State, or a regulatory entity that impacts the Demonstration.

Table 8 – Status of Corrective Action Plans (CAP)

Entity (CCO or MCO)	Purpose and type of CAP	Start date of CAP	Action sought	Progress during current quarter	End date of CAP	Comments

V. Evaluation activities and interim findings

Primarily narrative section focusing on the levers that are expected to drive quality improvement and cost trend reduction under the waiver, and results available to date regarding progress toward demonstration goals.

Reporting and discussion will include both OHA and CCO actions and may make reference to data presented in other sections of the quarterly report or in other documents (e.g. Section III of quarterly report, 2% trend reporting etc.)

Table 9 – Evaluation activities and interim findings

Lever	Report and Discussion
Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient- centered primary care homes (PCPCH)	*Discussion to include any rapid-cycle improvement activities planned as a result of findings, and reports on previous improvement efforts.*
Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes	
Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of	

Lever	Report and Discussion
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 Transformation Center	

Discussion of progress to date on waiver goals: reducing per-member cost growth, and improving quality, access, member experience and health outcomes.

VI. Public Forums – For any public forums held during the quarter**,** include public comment and summary report

VII. Transition Plan, Related to Implementation of the Affordable Care Act (ACA) – Effective 4-1-13 and ongoing, submit State's transition plan on 4-1-13, report and update on changes to or implementation of the plan quarterly, as necessary. The plan will include how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible.

VIII. Appendices

A. Quarterly enrollment reports that report:

1. SEDS
2. State reported enrollment tables
3. Actual and unduplicated enrollment, showing:
   a) The percent change in each category from the previous quarter and from the same quarter of the previous year
   b) The number and percentage of eligibles enrolled in managed/coordinated care and in FHIAP until FHIAP terminates upon the implementation of ACA

B. Complaints and Grievance reports by sub-categories

C. Neutrality reports:

1. Budget monitoring spreadsheet
2. CHIP allotment neutrality monitoring spreadsheet
3. Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

D. Two percent trend reduction tracking

E. DSHP tracking

F. Oregon Measures Matrix for Quarterly Reporting

IX. Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

The State may also add additional program headings as applicable.

Appendix F: Oregon Measures Matrix

NOTE: Measures with an asterisk (*) are those that are reported quarterly. All others are reported annually.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
Improving behavioral and physical health coordina-tion	*Alcohol or other substance misuse (SBIRT)	√	√			√	MN method** Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplishe d 44% initial screen after 2 years of focused, evidence-based intervention).	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based intervention).			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from predecessor	TBD			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
									organization.				
	*Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available by April 2013.	90% (Note: Benchmark based on Metrics & Scoring Committee consensus).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	90%			
	*Follow-up care for children prescribed ADHD meds	√			√	√	Oregon Medicaid baseline 2011: Initiation:	Medicaid 2012 NCQA National 90th percentile: Initiation:	Individual CCO baselines will be determined with 2011	Medicaid NCQA National 90th percentile:			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	(NQF 0108)						50% C&M: 57%	51% C&M: 63%	data from predecessor organization.	Initiation: 51% C&M: 63%			
Improving perinatal and maternity care	* Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 89%			
	* Prenatal and postpartum care: postpartum			√		√	TBD (baseline data available in	2012 National Medicaid benchmark 75th	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	care rate (NQF 1517)						Feb 2013)	percentile: 90th percentile: 74.7%					
	*PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could also use the 16% rate publically available	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Could also use the	5% or below.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
							from Joint Commission - Diane Waldo)		16% rate publically available from Joint Commission - Diane Waldo)				
Reducing preventable re-hospitaliza-tions	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%			
	*Ambulatory	√	√		√	√	TBD (baseline	TBD	MN method	2011 National Medicaid 90th			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	Care: Outpatient and ED utilization						data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	percentile (ED utilization): 44.4/1,000mm			
	*All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a			
Ensuring appropriate care is delivered in appropriate	*Ambulatory Care: Outpatient and	√	√		√	√	TBD (baseline data available in	TBD 2011 National Medicaid 90th	MN method with 3% floor. Individual CCO	2011 National Medicaid 90th percentile (ED utilization):			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
settings	ED utilization						Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	percentile (ED utilization): 44.1 / 1,000 mm	baselines will be determined with 2011 data from predecessor organization.	44.4/1,000mm			
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5 year period based on trends in Medicare and Commercial data).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor	2012 National commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile:			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
									organization.	61.34 (Based on Metrics & Scoring Committee consensus)			
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.	The percentage of dollars available to each CCO for this measure will be tied to the percentage of enrollees in PCPCH, based on measure formula.			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	*Developmen-tal screening in the first 36 months of life (NQF 1448)	√	√		√	√	Oregon baseline: 19.6% using admin data only.	50% (Metrics & Scoring Committee consensus)	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	50% (Metrics & Scoring Committee consensus)			
	*Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
								77.3%					
	*Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile: 56.9%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 75th percentile: 56.9%			
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
								90th percentile: 27.5%					
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a			
	Appropriate testing for children with pharyngitis (NQF 0002)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile:	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
								90th percentile: 83.9%					
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed or recommen	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
							ded medication s with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)						
Deploying care teams to improve care and reduce	*Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013)	TBD 2011 National Medicaid 90th percentile	MN method with 3% floor. Individual CCO baselines will	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
preventable of unnecessarily costly utilization by super users							ED utilization baseline (2011): 56 / 1,000 mm	(ED utilization): 44.1 / 1,000 mm	be determined with 2011 data from predecessor organization.				
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%			
	*Comprehen-sive diabetes care: LDL-C			√		√	TBD (baseline data	2012 National Medicaid	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
coordinating a broad set of resources, including CHW.	Screening (NQF 0063)						available in Feb 2013)	benchmark 75th percentile: 90th percentile: 83.5%					
	*Comprehen-sive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 91.1%	n/a	n/a			
	Diabetes: HbA1c Poor Control (NQF	√				√	TBD (baseline data	Pick percentile	MN method. Individual	Pick percentile NCQA National			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	0059)						available in Feb 2013)	NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile: 28% 75th percentile: 34%			
	*PQI 01: Diabetes, short term complication admission rate (NQF 0272)		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
	*PQI 05:		√	√		√	416.9	10% reduction	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	Chronic obstructive pulmonary disease admission (NQF 0275)						(2011)	from baseline Benchmark set based on Oregon's data (2002-2011)					
	*PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a			
	*PQI 15: Adult asthma admission rate		√	√		√	178.7 (2011)	10% reduction from baseline	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	(NQF 0283)							Benchmark set based on Oregon's data (2002-2011)					
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	**Access to Care** OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentil	**Access to Care** OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%			
	CAHPS 4.0H (child version including Medicaid and children with	√	√		√	√							

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	chronic conditions supplemental items).							e: 90.31% National average: 86.97%					
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 72.7%	n/a	n/a			
	*Cervical cancer			√		√	TBD (baseline data	2012 National Medicaid	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	screening (NQF 0032)						available in Feb 2013)	benchmark 75th percentile: 90th percentile: 78.5%					
	*Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a			
	Provider Access Questions from the Physician Workforce Survey:					√	In 2009: 52.4% of Oregon's physicians accepted	TBD	n/a	n/a			

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	1) To what extent is your primary practice accepting new Medicaid/ OHP patients? (include: completely closed, open with limitations, and no limitations) . 2) Do you						new Medicaid patients without limitations; 29.7% accepted with some limitations; and 17.9% were completely closed. 84% of physicians have Medicaid patients. The						

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	currently have Medicaid/ OHP patients under your care? 3) What is the current payer mix at your primary practice?						statewide payer mix for Medicaid is 15%.						
	Screening for depression and follow up plan (see above)												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	*SBIRT (see above)												
	*Mental and physical health assessment for children in DHS custody (see above)												
	*Follow-up care for children on ADHD medication (see above)												
	*Timeliness of												

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
	prenatal care (see above)												
	Colorectal cancer screening (see above)												
	PCPCH enrollment (see above)												
	*Developmen-tal screening by 36 months (see above)												
	*Adolescent well child visits (see above)												

	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	**CCO Incentive Measures**	**1115 Demonstration Core Performance Measures**	**CMS Medicaid Adult Core Measures**	**CMS CHIPRA Core Measures**	**Oregon Quality & Access 'Test' Measures**	**Baseline**	**Benchmark**	**Improve-ment from Baseline Target**	**Benchmark Target**	**CCO Average**	**Statewide Variation**	**Activities**
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		Monitoring/ Evaluation
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improve-ment from Baseline Target	Benchmark Target	CCO Average	Statewide Variation	Activities
Meaningful Use	EHR adoption (Meaningful Use 3 question composite)	√				√	TBD (Baseline data available in April 2013)	TBD	TBD (Baseline data available in April 2013)	TBD			

* These measures are reported quarterly

**The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Attachment B – Evaluation Guidelines

Section 1115 Demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS requires States with Demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their Demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to Demonstrations; States, Federal Government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the Demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or Demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the Demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality Demonstration programs. Should States have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and
    - Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
    - Hypothesis or research questions to be investigated;
    - Goals, such as:
        - Increase Access
        - Impact of title XXI cost sharing waiver for children in premium assistance
        - Cost Effectiveness
        - Improve Care Coordination
        - Increase Family Satisfaction and Stability
    - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
    - The type of research design(s) to be included -
        - Pre/Post Methodology
        - Quasi-Experimental
        - Experimental
    - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
    - Enrollment and outreach records;
    - Medicaid claims data;
    - Vital statistics data;
    - Provide record reviews;
    - School record reviews; and
    - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
    - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
    - How findings will be incorporated into outreach, enrollment and education activities;
    - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
    - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the Demonstration intervention.

ATTACHMENT C
Glossary of Terms Related to title XIX and XXI funded Children

Effective with the implementation of the ACA, changes to the Demonstration will require revision of the Glossary.

Exhibit 1: Glossary of Terms Related to title XIX and XXI funded Children

- **Healthy Kids*:*** Created by House Bill 2116 during Oregon's 2009 Legislative Session, *Healthy Kids* provides coverage for all uninsured children up to age 19 in the State. The plan offers comprehensive health care coverage that includes dental, vision, mental health and physical health care. The objective of *Healthy Kids* is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. *Healthy Kids* includes three different program components:

    1. Existing CHIP and Medicaid direct coverage (OHP Plus);

    2. Premium assistance administered by the Office of Private Health Partnerships (family coverage under FHIAP for children up to and including 200 percent of FPL, and Healthy Kids ESI child only premium assistance for kids up to and including 300 percent of FPL;

    3. A private insurance component, Healthy KidsConnect, which is provided under the CHIP state plan.

  The Federal government will provide match for children up to and including 300 percent of the FPL. The State will also permit uninsured children above 300 percent of the FPL to purchase the plan under Healthy KidsConnect without State or Federal match.

- **Family Health Insurance Assistance Program (FHIAP) for Families Enrolled in ESI or Individual Market:** The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA) administers FHIAP. The premium assistance program provides subsidies to help families and individuals pay for health insurance offered either through employer-sponsored insurance (ESI) or private health insurance carriers. Coverage provided by the insurance plans must meet or exceed the FHIAP benchmark criteria, which is approved at a level actuarially equivalent to federally mandated Medicaid benefits.

As of January 1, 2014: 1) Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP or Healthy Kids ESI components of this demonstration rather than enroll in the Medicaid or CHIP State plan, and 2) Parents and childless adults enrolled in FHIAP with income from 0 up to 133 percent of the FPL, will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP State plans. Individuals currently receiving premium assistance who, based on an initial screening evaluation, do not appear to be eligible under

the approved Medicaid or CHIP State plans will be afforded a full eligibility determination prior to termination. Individuals denied continued benefits will be offered the opportunity to have their information electronically transmitted to the State Affordable Insurance Exchange (Exchange) to be treated as an application for coverage and benefits through the Exchange.

- **Premium Assistance for children and families with incomes from zero up to and including 200 percent of FPL:** Subsidies are available to children in this income category through FHIAP or Healthy Kids ESI. Children determined eligible by DHS or OHA are referred to OPHP for enrollment and subsidy payment or go directly to OPHP and on the FHIAP reservation list. FHIAP pays premium subsidies ranging from 50 to 95 percent for adults. Both FHIAP and Healthy Kids ESI pay100 percent of the premium for children in this income group. Individuals (adults and children) who enroll in this program are subject to all other cost sharing provisions of the insurance plan. The children in this income group have the option of enrolling in FHIAP, Healthy Kids ESI, or CHIP direct coverage (OHP Plus), and children who choose FHIAP or Healthy Kids ESI can move back to State plan direct coverage at any time.

- **Healthy Kids ESI/Child Only Premium Assistance and Healthy KidsConnect for children in families with incomes above 200 up to and including 300 percent of FPL who have access to ESI:** Subsidies are available to children in this income category through ESI or the State's private insurance option, Healthy KidsConnect. Children in families with incomes above 200 percent FPL are not eligible for CHIP direct coverage (OHP Plus). Sliding scale subsidies are available for children who are able to enroll in the family's ESI.
    - Families with incomes above 200 up to and including 250 percent of FPL will receive State subsidies equaling about 90 percent of the child's monthly premium.
    - Families with incomes above 250 up to and including 300 percent of the FPL will receive State subsidies equaling about 80 percent of the child's monthly premium.
    - All other cost-sharing is subject to the cost of the employer plan.

- **Healthy KidsConnect:** This is a CHIP state plan direct coverage option provided under the State's separate child health program. Sliding scale subsidies are available to children who enroll in State-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP direct coverage (OHP Plus) benefit package.

- Families with incomes above 200 percent up to and including 250 percent of FPL will receive State subsidies equaling about 90 percent of the child's monthly premium; and
- Families with incomes above 250 percent up to and including 300 percent of the FPL will receive State subsidies equaling about 80 percent of the child's monthly premium.
- Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.

- **Oregon Health Plan (OHP) Plus:** OHP Plus is a CHIP state plan direct coverage option provided under the State's separate child health program. The State provides Secretary-approved coverage that is the same as coverage offered under the State's Medicaid program. The State's benefit package is based on the OHP Prioritized List of Health Services, which is a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration for its entire Medicaid population. Medically necessary services are defined in the Prioritized List. The benefit package includes mandatory services for children, including well-baby and well-child visits, immunizations and dental services. There are no premiums, co-payments, or deductibles for children in direct coverage.

- **FHIAP Reservation List:** Oregon uses reservation lists to manage enrollment in the premium assistance program. Only FHIAP-eligible families with income from 0 up to and including 200 percent of the FPL are subject to the reservation list.

  As of January 1, 2014 the FHIAP reservation list will no longer be applicable. Medicaid and CHIP eligible children who have voluntarily elected to receive premium assistance under the FHIAP component of this demonstration rather than enroll in the Medicaid or CHIP State plan, and parents and childless adults enrolled in FHIAP with income below 133 percent of the FPL will be enrolled in a CCO as long as they meet the applicable eligibility standards under the approved Medicaid or CHIP State plans.

  - **The individual reservation list** is for applicants who do not have access to ESI.
    - Once approved, individuals may select an individual health plan from a list of approved FHIAP insurers.
    - Only plans that meet FHIAP's benchmark are offered to individual members.

  - **The group reservation list** is for applicants who have access to ESI.
    - ESI plans must meet FHIAP's benchmark.

Attachment D - Summary Chart of Populations Affected by or Eligible Under the Demonstration through December 31, 2013

ACA Implementation. As set forth in paragraph 13 and upon implementation of the ACA on January 1, 2014, OHP eligibility criteria and income standards including but not limited to the eligibility expansion to individuals described under 1902(a)(10)(A)(i)(VIII) of the Act and the collapsing of certain eligibility groups will revert to the Medicaid State plan.

I. Mandatory Medicaid Populations*							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
1	Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL	None	OHP Plus	Base 1
3	Children 0 through 5	Title XIX	Title XIX State Plan and Section 1115	0% up to 133% FPL**	None	OHP Plus	Base 1
4	Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	0% up to 100% FPL	None	OHP Plus	Base 1
5	Foster Care/Substitute Care Children	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus	Base 2
6	AFDC low-income families (parents /caretaker relatives and their children)	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX	Title XIX State Plan	SSI Level	$2,000 for a single	OHP Plus	Base 2
21	Uninsured or underinsured	Title XIX	Title XIX	0% up to 250% FPL	None	Limited – case-by-case basis	Base 1

II. Optional Medicaid Populations***							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
8	Aged, Blind, & Disabled	Title XIX	Section 1115 and Title XIX State Plan	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus	Base 2

2	Pregnant Women	Title XIX	Section 1115 and Title XIX State Plan	From 133% up to 185% FPL	None	OHP Plus	Base 1
13	Pregnant Women	Title XIX	Section 1115 and Title XIX State Plan	From 133% up to 185% FPL	None	OHP Plus	Base 1
III. Expansion Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
9	General Assistance adults (ages 18 and older)	Title XIX	Section 1115	$314 for need group of one; $628 for a need group of two	$2,000 single individual; $3,000 for a couple	OHP Plus	Expansion
10	Uninsured Parents, ages 19 through 64	Title XIX	Section 1115	0% up to 100% FPL	$2,000	OHP Standard	Expansion
11	Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	0% up to 100% FPL	$2,000	OHP Standard	Expansion

IV. Optional and Expansion Medicaid /CHIP Populations							
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**
12	Participants in FHIAP as of 9/30/02; prior State-funded FHIAP parents and childless adults who already have insurance; FHIAP children	Title XIX	Section 1115	From 0 % up to 170% FPL	None	FHIAP	Expansion
Population	**Description**	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**EG Group**

14	Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	From 0% up to 185% FPL	None	FHIAP	Expansion
16	Until January 1, 2014: Uninsured targeted low income children ages 0 through 5, and Uninsured targeted low income children ages 6 through 18 These children choose voluntary enrollment in FHIAP.	Title XXI	Section 1115 and Title XXI	From 133% up to and including 200% FPL From 100% up to and including 200% FPL	None	FHIAP, including dental, well-baby, well-child, immunizat-ions and emergency services.	Optional
17	Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	From 0% up to and including 200% FPL	None	FHIAP	Expansion
18	Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	From 0% up to and including 200% FPL	None	FHIAP	Expansion

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
20	Until January 1, 2014, Uninsured children ages 0 through 18 with incomes above 200 up to and including 300 percent of the FPL, who meet the title XXI definition of a targeted low-income child and	Title XXI	Section 1115 and Title XXI CHIP State Plan	Above 200% up to and including 300% FPL	None	Healthy Kids ESI child only premium assistance, including well-baby, well-child, immunizat-ions, dental and emergency services	Optional

	choose voluntary enrollment in premium assistance under Healthy Kids ESI.						
22	Uninsured targeted low income children ages 0 through 5, and eligible for direct services under the CHIP State Plan Uninsured targeted low income children ages 6 through 18 and eligible for direct services under the CHIP State Plan Targeted low income children ages 0 through 18 who are eligible under the CHIP state plan (under Healthy KidsConnect). Uninsured target low income children ages conception to birth who reside in specific participating counties and are eligible for the unborn option.	Title XXI	Section 1115 and Title XXI CHIP State Plan	From 133% up to and including 200% FPL From 100% up to and including 200% FPL Above 200% up to and including 300% FPL From 0% to 185% of the FPL	None	OHP direct services; Healthy KidsConnect private product under contract with OHA; OHP direct services as limited for unborn population **	Optional

* Mandatory populations have the option of choosing FHIAP, in which case they would be in Population 14.

**Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the State also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by Federal regulations, since the State has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL.

***Optional Medicaid (OHP Plus) populations have the option of choosing FHIAP, in which case they would be in Population 14.

**** Unborn population is precluded from receiving the following services: abortion, death with dignity, sterilization, hospice services and postpartum services beyond the global rate

Attachment E: Menu Set of Quality Improvement in Focus Areas

The measures in bold would be the core measures for each focus area and would be required of any CCO selecting that focus area.[5] The purpose for these focus areas is to reduce costly, inappropriate, and unnecessary care where possible without decreasing the quality of care. The State may wish to add to this menu to account for how they will measure access and quality for individuals receiving care FFS—this should include populations receiving costly long term care and supportive services.

Goal	Example Measures (bolded measures are core for that focus area)	Example Interventions
1) Reducing rehospitalizations	**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 rehospitalizations and/or incentives for low rates (must remove the financial incentive to rehospitalize through incentives and penalties), care transition programs. Also see "super-utilizers" interventions
2) Addressing discrete 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	These will vary depending on issue identified, but could include disease specific measures such as Diabetes Care measure, pediatric asthma hospitalization	Ideally these would include a wide range of activities by multiple entities such as pediatric community based asthma initiatives, enhanced by coordinated public health interventions to target tobacco cessation. Clinical diabetes care initiatives can dovetail with public health interventions such as outreach programs and community based obesity reduction programs
Reducing utilization by "super-utilizers"	Cost of care measures (total cost of care per patient over	Community-based outreach programs to better address

[5] The rest of the measurement strategy will be determined later but sample additional measures are included for discussion purposes.

Example Measures (bolded measures are core for that focus area)		
	specific time period), and the **readmissions measures mentioned above, rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; and outpatient and ED utilization**	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 superutilizers. Oregon's proposal includes pieces of these, including community health workers to help beneficiaries navigate the system and access resources; coordination with long-term care case workers and providers for individuals receiving long-term care and/or developmental disabilities supports and services; CCO efforts to integrate information flow across providers. It is critical these services are appropriately targeted
Integrating primary care and 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 health assessment for children in DHS custody, mean cost for outpatient mental health and medications per patient; mean cost for inpatient	Global budget and single point of accountability for behavioral and physical 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

Example Measures (bolded measures are core for that focus area)		
	mental health and substance abuse care per patient	
Ensuring appropriate care is delivered in appropriate settings	**Rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization,** Hospital readmissions (across age groups); Plan all-cause readmissions, primary care access measures	Narcotics registries, programs to address "super-utilizers", targeted case management for frequent ED users, connect vulnerable patients with appropriate behavioral health and social services
Improving perinatal and maternity care	**Early elective delivery before 39 weeks**, 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
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, BMI recorded (and appropriate counseling), drug-to-drug and drug allergy checks, and maintain active	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 EHR adoption and meaningful use; PCMH participation incentives; shared incentives across primary, specialty, long-term, and acute care; improved access (e.g., after-hours physician availability, 24/7 access to an NP or doctor); PHRs; open-access scheduling and sick hours.

Example Measures (bolded measures are core for that focus area)		
	medication list (including allergies)	

Attachment F: CCO Services Inventory
(updated December 18, 2012)

This attachment provides the schedule for inclusion of new services into CCO global budgets and reflects OHA's planning as of December 2012. Oregon will notify CMS if contract amendment schedule is revised.

Pursuant to STC 36b, the inclusion of additional services in the global budget will be mutually agreed upon by the State and CMS and phased in over the course of the Demonstration. Oregon will submit proposed changes to the Regional Office as part of draft CCO contracts or contract amendments at least 45 days in advance of their effective date. Services outlined in Attachment F will generally be included in CCO global budgets as capitated services. For any services not paid as capitation, the state will identify the rate (referencing the state plan methodology or describing the rate methodology to CMS) and the rates will be subject to CMS review and approval.

	Program Area	**Program/Service/Function**	**Per Capita Trend Monitoring**					**Per Capita Trend Monitoring**	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
1	Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	X					Yes	Yes
2	Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities)	X					Yes	Yes
3	Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	X					Yes	Yes
4	Mental Health	Children's Statewide Wraparound Projects	X					Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
5	Mental Health	Exceptional Needs Care Coordinators	X					Yes	Yes
6	Mental Health	Non-forensic intensive treatment services for children(Inpatient Psychiatric Facility Services for Individuals Under age 21)	X					Yes	Yes
7	Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	X					Yes	Yes
8	Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	X					Yes	Yes
9	Mental Health	Supported Employment and Assertive Community Treatment		X				Yes	Yes
10	Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating	X			Yes	Yes
11	Addictions	Youth residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X			Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
12	Addictions	Adult residential alcohol and drug treatment (OHP carve out)	Optional	Optional until July 1, 2013	X			Yes	Yes
13	Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Optional in counties where currently operating	Optional in counties where currently operating	X			Yes	Yes
14	Targeted Case Management	HIV/AIDS Targeted Case Management			X			Yes	Yes
15	Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon			X			Yes	Yes
16	Maternity Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)		Optional where currently operating	X			Yes	Yes
17	Transportation	Non-Emergent Medical Transportation			X			Yes	Yes
18	Mental Health	Adult Residential Mental Health Services			X			Yes	Yes
19	Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)				X		Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
20	Dental	OHP dental coverage	Optional	Optional	Optional	X		Yes	Yes
21	Mental Health	Young Adults in Transition Mental Health Residential			X			Yes	Yes
22	Mental Health	Personal Care 20 Client Employed Provider					X	Yes	Yes
23	Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)					X	No	Yes
24	Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)					X	No	Yes
25	Long Term Care	Long term care institutional and community supports					X	No	Yes
26	Mental Health	State Hospital Care - Forensic					X	No	Yes
27	Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations				X		No	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
28	Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)					X	No	Yes
29	Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB					X	No	Yes
30	Mental Health	OHP-covered mental health drugs					X	No	Yes
31	Other	Hospital Leverages: GME, Pro-Share, and UMG					X	No	Yes
32	Other	FQHC Full-Cost Settlements				X		No	Yes
33	Other	A & B Hospital Facilities Settlements					X	No	Yes
34	Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)					X	No	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring					Per Capita Trend Monitoring	
			August 1, 2012	Jan. 1, 2013	July 1, 2013	Jan 1 2014 or beyond	Not currently planned	2% pmpm growth test	Program wide monitoring only
35	Targeted Case Management	Child Welfare Youth (Targeted Case Management)					X	No	Yes
36	Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)					X	No	Yes
37	Targeted Case Management	Tribal Targeted Case Management					X	No	Yes
38	Other	DSH					X	No	Yes
	Note: All services are state plan services with the overlay of the Section 1915(b) waiver for transportation and the Section 1115 demonstration that includes application of the Prioritized List of Health Services.								

Attachment G

Reimbursement and Claiming Protocol for Oregon Designated State Health Programs
Determination of Allowable DSHP Costs Per Waivers 21-W-00013/10 and 11-W-00160/10

Acronyms:

A & D – Alcohol and Drug
APD – Adults and People with Disabilities (formerly SPD)
AMH – Addictions & Mental Health
CAF – Children, Adults, and Families
CPMS – Client Process Monitoring System
DMAP – Division of Medical Assistance Programs
DSHP – Designated State Health Programs
eXPRS – Express Payment and Reporting System
OSPHL – Oregon State Public Health Lab
OMIP – Oregon Medical Insurance Pool
PHD – Public Health Division
SFMA – Statewide Financial Management System
SPD – Seniors and People with Disabilities

To support the goals of health system transformation, the State may claim Federal Financial Participation (FFP) for the following State programs subject to the annual limits and restrictions described in the Standard Terms and Conditions (STCs) # 55 -58 of Oregon's Health Transformation Waivers 21-W-00013/10 and 11-W-00160/10 through June 30, 2017. This attachment contains the protocol for such determination of cost.

Office of Management and Budget (OMB) Circular A-87 (2 CFR Part 225), Cost Principles for State, Local and Indian Tribal Governments, section C.4. requires federal grants be provided net of any applicable credits. The State is required to offset all revenues received relating to eligible expenditures identified under this attachment.

For purposes of this protocol, CMS will recognize as allowable costs under this demonstration the total amounts expended by the state without reduction to FFP to reflect revenues in the form of premiums and tuition paid by program enrollees that might be otherwise treated as applicable credits. This exception is only available for approved expenditures associated with the Oregon Medical Insurance Pool through June 30, 2014, and for approved education expenditures associated with for Workforce Training at the State of Oregon's public colleges and universities through June 30, 2015.

All sources of non-Federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval. CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding. For purposes of expenditures claimed under this protocol, the State cannot utilize provider-related donations as a source of the non-Federal share.

Below are descriptions of each DSHP program that was approved under waivers 21-W-00013/10 and 11-W-00160/10. The following programs have been arranged based on program groups.

PROGRAM GROUP: AMH—Addictions and Mental Health

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the AMH non-contract program group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the State. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure.

For each program in this group that involves contractual services, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual services delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the AMH Contractual Services Program Group is R-Base.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the AMH R-Base data base system (R-Base), a contract database subsidiary system for accounting data to the SMFA accounting system, the official 'book-of-record' for the State. The R-Base system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with State Funds only will be so identified. Coding tables in R-Base are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. Data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

<u>Program: Mental Health (MH) Non-Residential Adult Services</u>

- **Brief Description:** MH services delivered to persons diagnosed with serious mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. The following services are provided via this program:

  - Vocational and social services
  - Medication and medication monitoring
  - Counseling for emotional support
  - Individual/family and group counseling and therapy
  - Support to locate and obtain housing
  - Coordination of care services

  Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Adults 18 years or older with serious mental illness who do not qualify for Medicaid.

<u>Program: MH Children and Adolescent</u>

- **Brief Description:** Mental health services for children and adolescents with primary mental, emotional or behavioral conditions. The following services are provided via this program:

  - Provision of screening
  - Assessment and Level of Service Intensity
  - Referral and care coordination services
  - Skills training

- Crisis planning
- Respite care
- In-home support.

Services may be delivered, as appropriate, in a clinic, home, school or other settings familiar and comfortable for the individual receiving such services. Other settings may be aftercare/daycare, county case manager office, mental health clinic, and primary care clinic.

Room and board costs cannot be included as expenditures claimed for this program.

- **Eligible Population:** Individuals under age 18 who have primary mental, emotional or behavioral conditions and are not eligible for Medicaid.

Program: MH Regional Acute Psychiatric Inpatient

- **Brief Description:** Stabilize, control or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the individual to a less restrictive environment. The following services are provided via this program:

  - Ancillary services such as regional coordination and enhancements to County, Community Mental Health Program (CMHP) ; treatment plan development that include identification of goals, strengths, target behaviors, methods for change; coordination of care, evidence-based interventions with families, advocates, representatives of community agencies; and medication management; individual and group therapy that addresses issues identified in the treatment plan.
  - Services that serve to expedite the movement (including secure transportation) of individuals into and out of facilities where inpatient psychiatric services are delivered and to divert persons from acute care services, collaboration with families, parenting support, crisis planning, skills training for client and family members, continuum of care plan to move client to less restrictive settings.

- **Eligible Populations:** Individuals in need of inpatient psychiatric services who are uninsured and/or indigent and are not eligible for Medicaid. These are individuals who suffer from an acute mental illness, or other mental or emotional disturbance posing a danger to the health and safety of the individual or others.

Program: MH Residential Treatment for Youth

- **Brief Description:** Services for individuals needing continued long-term services to avoid hospitalization. The following treatment services are provided via this program:

  - Medication and Medication monitoring supervision)
  - Vocational and social services
  - Individual and family group counseling
  - Counseling emotional support
  - Coordination of care services
  - Services delivered on a 24-hour basis.

Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Residential Treatment for Youth: Young adults through age 25 who are eligible, under ongoing review of the jurisdiction of the Juvenile Psychiatric Review Board or in the Youth and Young Adult in Transition Program, with mental or emotional disorders who

have been hospitalized or are at immediate risk of hospitalization, who need continuing services to avoid hospitalization or who are a danger to themselves or others or who otherwise require long-term care to remain in the community. These individuals are not eligible for Medicaid.

Program: MH Adult Foster Care

- **Brief Description:** This program includes continuing services, including ongoing supervision, which are provided to adults to avoid higher level services or hospitalization. The following services are provided via this program:

  - Clinical assessment
  - Develop individual plan of care that addresses clients MH diagnosis
  - In-home case management
  - Counseling (individual and family group)
  - Coordination of care services
  - Skill training
  - Transition support to move to the next step to independent living.
  - These services are delivered in family home or facility.

- **Eligible Population:** Adults 18 years old or older who are in need of continuing services to avoid hospitalization, or who have been hospitalized, or who pose a danger to the health and safety of themselves or others, and who are unable to live by themselves without supervision. These individuals are not eligible for Medicaid.

Program: MH Older and Disabled Adults

- **Brief Description:** This program includes specialized geriatric mental health services delivered to older and disabled adults with mental illness. The following services are provided via this program:

  - MH services
  - Medication management
  - Follow-up services.
  - Medical condition follow-up (many of these clients have ongoing medical conditions).
  - Coordination of care

- **Eligible Populations:** Older and disabled adults with mental illness needing mental health services. These individuals are not eligible for Medicaid.

Program: MH Special Projects

- **Brief Description:** These are projects that provide enhanced services, services to enable service delivery expansion, peer delivered services, and, educational and employment support services. The following services are provided via this program:

  - Peer delivered services (PDS): is the social, emotional and instrumental support offered or provided by persons with a mental health condition, to others who share a similar mental health condition in order to bring about a desired social or personal change. This overall service includes an array of agency or community-based services and supports provided by peers and peer support specialists.

Included is assistance for people with Serious Mental Illness (SEMI) to meet their education and/or recovery goals and/or become gainfully employed through the education and training acquired during postsecondary education.
    - Skill training
    - Counseling for emotional support
    - Community integration
    - Crisis support

- **Eligible Population:** Adults and Children with mental illness in unique condition situations who need special mental health services. These individuals are not eligible for Medicaid.

Program: MH Community Crisis

- **Brief Description:** This program provides immediate MH crisis intervention (24/7) and assessment; triage and intervention services (psychological treatment services and crisis counseling services) delivered to individuals experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. This program also includes the following psych services which can be rendered at a hospital or a non-hospital facility. Services are of limited duration and are intended to stabilize the individual and prevent further serious deterioration in the individual's mental status or mental health condition.

- **Eligible Population:** Adults and Children in a crisis situation who are not eligible for Medicaid.

Program: MH Support Employment

- **Brief Description:** This program includes the following services which are delivered to individuals to enable them to obtain and maintain employment:

    - Supervision and job training
    - On-the-job visitation
    - Consultation with the employer
    - Job coaching
    - Counseling
    - Skills training
    - Transportation
    - Transitional employment services: On-the-job skills development for the next level—to obtain a better job, job counseling.

- **Eligible Population:** Individuals 18 years or older with chronic mental illness needing to obtain and maintain employment. These individuals receive non-residential adult services and need evidence-based supported employment services. These individuals are not eligible for Medicaid.

Program: MH & Alcohol and Drug (A & D) Homeless

- **Brief Description:** This program provides transitional services to a supported environment, i.e., treatments services, housing/living environments that maintain and reinforce the client's recovery efforts. This program provides a broad range of transition services that include:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation and rehabilitation services
- Community MH services, A&D treatment services
- Staff training
- Case management services
- supportive and supervisory services in residential settings
- Referrals for primary health services
- Job training
- Educational services
- relevant housing assistance services (locating and securing housing)

Room and board is not considered in the amounts that will be claimed for this program

- **Eligible Population:** Individuals with serious mental illness that may have co-occurring substance abuse use disorders and who are homeless or at risk of being homeless. These individuals are not eligible for Medicaid.

Program: MH Residential Treatment for Adults

- **Brief Description:** This program includes crisis stabilization and intervention services, including:

  - Behavior management
  - Daily living activity coordination
  - Crisis stabilization services
  - Crisis intervention services
  - Residential treatment services determined upon individualized assessment of treatment needs and development of plan of care
  - Management of personal money and expenses
  - Supervision of daily living activities
  - Life skills training
  - Administration and supervision of medication
  - Provision or arrangement of transportation
  - Management of behavior
  - Diet management.

- Services are delivered on a 24-hour basis to individuals who need continuing services to remain in the community and to avoid higher levels of services or hospitalization or who are a danger to themselves or others or who otherwise require continuing care to remain in the community.

  Room and board is not considered in the amounts that will be claimed for this program.

- **Eligible Population:** Adults 18 years or older who are determined unable to live independently without supervised intervention, training or support, and who do not qualify for Medicaid.

Program: MH Non-Residential, Designated

- **Brief Description:** These individuals in this program have low frequency, high intensity needs above the standard non-residential structure. Services include:

    - Vocational and social services
    - Support to obtain and maintain housing (locating and securing housing)
    - Medication and medication monitoring
    - Emotional support
    - Individual, family and group counseling and therapy
    - Case management services

- **Eligible Population:** Adults 18 years old or older, who are uninsured needing mental health services delivered to designated persons (adults) diagnosed with serious, chronic mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. These individuals are not eligible for Medicaid.

Program: A & D Special Projects

- **Brief Description: This program includes the following** treatment enhancement activities:

    - Early screening and assessment for alcohol and drug problems
    - Facilitation of collaboration between schools and partner agencies in developing and maintaining screening and referral processes
    - Outreach
    - Case management

- **Eligible Population:** Youth at high risk of problems with alcohol and drugs and their families. These are Non-Oregon Health Plan individuals or may pay for services not provided by OHP. This program is specifically designed for families at risk of Temporary Assistance for Needy Families (TANF) involvement or in the TANF program.

Program: A & D Residential Treatment, Adults

- **Brief Description:** This service is to support, stabilize and rehabilitate individuals and to permit them to return to independent community living. Services provide a structured environment for an individual on a 24-hour basis consistent with chemical dependency placement, continued stay and discharge criteria Level III-services (twenty-four hour supervision is needed using a structured 7-day-a-week therapeutic environment to achieve rehabilitation). The services within this program address the needs of diverse population groups within the community. This program helps people stabilize physically and mentally so they are able to transition to a lower level of care including self-directed recovery management.

- **Eligible Population:** Individuals 18 years of age or older who are unable to live independently in the community and cannot maintain even a short period of abstinence and are in need of 24-hour supervision, treatment and care. These individuals are for non-OHP eligible and must be indigent status with income at 100 percent or lower of the Federal Poverty Level (FPL). These individuals are not eligible for Medicaid.

Program: A & D Continuum of Care

- **Brief Description:** This program provides outpatient substance abuse disorder treatment including medication-assisted treatment (primarily methadone). This program also includes non-hospital detoxification, case management and wrap around services such as:

    - Peer mentoring
    - Child care
    - Transportation
    - Relapse prevention
    - Healthy eating and wellness counseling
    - Connection to social support groups

    Services build upon resilience, assisting individuals to make healthier lifestyle choices and to promote recovery from substance use disorders. Services consist of case management, clinical care and continuing care delivered when therapeutically necessary and consistent with the developmental and clinical needs of the individual, Level I (Outpatient), Level II (Intensive Outpatient), Level III (Non-medical Detoxification, and Intensive Treatment and Recovery Services).

- **Eligible Population:** Services delivered to youth and adults with substance use disorders. These are individuals who are indigent with no OHP or insurance coverage. These individual are not eligible for Medicaid.

PROGRAM GROUP: Children, Adults and Families (CAF)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

<u>Any combination of the above codes can identify the DSHP allowable expenditure.</u>

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the CAF program group is Oregon Kids System (OR-KIDS).
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the OR-KIDS, an interface sub-system for accounting data to the State accounting system official 'book-of-record' SFMA. The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the OR-KIDS system as they are then authorized for service payments to providers providing the designated client care services. The system checks the client eligibility status then matches to the appropriate fund source based on the client eligibility status. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with State Funds only will be so identified. Only those services funded with State Funds only are allowable for DSHP match. Coding tables in OR-KIDS, are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: System of Care

- **Brief Description:** This program consists of purchased services provided to meet the individualized needs of children and parents involved with Child Welfare. This program is only applicable to services not rendered by any other State program. The following services are provided via this program:
    - Wrap-around planning services
    - Healthcare services for uninsured parents

- **Eligible Population:** Children and families being served by Child Welfare where caseworkers have identified needs for supports and services unmet by any other State resource.

Program: Community Based Sexual Assault

- **Brief Description:** This program consists of contracted services for Sexual Assault Counselors to provide counseling and support services to victims of sexual assault.
- **Eligible Population:** Victims of sexual assault who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Community-based Domestic Violence

- **Brief Description:** This program consists of contracted services for Domestic Violence Advocates to provide support and treatment services to victims of Domestic Violence.
- **Eligible Population:** Victims of domestic violence brought to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: Family Based Services

- **Brief Description:** This program consists of services to provide in-home safety and reunification services. As a result of this program, families remain together while safety supervision and parenting support/coaching are provided. Services include:
    - Parent training
    - Therapeutic support
    - Supportive remedial day care.
- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Foster Care Prevention

- **Brief Description:** This program consists of Child Welfare services for families with children at risk of out-of-home placement. The following services are provided via this program:
    - Therapeutic supports
    - In-home case management
    - Counselling
    - Referrals to families to help them transform their lives.
- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Enhanced Supervision

- **Brief Description: This program consists of** one-on-one supervision services to children in out-of-home care to assure their safety or the safety of those around them. These are children that have emotional, behavioral or medical issues. This program involves assessment services to identify services needed, and the supervision of the process by which the client receives those services.

- **Eligible Population:** Children placed in out-of-home care due to allegations of abuse and/or neglect requiring additional supervision to assure safety.

Program: Nursing Assessments

- **Brief Description:** This program involves Individualized assessments provided by a Registered Nurse to determine the need for Personal Care services to be provided to a child in an out-of-home care setting.
- El**igible Population:** Children placed in out-of-home care that may have medical needs requiring ongoing care in a home setting.

Program: Other Medical

- **Brief Description:** This program consists of contracted services for assessments and evaluations deemed necessary for the comprehensive and coordinated care planning needed for children and families involved with Child Welfare.
- **Eligible Population:** Parents and children who have come to the attention of Child Welfare. These individuals are not eligible for Medicaid.

Program: IV-E Waiver Demonstration Project

- **Brief Description:** This program consists of additional supports in the form of Peer Mentoring or Relationship Based Visitation for parents and children being served by Child Welfare. These supports are in addition to traditional child welfare programs that provide services for prevention and reunification (of families). Traditional services and community supports include mental health counseling, parenting training, and assistance navigating the process (e.g., court processes) for victims of domestic violence.
- **Eligible Population:** Parents and children served by Child Welfare, not receiving Medicaid or services via any other federal program.

Program: Personal Care:

- **Brief Description:** This program consists of the provision of medical services including skilled services delegated by a Registered Nurse under Oregon's Nurse Practice Act, identified in an individual care plan and provided to eligible children in a family foster care setting. Services provided in this program can include: medication supervision and monitoring assistance, assistance with activities of daily living, specific medical procedures (e.g. trachea support), and incontinence management procedures.
- **Eligible Population:** Children served by Child Welfare that must be in out-of-home care due to allegations of abuse and/or neglect, and have medical needs requiring an individualized care plan approved by the State.

PROGRAM GROUP: Adults and People with Disabilities (APD) (formerly SPD—Seniors and People with Disabilities)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> > **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-systems for the APD (formerly SPD) Program Group are the House Keeper System for Oregon Project Independence, and the CPMS and eXPRS interface sub-systems for Family Support and the Children's Long-Term Support programs.
>
> **Step 4b—**When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- **House Keeper System :** The process of the determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients, and entry of the data into the House Keeper system as they are then authorized for service payments to providers providing the designated client care services. In the Housekeeper system, the status identifies the client for Oregon Project Independence (OPI) services and the system generates provider payments. The system assigns SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) that identify the clients' services and related costs attributable for DSHP. Payment data is interfaced to the State SFMA system from which payment (expense) reports are produced. The accounting reports pull data directly from the SFMA system, and/or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **eXPRS System:** Payment source data is from the eXPRS system, an interface sub-system for accounting data to the SFMA accounting system, the 'book-of-record' for the State. The eXPRS system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with State Funds only will be so identified. Coding tables in eXPRS are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.
- **CPMS System:** The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the CPMS system. A report is pulled from CPMS source data and reconciled on a quarterly basis with the payment as authorized by the eXPRS System and paid by SFMA. Only those services funded with State Funds only are allowable for DSHP match.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Project Independence (OPI)

- **Brief Description:** OPI provides in-home services to seniors who require the same level of care as people in nursing homes, but who do not qualify for Medicaid. Services can be received in their own homes, and include personal assistance, nursing tasks and help with housekeeping. Services may also include help with activities of daily living, memory and confusion, mobility and transfers, housekeeping and laundry, meal preparation or delivery, shopping and transportation, medical equipment, assistance with medications.

- **Eligible Population:** Eligibility for OPI is age (60 years of age or older or under 60 with a diagnosis of Alzheimer or related dementia) and a Client Assessment & Planning System assessment evidencing a service priority level (SPL) of 1-18. These services are provided statewide through Area Agencies on Aging local offices. Clients with net incomes between 100 percent and 200 percent of Federal Poverty Level (FPL) are expected to pay a fee toward their service, based on a sliding fee schedule. Families with net incomes above 200 percent FPL pay the full hourly rate of the service provided.

Program: Family Support

- **Brief Description:** Services are provided for eligible children with developmental disabilities, in their parents' or relatives' home. Through this program, families determine what they need most. Families have the flexibility to choose services and providers. Families and service coordinators work to develop a plan revolving around the child and family needs. In some cases, a family may access family support for a brief time while other families may need an on-going family support plan. The program strives to help children and families remain independent, healthy and safe. The service coordinator and family work to identify all available resources from the family and community. These might include people, support-groups, public and private programs, private insurance, and many other resources. Services include assistance in determining needed supports, respite care, purchase of adaptive equipment; services are proactive, and are intended to help prevent families from going into crisis.

- **Eligible Population:** Families who have children with developmental disabilities. It is a capped program ($1,200 per eligible child per year) with a current caseload of approximately 500. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and have tried to get access to funds to cover their needs prior to submitting request for Family Support. These individuals are not eligible for Medicaid.

Program: Children Long-Term Support

- **Brief Description:** This program provides supports to a child with a developmental disability at risk of out-of-home placement (foster care, residential, etc.). Children are assessed for level of service by the local Community Developmental Disability Program Service Coordinator. With the family, the Service Coordinator assists in plan development that identifies supports needed for the child to stay in the home. Supports include:

  - In-Home Supports
  - Respite
  - Behavior Consultation
  - Family Training
  - Environmental Adaptations
  - Specialized Medical Equipment and Supplies.

- **Eligible Population:** Families who have children with developmental disabilities who are at risk for out of home placement. This is a capped program with a current caseload of approximately 180. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and meet a crisis criteria of risk of out of home placement. These individuals are not eligible for Medicaid.

PROGRAM GROUP: Public Health Division (PHD)

- **Funding Sources:** State General Funds, Other Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Public Health Division Program Group is the Oregon Statewide Payroll (OSPS) system.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the State. The service that is eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with State Funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All PHD expenditures are processed directly in the SFMA system.

- **Payroll System**: Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses

(OPE) directly to the PHD programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination is entered to ensure their time is properly allocated to DSHP. Coding tables in OSPS are accessed that assign an SFMA coding structure and are interfaced to SFMA system.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

Program: PHD Licensing Fee (Health Care Regulation and Quality-HCRQI)

- **Brief Description:** The Health Care Regulatory & Quality Improvement Section (HCRQI) is statutorily mandated to regulate, inspect, license and provide certification approval for the following entities and individuals: Ambulatory Surgical Centers, Birthing Centers, Dialysis Facilities, Hemodialysis Technicians, Home Health Agencies, Hospice Agencies, Hospitals, In-Home Care Agencies, Special Inpatient Care Facilities, Trauma Hospital designations.
  HCQRI is responsible for the entire licensure and certification processes for each of the above-listed individuals or entities. HCRQI also provides licensing information to the public and other agencies. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

- **Eligibility:** HCRQI does not provide direct care to Oregonians so there are no eligibility criteria. However, the ultimate beneficiaries are Oregonians who are able to find access to safe, high-quality and patient-centered health care because of HCRQI's efforts. All Oregonians benefit from having a wide access to health care. The program ensures that the health care will be safe, of high quality, and meet or exceed State and federal standards.

Program: PHD, Oregon State Public Health Lab (OSPHL) General Microbiology Testing Program

- **Brief Description:** The OSPHL General Microbiology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitters. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: PHD OSPHL Virology/Immunology Testing Program

- **Brief Description:** The OSPHL Virology/Immunology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitter. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: State Support for Public Health

- **Brief Description:** This program consists of services rendered by Local Public Health Departments (LPHA) to operate a Communicable Disease control program This program includes the following components: (i) epidemiological investigations that report, monitor and control Communicable Disease, (ii) diagnostic and consultative Communicable Disease services, (iii) early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases, (iv) appropriate immunizations for human and animal target populations to control and reduce the incidence of Communicable Diseases, and (v) collection and analysis of Communicable Disease and other health hazard data for program planning and management. LPHAs must operate its Communicable Disease program in accordance with the Coalition of Local Health Officials (CLHO) Standards for Communicable Disease Control and the requirements and standards for the Control of communicable disease set forth in Oregon Revised Statutes (ORS) Chapters 431, 432, 433 and 437 and Oregon Administrative Rule (OAR) Chapter 333, Divisions 12, 17, 18, 19 and 24, as such statutes and rules may be amended from time to time. As part of its Communicable Disease control program, LPHAs must, within its service area, investigate the outbreak of Communicable Diseases, institute appropriate Communicable Disease control measures, and submit to the Oregon Health Authority as prescribed in the Oregon Health Authority Communicable Disease Investigative Guidelines.

- **Eligibility:** All Oregonians benefit from the communicable disease control program provided to Local Health Departments. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: PHD Laboratory Northwest Regional Newborn Screening (NBS) Program

- **Brief Description:** The Northwest Regional Newborn Screening Program conducts screening of all newborn infants to prevent mental retardation and premature death in children through early detection and treatment of congenital disorders by: screening and testing for selected diseases and conditions; serving as the regional center for newborn screening; contracting for the medical consultation needed for the initial clinical follow-up; and maintaining a data base of all screened infants for use in follow-up, tracking, and monitoring disease incidence. Oregon designates practitioners as being responsible for specimen collection. The definition of "practitioner" includes physicians, nurses, and midwives who deliver or care for infants in hospitals, birth centers or homes. Also, parents are responsible to ensure that their infants are tested.

- **Eligibility:** Newborn screening activity is not divided among specific eligibility groups within Oregon newborn infants. It is a population-based service applicable to all newborn infants in the state. Oregon statutes require that every infant be tested. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees and driven by volume or amount of tests received by the Lab for which they receive test fee revenues.

Program: Prescription Drug Monitoring Programs (PDMP)

- **Brief Description:** Oregon-licensed pharmacies are required to report to the Oregon Health Authority PDMP system all Schedule II – IV controlled substances dispensed to patients. The system must be accessible by healthcare providers and pharmacists 24/7. The intent behind the PDMP is to help improve patient management particularly among pain patients. Health improvements include pain care, addictions treatment and reduced overdose.

- **Eligibility:** Services are provided to any Oregonian who requests a copy of their own patient record. Services are provided to any authorized PDMP system user that can include any Oregon-licensed healthcare provider who prescribes controlled substances or any Oregon-licensed pharmacist who dispenses controlled substances. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: HIV Community Services

- **Brief Description:** The HIV program provides case management and support services (case managed, treatment and support plan) for people already tested and living with an HIV diagnosis.

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: General Funds – HIV, Sexually Transmitted Disease, Tuberculosis (HST)

- **Brief Description:** The HST program works with local health authorities and community based organizations to provide guidance on the delivery of services to the populations impacted by HIV, STD, and TB. This program is administered by local health authorities that primarily screen, treat or control the transmission of those diseases. As well, this program provides support administration, prevention, TB case management and medications for STD's and TB

- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable STD's TB or HIV This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: Sexually Transmitted Disease

- **Brief Description:** The program provides Clinician Training for the clinician workforce in Oregon. The training is a two-day didactic training designed for clinicians. Training is intended to provide an update on HIV, HPV, Cervicitis, Chlamydia, Gonorrhea, Syphilis and other STD's.

- **Eligibility:** Clinicians workforce in Oregon to provide training on reducing and detecting STD's.

PROGRAM GROUP: Oregon Youth Authority (OYA)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the OYA Program Group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services. The Waiver approval for DSHP included mental health and A & D treatment services funded through state funds only. The Protocol identifies the allowable state fund only funding stream(s) for these DSHP allowable services and expenditures for non-Medicaid eligible youth. The youth receiving and benefiting from these services (mental health and A & D) may be placed in the custody of the OYA, but are not incarcerated in a close custody setting. DSHP does not allow nor include expenditures for services

rendered to youth in a close custody setting, in other words, for incarcerated youth. Expenditures for which DSHP is claimed are community based, delivered in the youth's place of residence or in a licensed professional provider's office or clinic. Youth are living at home or in an out-of-home non-secure placement (not a residential treatment facility), where youth are free to leave the premise. The youth are not incarcerated, not associated with the prison system, not in secure facilities operated by OYA and are not in the physical custody of OYA. The youth may be in the custody of OYA, e.g. adjudicated youth served by county probation or diversion programs, are not Medicaid eligible, and are receiving mental health and A & D treatment funded by state funds only.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the State. The service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with State Funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OYA contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the R*STARS accounting database. Code and expenditures will be displayed.

Program: Alcohol & Drug Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Alcohol and drug abuse treatment provided to youth in community settings occurs through community service contracts for non-Medicaid eligible youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: alcohol and drug abuse treatment services in the community include: assessment, group treatment, individual treatment, individual care coordination, recovery, maintenance and relapse prevention.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for alcohol and drug treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

Program: Mental Health Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Mental health services provided to youth in community settings occurs through community service contracts for non-Medicaid eligible

youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: mental health treatment services in the community include: assessment of mental health needs, psychotropic medication management, group treatment, individual treatment, individual care coordination, crisis intervention and family therapy.

- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for mental health treatment services. These individuals are not Medicaid eligible.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

9.

PROGRAM GROUP: DMAP – Division of Medical Assistance Programs

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

Step 2a—State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.

Step 2b—State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.

Step 2c—State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 - Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the DMAP Program Group is MMIS.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the MMIS data base system that contains the requirements (i.e., edits) for processing claims for this population. MMIS is a subsidiary system for accounting data to the State SFMA accounting system, the 'book-of-record' for the State. From client and related payment data entered in MMIS, payments to providers are produced. The payment/expenditure data is interfaced to SFMA from which provider payments and expense reports are produced that identify the relevant category in which the DSHP allowable expenditure is incurred. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly. The SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) identifies the program, funding, and client are entered with the MMIS data. The coding is mapped to specific service tables that include each service funding source, thereby isolating the claims and associated payments for this population. The coding generated by the MMIS interfaces to SFMA. For this program, those services that match to State Funds only, will be allowable for FFP. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Formerly Medically Needy (Organ Transplant) Clients

- **Brief Description:** The program provides limited drug coverage for individuals receiving post-transplant services, formerly eligible for the Medically Needy program, which ended in 2003. Oregon Administrative Rule (OAR) 461-13-120-1195, chapter 461 filed with the Secretary of State, 9-30-2011, defines the population and covered services. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds and limited to 22 identified individuals.

- **Eligible Population:** This program provides services for 22 identified individuals receiving post-transplant services who were participating in the formerly Medically Needy program, as of January 31, 2003.

PROGRAM GROUP: Workforce Development and Education

- **Funding Sources:** State General Funds, Tuition and Fees

Expenditures for DSHP allowable Workforce Development Training expenditures are defined in the Waiver agreement, as those incurred by universities, colleges, and community colleges in the course of workforce training of health professionals in fields likely to benefit Medicaid beneficiaries. Source data elements are used to support the expenditures and payments of DSHP allowable Workforce Development Training and for the certification of DSHP allowable expenditures. The source data elements are:

- **Audited Financial Statements**
- **Invoices**
- **Payroll data**
- **Funding Source (ensures restriction to state only funds through the accounting elements and structure)**

Each university/college entity uses an integrated accounting system. Though they are not all the same system, they accumulate, process, and employ coding structures in similar formats for reporting and audit processes. These systems are the 'book of record' for each entity. They are complete systems with modules devoted to accounting, purchasing, accounts payable, fixed assets, grants, and budget development. The charts of accounts structures have these primary coding structure elements: Fund, Organization, Account, and Program. Transactions in the systems require these coding structures to store, process, and report out expenditures for all programs, including DSHP. The coding structure elements are hierarchical and roll up from lower data entry levels to higher summary levels. The DSHP expenditures roll into the regular monthly and annual final statements. Typically these types of expenses are tracked at a lower level of the accounting system coding structure and while they are not visually displayed in annual financial reports, they are included in the respective Instruction line displays in the financial statements.

For each Workforce Development Training program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #57(b). The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – Original source data is identified where data from the source documents is reviewed, and approved for coding and entry into the appropriate financial accounting sub-system for each Workforce Development Training program (e.g., accounts payable, payroll-personnel).

Step 2 – The financial data accumulation begins with initial entry into source data systems for the following:

- Invoices received for services and set up in the accounting system accounts payable module: invoices reviewed, services received verified, payment amounts approved, specific coding verified for programs and unique projects (e.g., DSHP - Instruction)

- Employee data set-up in the payroll system: Personnel payment data, pay rates, default cost center to be charged, etc.. Specific coding identified for additional programs/projects to where employee work time should be charged. Time sheet data, for time and effort recording, including proper employee and supervisory verifications/authorizations.

Step 3 – Source data systems access internal data and coding tables, and based on entry data, assigns to expenses the accounting coding element structures (i.e., codes: Fund, Organization, Account, Mission, Object). ***See Table 1,*** below.

TABLE 1 – Coding Elements

Oregon Health Sciences University

- *Fund code:* University General Fund 0151
- *Organization code:* Identifies the Schools: Medicine 54000-54999, Nursing 58000-58999, Dentistry 60000-69999.
- *Mission code:* Non-Sponsored Instruction & Training 11; Student Admin and Services
- *Object code:* Functional description of expenditures, Wages 5100-5199; Supplies 5300-5399; Cost of goods 5400-5499; Purchased services 5500-5599

A combination of the above codes identifies DSHP allowable expenses.

Oregon University System

- *Fund code:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Department of Community Colleges and Workforce Development

- *Fund Type:* College General Fund
- *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
- *Account code/Account Type:* Specific financial transactions, e.g. revenues, expenses by natural class
- *Program code:* Function that the transaction is related to i.e., Instruction

A combination of the above codes identifies DSHP allowable expenses.

Step 4 – Source data systems compile data during the system scheduled maintenance runs for interface to the financial accounting system, the 'book-of-record', source for all financial audits (e.g. general; A-133; other audits).

Step 5 – Accounting system processes are compiled, interfaced data configured according to the system processing design and the internally established chart of accounts. It matches the coded expense data to the internal chart of accounts (See ***Table 3 – OUS Example*** below). At period end close, the Overhead Cost Allocation module is run, charging indirect cost expenses (e.g. Administration and General (A & G)) to revenue producing cost centers, based on standard, approved cost allocation principles **(See *Table 2 – Cost Allocation***, below**)**. Closed period end financial data is downloaded to a database system (e.g., a financial services 'datamart') that can be queried using specific general ledger established accounting coding elements to pull out DSHP expenditure data (see ***Table 1 –Coding Elements above***).

TABLE 2 – Cost Allocation

DSHP approved program expenditures can include direct charged costs as well as indirect costs (i.e., a cost necessary for the functioning of the organization as a whole, but which cannot be directly assigned to one service or product, and therefore must be allocated). Very similar to the Medicare cost finding principles, cost allocation is a process, to identify common costs (e.g., A & G—executive staff, accounting, legal, human resources, etc.) to the courses of health care

professionals in fields likely to benefit Medicaid recipients. The entity can determine those costs that can be accurately direct charged, or charge them to an allocation cost center for charging via the allocation process. --Medicare Reimbursement Manual form 2552-10, 40-93

Step 6 – Report queries are run against the financial services datamart using the coding element structures unique to the DSHP program/project. (***See Table 1***, ***Coding Elements above***)

Step 7 – Expense Reports for DSHP expenditures are run after the accounting period end close. Accounting period close may be monthly, quarterly or annually.

Step 8 – Certification of Public Expenditures (CPE) form, certifying allowable DSHP expenditures per STCs #55 – 58 are represented in the expense reporting, will be sign by the appropriate and authorized college or university authority and provided to the State.

If an expenditure made under DSHP Workforce Training Program Group is found, in a future audit or financial review requiring corrective action, the prior period transaction(s) will be reconciled in the current DSHP claiming period using CMS 64 established guidelines. The CMS 64 reporting will reflect this reconciliation.

Accounting System, DSHP Expense Report Crosswalk to Financial Statements: DSHP Workforce Training expenditures, processed through the respective accounts payable and/or payroll systems are coded with organization department and instruction program coding elements (described in the preceding individual protocol narratives) that will identify DHSP allowable expenditures, per STCs # 55-58.

DSHP expenditures are a small subset of the overall individual operation of each university, college and community college. Expenditures to be claimed as DSHP, per STCs #55-58, are included in the annual year end audited statements as specific amounts at a lower level than displayed on the Instruction report line. These expenditures can be audited down to individual transactions for which original source documents can be pulled. Table 3 below illustrates this process.

Agreements will be in place between OHA and workforce entities to include allowance for audit by OHA of DSHP allowed expenditures. DSHP Expense Reports will be certified, and the amounts on the DSHP expense reports can be directly tied to the individual university, college and community college audited financial statements.

The total computable amount to be claimed to the federal government begins with the amount recorded for Instruction within the university, college or community college's audited financial statement. The financial statements may include the amount applicable to Instruction for one institution, or multiple institutions, depending on the structure of the university/college system.

In support of the total computable amount to be claimed under DSHP, supporting documentation will include the university's/college's expenditure report/account detail. The expenditure report classifies expenditures (as detailed in Table 1 – Coding Elements) by code, including fund code, organizational code, mission code and object or program code. The organization and fund type level codes will be primarily used to distinguish between aggregate expenditures applicable to Instructions and expenditures applicable to Instruction eligible under DSHP, per STCs #55-58.

Categorical Examples of Workforce Development Training DSHP allowable programs
School of Medicine
School of Nursing
School of Dentistry
Clinical Laboratory Science
Radiologic Technology/Diagnostic Imaging

Respiratory Care
Clinical Care
Medical Assistant
Dental Assistant/Dental Hygienist
EMT/Paramedic
Nursing Education/Certified Nursing Assistant
Pharmacy Technician

The examples above are not intended to be an exhaustive list of each course offered by the individual college or university. Rather, they an example by category of the type of DSHP allowable graduate and undergraduate workforce training programs available at the colleges and universities.

Upon receipt of the specific college and university expenditure report, OHA will verify the expenses reported are for health-care and health-care related fields of education and training. The specific listing of the DSHP allowable health-care and health-care related course offerings will be made available to OHA by each college or university, and will become a part of the DSHP report to CMS Region X for purposes of claiming via the CMS 64 Report. By keeping the specific list(s) apart from, yet referenced herein Attachment G, as a college or university changes, adds or deletes a DSHP allowable course, it would not be necessary to amend Attachment G.

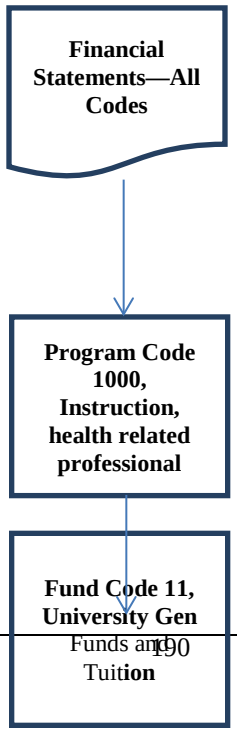
Verification of the DSHP allowable course may be accomplished in a three-fold manner using the 1) published course offering/calendar of the college or university; 2) through enrollment information, and; 3) through the college and university expenditure reports.

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for Workforce Training will be computed without taking into account program revenues from tuition. However, to the extent the above universities and colleges receive funds that are directly used to support Workforce Training applicable offsets will be made to the amount claimed to the federal government as an allowable DSHP expenditure per the above referenced STCs.

- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the Workforce entities accounting systems databases. Codes and expenditures will be displayed

Table 3 – OUS Example

Highest Level -- Financial Statements: Includes all accounting data codes. To reconcile to financial statements, the report query would not restrict to specific codes; all would be pulled.
Program Codes: Report query, restrict codes to program code 1000 for Instruction Courses of health care professionals in fields likely to benefit Medicaid recipients.
Funds: Further restrict report query to fund code 11, university general funds (incl tuition).



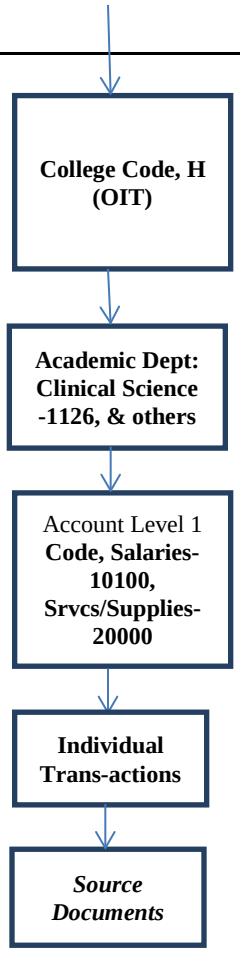
College Codes: Further restrict report query to college code H for OIT

Organization Codes: Further restrict report query to academic codes, 1126 & others.

Functional Codes: Further restrict report query to account level one codes for personnel, materials & supplies, etc.

Lowest Level -- Transactions: Further restrict to the lowest level Transactions that identify vendor/payee and personnel/ staff payee.

Documents Level -- Based on the transaction list pulled (i.e., showing the amounts entered, vendor, other identifying data; payroll time & effort data) supporting documents can be pulled.



PROGRAM GROUP: Oregon Medical Insurance Pool (OMIP)

- **Funding Sources:** State General Funds

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for the Oregon Medical Insurance Program will be made without considerations for high risk pool healthcare premiums.

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**There is no interface sub-system for the OMIP Program Group as services paid for are a direct charge into SFMA.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the State. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All OMIP contract expenditures are processed directly within the SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Medical Insurance Pool

- **Brief Description:** The Oregon Medical Insurance Pool (OMIP), administered by the State Office of Private Health Partnerships (OPHP), is the high-risk health insurance pool for the state established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions. OMIP also enables continuance of insurance coverage for those who exhaust COBRA benefits and have no other options. The funding for OMIP comes from two sources. Premiums paid by enrollees currently cover about 52% of program costs. Statutory requirements for establishing premiums limit them to no more than 125% of average market premiums for comparable benefits. The remaining 48% of the costs are funded from assessments the OMIP Board charges the licensed Oregon commercial health insurers on a per covered life basis.
-
- **Eligibility:** Enrollees must be residents of Oregon when they enroll and, once enrolled, they must demonstrate that they have lived in Oregon for at least 180 days during each benefit year. It does have a six-month pre-existing condition waiting period for which enrollees can get credits if they have had prior comparable coverage. To be eligible for portability coverage, they must not have access to a commercial portability insurance plan.

PROGRAM GROUP: Oregon State Hospital (Gero-Neuro)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #58. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #58, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

Step 2 – State identifies in the accounting system the Fund Table (state fund only) for the allowable DSHP expenditure.

> **Step 2a—**State identifies the specific Program Cost Account (PCA) coding element for allowable DSHP expenditure. The PCA identifies/links the Fund Structure, Appropriation number, Program Structure, Project (number) and Grant (number) structures.
>
> **Step 2b—**State identifies the specific Index coding element for allowable DSHP expenditure. The Index identifies/links the Fund Structure, Appropriations number, Organizational Structure, Projects and Grants. Both the PCA and Index determine how the transaction will post to the agency's accounting structure.
>
> **Step 2c—**State identifies the specific Transaction coding element for allowable DSHP expenditure. The Transaction Code determines the general ledger (GL) accounts and financial tables to which a transaction will post.

Step 3 – State identifies the Agency Object coding element that identifies services reimbursed for DSHP allowable expenditure. The Agency Object code is used to group transactions, e.g., by the kind of expenditure and service paid for.

Any combination of the above codes can identify the DSHP allowable expenditure.

Step 4 – Source data systems access internal data and coding tables, and assigns accounting coding element structures based on entry data (i.e. coding element: Fund Code/PCA/Index/Transaction Code/Agency Object).

> **Step 4a—**Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #55 – 58, paid to the vendor. The interface sub-system for the Oregon State Hospital Program Group is the Oregon Statewide Payroll (OSPS) system.
>
> **Step 4b—**As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 55 -58, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #55-58 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #55 – 58 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the 'book-of-record' for the State. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All Hospital expenditures are processed directly within the SFMA system.
- **Payroll System:** Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses (OPE) directly to the various Hospital programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination can be entered to ensure their time is properly allocated to DSHP.
    - The Hospital is accounted for as an enterprise fund where all costs for the program are recorded as one fund source. However, any resources from insurances (e.g., Medicaid, Medicare, Private pay) are identified to the various wards and are subtracted to record the State Only Fund expenditures that are allowable under the DSHP Waiver amendment. Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Coding and expenditures will be displayed.
-

Program: Gero-Neuro Wards at the Oregon State Hospital (MH, Psychiatric)

- **Brief Description:** This program is for patients who require a hospital level of care for dementia, organic brain injury or mental illness. Patients in this program require physically secure, 24-hour care that is not available through community programs. These patients often have significant medical issues. Some are either civilly committed or voluntarily committed by

a guardian because they are a danger to themselves or others, or are unable to provide for their own health and safety needs. Some patients who require significant medical care come through the criminal court system. Those admitted under criminal commitments are excluded, are not approved for DSHP Federal Funds Claiming. The program's goal is for everyone to return to a community-care setting. From the day of admission, the treatment team works with the patient toward this goal. The program uses the following treatments:

- Sensory and behavioral therapy
- Recreation
- Coping and problem-solving skills learned through group and individual therapy in the treatment mall setting.

- Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.

- **Eligibility:** Elderly persons with a mental health diagnosis that requires hospital level of care, or all ages with special needs due to related neurological impairment. Inpatient services are available to older adults who have major psychiatric disorders and adults older than 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive community care nursing home system environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical-surgical hospital.

Attachment H: Calculating the Impact of Health Systems Transformation
(updated December 18, 2012)

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State of Oregon

Attachment H: Calculating the Impact of Health Systems Transformation -

Oregon's Accountability Plan and Expenditure Trend Review

December 18, 2012

Attachment H: Calculating the Impact of Health Systems Transformation

Table of Contents

Executive Summary

Section A - Oregon Accountability Plan

Part I: Quality Strategy

I. Introduction 208

II. Improvement Strategies 210

III. Oregon's Goals 224

- A. Lower Costs 224
- B. Better Care: Quality of Care 227
- C. Better Care: Access to Care 230
- D. Better Care: Experience of Care 232
- E. Better Health 233

IV. Assessment 237

- Performance Monitoring 237
- Data Sources 239
- Credentialing 240
- Health Information Technology 240

V. Contract Compliance 242

- Standards for Managed Care Contracts 242
- Delivery Services Performance Monitoring 242
- Enforcement 244

VI. Review of Quality Strategy 244

VII. Achievements and Opportunities 245

Appendix 1.A: Coordinated Care Organization Service Area Density 246

Appendix 1.B: Theory of Action Model 247

Appendix 1.C: Quality Pool Structure 248
Appendix 1.D: Innovator Agent Plan 256
Appendix 1.E: Contract Compliance 260
Appendix 1.F: List of Conditions that can result in Sanctions 264

Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluation

Preface 268
Oregon Special Terms and Conditions 52, 54, 64, 86 and 88 268
Introduction 274
Statewide Quality and Access Test 277
Evaluation 283
Evaluation Objectives 283
Contextual Considerations 284
Research Questions, Data Sources, and Analytic Approach 287
Table 1 – Formative Evaluation 288
Table 2 – Summative Assessment 292
Timeline 298

Part III: Oregon's Measurement Strategy

Introduction 300
OHA Measurement Framework 300
Incentive Measures 301
Ensuring Continuous Quality Improvement 302
Data Collection 303
Measurement Year 303
Data Analysis 304
Data Reporting 304
Appendix 3.A: Measure Sets by Population and Domain 306
Appendix 3.B: Oregon Measures Matrix 310
Appendix 3.C: CCO Incentive Measure Specifications 328

Appendix 3.D: Rationale for Incentive Measures 351

Appendix 3.E: Measures for Consideration in Demonstration Year 3 360

Section B - Draft Expenditure Trend Review

Description of Costs 326
Treatment of Populations within the Workbook 329
Description of Elements in the Workbook 332
Expenditure Trend Review Workbook 333

Executive Summary

Oregon has a long history of choosing innovative means of managing its Medicaid program. Yet, Oregon has faced a number of challenges in recent years familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and government (both state and federal); cost growth that far outpaces the state's general fund revenue; and a system focused on volume, not value. For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical.

Instead of responding to these challenges with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon chose a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon developed a coordinated care model for this transformation built on the three-part aim of better health, better care and lower costs. In alignment with that aim, the two overarching goals of Oregon's 2012-2017 demonstration are to reduce the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

This document contains Oregon's Accountability Plan, a multi-pronged strategy to achieve the three-part aim and methodology for the two percent trend reduction test. The document represents a shift toward a new model of care encouraging continuous learning and transformation, increased transparency, and clear expectations and incentives for improvement along with a significant investment in measurement, analytics, and evaluation.

Attachment H is divided into two sections: Oregon's Accountability Plan (Section A) and the Expenditure Trend Review (Section B).

Section A: Oregon's Accountability Plan is divided into three parts:

Part I: Coordinated Care Organization Quality Strategy

Part I of the Accountability Plan (pages 9-66) contains Oregon's Coordinated Care Organization (CCO) quality strategy, which describes the process by which the CCOs will work towards the three-part aim. The CCOs will be held accountable for spending through a comprehensive capitated per-member-per-month payment (PMPM). Under this capitated arrangement, beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures.

CCOs will also be rewarded for improving quality. At the start of the demonstration, two percent of the PMPM budget will form a quality incentive pool and will be available to CCOs that achieve specific quality goals. The percent assigned to this pool will increase over the course of the demonstration, subject to approval from CMS where necessary. By holding CCOs responsible for spending as well as quality, and by shifting incentives towards outcomes over time, the CCO model will increasingly reward value and outcomes rather than utilization.

A key part of the strategy is changing the way care is delivered in key focus areas. Each focus area was chosen because of prior evidence suggesting that improvement in these areas can achieve the three-part aim. Each CCO will address four of seven quality improvement areas:

- Reducing preventable re-hospitalizations;
- 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 federal and state programs;

- Deploying care teams to improve care and reduce preventable, unnecessary and costly utilization by frequent utilizers;
- Integrating primary care and behavioral health;
- Ensuring appropriate care is delivered in appropriate settings;
- Improving perinatal and maternity care; and
- Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness.

The state will support CCO efforts with a wide array of resources and supports:

- **The Oregon Transformation Center:** Once launched in 2013, the Oregon Transformation Center will act as the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state. The center will provide support mechanisms that include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a range of topics including health equity. A patient-centered primary care home (PCPCH) technical assistance institute, that is already operational, will coordinate with the Oregon Transformation Center's learning collaboratives once launched.
- **Innovator agents:** Innovator agents will be assigned to each CCO. They will be a single, constant point of contact between the CCO and OHA and will help champion and share innovation ideas in support of transformation, within either the CCOs or the state agency. The state's innovator agent plan is included in this master document.
- **Non-Traditional Healthcare Workers:** These workers include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems
- **Patient-Centered Primary Care Homes:** The adoption of patient-centered primary care homes (PCPCH) is integral to transforming the health system. The primary care home model of care is defined by Oregon's statewide PCPCH standards and measures. These measures call for a patient-and-family-centered approach to all aspects of care, wellness and prevention. This includes culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner.

- **Evidence-based clinical decision tools:** Disseminated through the Oregon Transformation Center, these tools, based on extensive research and expertise on treatment effectiveness in achieving meaningful clinical outcomes, will provide guidance to providers and CCO clinical advisory panels in delivering clinically and cost-effective care.

- **Transparency:** Quarterly public reporting on a wide range of quality, access, and beneficiary experience measures, via CCO dashboards, will synthesize performance data to make it clear and understandable to all stakeholders, most importantly Medicaid beneficiaries.

- **Timely feedback:** Feedback will be presented to CCOs about progress, opportunities, and areas for improvement through a robust measurement strategy and analytics infrastructure.

Part II: Statewide Quality and Access Tests and Evaluations

Part II of the document (pages 67-97) provides information about statewide activities to support and incent quality and access, including an annual statewide test of quality and access required by CMS to assure that the demonstration's cost control goal is not being achieved at the expense of quality. The tests are structured to encourage improvement in quality, but if quality and access significantly diminish, a Designated State Health Programs (DSHP) penalty specified in the demonstration Special Terms and Conditions (STCs) will apply. Part II of the Accountability Plan also includes demonstration evaluation plans to support continuous quality improvement as well as a summative evaluation as required by the STCs.

The goal for these tests and evaluations is to create a new paradigm of accountability between CMS and the state. The key elements of this are:

- **Structured access and quality test:** Not only is the state required to meet the expenditure test outlined in Section B of this document, but in years where it meets that test, it is also required to meet a structured access and quality test to ensure that cost containment goals are not achieved at the expense of access or quality. The quality and access test consists of two parts: a relatively simple initial comparison of annual performance on a broad set of metrics against a baseline; and a more complex analysis of the associated between transformation activities and performance on access on quality, to be conducted only if the state fails part one of the test.

- **Formative, midpoint, and summative impact evaluations:** Building on the measurement strategy described in the first part of this document, the state will track and report regularly on OHA and CCO actions, the "levers" for health system transformation described in the STCs, and progress toward the goals of the three-part aim. The formative evaluation will provide timely and actionable feedback to CCOs, the state, and CMS. The midpoint and summative evaluations will be conducted by external, independent contractors and will employ more sophisticated analytic methods in order to determine whether changes in quality and outcomes resulted from the state's transformation activities.

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. The expansions and delivery reforms under this demonstration are intended in part to bridge the transition to implementation of the ACA, making monitoring the changes in 2014 an essential part of the state's efforts. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the quality and access tests will apply no differently in 2014 than in other demonstration years, except that the midpoint assessment is designed to provide analytical insight into progress as of 2014.

Part III: Measurement Strategy

Part III of the document (pages 98-170) describes the measurement strategies to support both CCO level quality activities in Part I as well as statewide quality activities in Part II.

Performance for all of these metrics will be made transparent, and will be reported by race, ethnicity and language to the extent possible, to ensure improved outcomes for all communities. CCO level dashboards will also be created to assist in rapid cycle improvement.

Metric groups:

- **Oregon CCO Incentive Measures:** The state's Metrics and Scoring Committee is responsible for identifying and adopting metrics for a program that establishes CCO financial incentives for improved outcomes. The Committee has identified an initial set of 17 metrics.
- **Oregon Demonstration Core Performance Measures:** Oregon's 1115 demonstration also includes ten additional measures that represent a broad snapshot of the Medicaid program.
- **CMS Adult Core Set for Medicaid**: These are the core set of measures recommended by an expert panel and established by CMS to track quality of care for the adult Medicaid population.
- **CMS Child Core Set for Medicaid and the Children's Health Insurance Program**: These are the core set of measures established by CMS for the pediatric population, also recommended by an expert panel. Both core sets will be part of the reporting format to the extent feasible, even as the sets evolve.

There is considerable overlap among these metric groups. The CCO incentive measures will determine the disbursement of the CCO-level quality pool and will serve as a strong incentive for quality improvement. The other measure sets, to the degree they are not included in the incentive measures, will serve as a broad snapshot of the Medicaid program in order to ensure that there is no degradation in some areas as the CCOs focus on the quality improvement areas represented by the incentive measures.

The statewide tests for quality and access that can trigger DSHP penalties include a very broad set of measures from all of these metric groups.

Section B: Expenditure Trend Review (pages 168- 188)

The expenditure trend review provides the methodology and template for measuring the required two-percentage point reduction in the rate of growth of Oregon Health Plan per capita expenditures. The test consists of three levels that capture growth in: 1) CCO global budget services; 2) total Medicaid expenditures for CCO enrollees; and 3) new administrative costs that may accrue to Medicaid in order to provide care under health system transformation in Oregon.

Along with submitting the expenditure trend review data quarterly, the state has agree to conduct an exploratory stakeholder process regarding opportunities, barriers, and strategies to integrate long term care into CCO global budgets. The state will also augment the expenditure review test reporting in March of each year with trends on hospital uncompensated care in the state for monitoring purposes.

Conclusion

The overall purpose of this demonstration is to help support fundamental changes in the delivery system. These changes can in turn help not only achieve the three-part aim, but also to prepare the state for the transition to 2014 when more of its population will be enrolled in CCOs.

Oregon's Accountability Plan and Expenditure Trend Review memorialize agreements negotiated between the state and CMS to ensure robust monitoring of the State's innovative health system transformation activities. Through regular reporting and rapid cycle improvement activities, both CMS and Oregon hope to learn lessons that can be applied to other payers and perhaps in other states.

Part I

Coordinated Care Organization (CCO)

Quality Strategy for the Oregon Health Plan 2012

CCO Quality Strategy Table of Contents

I. Introduction 208

II. Improvement Strategies 210

III. Oregon's Goals 224

A. Lower Costs 224

B. Better Care: Quality of Care 227

C. Better Care: Access to Care 230

D.Better Care: Experience of Care 232

E. Better Health 233

IV. Assessment 237

Performance Monitoring 237

Data Sources 239

Credentialing 240

Health Information Technology 240

V. Contract Compliance 242

Standards for Managed Care Contracts 242

Delivery Services Performance Monitoring 242

Enforcement 244

VI. Review of Quality Strategy 244

VII. Achievements and Opportunities 245

Appendix 1.A: Coordinated Care Organization Service Area Density 246

Appendix 1.B: Theory of Action Model 247

Appendix 1.C: Quality Pool Structure 248

Appendix 1.D: Innovator Agent Plan 256

Appendix 1.E: Contract Compliance 260

Appendix 1.F: List of Conditions that can result in Sanctions 264

I. Introduction

Oregon has a long history of choosing innovative means of managing its Medicaid program. Almost all of the state's Medicaid population is in managed care, and most of its long-term care program is in-home and community based services. When faced with the need to curb costs, the state developed the Prioritized List of Health Care Services to ensure that there was a rational, open process for selecting services to be covered based on their impact on population health. Even with this history as background, Oregon has faced a number of challenges in recent years familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and for the state and federal government; cost growth that far outpaces the growth in state general fund revenue and personal income; and a system focused on volume, not value.

For all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical. Nationally, it is estimated that about 30 percent of care provided is either unnecessary or does not lead to patient health. For racial and ethnic minorities, access to care and health status are worse than for the general population. For example, 35 percent of minority women in Oregon have no regular care provider, compared to 18 percent for Caucasian women, and the life expectancy for African Americans and American Indians/Alaska Natives in Oregon is two years less than for Caucasians. People of color disproportionately represent one in four covered lives in the Medicaid population. Native Americans have lower utilization rates of preventive services for children (birth through 10 years old), when compared to Caucasians, Latinos, and Asian Americans. African Americans and Native Americans have high rates of ambulatory care sensitive condition hospitalizations than Caucasians, Latinos and Asian Americans. Oregon's Action Plan for Health issues a call for action to address racial and ethnic health disparities. Addressing these disparities will go a long way toward improving Oregon's health system.

Instead of responding to trends over the last several years with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon has chosen a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon has developed a coordinated care model for this transformation that is built on the three-part aim of better health, better care and lower costs, and is being implemented in Oregon's Medicaid program through Coordinated Care Organizations (CCOs).

The coordinated care model was the logical next step for Oregon's health reform efforts that began in 1994 with the creation of the Oregon Health Plan (OHP). The coordinated care model grew out of recognition that the services people need are not integrated, leading to poorer health and higher costs. Physical health, mental health, substance abuse, and oral health, services are fragmented and are insufficiently tailored to meet the diverse needs of Oregon's

population. There is a sense of urgency in the state to rein in these costs or they will continue to overwhelm state, business and personal budgets.

Coordinated Care Organizations are community-based organizations governed by a partnership among those sharing in financial risk, providers of care, and community members. CCOs are and will be the single point of accountability for the health quality and outcomes for their members. They have the flexibility, within model parameters, to institute their own payment and delivery reforms that achieve the best possible outcomes for their membership.

Oregon's first eight Coordinated Care Organizations were certified to begin enrolling new members as of August 1, 2012. As of December 2012, there are 15 CCOs extending across every county in the state and approximately 90 percent of the Medicaid enrollees *(See attached map in Appendix 1.A)*.

As in the past, Oregon will continue to develop and maintain a quality strategy to assess and improve the quality of CCO services and to ensure compliance with standards. Section A, Part 1 of this Accountability Plan (the current section) satisfies both STC 45 and 42 CFR Part 438, subpart D requirement for a state quality strategy. Oregon will continue its robust monitoring of system performance and will continue to assure that standards of access, program operation, and quality are met. Although many oversight mechanisms used today will continue in the future, the transition from managed physical and mental health care to CCOs has greater implications for quality assurance and performance improvement focus areas than for methods of oversight.

CCO accountability measures and related incentives will be core elements of the state's quality strategy. These measures will allow the Oregon Health Authority (OHA) to set clear expectations for care delivery and health systems transformation and to monitor CCOs' performance against those expectations. OHA will institute a system of progressive shared accountability that maximizes the opportunity to succeed but also protects the public interest.

OHA will perform periodic reviews of the quality strategy to determine the need for revision and to assure CCOs are in contract compliance and have committed adequate resources to perform internal monitoring and ongoing quality improvement activities.

II. Improvement Strategies

To meet the goals of the three-part aim, Oregon's coordinated care model and FFS delivery systems 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 will take in the form of the stimuli and supports described below, 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 alternative payment methodologies 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

OHA will employ a variety of stimuli to promote the action of the levers and supports to enhance their effectiveness. *See the theory-of-action visual in Appendix 1.B for more details on the interaction between these levers and supports.*

STIMULI

Contractual requirements

One of the hallmarks of Oregon's health system transformation is local governance and flexibility, which requires a unique approach to a quality strategy in that it must recognize that each organization is unique in its approach to a model of care that meets the three-part aim. To that end, the state has included in its contracts a requirement that each CCO submit a draft transformation plan for approval by OHA by January 15, 2013. These plans must incorporate all

the contractual requirements of transformation, including milestones and benchmarks in each of the following areas:

- The model of care that the CCO will adopt;
- Their strategies for integrating behavioral, physical and oral health;
- The use of flexible services;
- How they will coordinate care;
- How they will adopt alternative payment methodologies for compensating providers;
- How they will work with diverse community partners and their Community Advisory Council;
- How they will reduce health disparities and advance health equity for culturally and socially diverse communities;
- How they will employ non-traditional healthcare workers and health care interpreters; and
- How they will address four of the seven focus areas in the STCs, three of which will be addressed as performance improvement products (PIPs). See below for a detailed discussion.

OHA will negotiate the content of the transformation plans with the CCOs and the final plans will become part of the CCO contracts as addenda. *See also section V of the Quality Strategy for further discussion of contract compliance and the repercussions for CCOs of non-compliance*.

Global budgets for CCOs (STC 36b)

CCO global budgets integrate previously separated funding streams – physical, mental and, beginning in 2013, oral health – and represent the total cost of care for all services a CCO is responsible. CCOs are held accountable for managing the total array of services, either through a capitated per-member-per-month (PMPM) payment or though payment for outcomes. In addition to reducing administrative overhead and promoting administrative simplification by combining the infrastructure and function of previously separate organizations, global budgets require coordination of care across all services and promote accountability. By shifting some services away from capitation and toward payment for outcomes (subject to CMS approval where necessary), Oregon is moving toward a system that increasingly pays for value rather than utilization.

This global budget is neither a per-capita cap nor a global cap. Beneficiaries enrolled in the demonstration will continue to be entitled to receive covered services as needed, and federal funding will be provided to match all appropriate expenditures. Per person spending trends will be measured to assure the demonstration is on track to save state and federal funds, but do not in any way serve as a cap on federal funding for medical assistance provided to Oregon's Medicaid beneficiaries.

Transparency

Beginning in January 2013, data supporting measures of cost, quality, access, experience of care, and health status will be collected by OHA over all delivery settings and populations. These measures include the core performance measures listed in the Oregon demonstration; others will be drawn from the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measures, the Medicaid adult core set, and a set of measures specifically addressing the needs of the severely and persistently mentally ill (SPMI) population. (*See Oregon's Measurement Strategy in Part III for the complete listing of metrics*). Data to track these measures will also be collected by race, ethnicity and language, to ensure improved outcomes for all communities. These measures will be reported publicly beginning June 2014 and will be updated either quarterly or annually depending on the measure. In addition, CCO dashboards will be created that will synthesize performance data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries.

Financial Incentives

A legislatively mandated stakeholder group, the Metrics and Scoring Committee, identifies metrics for financial incentives and makes recommendations to OHA about the design of the incentive structure. Incentive payments linked to metrics recommended by the Committee will form the basis of a fully-at-risk quality pool. The quality pool is a bridge strategy to move CCO payments from utilization to value. Over time, the proportion of a CCO's global budget based on capitation is expected to decrease as the proportion based on incentives tied to improvements in outcomes and efficiency increases, with prior CMS approval as needed.

The Oregon Metrics and Scoring Committee has worked with national experts to create the appropriate metrics and incentives that are aligned with the state's Medicaid quality strategy. Beginning July 2014, incentives will be linked to each CCO's performance on quality, cost and access measures as well as electronic health record adoption. In addition, in order to maximize the potential for achieving quality goals, CCOs will be required to align their provider incentives with the quality pool incentives; that requirement is reflected in CCO contracts. Timelines and milestones for implementation of alternative payment methodologies that further align CCOs and their providers with health system transformation objectives are addressed as part of CCO

transformation plans (drafts due January 15, 2013). *See Oregon's Measurement Strategy in Part III and the Quality Pool Structure in Appendix 1.C for a fuller description of financial incentives*.

One Percent Administrative Withhold

In accordance with STC 37b.i., OHA will withhold one percent of capitation revenue from CCOs in each year of the demonstration in order to ensure timely and accurate data submission. CCOs will forfeit up to the full one percent if they do not meet Oregon's standards for timely and accurate submission of encounter data. The specific contractual requirements are reflected in Oregon's January 2013 CCO contract amendments.

Quality Improvement Focus Areas

As required by contract and STC 25b.i., each CCO must address four of the quality improvement focus area 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 problem identified,
- Implement the action plan,
- Study its effects, and
- Refine the intervention.

Three of the focus areas will be conducted as performance improvement projects (PIPs). In Demonstration Year 11 (DY11), one of the three required PIPs will focus on integrating primary care and 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. Integrating primary care and behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care; and

7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. Finally, Attachment E of the demonstration's STCs outlines example measures that would be required of any CCO selecting specific focus areas.

SUPPORTS

The Oregon Health Transformation Center

In 2008 the Oregon Health Fund Board recognized the need for an infrastructure to stimulate system innovation and improvement. The Oregon Health Policy Board directed OHA in creating "Oregon's Action Plan for Health" to provide necessary supports for success of the model of coordinated care. As an important support, Oregon is forming a Transformation Center in the winter of 2013 to support the rapid learning and improvement necessary to implement the coordinated care model and to make any required mid-course corrections quickly. In Oregon's vision, the Oregon Transformation Center is the state's hub, or integrator, for innovation, improvement, and for implementing the coordinated care model successfully and rapidly throughout the state.

The activities of the Transformation Center will be aimed at creating the optimal conditions for the rapid spread of the key elements of the coordinated care model. Everett Roger's Diffusion of Innovation theory suggests that there are eight critical components in the successful spread of innovation.[6] In accordance with this work, the Transformation Center will conduct activities aimed at identifying or achieving:

- **Change leaders:** respected individuals who can serve as key messengers for the innovations;
- **Active learning networks:** peer-to-peer networks, collaboratives and other communication channels that enable stakeholders (CCOs and other payers, their providers, communities and consumers) to engage in learning and sharing information about the innovations;
- **Relative advantage:** stakeholders believe that the innovations are an improvement over current practice and their benefits outweigh the risks;

[6]Everett M. Rogers, *Diffusion of Innovations*, Fifth Edition 2003, Free Press, New York

- **Compatibility:** stakeholders understand how the innovations fit in with their current system and community needs;
- **Simplicity:** innovations are as easy as possible to implement;
- **Trialability:** stakeholders are able to try out an innovation with minimal investment before moving to full implementation;
- **Observability:** stakeholders see demonstrated evidence that an innovation works; and
- **Reinvention:** stakeholders can appropriately adapt innovations to serve local community needs.

The specific tools and support mechanisms to be provided by the Transformation Center include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a variety of topics including advancing health equity. Timely data and targeted analytic tools are among the most important supports that the Transformation Center will provide. In order to make sustainable progress towards integrating and coordinating care, CCOs and other health system partners will need better tools and stronger incentives to improve performance.

In cooperation with OHA's Office of Health Analytics, the Transformation Center will provide, both through Innovator Agents (described below) and directly to CCOs:

- Timely, reliable information and analysis to improve the targeting and delivery of services and to improve health equity;
- Data to drive accountability mechanisms, such as alternative payment methodologies aligned with performance measures and health outcomes; and
- Clear communication of analyses of performance, progress, and opportunities for improvement to help develop consensus around priorities and improve decision-making.

See Part III for descriptions of data sources and measurement details.

Learning Collaboratives

The Oregon Health Authority will establish a CCO learning collaborative as required by STC 25d within the Transformation Center, the purpose of which is to promote innovations and activities that will contribute to the objectives of health system transformation and accountability for achievement of the three-part aim of better health, better health care and

lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. In addition to learning collaborative areas of focus to be defined by OHA, CCO learning collaborative members will work together to decide upon additional focus area(s) of the collaborative and work with OHA to develop appropriate performance measures.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract. Also established by contract is a requirement 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.

Innovator Agents

STC 25d. and Senate Bill 1580 require OHA to provide CCOs with "innovator agents" who will act as a single point of contact between the CCO and OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation's three-part aim: better health, better care, lower cost. The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight. (*See section V for additional details on contract monitoring and oversight*).

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication and allowing streamlined reporting, reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports.
- Assist the CCO in managing and using data to accelerate quality improvement.

- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The innovator agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other innovator agents, CCOs, community stakeholders and/or OHA.

Innovator agent performance will be assessed annually through a "360" review process that includes input from the Community Advisory Councils, CCO management, OHA partners and other relevant stakeholders.

For more details on innovator agents and the Transformation Center, see the innovator agent plan, Appendix 1.D.

Community Advisory Councils (STC 25a)

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 council must:

- Include representatives of the community and of each county government served by the coordinated care organization, 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 coordinated care organization; and
- Annually publishing a report on the progress of the community health improvement plan.

Community Advisory Council members will be surveyed annually to assess their satisfaction with the level and quality of their engagement with the functions of the CCO board.

Community Health Assessments and Community Health Improvement Plan (STC 25a)
Community health assessments and the resulting community health improvement plan are required annually of each CCO. 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.

Non-Traditional Healthcare Workers (STC 18j)
Non-Traditional Healthcare Workers (NTHW) include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems, including reaching fee-for-service members. NTHWs take health care beyond the four walls of clinics and hospitals, out into homes and the community, supporting healthcare transformation in a variety of ways.

By focusing on culturally sensitive and linguistically appropriate approaches, NTHWs support adherence to treatment and care plans, coordinate care and support system navigation and transitions, promote chronic disease self-management, and foster community-based prevention. In order to build a health care workforce for the future, Oregon will:

- Establish systems for certifying NTHWs and certify 300 new community health workers by December 2015;
- Establish infrastructure to accelerate the certification of health care interpreters and certify 100 interpreters by June 2016; and
- Establish a curriculum within the Transformation Center learning collaboratives that supports best practices in using this new workforce to improve access and outcomes.

Patient-Centered Primary Care Home (PCPCH) Adoption (STC 18k, 25, 40c.viii, ix)

The Patient-Centered Primary Care Home (PCPCH) is integral to health systems transformation, and is defined by Oregon's statewide PCPCH standards and measures[7], developed through a public process to advance the three-part aim. These PCPCH standards call for a focus on patient-and-family-centered approach to all aspects of care, wellness and prevention, culturally and linguistically specific needs of patients, integration and coordination of care, active management and support of beneficiaries with special health care needs, and an emphasis on whole-person care in order to address physical and behavioral health care needs in an integrated, outcomes-oriented manner. PCPCHs are available for both CCO and FFS members alike.

Practices are recognized to meet the criteria for one of three tiers, with tier one being the basic level, tier two an intermediate level, and tier three a more advanced level of practice. There is a crosswalk so that practices that are NCQA-certified medical homes can use that as a portion of their requirement for designation. Health plans and other payers can then use the tiers to determine payment to incent and support the model.

Through a state plan amendment, OHA is currently providing tiered payments to recognized clinics for care to Medicaid enrollees with specific chronic diseases using federal funding through the Affordable Care Act's Section 2703. Several private payers are also paying an incentive payment to certified clinics based on the Oregon PCPCH standards, including those in partnership with the state and Medicare through the Centers for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care Initiative to 70 Oregon clinics.

House Bill 3650 (the enabling legislation for health system transformation) calls for CCOs to provide access to services through PCPCHs to the greatest extent possible. Through its contracts with CCOs, Oregon will encourage CCOs to use alternative payment methodologies that support PCPCH functions. Oregon will assess the implementation of PCPCHs through the

[7]See:http://www.oregon.gov/oha/OHPR/pages/HEALTHREFORM/PCPCH/standards.aspx

statewide PCPCH recognition process, CCO performance monitoring, and by assessing the percentage spent on primary care services and numbers of enrollees attributed to PCPCHs over time.

CCOs will demonstrate how they will use PCPCH capacity to:

- Partner with and/or implement a network of PCPCHs to the maximum extent feasible;
- Require other contracting health and services providers to communicate and coordinate care with PCPCHs in a timely manner using HIT/HIE technologies;
- Incent and monitor for comprehensive transitional care;
- Assure that beneficiaries receive integrated, person-centered care and are fully informed partners in transitioning to this new model of care;
- Assure that beneficiaries are informed about access to non-traditional providers as they are available through the CCO. Non-traditional providers may include personal health navigators, peer wellness specialists, and community health workers; and
- Assure that the primary care team provides culturally and linguistically appropriate assistance to beneficiaries in accessing needed services.

To further support the development of PCPCH capacity in Oregon, with funding from the Northwest Health Foundation and the Health Resources and Services Administration (HRSA) State Health Access Program, OHA awarded a $1.3 million contract to the Oregon Health Care Quality Corporation (Quality Corp) to establish a public-private partnership focused on supporting primary care transformation. The PCPCH Institute will provide technical assistance to Oregon clinics looking to improve care and gain recognition as patient-centered primary care homes.

Quality Corp will facilitate a collaborative and open process to establish the PCPCH Institute, beginning with the appointment of an expert oversight panel. The panel will include practicing providers with PCPCH knowledge and experience, experts in PCPCH learning techniques, behavioral health experts, public and private health system representatives, Independent Physicians Association representatives, and OHA staff. The Institute will invite proposals from interested technical assistance providers and organizations and the expert panel will oversee the selection process.

Once organizations are selected for providing specific services, a broad array of technical assistance will dramatically expand the quality and capacity of resources available to primary care clinics in Oregon including:

- The PCPCH learning collaborative

- A comprehensive, interactive learning system website
- Online learning modules and webinars
- Practice facilitation or "coaching" services
- Quality improvement training via a train-the-trainer model.

The Oregon Health Authority, Northwest Health Foundation, and Quality Corp will also be working to sustain the PCPCH Institute as an ongoing vehicle to support the patient-centered care model that will result in significant improvements in health care quality and outcomes in Oregon.

The Public Health Division (PHD) and the Office for Oregon Health Policy and Research are collaborating on the implementation and oversight for the PCPCH Program evaluation site visits in order to maintain the integrity and outcomes of the Program. PHD will train site evaluators that will conduct site visits in order to assist PCPCHs in identifying areas of strength and improvement.

In addition to these supports, the quality pool for CCOs will include an incentive for member enrollment in PCPCHs. *See Part III and Appendix 1.C for more details on Oregon's Measurement Strategy and Quality Pool Structure.*

Health Information Technology (HIT) is another tool that will support transformation; see the discussion of HIT initiatives at the end of Section IV, under the heading Health Information Technology.

Coordination with Other State Agencies

Public Health Division

Many of the factors that lead to chronic disease and disability, including unhealthy behaviors, 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 systemic barriers and root causes of poor health outcomes as well as corresponding risk factors such as tobacco use, poor nutrition and physical inactivity. Oregon's healthcare transformation initiative specifically delineates expectations that CCOs will address these root causes through the community needs assessment, community health improvement plan, the Community Advisory Council and collaboration with state and local public health agencies and community partners.

Through the Transformation Center, the state's Public Health Division will work with local health departments to collaborate in developing training and technical assistance for CCOs that

includes webinars, group training, individual coaching, and sharing of best practices, related to health promotion and disease prevention. This would include topics such as:

- The development and implementation of evidence-based cessation services, including benefits, referral systems, tobacco use as a vital sign, and integrating cessation support into electronic health records.
- The development of tobacco-free campus/worksite policies.
- The development of nutrition standards for hospital campuses, worksites and health care settings.
- USPSTF clinical preventive services recommendations for colorectal, breast, and cervical cancer screening, with specific emphasis on the importance of evidence-based colorectal cancer screening.
- The development and implementation of evidence-based chronic disease self-management programs, including referrals through electronic health records.

OHA will also be establishing a prevention policy committee that spans its operating divisions, including mental health, Medicaid, and public health to ensure that the OHA's policies support prevention in healthcare settings, extend prevention linkages between healthcare settings and communities, and integrate a variety of programmatic and professional approaches. This policy committee will consider issues related to supporting the CCOs, including operational policy issues and payment policy issues to support the three-part aim through prevention, and will review and make recommendations upon the request of the OHA Director. Issues the committee might consider include facilitating payment mechanisms for evidence-based chronic disease self-management programs such as Living Well with Chronic Conditions that are known to reduce the burden and costs associated with chronic diseases.

Office of Equity and Inclusion (OEI)

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.

Through the Transformation Center, the Office of Equity and Inclusion (OEI) will assist in developing a curriculum for CCOs and Medicaid providers that will include webinars, group training, individual coaching, information sharing, and technical assistance related to health equity. This would include topics such as:

- Language access services such as interpretation, translation, signage, web sites.
- Job descriptions, training, recruitment and retention of community health workers and other non-traditional health workers.
- Diversifying the health care workforce.
- Diversity and inclusion best practices.
- Diversifying community advisory boards.
- Including equity and diversity in CCO community health assessments and improvement plans.
- Cultural competence continuing education for all staff.
- Race, ethnicity, and language data collection, analysis, and reporting for quality improvement, and
- Community outreach and partnership with trusted culturally competent community and faith based organizations.

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. 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. OHA is coordinating with the ELC to ensure that a broad view of early learning is adopted, one that 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 ELC and OHA are seeking shared opportunities for coordination of services, workforce training, data sharing, quality measurement, and accountability for child outcomes.

Oregon Patient Safety Commission

OHA will partner with the Patient Safety Commission to make the Commission's Breakthrough Series Collaboratives available to CCOs, and to bring learnings from the work of the commission to improving patient safety throughout the Medicaid population.

III. Oregon's Goals

Oregon is engaged in multiple efforts to achieve the three-part aim. Through specific objectives, ideal behaviors, supportive stimuli, and through an infrastructure of learning systems to support rapid cycle improvement, the state can achieve lower costs, improve quality of care and improve the patient experience.

A. Lower Costs

In the past two decades, Oregon's health care expenditures have been increasing exponentially. It is one of the sectors of Oregon's economy with the highest growth rate, averaging 7.6 percent annually. Medicaid served 14 percent of the Oregon population in 2010. Its expenditures, at $3.3 billion, represented 12 percent of the total healthcare spending in 2010, and per capita Medicaid expenditures were $6,049.[8]

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as $10 billion in the FY 2017-2019 biennium with more than 900,000 individuals enrolled in the program. This figure includes approximately over 200,000 newly eligible under federal health reform expansion provisions that take effect in 2014.

With healthcare costs increasing unsustainably, a key goal of healthcare transformation in Oregon is to reduce the growth in statewide PMPM Medicaid spending by one percentage

[8]Sources: Population counts: Portland State University; 2010 expenditures by payer type from 1990-2004 National Health Expenditure (NHE) Data, Center for Medicare & Medicaid Services (CMS).

point in demonstration year two and by two percentage points over demonstration years three, four, and five.

Specific objectives:

1. Decrease trend rate by two percentage points as evidenced by total cost PMPM.
2. Meet or exceed 90th percentile national Medicaid benchmark for ED visit rates.
3. Meet or exceed national Medicaid benchmark for all cause readmissions

LOWER COST			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	Align provider financial incentives to achieve the Three-part aim Take meaningful action to reduce administrative waste Be creative with deploying flexible services Be creative with deploying caregivers directly when appropriate	Global budget creates incentive to coordinate care and eliminate redundant organizational structures Transparency: o Avoidable ED visits o ED utilization o PQI o Re-admissions to hospital o % of service dollars for enabling services for SPMI populations o Length of stay in various care settings for SPMI population Incentives: o Follow-up after hospitalization for mental illness o EHR adoption	• Analytic support: quarterly analysis of: o PQI o Avoidable ED visits o Expenditures per CCO o High utilizers • Innovator agents work with CCO to use results of analysis to determine most efficacious interventions in rapid cycle improvement (RCI) • Innovator agents recommend and provide information regarding best practices, innovative models, to address issues in RCI, e.g.: o Financial models, including alternative payment methodologies o Financial tools, such as groupers o Models for administrative simplification

	Ideal Behaviors	Stimuli	
		o ED utilization Contract requirements for: • Flexible services • NTHWs • APMs	• Transformation center provides TA and tools related to the "starter set" of promising alternative payment models (APMs) including: o Bundled payments o Risk and gain sharing arrangements o Global payments o Service agreements aligning primary and specialty care incentives
Providers:	• Coordinate care with other providers • Coordinate care with community resources and services • Offer after-hours help and alternatives to the emergency department • Avoid duplicative and unnecessary services	Alternative payment methodologies Flexible services	• PCPCH adoption • Case managers and NTHWs • Support with community health solutions • Innovator agents work with CCO to share data analyses with PCPs • Transformation Center supports innovative strategies such as community health workers to address needs of high utilizers; use of flexible services

B. Better Care: Quality of Care

An in-depth examination of Oregon managed care organizations' (MCOs) historical performance on a number of measures of quality of care reveals significant areas where performance should improve to equal the national Medicaid average. In other measures, Oregon performs at the national average. In either case, it is important to maintain the level of quality and strive to improve it. Thus, Oregon set objectives to meet or exceed national Medicaid averages where they are available, focusing on areas that are closely aligned with the overall goals of health system transformation. For some measures, an Oregon baseline has not yet been calculated, but it is believed that the measure is critically important to evaluating the quality of care provided.

Specific objectives:

1. Improve developmental screening by 36 months to align with Oregon Early Learning Council objectives (no national baseline available).
2. Meet or exceed the 75th percentile of the national Medicaid average on HEDIS timeliness of prenatal care visits.
3. Meet or exceed the March of Dimes goal of <5% rate of elective deliveries before 39 weeks. Establish baseline in DY11.
4. Meet or exceed the 75th percentile national Medicaid benchmarks for diabetes care (HbA1C poor control).
5. Meet or exceed the 75th percentile national Medicaid average for controlling hypertension (HEDIS). Establish baseline in DY11.
6. Maintain or improve colorectal cancer screening. Set target at 49% (based on improvement across Oregon's Medicaid plans since 2002).
7. Improve substance abuse screening (SBIRT): Establish baseline in DY11 and set benchmark for DY12.
8. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.
9. Maintain or improve to meet or exceed the 90th percentile of the national Medicaid average for follow up after hospitalization for mental illness.
10. Improve mental health and physical health assessment in children in DHS custody. Establish baseline in DY11 and set benchmark for DY12.

11. Improve screening for clinical depression and follow up plan. Establish baseline in DY11 and set benchmark for DY12.

12. Meet or exceed the 90th percentile national Medicaid benchmarks for follow up care for children on ADHD medication

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to improve care coordination, including behavioral health • Encourage providers to exceed benchmarks for meaningful use and participate in HIE • Engage meaningfully with community, including culturally and linguistically diverse communities, to address its health needs • Encourage members to take an active role in their care	Global budgets provide stimulus for integrating and coordinating care Financial incentives: • Screening for addiction, brief intervention and referral to treatment (SBIRT) • Follow up after hospitalization for mental illness • Diabetes control • Colorectal cancer screening • Hypertension control • Elective delivery before 39 weeks • Timeliness of prenatal care visits • Developmental screening by 36 months • Mental health and physical health assessment for children in DHS custody • EHR adoption	• Learning collaboratives that target areas of concern • Provide TA as needed on PIPs • Innovator agents champion and share ideas • Transformation Center supports analysis of data by race, ethnicity and language to assure equitable quality of care • Support and encourage employment of NTHWs through registry of workers, establishment of certification criteria, and partnerships with community colleges • Transformation Center shares best practices, evidence-based interventions, and care models across communities • Public health supports through evidence-based interventions to improve population health • Work with Oregon Patient Safety Commission to bring information about best practices and evidence-based

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
		Transparency: Quality measures will be tracked and posted on the OHA website. See Part III for the complete listing. Contract requirements for: • Focus areas (PIPs) • Community needs assessment • Community Advisory Council • Transformation plan	interventions to improve patient safety to CCOs
Providers:	• Strive for tier 3 PCPCH status • Coordinate care with other providers • Coordinate care with community resources and services • Help patients navigate the healthcare system • Encourage patients activation • Show respect to patients and families • Adhere to clinical guidelines • Use data to ensure timely follow up, prevention, and interventions • Increase healthcare workforce diversity, including non-traditional	• Incentives for PCPCH status • Incentives for EHR adoption • Payment methodologies that incentivize performance	• Community support through public health • Utilization of NTHWs • Transformation Center and Innovator agents share best practices and resources • Feedback on performance measures

QUALITY OF CARE			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
	health care workers • Access cultural competency continuing education		

C. Better Care: Access to Care

Oregon exceeds national Medicaid benchmarks in some measures of access, particularly for access to primary care and ambulatory care visits. For Consumer Assessment of Healthcare Providers and Services (CAHPS) measures, Oregon is often just below national Medicaid CAHPS measures of access. For adolescent well care visits, Oregon is below national Medicaid average and our goal is to improve it to meet that standard.

Specific objectives:

1. 100% of beneficiaries will have access to a certified PCPCH.
2. 75% of PCPCH sites will be certified as tier 3.
3. Rates for primary care sensitive admissions (PQI) will be reduced 10% from Oregon's baseline.
4. Rates for avoidable ED visits will meet or exceed (i.e., be lower than) national Medicaid averages.
5. Dental visits for children (after 2014) will meet or exceed national Medicaid averages.
6. Improve adolescent well child visits to meet or exceed the 75th percentile of the national Medicaid average.

ACCESS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Encourage providers to meet level 3 PCPCH certification • Care about and take action to increase access • Encourage use of NTHWs • Support culturally and linguistically specific outreach and engagement to promote access • Support availability and use of culturally and linguistically appropriate materials	Transparency: Access measures will be tracked and reported on the OHA website. See Part III for additional details. Contractual requirements for: • Transformation plan must incorporate model of care that addresses access issues • Community needs assessment must address access • Community Advisory Council provides ongoing feedback on access to CCO Financial incentives: • CAHPS survey questions about access • ED utilization • Access to PCPCH • Adolescent well visits	• Support for NTHW, who help increase access by helping members navigate the healthcare system and advocating for them as needed • Data analytic support on measures of access • Innovator agents bring resources on best practices and innovations to increase access • Learning collaboratives focus on improving access • Support from Office of Equity and Inclusion to promote culturally competent care that is welcoming to all and increases access
Providers:	• Offer after-hours help and alternatives to the emergency room • Help patients navigate the healthcare system • Diversify the workforce	PCPCH financial incentives	• Learning collaboratives • NTHWs and HCIs

D. Better Care: Experience of Care

Patient-centeredness is the key component of the care Oregon aspires to provide to Medicaid beneficiaries. By encouraging feedback from patients about their experience of care, OHA learns how to make significant improvements in the quality of the care provided and build a model of care that meets their needs. In Oregon, CAHPS scores for patient experience of care measures for individuals are slightly lower than the national Medicaid average for adult members reporting getting needed care and positive communication with a doctor, but slightly higher for getting care quickly.

Specific goal:
Meet or exceed the 75th percentile of the national average for Medicaid CAHPS (for both adults and children) experience of care tools for specified composite measures that focus on areas critical to Oregon's goals for health system transformation:

- Access to care composite, for both children and adults

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
CCOs:	• Adopt value-based purchasing • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care	Transparency: OHA will post on its website: • CAHPS survey results • Performance metrics by race and ethnicity. Financial incentives: CAHPS survey questions are included in quality pool metrics: ▪ Composite: Health plan's customer service gave information or help you needed ▪ Composite: Getting care quickly Contract requirements include quarterly reporting of grievances and appeals by CCOs (*see section IV)*	• Data from CAHPS and other surveys used to identify learning needs • Innovator agents : o support improvement with learning collaboratives, peer-to-peer learning o Collaborate with the OHA Ombudsman to monitor emerging trends in complaints and appeals assigned CCOs. o Provide feedback to assigned CCOs and identify needs for peer-to-peer and learning collaboratives to address problems as they arise. • Community Advisory Council monitors patient experience and works with CCO to improve in identified areas • Office of Equity and Inclusion

Setting	Ideal Behaviors	Stimuli	Learning Systems and Supports for Rapid Cycle Improvement (RCI)
			supports provision of culturally competent care which will improve the patient experience
Providers:	• Help patients navigate the healthcare system • Are accessible • Put patients first • Encourage patients to play an active role in their care • Show respect to patients and their families	Value-based purchasing and provider incentives encourage providers to address needs of patients	• Community support through public health • NTHWs support members in navigating healthcare system and getting needed services • Best practices and sharing of resources (e.g. Quit Line)

E. Better Health

The ultimate test of the effectiveness of a healthcare system is the health of the people who use it. While pursuing the goals of lower cost and better experience of care, it must be assured that at the very least health and healthcare are not degraded, and aim to improve them.

To improve population health and lower costs, Coordinated Care Organizations must address the increasing burden of chronic diseases. Chronic diseases account for 75 cents of every health care dollar spent. Eighty percent of health care resources are spent on 20 percent of members,[9] most of whom have multiple chronic conditions that are complex to manage. Chronic diseases that remain undetected untreated and poorly managed result in increased hospitalizations, costly medical interventions, lower productivity and, most importantly, lower quality of life for Oregonians.

Health status: Oregon's baseline data for Medicaid, taken from the 2011 Medicaid Adult CAHPS survey, reveals health status responses that are below national averages as well as health status of Oregon's general population as reported on the 2010 BRFSS:

[9] Agency for Healthcare Research and Quality

	Oregon CAHPS (Medicaid)	National Average CAHPS (Medicaid)	Oregon BRFSS Adult General Population
Excellent	7%	11%	19%
Very good	16%	22%	33%
Good	33%	32%	30%
Fair	29%	24%	13%
Poor	14%	10%	5%

Obesity: Oregon's 2010 BRFSS data reveal an adult Medicaid obesity rate of 38.3 percent, compared to 27.7 percent of the general population in Oregon. *(Note: the Medicaid data are not age adjusted, while the general population data are)*.

Tobacco: The current adult Medicaid rate of tobacco use is 31 percent (CAHPS 2011), compared to 23 percent in the general population in Oregon (BRFSS 2010). Oregon Medicaid is below the national average of 37 percent (Medicaid CAHPS), but tobacco use is a major driver of long-term health risks.

Specific objectives:

1. Reduce the proportion of beneficiaries who report their health status to be poor to 10 percent by 2017**.** Oregon will initially assess health status through the use of the CAHPS survey. It is expected that health status will be evaluated through a self-assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

2. Obesity as calculated from self-reported height and weight will not exceed 41 percent over course of the demonstration. Oregon will initially assess obesity through the use of the CAHPS survey. It is expected that a self-assessment tool will be available as part of a new online enrollment system projected to come on line in 2014. Enrollees will be asked to state their height and weight, from which a BMI can be calculated.

3. Decrease tobacco use in the Medicaid population to 25 percent over the course of the demonstration. Oregon will initially assess tobacco use through the use of the CAHPS survey. It is expected that tobacco use status will be determined through a self-assessment tool that will be available as part of a new online enrollment system projected to come on line in 2014.

4. Reduce ethnic and racial disparities over the course of the demonstration. Establish baseline in first year of the demonstration. Use enrollment data, which identifies race,

ethnicity, and foster child status to compare these groups for health status, obesity and tobacco use. In the first year of the demonstration, develop strategy to identify disabled and Serious and Persistent Mental Illness (SPMI) populations, and establish baseline for disparities among all groups.

HEALTH STATUS			
Setting	**Ideal Behaviors**	**Stimuli**	**Learning Systems and Supports for Rapid Cycle Improvement (RCI)**
CCOs:	• Care about and take actions to guarantee strong member outcomes • Use value-based purchasing to improve outcomes • Engage meaningfully with community to address its needs • Take action to engage members to become more active in their own care • Focus on health equity	Contract requirements: • CCOs must perform a community health assessment in the first year • CCO's transformation plan must reflect the community health assessment • Community Advisory Council (CAC) will guide the development of the community health assessment, connect the CCO with the community, and hold it accountable to improving the health of beneficiaries enrolled Financial incentives for PCPCH adoption Transparency: publish health outcomes data by CCO on the OHA website. Relevant performance measures include: • Health and functional status among CCO	The Transformation Center will provide data and analytic support to CCOs for race/ethnicity composition of their population and inequities in performance metrics and the community health assessment Innovator agents work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work, champion and share ideas. Office of Equity and Inclusion will support CCOs in designing culturally appropriate strategies to improve health

		enrollees; • Rate of tobacco use among CCO enrollees; • Obesity rate among CCO enrollees • Reduction of disparities: differences in these metrics among race and ethnicity categories Community Advisory Council Community Needs Assessment PCPCH incentives	
Providers:	• Encourage patients to play an active role in their care	PCPCH incentives	• The Public Health Division will work with local health departments to support the implementation of evidence-based community interventions • Support for the employment of NTHWs through a registry of workers, establishment of certification criteria, and partnerships with community colleges

IV. Assessment

To monitor how well Oregon's coordinated care model is achieving its goals of access and quality improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have a robust measurement and reporting strategy and mechanisms to monitor and assess all Medicaid delivery systems (including Coordinated Care Organizations and Fee-for-Service). Full details on how the Oregon Health Authority will measure quality of and access to care for the Oregon Health Plan population are available in Part III: Oregon's Measurement Strategy. The format for the state's required quarterly reporting to CMS on quality, access, and many other elements of the demonstration can be found in STC Attachment A, Quarterly Report Guidelines. This section describes Oregon's assessment program, available data sources, requirements for credentialing, and an overview of health information technology.

Performance Monitoring

As required by CFR 438.202(d), the state assesses how well the Coordinated Care Organizations 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. Oregon's evaluation plans, described in Part II, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries.

In addition, OHA monitors plans activities on an ongoing or periodic basis for the level of contract compliance. Assessment program components are described below:

On-site operational reviews – Operational reviews are conducted on a regular basis. These reviews are designed to supplement other state monitoring activities by focusing on those aspects of CCO performance that cannot be fully monitored from reported data or documentation. These reviews focus on validating reports and data previously submitted by the CCO through a series of review techniques that include an assessment of supporting documentation and conducting a more in-depth review of the CCO's quality assurance activities.

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 the 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 reviews – 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.

Complaint, grievance and appeals reports – 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.

Fraud and abuse reports – 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 committee 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.

Data Sources

Oregon assesses the quality and appropriateness of care through the collection and analysis of data from many sources. The state has developed many systems to collect data from plans and plans are required to have information systems capable of collecting, analyzing, and submitting the required data and reports. Data sources include:

Administrative Data – All CCOs, managed care plans, 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.

In the MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Ethnicity is currently defined as Hispanic/non-Hispanic. Oregon does not have data on multiple races. Oregon only has data on preferred household language, not language spoken by an individual client.

Community Health Assessment – CCOs are contractually required to submit the community health needs assessment to OHA. For additional detail on the community health assessment, see section II, above.

Enrollment Data – Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

As the state moves to an online enrollment system in 2014, data collection on race, ethnicity, and language will be improved and additional data will be collected through this system, including tobacco use status and body mass index (BMI). All enrollment data is shared with the plans.

Member Satisfaction Surveys – Oregon, in conjunction with its external quality review agent (EQRO), conducts statewide-standardized surveys of patients' experience of care (satisfaction). These surveys allow for plan-to-plan comparisons. Plans are required to participate, as appropriate, in the performance of such surveys. Plans whose results are meaningfully and statistically below acceptable thresholds may be required to develop a corrective action plan that the state will review and monitor. The results of the surveys are made available to

Medicaid beneficiaries to assist them in the processes of selecting an appropriate plan. Survey results are shared with plans and reports are published on the OHA website.

Participating provider network reports – Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turn over.

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 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.

Credentialing

Managed care 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.

CCOs must also work with OHA through the Addictions and Mental Health Division and Public Health Division to assure proper credentialing of Mental Health Programs, associated providers and non-traditional health care workers. *See Appendix 1.E for a list of contractual elements and associated OARs.*

Health Information Technology

Adoption of Electronic Health Record Technology and Meaningful Use (STC 25c)

The Medicaid Electronic Health Record (EHR) Incentive Program provides incentives to certain providers who adopt and demonstrate meaningful use of certified electronic records. The program began in 2011 and concludes in 2021. Initial participation by eligible professionals (EPs) may begin any time until 2016. Oregon requires that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers. The Metrics and Scoring Committee is developing measures and benchmarks that will demonstrate CCO commitment to exceed the federal standards for EHR adoption. *See Part III for details on measures and benchmarks.*

Information Sharing

Health information exchange activities are critical for central elements of this demonstration, including reporting of quality metrics, progress with meaningful use of electronic health

records, meaningful care coordination, and real-time data assessments. CMS has made funds available, at state request, for the Medicaid portions of the health information exchange infrastructure. These funds could help support the HIE provisions outlined in STC 25(c).

The Health Information Technology Oversight Council (HITOC), created legislatively in HB 2009, has guided the development of Health Information Exchange (HIE) work in Oregon. HIE is not a single technical solution, but rather includes any solutions that allow health information to be made available to the provider at the right time and in the right place to meet patient needs. For Oregon's first phase of HIE, HITOC selected the standards for secure, HIPAA-compliant electronic messaging developed by the Direct Project through the Office of the National Coordinator for Health Information Technology (ONC). Using these standards, statewide Direct Secure Messaging was developed through the Oregon Office of Health Information Technology (OHIT) and launched in May 2012 under the brand CareAccord™. OHIT is tracking the number of Direct addresses in use and number of Direct messages being sent through CareAccord™ as one way to measure growth in information exchange.

Direct Secure Messaging is not the totality of HIE, and currently Oregon is in the process of gathering stakeholder input from within the state, from CCOs, from patient groups, and others to determine the right path for the development of further HIE services.

Recommended measures start with those that ONC has published in a program information notice (PIN) for HIE which established that states report the following measures annually:

- Percent of pharmacies participating in e-prescribing
- Percent of clinical laboratories sending lab results electronically and in structured format
- Percent of providers and hospitals sharing patient care summaries electronically
- Percent of state health programs within the Oregon Department of Health electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results

In addition, each CCO is contractually obligated to meet standards in foundational areas of health IT. This includes facilitation of providers' adoption and meaningful use of EHRs and ensuring that every provider either is registered with a statewide or local Direct-enabled health information service provider (HISP), or is a member of a health information organization (HIO) that enables electronic sharing of information with other providers in the CCO's network. Also, each CCO must develop a transformation plan that demonstrates, among other elements, how it will develop EHRs, HIE and meaningful use. The Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) are also investigating the inclusion of measures for HIE in future contracts.

These developments in EHR adoption and HIE support better collection of timely, actionable data to enable quality measurement and improvement.

Trailblazer State Project

The HIT Trailblazer Project is a new technical assistance award from ONC and supported by the National Academy for State Health Policy (NASHP) for a small number of states that are leading the nation in health system transformation. An action plan will be developed by March 2013 for the technical infrastructure for statewide quality reporting and feedback. Part of the assistance that the federal partners will be providing Oregon is an understanding of the federal vision for quality measures and how those can be aligned with the state measures to reduce the burden on providers for reporting while providing metrics that are meaningful to Oregon's specific implementation of health system transformation.

V. Contract Compliance

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 1.E 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.

Delivery System Performance Monitoring

Oregon has developed a comprehensive program to assess all aspects of the delivery system. As described in section IV, above, 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.

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 described in section IV above.

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.

External Quality Review Organization Activities

OHA has contracted with Acumentra Health to serve as its external quality review organization (EQRO). In compliance with Federal regulations, the scope of work includes all mandatory activities: compliance reviews every three years, validating health plan Performance Improvement Projects; 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.

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. These Quality Management Plans (QMPs) are reviewed, along

with documentation of the activities and studies undertaken as part of the QMP during both the certification process and ongoing EQRO reviews.

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. A list of conditions that may result in sanctions can be found in Appendix 1.F.

VI. Review of CCO Quality Strategy

The Quality Strategy shall be reviewed annually by OHA. This annual review and update will begin each August and shall be completed by December of each year. The Quality Strategy update will be provided to CMS in December of each year upon significant changes.

The OHA Quality Committee 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:

- AMH Planning and Management Advisory Council (PAMAC)*
- Medicaid Advisory Committee*
- DMAP/AMH Executive Team
- OHP Medical Directors
- OHP Contractors

- OHP Quality Management Coordinators
- Local Government Advisory Committee*
- DHS 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.

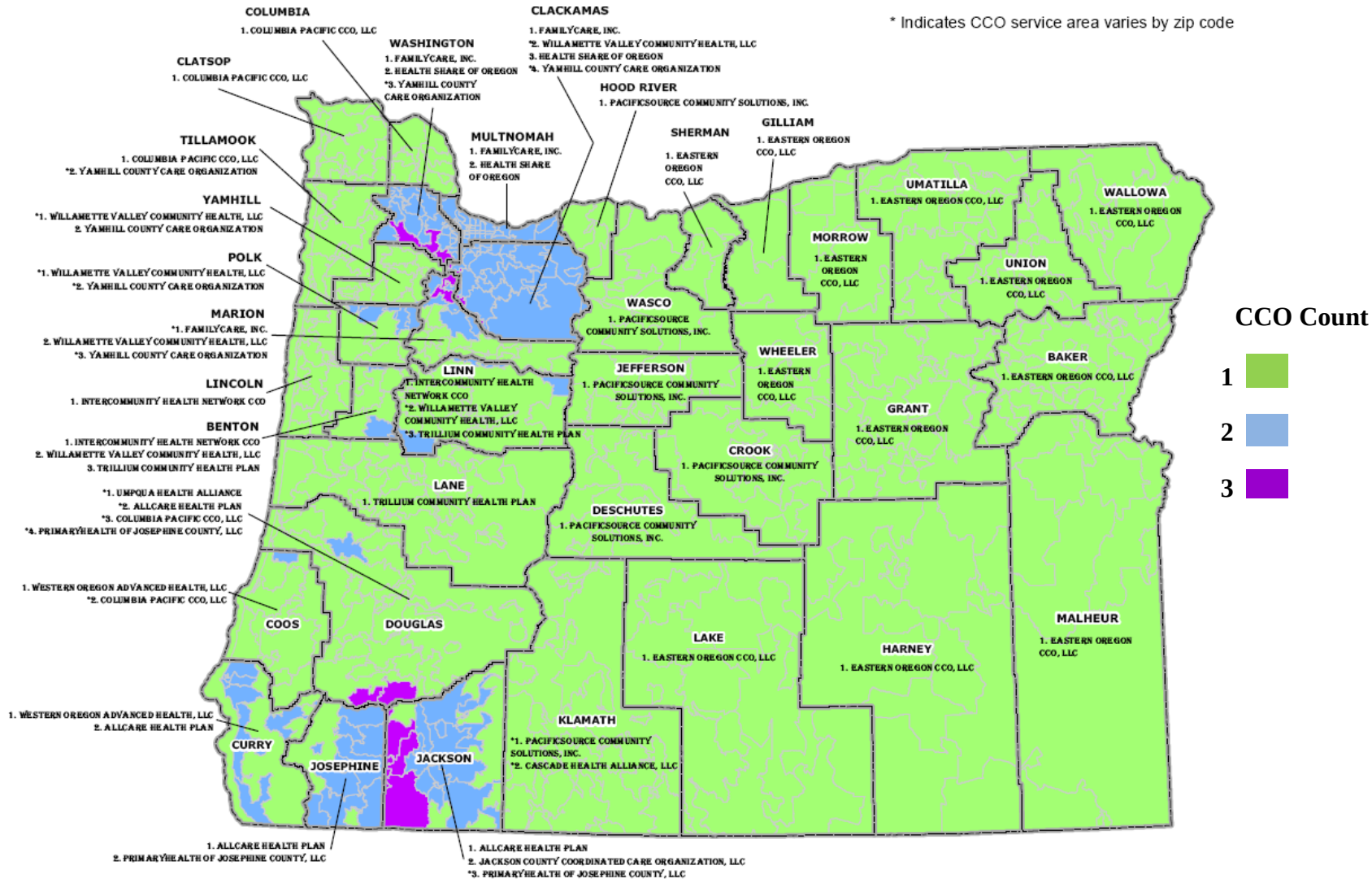
VII. Achievements and Opportunities

Passage of House Bill 2009 and HB 3650 are important achievements for the state and present a significant opportunity for Oregon to expand work already in progress to improve population health and increase access to high quality, efficient, and cost effective health care.

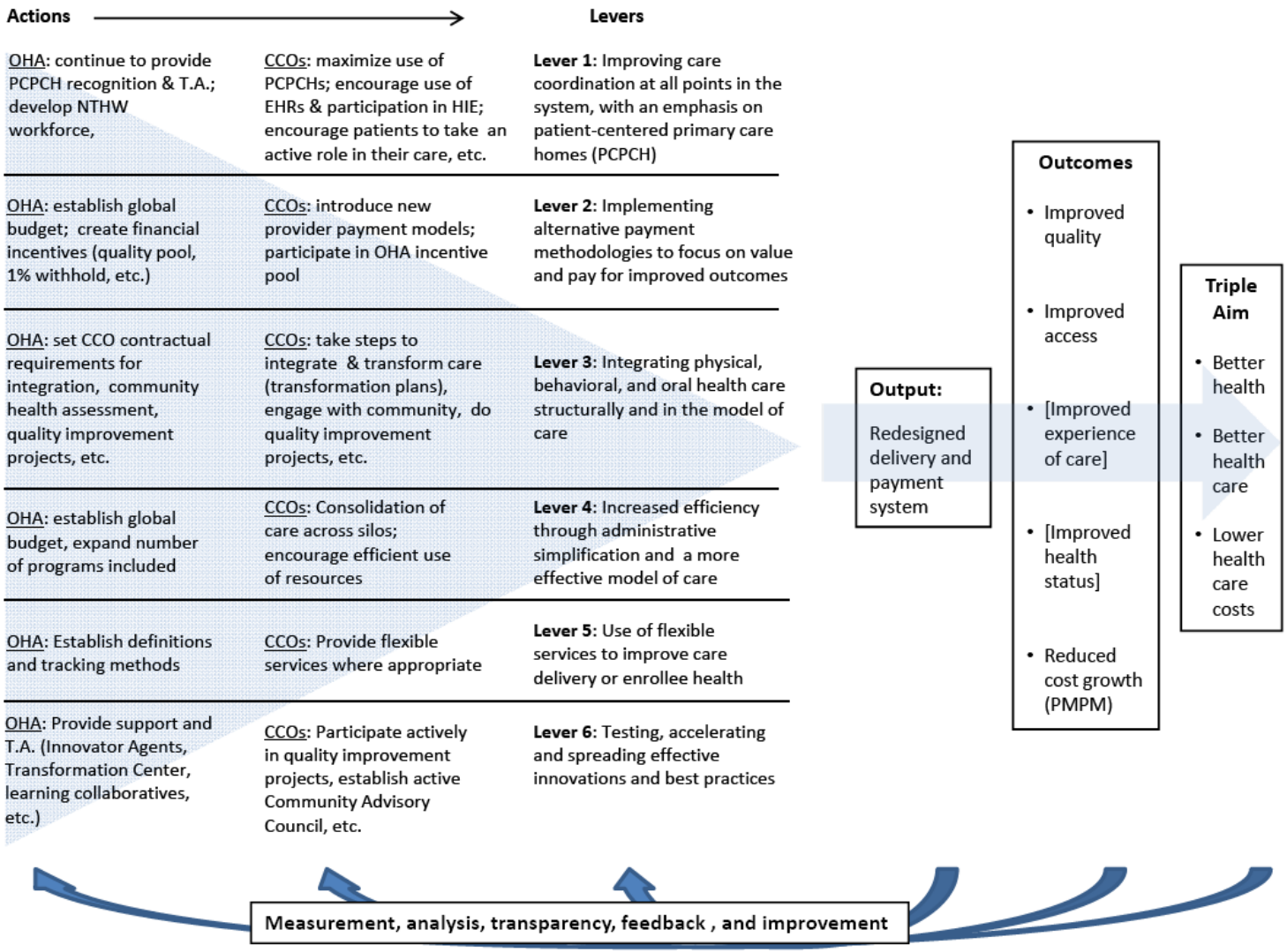
Oregon has a strong foundation for future health system transformation based upon the 20-year history of the Oregon Health Plan, and the extensive knowledge and experience developed during that time, including the unique use in Oregon of the Prioritized List of Health Services under the Health Services Resource Commission.

With the creation of the Oregon Health Authority consolidating all state health agencies in Oregon, there is further opportunity for increased focus and support for the Quality Strategy, including alignment with other quality and health improvement initiatives.

Appendix 1.A: Coordinated Care Organization Service Area Density



Appendix 1.B: Theory of Action Model



Appendix 1.C: Quality Pool Structure (STC 37b.ii)

Introduction

Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. By establishing a quality incentive pool as required by STC 37b.ii, the state is taking the first step in this process. It is expected that over time, savings accruing from the restructuring of 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.

OHA's Strategy for Annually Setting the Amount of CCO Payment at Risk for Performance

OHA's strategy is to annually increase the percentage of CCO payment at risk for performance over the term of the demonstration. OHA believes that unless CCOs have a meaningful percentage of their payment at risk for performance, they are unlikely to take the steps necessary to achieve significant performance improvement and affect transformative change in care delivery. OHA also believes that it must be careful to not make the at-risk amount so large as to threaten the financial viability of a CCO should it not perform well relative to the contractual targets.

Because performance-based contracting is new to both OHA and CCOs, OHA anticipates the need to annually assess experience, with CCO and Metrics and Scoring Committee input, and then determine both a) changes to the quality incentive pool methodology, and b) the desired level of CCO financial risk for the next contract year.

OHA recognizes that while a substantive incentive payment will provide meaningful motivation for CCOs, research has shown that fear of loss is a greater motivator than is the potential for gain.[10] For this reason, OHA intends to increase the at-risk amount by a percentage point each year of the demonstration—meaning poor performance could result in a loss of margin–although not a loss so large as to threaten the CCO's stability.

OHA's Planned Approach for Defining the At-Risk Amount for the DY12 Contract Year

OHA plans to finance the Quality Pool for the demonstration year 12 (DY12) contract year at two percent of the aggregate value of the per member per month (PMPM) CCO budget.

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[10]Kahneman, D. and Tversky, A. "Choices, Values, and Frames." American Psychologist39 (4): 341–350 (1984) and Kahneman, D., Knetsch, J., & Thaler, R. "Experimental Test of the endowment effect and the Coase Theorem" *Journal of Political Economy* 98(6), 1325-1348 (1990).

Specifically, OHA will make disbursement of these funds contingent on CCO performance relative to both absolute (benchmark) targets and improvement targets on selected measures. Using OHA's planned methodology, there will be two rounds of funding distributions. In Round One, each CCO will have a maximum amount of Round One dollars from the incentive pool for which it is eligible in any particular contract year. This pre-determined amount will be calculated by multiplying a common PMPM value by the CCOs' beneficiary average monthly member count for the contract year. OHA plans, however, to set a floor such that regardless of enrollment, each CCO shall be eligible to earn at least $1 million dollars, assuming maximal performance, through the incentive pool. OHA has adopted this strategy in order to ensure that small CCOs have sufficient grounds for making necessary investments in quality improvement.

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs in a second round of funding distribution called the "challenge" round. The challenge funds will be distributed to those CCOs that meet the performance targets on a subset of four incentive measures described in this document as "challenge measures." A complete description of the challenge measures and the distribution of challenge funds are provided below.

CCOs will only be rewarded for attaining performance targets ***or*** improving performance; there will be no penalties assessed related to performance in DY12.

OHA believes this strategy is appropriate for the first year for the following reasons:

- CCOs will view an incentive pool equivalent to the aggregate size of the rate increase to be sizeable, particularly given the large rate cuts experienced previously by the predecessor MCOs. The CCOs will be motivated to achieve this potential reward.
- This approach has been used by commercial health plans with providers with positive results.[11]
- Use of a challenge pool will allow CCOs to give special attention to those aspects of performance that are most important to OHA for DY12.
- The CCOs have never been measured or been held accountable for performance relative to many of the adopted measures. Neither OHA nor the CCOs can be absolutely certain regarding the feasibility of CCO target attainment. As CCOs develop experience with the measures and with implementing efforts to generate improvement to attain targets, they will be better prepared to accept higher levels of risk.

[11]Richard Weisblatt, Harvard Pilgrim Health Care, personal communications, March 8, 2011 and October 24, 2012.

For the above reasons, a first-year approach that offers a meaningful incentive appears appropriate as OHA and the CCOs transition to a new method of contracting and doing business.

Timeline for Distribution of Funding in DY12

The incentive funds will be distributed on an annual basis. The incentive period will run for one calendar year (January – December 2013); there will be an additional three-month period following the incentive period to account for the time lag to obtain complete claims data and conduct chart reviews, with the incentive payments to be made by June 2014.

The baseline measurement year for each of the incentive metrics will be 2011 and will be derived from combining the predecessor organizations (MCO + MHO) metrics in each service area. In areas where there is no predecessor MCO, the statewide average will be applied.[12]

The first measurement year and reporting period for the incentive measures will be 2013. Results will be available in early 2014, in time for the first quality pool distribution in the second quarter of 2014. The year two data measurement and reporting period for incentive measures will be 2014. Using this timeline, the final incentive payments of the demonstration program will not be paid until several months after the end of the demonstration period.

Process for Distributing Incentive Pool Dollars in Round One

The Metrics and Scoring Committee has selected an initial set of 17 measures, listed below. OHA will be collecting baseline data for these measures and conducting some statistical testing to determine if the selected measures and performance targets are feasible. Any revisions to the measure set will be made in coordination with the Metrics and Scoring Committee.

Measures selected by the Oregon Metrics and Scoring Committee as of Oct. 22, 2012 and negotiated with CMS as of December 12, 2012:

Prevention

1. Developmental Screening in the first 36 months of life (NQF 1448)
2. Assessment of Children in DHS Custody within 60 days (mental health and physical health)
3. Adolescent Well Care Visits
4. Colorectal Cancer Screening

[12] Most CCOs have predecessor MCO organizations. In every case, they have structurally and organizationally restructured to adopt the CCO business model as well as the coordinated care model.

Access and Patient Satisfaction and Access

5. Rate of Patient-Centered Primary Care Home enrollment (*Challenge Measure*)
6. CAHPs composite "Getting Care Quickly" (adult and child)
7. CAHPs composite "Health Plan Satisfaction" (adult and child)

Chronic Illness Management

8. Diabetes Control: HbA1c >9% (*Challenge Measure*) (NQF 0057)
9. Controlling High Blood Pressure (BP less than 140/90) (NQF 0018)

Behavioral Health

10. Screening for Clinical Depression and Follow-up Plan (*Challenge Measure*)
11. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT) (*Challenge Measure*)
12. Follow up for children prescribed ADHD medications (NQF 0108)
13. Follow-up after Hospitalization for Mental Illness (NQF 0576)

Maternal Care

14. Timeliness of Prenatal Care (NQF 1517)
15. Reducing Elective Delivery Before 39 weeks (NQF 0469)

Overuse

16. Ambulatory Care: Outpatient and Emergency Department Utilization

EHR Adoption and Use

17. EHR Composite (Implement drug-drug and drug-allergy interaction checks, e-prescribing, active medication list)

In order to access the incentive pool, CCOs will be measured against a specified benchmark for each measure. CCOs that don't meet the benchmark for a given measure will be assessed against an improvement from baseline target. The benchmark and improvement targets for each measure are described in detail in Part III. The target levels of performance and improvement are the same for all CCOs, regardless of geographic region and patient mix. All of these measures are independent from one another such that a CCO can receive an incentive payment if performance on a specific measure warrants it, regardless of overall performance.

All of the measures are valued equivalently in the algorithm. For all measures except for the Patient-Centered Primary Care Home (PCPCH) measure, performance is treated on a pass/fail basis. For example, if the benchmark is met or minimum improvement level achieved, the CCO

receives all of the credit available for that measure. If neither target is met, the CCO does not receive any credit for the measure.

For the PCPCH measure, performance is measured according to the following formula known as the "tiered formula." This formula multiplies the number of members enrolled in each tier (1, 2 and 3) with the level of the tier (if 100 people are enrolled in tier 3, multiply 100 by 3), adds the totals and divides by the total number of members enrolled in the CCO multiplied by 3. The goal is to have all members enrolled in a tier 3 PCPCH so the result of the tiered formula provides a sense of where the CCO is relative to the goal. The formula is below.

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

Once OHA has calculated how much incentive funding each CCO is eligible to receive and determined each CCO's level of performance against the measure targets, then it will calculate the amount of the incentive funds each CCO will receive based on its level of performance. For each measure (except for PCPCH), there are ten performance tiers with the incentive payment for each tier ranging from 10 percent to 100 percent. As the CCOs meet more benchmark or improvement targets, they receive a higher payment. If the CCO attains the benchmark or the improvement target on at least 75 percent of the measures (12.6 measures) and met or exceeded the benchmark or improvement target for the EHR measure, then the CCO will receive 100 percent of the incentive funds. If the EHR measure is not met, then the maximum incentive payment that the CCO can receive is equivalent to the second tier of incentive payment. If the CCO gets fewer than .6 measures, then the CCO does not receive any incentive funds. A detailed definition of the tiering methodology is provided in Table 1 below.

Table 1: Example of Initial Round Quality Pool Distribution

Tier	Percent of targets met (benchmark or improvement)	Number of targets met (benchmark or improvement)	Percent of total incentive payment for which the CCO is eligible
1	74.12-100% (with EHR)	At least 12.6 (with EHR)	100%
2	68.24%	At least 11.6 (does not require EHR)	90%
3	62.35%	At least 10.6	80%
4	50.5%	At least 8.6	70%
5	38.82%	At least 6.6	60%
6	27.06%	At least 4.6	50%
7	21.18%	At least 3.6	40%
8	15.29%	At least 2.6	30%
9	9.41%	At least 1.6	20%
10	3.53%	At least .6	10%
Nothing	Less than 3.53%	Fewer than .6	No incentive payment

Process for Distributing Incentive Pool Dollars in the Challenge Round

Incentive pool funds that are not earned by CCOs in Round One will be distributed to the CCOs that met the benchmark or improvement target for one or more of the following measures:

1. Rate of Patient-Centered Primary Care Home Enrollment (PCPCH)
2. Screening for Clinical Depression and Follow-up Plan (Depression)
3. Alcohol and Drug Misuse, Brief Intervention and Referral for Treatment (SBIRT)
4. Diabetes Control: HbA1c > 9%

In the challenge round, OHA will determine the aggregate number of instances in which a CCO achieves either the benchmark or improvement target for each of the four challenge measures (Diabetes Control, Depression, PCPCH, SBIRT). Since the PCPCH measure does not have a benchmark, OHA will assume that all of the CCOs achieved the target. OHA will then calculate the base amount for achieving the target on this measure by dividing the challenge pool funds

into equal portion equivalent to the total number of challenge targets met (e.g. if all 16 CCOs met a PCPCH target, 5 CCOs met an SBIRT target, 6 met a Depression target, and 3 met a Diabetes Control target, then the incentive fund would be divided into 30 equal portions (the "base payment").

For the Diabetes, Depression, and SBIRT measures, OHA will calculate the payments for each CCO that achieved a target on each challenge measure by adjusting the "base payment" described above based on the CCO's enrollment relative to the mean for those CCOs that met a specific challenge measure's target. This calculation will be performed separately for each of the three measures. An example of this calculation is detailed in Table 2 below.

Table 2. Example of Challenge Fund Distribution for Standard Measures (Diabetes, depression, SBIRT)

CCO Name	Base Payment	Member Months (MM)	CCO's ratio of MMs to total MM	Adjusted Challenge Fund Payment
CCO A	$ 1,666.67	29,588	1.459	1,666.67*1.459= $ 2,432.26
CCO B	$ 1,666.67	23,343	1.151	1,666.67*1.151= $ 1,918.90
CCO C	$ 1,666.67	22,788	1.124	1,666.67*1.124= $ 1,873.27
CCO D	$ 1,666.67	18,014	0.889	1,666.67*.889= $ 1,480.83
CCO E	$ 1,666.67	16,394	0.808	1,666.67*.808= $ 1,347.66
CCO F	$ 1,666.67	11,521	0.568	1,666.67*.568= $ 947.08
	$10,000 (Total pool for measure #1)	121,648 (Total MM)		$ 10,000 (total)
		20274.67 (Mean MM)		

For the PCPCH measure, the funding will be distributed to the CCOs based on a combination of results of the tiered formula and overall enrollment. For each CCO, OHA will multiply the result of the tiered formula with the total number of member months for the CCO to get an adjusted number of member months. OHA will then multiply this adjusted enrollment with an adjustment factor (the adjusted member months relative to the mean) and multiply that by the "base payment" described above to determine the total incentive payment amount for PCPCH. An example of this calculation is detailed in Table 3 below.

Table 3: Example of Challenge Fund Distribution for PCPCH

	Base Payment	Result of Tiered formula	Member Months	Adjusted Member Months	Adjusted Member Months Relative to the Mean		Adjusted challenge fund payment (PCPCH)
CCO A	$ 1,666.67	0.4 *	29,588	=11,835.2	0.969	$ 1,666.67*.969=	$ 1,615.21
CCO B	$ 1,666.67	0.5 *	23,343	=11,671.5	0.956	$ 1,666.67*.956=	$ 1,592.87
CCO C	$ 1,666.67	0.6 *	22,788	=13,672.8	1.120	$ 1,666.67*1.120=	$ 1,866.00
CCO D	$ 1,666.67	0.7 *	18,014	=12,609.8	1.033	$ 1,666.67*1.033=	$ 1,720.92
CCO E	$ 1,666.67	0.8 *	16,394	=13,115.2	1.074	$ 1,666.67*1.074=	$ 1,789.90
CCO F	$ 1,666.67	0.9 *	11,521	=10,368.9	0.849	$ 1,666.67*.849=	$ 1,415.10
	$10,000 (Total pool for PCPCH measure)			73,273 (Total adjusted member months)			$ 10,000.00 (total)
				12,212 (mean adjusted member months)			

Appendix 1.D: Innovator Agent Plan

Innovator agents and Learning Collaboratives

Learning Collaboratives (STC 25d)

The Oregon Health Authority will establish a CCO learning collaborative, the purpose of which is to promote innovations and activities that will contribute to the goals of health system transformation and accountability for achievement of the three-part aim of better health, better health care and lower costs. The CCO learning collaborative will enable CCOs to share best and emerging practices in areas such as alternative payment methods; care management, coordination and integration; use of flexible services; health equity; quality improvement; and reducing administrative waste. CCO learning collaborative members will work together to decide upon the area(s) of focus of the collaborative and work with OHA to develop appropriate performance measures. OHA reserves the right to select some of the learning collaborative topics.

Collaboratives will convene via phone, web and/or video conferencing at least every other week. This frequency will be established by contract as will a requirement that when a CCO is identified by OHA as underperforming in access, quality or cost against metrics established by the OHA Metrics and Scoring Committee, the CCO will be required to participate in an intensified innovator/learning collaborative intervention.

Role of the Innovator agents (STC 25d)

Senate Bill 1580 requires OHA to provide CCOs with "Innovator agents" who will act as a single point of contact between the CCO and the OHA and to help champion and share innovation ideas, within either the CCOs or the state agency, in support of health transformation's three-part aim of better health, better care and lower cost.

The innovator agents are critical in linking the needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO.

Innovator agents will work closely with CCOs and the community served by a CCO to enhance CCO accountability for achieving the three-part aim. However, existing state managed care staff responsible for assurance and compliance will have some reasonable distance from the innovator agents in order to provide objective contract oversight.

The role of the innovator agent will be to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication; allowing streamlined reporting and reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports
- Assist the CCO in managing and using data to accelerate quality improvement.
- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other Innovator agents, CCOs, Community Stakeholders and/or OHA.

Tasks to be performed by innovator agents:

- Complete OHA innovator agent training (training will be developed in consultation with national experts and based on other national models, such as the CMMI Innovation Advisory program training).
- Assist and support the CCOs in developing and implementing their transformation plans.
- Assist the CCO with gathering and interpreting data to target areas of local focus for improvement.
- Gather input on CCO performance from other state agency staff working directly with the CCO, primarily the Quality Improvement Coordinator and Health Plan Coordinator.
- Communicate at least every other week with all other innovator agents (and meet in person at least once each quarter) to discuss ideas, projects and creative innovation planned or undertaken by their assigned CCO.
- Attend Community Advisory Committee meetings and provide input into Community Health Assessment process.
- Participate in innovator agent learning collaborative; Participate and/or convene in other learning collaboratives as appropriate (CCOs, providers, etc.).
- Ensure rapid-cycle stakeholder feedback to identify and solve barriers; to assist with adapting innovations to simplify and/or improve rate of adoption; and to increase stakeholder engagement.

- Track questions / issues from CCOs and the answers/resolution, establishing a database not only to serve as the basis for a FAQ and information sharing among innovator agents, but also to identify potential systemic issues.
- Participate in information sharing through an interactive website, sharing documents, communicate, collaborate, and developing resources to share with the team.

Innovator Agent Reporting Requirements:

- Monthly reports on CCO progress toward the implementation of the CCO's transformation plan.
- Monthly reports about CCO progress toward achieving "ideal behaviors".
- Quarterly reports on promising practices and/or innovations occurring within the CCO.

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.
- Secure website with a database into which the Innovator Agent will log all CCO/ Community Stakeholder questions and answers.
- Not less than once every calendar quarter, 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.

Measures of Effectiveness

The success and effectiveness of innovator agents will be measured in a variety of ways, but initially will focus on measures of the IAs level of engagement with the CCO and the community it serves as well as shared accountability for CCO outcomes, including:

- Survey rating innovator agent's performance to be completed by CCO leadership, Community Advisory Council members, and other relevant stakeholders.
- Number of questions answered (tracked in online database as outlined above) and number of meetings/ events an innovator agent has in the community.
- Number and success of innovations adopted by a CCO.
- Rate at which CCOs test new ideas and improve.
- Successful implementation of CCO's transformation plan, the measures for which will be developed upon completion of the CCO's transformation plan.
- The measures used to gauge the effectiveness of learning collaboratives (number of meetings, level of engagement, etc.) may also be used to measure efficacy of innovator agents.
- CCO performance on metrics as identified by the Metrics and Scoring Committee: improved access and quality, decreased per capita costs.

Appendix 1.E: Contract Compliance

The following 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, Subsection 3.a. • Exhibit G,1.b. • Exhibit B, Part 4, Subsection 2.m. • Exhibit B, Part 4, Subsection 3.a. (6) • Exhibit B, Part 4, subsection 3.b.(1) • Exhibit B, Part 4, subsection 3.a.(1)
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 3.a.(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	Model Contract: • Exhibit B, Part 4, 2.i. • Exhibit B, Part 4, 2.e.

Required Component	
with special health care needs. Special health care needs are defined as: 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 M, subsection 7
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, 3.b.
438.218 - Enrollee information • Plans must meet the requirements of 438.10	Model Contract: • Exhibit N
438.224 - Confidentiality • Plans must comply with state and federal confidentiality rules.	Model Contract: • Ex. B, Part 4, Section 5.b.(3)

Required Component	
438.226 - Enrollment and disenrollment • Plans must comply with the enrollment and disenrollment standards in 438.56.	Model Contract: • Ex. B, part 3, subsection 6
438.228 - Grievance systems • Plans must comply with grievance system requirements in the Federal regulations.	Model Contract: • Ex. B, part 3, subsection 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: • Ex. M, subsection 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. • 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.	Model Contract: • Ex. B, Part 9

Required Component	
• 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

Appendix 1.F: List of Conditions that can 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.

Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluations

Evaluation Design and Quality and Access Tests

Table of Contents

Preface 268

Oregon Special Terms and Conditions 52, 54, 64, 86,and 88 268

Introduction 274

Demonstration Overview 275

Statewide Quality and Access Test 277

Evaluation 283

Evaluation Objectives 283

Contextual Considerations 284

Research Questions, Data Sources, and Analytic Approach 287

Table 1 – Formative Evaluation 288

Table 2 – Summative Assessment 292

Timeline 298

Preface

The prior part of this document describes the Oregon quality improvement strategy, and primarily addresses the interactions between the state and the CCOs as part of this demonstration.

Part II describes the efforts to monitor and assess quality and access at a statewide level to ensure that statewide quality and access are improving over the course of the demonstration.

The relevant special terms and conditions relating to evaluation, monitoring, and statewide tests are listed below.

Oregon Special Terms and Conditions 52, 54, 64, 86, and 88

Oregon's Special Terms and Conditions (STCs) for the Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115(a) Medicaid Demonstration extension ("demonstration"), contain the following provisions related to monitoring quality and access (STC 52) and standards of quality and access, including the standard that must be met for purposes of DSHP expenditure authority (STC 54):

52. ***Measurement of Quality and Access Under the Demonstration***. The state will also monitor *and report quarterly and annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by paragraph 64. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.*

Within 120 days of approval of the demonstration, the state will submit to CMS for review, technical assistance, and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's Medicaid population as a whole. The state's plan will propose methods for measuring quality and access, and for determining whether the state's efforts have improved or worsened quality and access in the state (including methods of analyzing quality and access year to year, and whether those methods should be supplemented by comparison with control groups, or in relationship to quality and access in other states, as well as the degree of statistical significance that would enable a determination by CMS that quality and access have changed as a result of the state's actions). state quality and access reporting will take place on the same timeframes as the state's annual expenditure review. Specific timeframes will be identified in the 120-day post-approval period.

54. ***Reduction in DSHP Expenditure Authority for Failure to Meet Trend Reduction Targets.*** *This demonstration authorizes time-limited expenditures on certain Designated State Health Programs (DSHP), as specified in Section IX. In order to align incentives and support progress, if demonstration*

goals are not realized, CMS will reduce authorized DSHP funding according to the conditions specified below.

a. Funding Reductions for Lower than Forecasted Reductions in Per Capita Growth Rates. CMS shall review the expenditures and trend reduction targets calculated pursuant to paragraphs 48 and 49, and submitted pursuant to paragraph 64, to determine the annual percentage point reduction in Medicaid per capita expenditure growth achieved by the end of each demonstration year. If the per capita expenditure growth reduction target identified in Table 3 is not achieved over the course of each demonstration year, CMS will prospectively reduce DSHP expenditure authority for the succeeding year, as identified in paragraph 56 (Table 4), according to the amounts specified in Table 3.

Demonstration Year	**Per Capita Expenditure Growth Reduction Target** (measure following DY close)	**Reduction in DSHP Expenditure Authority** (reduce succeeding DY's DSHP expenditure authority)
DY 11	NA	NA
DY 12	1 percentage point	$54 million
DY 13	2 percentage points	$68 million
DY 14	2 percentage points	$68 million
DY 15	2 percentage points	NA

If, based on an analysis of quality and access data submitted by the state in accordance with various reporting requirements, CMS determines that quality or access have significantly diminished in any year of the demonstration in which the state has met its per capita expenditure growth reduction target, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year.

b. Earn Back Option. For any demonstration year following a year in which a reduction in DSHP expenditure authority is applied for failure to meet per capita expenditure growth reduction target:

> *i. If the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target in the following year and significantly improved access to and quality of care, CMS will prospectively restore 50 percent of the previous year's forfeited amount.*

ii. For any demonstration year following a year in which a reduction in DSHP expenditure authority was applied, if the state undertakes a corrective action plan to achieve improvement and CMS determines that the state has met the per capita expenditure growth reduction target but has not made significant improvements in access and quality, CMS will prospectively restore 40 percent of the previous year's forfeited amount.

iii. Forfeited DSHP funds will not be restored simply based on the results of an updated expenditure review.

Quarterly reporting requirements are outlined in STC 64 and are an integral part of monitoring the demonstration:

64. Monitoring To Assure Progress in Meeting Demonstration Goals: *The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the State's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care. A final report will also be required to demonstrate annual achievement of Demonstration goals.*

a. ***Interim Reporting Format.*** *The state and CMS will collaborate to develop the quarterly report format, which CMS will approve, within 120 days from the date of the demonstration approval. The data to be reported is specified in the following sections of the STCs:*

i. Reducing Per Capita Expenditure Trend Growth: Section VIII;

ii. Quality Improvement Metrics: Section VII;

iii. Access to Care measures: Section VII;

b. ***Timeframe for Reporting.*** *The state will submit the required reports within 60 days of the end of each quarter, beginning at the end of the second quarter of DY11.*

c. ***Data Sources:***

i. Goal 1:

1. Base line expenditures by eligibility group (children, adults, ABD, etc.) and service super group (IP, OP, mental health, LTC, ambulatory services, TBD mutually with state);

2. CCO Medicaid billing per beneficiary within eligibility and service subgroups;

3. Total Medicaid service spending per beneficiary; and

4. *CCO provider spending per beneficiary.*

ii. *Goal 2:*

1. *Benchmarked metrics tied to incentive payments, including patient experience surveys;*
2. *Data from the all payer-all claims database;*
3. *Process Improvement Projects (PIPs);*

    a. *EQRO studies;*
    b. *Complaints and grievances;*
    c. *Health risk assessment data;*
    d. *Public health data;*
    e. *Health risk assessment data;*
    f. *Meaningful use attestation data;*
    g. *State CCO monitoring reports; and*
    h. *Additional data sources to be specified at the beginning of DY 2, including but not limited to evaluation of the Duals Demonstration.*

d. ***Final Annual Report:*** *The state shall submit a Final Annual Report for all of the elements required in the quarterly interim reports. The reporting timelines specified in subparagraph (b) shall apply to the Final Report. The state will submit and CMS will approve an annual reporting format within 120 days of the demonstration approval date.*

e. ***Penalty for Late Reporting:***

i. *If the state fails to meet the reporting timelines for the Interim or Final Annual Report, CMS will reduce FFP for quarterly administrative costs attributable to the Demonstration, by issuing a reduction to the grant award in the amount specified in the table below. Any such reduction will be made with 30 days advance notice, including the amount of funds that will be reduced and the quarter to which any reduction will be applied. The state may upon such notice provide CMS with information that documents reasons that that a reduction is unwarranted. In the event of an emergency, such as a natural disaster, that prevents the state from reporting timely, the state can request an exception to these timeframes and penalties.*

Percentage withheld of quarterly demonstration administrative funding	***Days late***
.2	*15-30*
.4	*30-40*
.8	*41-50*
1	*51+*

The STCs also include the following language specific to Evaluation Design and Final Evaluation Design and Implementation:

86. ***Evaluation Design.*** *In the 120 days following the date of approval of this Demonstration, the state shall submit and CMS will approve a comprehensive evaluation plan for the health system transformation amendment and extension in a manner that complements and does not duplicate the evaluations of cost, access, and expenditure trend that are part of the terms and conditions of this demonstration. In so doing, the state will consider the Evaluation Guidance in Attachment B. The evaluation will include:*

a. *A discussion of the Demonstration hypothesis that will be tested, focusing on key areas of the State's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional Demonstration outcome measures;*

b. *An analytical plan for assessing Oregon's success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.*

c. *Any other information pertinent to the State's evaluative or formative research via the Demonstration operations.*

d. *Describe the data sources and sampling methodology for assessing these hypotheses and outcomes;*

e. The draft plan shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation; and

f. Any other information pertinent to the State's evaluative or formative research via the Demonstration operations.

88. ***Final Evaluation Design and Implementation.*** *CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the state shall submit its final design within 60 days after receipt of CMS comments. The state shall implement the evaluation design and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 after the expiration of the Demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after the receipt of CMS comments.*

Introduction

The statewide assessments of quality and access serve multiple functions for the demonstration.

First, the assessments help CMS determine the impact of the demonstration on quality and access, consistent with STCs 52 and 54. The state must pass these "tests" in order to avoid financial penalties as per STC 54. The first section of this Part II describes how these "tests" will function.

The second section of this Part II describes three types of evaluations. Each evaluation examines a specific set of questions. Although the analyses may be similar with regard to method, the demonstration evaluation is distinct from the quality and access “tests” associated with designated state health program (DSHP) expenditure authority under STC 54. The results of demonstration evaluation activities—including the midpoint assessment—have no bearing on the state’s DSHP authority.

Quarterly reports, as described here and as required by STC 64, will provide frequent feedback in order to inform ongoing operations. Elements of the quarterly reports are part of the "formative evaluations." These formative evaluations are intended to provide frequent feedback in order to ensure that course corrections are made, and that the results from those course corrections are understood in a timely fashion so as to continue the feedback cycle.

At the midpoint of the demonstration, a broader effort to learn from the demonstration will be conducted, called here the "midpoint assessment." This type of statewide assessment will provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

Finally, the state will conduct a "summative evaluation," which is required by STC 86 and 88 and is intended to summarize the experiences to ensure that this innovative demonstration is fully analyzed to determine whether it has been successful in achieving the stated goals.

As with the prior section, the measurement strategy is more fully described in Part III of this overall document.

Demonstration Overview

Demonstration Context

Health care costs are increasingly unaffordable. Despite the success of the Oregon Health Plan (OHP), which Oregon estimates has saved the state and federal government an estimated $16 billion since its inception in 1994, the growth in Medicaid expenditures in Oregon far outpaces the growth in General Fund revenue. And while health plan performance is generally strong, the growth in expenditures has not been matched by improvement in health outcomes. There are still significant opportunities to enhance access to care, improve care delivery, and advance health outcomes at the community level.

The structure of separate managed care organizations, mental health organizations and dental care organizations limits Oregon's ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. OHP clients face a sometimes dizzying array of plans and rules and the current payment system provides little incentive for the prevention or disease management actions that can improve health and lower costs.

Demonstration Goals

The July 2012 amendment and extension of Oregon's 1115 demonstration seeks 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 and access. Oregon will utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

The current demonstration aims to accomplish two equally important and inter-related goals: reducing the trend in statewide Medicaid per capita spending at the same time as improving access and quality.

These two goals form **the hypotheses to be tested as part of this demonstration**:

I. Oregon will reduce the growth in statewide PMPM Medicaid spending by 1 percentage point in demonstration year two and by 2 percentage points in demonstration years three and beyond; and

II. Over the course of the demonstration, Oregon will achieve control of PMPM cost growth while improving access to and quality of care for Oregon's Medicaid

beneficiaries.

Reflecting the state's commitment to the three-part aim, Oregon also proposes to evaluate the impact of Medicaid transformation on beneficiary experience of care and health outcomes.

Medicaid Transformation, Theory of Change

The Coordinated Care model, as implemented in Medicaid through Coordinated Care Organizations (CCOs), begins to address the health system shortcomings described above using several different approaches, or levers, to drive savings and quality improvement:

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on patient- centered primary care homes (PCPCHs)
- Lever 2: Implementing alternative payment methodologies 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 through administrative simplification and a more effective model of care
- Lever 5: Implementation of flexible services to improve care delivery or enrollee health
- Lever 6: Testing, accelerating and spreading effective innovations and best practices

These levers are described in more detail in Part I: Oregon's Quality Strategy, above, and are aligned with Oregon's quality improvement focus areas.

The OHA and CCO actions (including "ideal" behaviors) that power those levers are shown above in Appendix 1.B: theory of action model.

OHA and the CCOs will work toward improvement in specific focus areas (as outlined in Attachment E and elsewhere in this document) that can result in achievement of the three-part aim.

Statewide Quality and Access Test

Overview

The following section lays out the details of a "quality and access test" (the test), which will be applied each program year that the state achieves its cost control goal to determine whether Oregon's Health System Transformation (HST) has caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen. "Failing" the test results in reductions in a portion of DSHP funding to the state, as described in STC paragraph 54.

The quality and access test consists of two "parts," both described in detail below and in satisfaction of STCs 52 and 54. In brief, part 1 of the quality and access test is a relatively simple comparison of program period quality and access to historical baseline levels of quality and access; part 2 is a more complex comparison of program period quality and access to a counterfactual level of quality and access that would exist had HST not been undertaken. Part 2 of the quality and access test is required only if the state fails part 1, and Oregon fails the test for that year if and only if it fails both part 1 and part 2.

Seeking to balance the need for accurate and complete information against timeliness, CMS and the state have negotiated a streamlined reporting structure to monitor the goals of the demonstration while meeting the analytic requirements specified in STC 52 on an annual basis. This document memorializes CMS and the state's agreement to an annual test to assess whether unadjusted metrics for quality and access under the demonstration have stayed constant or, in later years, have improved. For the first two years, this first order test is passed if the score for the quality or access metrics remains constant or improves as compared to the historical baseline. After that, the first order test is passed only if the quality and access test shows improvement. If the State does not pass the first order test in any year to which it is applied, the state will undertake, and submit to CMS, a more detailed counterfactual analysis (as prescribed by STC 52 and conducted by an independent, third party evaluator) to determine whether quality and access have significantly diminished in a manner attributable to the state's efforts under the demonstration. If this counterfactual analysis indicates a significant diminishment in quality and access under the demonstration in a given year (or is not completed according to the timeframes specified below), CMS will apply the five percent DSHP reduction to the FFP claimed in the year immediately following the year for which the

determination was made as specified in STC 54. As described, after two demonstration years, Oregon will also undertake a robust midpoint analysis that will provide more detailed information about achievement of the demonstration's goals.

If the state has met its per capita expenditure growth target in any year, as described in Attachment H, Section B, but fails to achieve its quality and access goal as determined by the analysis conducted pursuant to STCs 52 and 54, beginning at the end of DY 12, the STCs give CMS the authority to prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to five percent of total DSHP funding for that year. Recognizing that data lags will prevent CMS from determining Oregon's satisfaction of yearly demonstration goals until several months after the close of the demonstration year, the prospective reduction will be applied at the beginning of the next succeeding demonstration year, as follows:

- Oregon may begin each new demonstration year claiming DSHP up to the full amount authorized in that year but will be at risk for a penalty of five percent of that year's DSHP allotment should CMS subsequently verify through the required reporting that, in the demonstration year in question, Oregon achieved a cost trend reduction at the expense of quality and access, or that the analyses were not submitted in accordance with the STCs.
- Once CMS has made such a determination and informed OHA of the rationale and the amount of expenditure reduction which it is subject to, Oregon must refund the funds identified as the agreed upon DSHP expenditure reduction in the quarter following the CMS determination.
- If the state does not voluntarily refund these funds, CMS may exercise the option of taking a deferral or disallowance for the amount.

Part 1 Quality and Access Test

A single "aggregate" indicator will be constructed using a number of "component" quality and access measures. A test result will be generated based on the difference between performance on this aggregate indicator in the current period (using the most recent full demonstration year) and a baseline period (calendar year 2011).

Component Measures

Oregon and CMS determined the component measures that will be used to construct the single quality and access aggregate indicator.

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 encourages broad-based improvement and tends to increase the precision of the aggregate. Measures included in the CCO incentive measure set are particularly attractive candidates, as the objectives of CCOs should be aligned with those of the state as much as possible. In general, measures for which the state is already planning to collect data should be included in the aggregate unless there is good reason to exclude that measure. Good reasons to exclude a measure are: no data are available for that measure in the baseline period; that measure would contribute so much uncertainty to the aggregate that judgments about the aggregate would be affected; it is not possible to establish a functional benchmark for the measure; or there is a lack of consensus at the state level about the value of the measure.

The component measures to be used in constructing the quality and access aggregate measure, as well as baseline and benchmark information for as many measures as possible are indicated on the *Oregon Measures Matrix* in Part III, below.

Aggregation of Component Measure Results

Because component measures may be in different units, on different scales, for different populations, and at different levels of performance compared to an ideal target, each component measure will be "translated" to a common scale, reflecting the fraction of the performance gap between baseline and ideal performance closed since the start of Medicaid system transformation. The algorithm for generating these translated measure values is as follows:

1. For each measure, Oregon and CMS will agree to a "target" level of performance, reflecting the best possible performance that Oregon would be able to achieve as a high performing program. Where possible, these targets are aligned with the CCO incentive benchmarks.

2. For each measure, the baseline (calendar year 2011 as described above) level of performance will be calculated.

3. For each measure, for each program period, the translated level of performance for the measure will be calculated as the difference between current and baseline performance divided by the difference between target and baseline performance. (Note that this formula applies whether or not the component measure has improved or worsened over time compared to a baseline.)

4. The translated value for each component measure takes the form of a percentage.

For each of the quality and access subtests, the aggregate measure is then constructed by taking the average of the component measures' translated values and rounding to the nearest first decimal place, i.e., to the nearest tenth of a percentage.

Metrics may be modified over time in the manner described in Part III of this document, regarding Oregon's Measurement Strategy.

Definition of Passing

Subject to CMS review and approval of reported findings and calculations, Oregon will be considered to have passed part one of the quality and access test for the DSHP performance periods of DYs 12 and 13 if the aggregate measure value for this test, rounded to the nearest tenth of a percentage, is greater than or equal to zero percent. In subsequent years (DYs 14 and 15), Oregon will be considered to pass a subtest only if the aggregate measure value, rounded to the nearest tenth of a percentage, is strictly greater than 0.

Timing and Deadlines

The statewide quality and access test applies only in years when the state meets its target for cost growth reduction. The first target is a one percentage point reduction for DY 12 (July 2013 – June 2014), so, allowing for data lag, the earliest point at which the test might be performed would be 6 months after the end of the end of the demonstration year in question, or early 2015. To align with quarterly reporting deadlines, the state will report test data and results to CMS in February 2015. However, the state will also calculate and report the aggregate measure to CMS in June 2013 on a practice basis only, using as much DY 11 performance data as is available at the time. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a report to CMS by the August following the end of the demonstration year in question (see Timeline).

The quality and access test for any year in which Oregon has met the cost growth reduction target will be based on measurements from the most recent full demonstration year, as follows:

DSHP Quality and Access Test Data Periods
DY 12 (7/1/13-6/30/14)
DY 13 (7/1/14-6/30/15)
DY 14 (7/1/15-6/30/16)
DY 15 (7/1/16-6/30/17)

2014

As described above, the period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act (ACA) will take effect. Oregon's investments in health systems transformation are intended to both improve quality for current Medicaid beneficiaries and strengthen the system for those expected to enroll in 2014. Therefore, the part 1 quality and access test will not be any different for 2014 in order to reflect the expectation that the demonstration will continue to provide high quality care and to preserve the simplicity of the part 1 quality and access test approach. Nevertheless, it would not be surprising if part 2 of the quality and access test were to be necessary for this year and the part 2 quality and access methodologies should specifically account for the particular circumstances in this year.

Subpopulation Subtests

Due to potential technical challenges, and the increased risk of false-negative test results associated with a substantial increase in the number of comparisons, CMS will not require Oregon to demonstrate any minimum level of quality and access performance for beneficiary subpopulations as part of part one quality and access test.

However, these analyses should be included in evaluation analyses, and performance of metrics for subpopulations should be made transparent in a similar fashion to the core performance metrics. See Part III: Oregon's Measurement Strategy below for additional details about planned subpopulation analysis and public reporting.

Part 2 Quality and Access Test

As described above, if Oregon fails to pass part one of the quality and access test, a more complex analysis will be undertaken to determine whether the performance decline compared to baseline was attributable to the state's transformation efforts. Methodologically, part 2 of the quality and access test will largely follow the rigorous independent analysis of the association between state transformation activities and changes in access and quality (controlling for external forces) that is described under Midpoint Assessment. (There is one exception: part two of the quality and access test will not include any subgroup specific analysis.) Practically, however, the part 2 test and any evaluation activities differ in both cause and consequence:

- Part 2 of the quality and access test is only triggered if the state does not pass part one of the test for a particular year. Formative, midpoint and summative evaluations will occur as planned, regardless of the state's performance related to cost growth reduction targets or part one of the test.

- Evaluation activities have no bearing on DSHP expenditure authority. In other words, if part 1 of the quality and access test is passed in a particular year, the state passes the test for that year and incurs none of the DSHP penalties described in STC 54, even if a concurrent rigorous analysis may be occurring as part of a formative, midpoint, or summative evaluation.

Definition of Passing

Oregon will be deemed to have passed the part 2 quality and access test if access and quality have not significantly diminished relative to changes in a comparison group or counterfactual scenario across the same time period. Thus, Oregon will pass as long as the difference between CCO members and the comparison group does not significantly change to the detriment of CCO members.

Responsibilities of Oregon

Oregon will issue a Request for Proposal for and contract with an independent evaluator or evaluators, which will be responsible for performing the part one and, if necessary, part two analyses in all required years. The state will convene a review group consisting of key state partners and independent scientific experts with appropriate expertise to review and score all proposals. The evaluator's responsibilities will include:

- Develop a detailed methodology for the execution of each part of the test, in advance of their use;
- For each required program year, review the relevant raw data, verify its accuracy, and, if necessary, clean the data;
- Produce the part one quality and access test —and, if necessary—part two quality and access test results described above.
- Deliver a package to CMS and Oregon containing (1) the cleaned datasets; (2) the detailed methodology; and (3) any results produced, by the required deadlines

Allowing for data lag, the state will submit the part one of the quality and access test to CMS in the February following the end of each demonstration year in which the test applies (see Timeline below). Failure to submit the required data also will result in application of the DSHP withhold specified in STC 54, as well as invoke the penalties for late reporting that are described in STC 64. If the state does not pass part one of the test, the more detailed analysis called for in part 2 will be conducted in the 6 months following the part one submission, with a report to CMS by the August following the end of the demonstration year in question (see Timeline).

Responsibilities of CMS

CMS will fully review the data, methods, and results produced for each year's test to ensure that calculations were made appropriately. Upon such a determination, CMS will notify the state that the DSHP penalty authorized by STC 54 shall not apply. If the state fails the test, the DSHP penalty described earlier will apply.

Evaluation

This section contains four parts: evaluation objectives; contextual considerations; research questions, data sources, and analytic approaches; and plan development.

Evaluation Objectives

This evaluation has three objectives:

(1) To perform a formative evaluation of Medicaid transformation that seeks to provide timely and actionable feedback on the initiative's progress, in terms of both outcomes and implementation activities. The formative evaluation will track and report regularly on OHA and CCO actions, progress toward achieving a health care system characterized by the key transformation levers; and progress toward achieving the primary goals of Medicaid transformation.

(2) To perform a midpoint assessment of Oregon's Medicaid transformation to provide broader learning both within the state and enhance the national learning from this effort. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.

(3) To perform a summative assessment of Oregon's Medicaid transformation describing changes in Medicaid per capita expenditure trend and quality and access outcomes, as well as other outcomes of interest, and to identify the changes in outcomes resulting from transformation activities.

Note that there will be some overlap in the research questions, data sources, and measures used to fulfill these three objectives. In particular, early and medium-term results for certain questions will be addressed in a midpoint assessment in the third year of the demonstration, but may also be addressed in a formative or summative evaluation.

Contextual Considerations

Analytic challenges

The period of the current demonstration spans 2014, when the bulk of the provisions of the Affordable Care Act will take effect. Expansion of Medicaid eligibility is expected to extend additional benefits to some adults already enrolled in the demonstration and bring more than 200,000 new individuals into the program and on to CCOs' membership rolls. These individuals, many of whom will have been uninsured previously, may need and utilize Medicaid services differently than the previously eligible group. In addition, all other large scale reforms—the individual mandate, guaranteed issue, tax subsidies for coverage through the Exchange etc.—are likely to have a significant impact on the capacity of the delivery system. The expansions and delivery reforms under this demonstration are intended to help bridge the transition to this new challenge, and so monitoring the changes in 2014 is an essential part of the efforts. The transitions in 2014 do create a few inter-related analytic challenges for assessing the impact of Oregon's Medicaid transformation, most notably:

- How to account for any effect the needs and experiences of the newly eligible group might have on aggregate trends of quality, access, and cost for Medicaid populations over the 5 years of the demonstration;
- How to account for any effect that the delivery system's response to health care reforms outside of Medicaid may have on measures of access, quality, and cost for Medicaid populations;
- How to isolate the impact of Oregon's Medicaid transformation activities from contemporaneous trends in quality, access, and cost.

Oregon will contract for independent analysis that includes a triangulated approach to addressing these analytic challenges including tracking outcomes for the expansion population separately, development of a sound comparison group, and in-depth or complex mixed methods analyses. On some questions, it will also be useful to compare Medicaid enrollees to those with other sources of coverage (via the state's All-Payer All-Claims data system or population surveys such as BRFSS), although there are likely to be some spill-over effects given that almost 85 percent of Oregon's health care providers serve Medicaid clients. A difference-in-differences design may also be helpful as part of this triangulated approach to compare changes over time among Medicaid CCO enrollees to an appropriate comparison population, at the mid- and end-points of the demonstration period. Together, these should provide a reasonable picture of the success of Oregon's Medicaid transformation against its stated goals.

External evaluations

Oregon has an active and engaged health services research community and a history of sophisticated, policy-relevant research on the Oregon Health Plan including the landmark Oregon Health Study (OHS). The Oregon Health Research & Evaluation Collaborative (OHREC) serves as a point of collaboration and connection between state staff researchers from a variety of organizations. Two OHREC-affiliated research projects have already received funding from a mix of foundation, government, scientific, and philanthropic sources:

- The Robert Wood Johnson Foundation-funded SHARE grant is a mixed-methods study building on the OHS to assess what CCOs in Oregon actually do, how they impact health care access, use, quality, costs, and health outcomes, and how each CCO's outcomes are associated with its individual design. The partners in the study are the Office for Oregon Health Policy and Research in the Oregon Health Authority, Portland State University, Oregon Health & Sciences University and the Center for Outcomes Research at Providence Health System.

- An NIH-funded economic study focuses on the impact of spending reductions implemented through the CCO global budgets and the financial integration of behavioral specialty care and primary health care. The study includes cross-state comparisons, and also includes a qualitative component. This study is being conducted by researchers at Oregon Health & Sciences University, Portland State University, and the University of Colorado Denver.

Other proposals are currently under review at different funding agencies.

The state will use results from these and future independent evaluations to supplement its own demonstration evaluation work and provide independent analysis on the demonstration hypotheses. In addition to taking advantage of related research, Oregon intends to issue a request for proposals (RFP) and to contract directly with independent evaluators for two products: a midpoint assessment of quality and access (described in more detail shortly); and a summative evaluation at the end of the demonstration that will address the major research questions described under Summative Assessment below, synthesizing and summarizing findings from earlier evaluation and research.

The demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. Among the characteristics of rigor that will be met for the midpoint and summative evaluations are use of best available data; controls for and reporting of the limitations of data and their effects on results and the generalizability of results. Treatment and control or comparison groups will be

used, except (in the common circumstance) where randomization is difficult, in which case appropriate methods will be used to account and control for confounding variables. The evaluation design and interpretation of findings will include triangulation of various analyses, wherein conclusions are informed by all results with full explanation of the analytic limitations and differences.

An independent third party, selected by some means other than sole source contracting, following applicable state procurement, selection and contracting procedures, will conduct the midpoint and summative evaluations. The third party selected for the evaluation shall be screened to assure independence and freedom from conflict of interest. The assurance of such independence will be a required condition by the state in awarding the evaluation effort to a third party.

STC 88 requires that the state will provide to CMS within 120 days after expiration of the Demonstration a draft summative evaluation report. Recognizing data lags and complexity of the analyses that comprise the midpoint and summative evaluations, we have agreed that CMS will not hold the state to be out of compliance with the timing requirements of STC 88 if the state provides to CMS its draft summative evaluation report within 180 days after the end of Demonstration Year 15. In addition, CMS will not hold the state to be out of compliance for the draft midpoint analysis if submitted to CMS 180 days after the close of the initial review period, July 1, 2012 through June 30, 2014.

For both reports, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the state or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the contractor.

Draft reports related to the midpoint and summative evaluations will not be routinely released except as required by state and Federal law. Until the later of the following two dates – July 1, 2019 (two years after the end of the demonstration) or 12 months from the date that the final reports for these evaluations are provided to CMS, CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the contractor or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

In light of the flexibility that CMS has offered in enforcing these evaluation deadlines, Oregon has agreed that in each demonstration year, when draft and final midpoint and summative evaluation reports are due, it will reduce claimed DSHP expenditures by one half of one percent (0.5) for the year to follow if any of these reports are not provided or are found by CMS to be unacceptable because they do not represent adequate rigor and independence and do not adequately implement the final evaluation design. The claimed expenditures withheld by CMS would be authorized only if revised reports are provided and found by CMS to be acceptable within a year of their original due dates under STC 88. The penalties related to quarterly and annual reporting submission deadlines, as specified in STC 64(e), continue to apply as specified in the STCs.

Research Questions, Data Sources, and Analytic Approach

Formative Evaluation

The formative evaluation will track and report regularly on: (1) OHA actions; (2) CCO actions; (3) progress on the "levers" intended to drive savings and quality improvement; and (4) progress toward achieving the primary demonstration goals. (See the Quarterly Report Guidelines—Attachment A of the STCs—for details on who information from the formative evaluation will inform the state's quarterly reports.) The formative evaluation is designed both to provide actionable information for quality improvement and to help inform/explain the summative assessment and will therefore include analysis by individual CCO, as well as in the aggregate.

Data and findings resulting from all stages of the evaluation—formative, midpoint, or summative—will be shared widely as part of the state's commitment to feedback and continuous improvement. Key pathways for dissemination and use of evaluation findings beyond the required reporting to CMS include:

- The Oregon Transformation Center, which will act as the state's hub for innovation and improvement. The CCO learning collaboratives to be convened by the Transformation Center will be a primary venue for sharing evaluation information, posing additional analytic questions, and sharing best practices or potential solutions to problems;
- The state's innovator agents, who are expected to help CCOs review their own data and identify opportunities for improvement;
- Formal publications and presentations (primarily for midpoint or summative evaluations) aimed at a variety of different audiences, including service providers, beneficiaries, and communities and their members; and
- Internal reporting for OHA leadership and program personnel.

The data sources identified to address specific evaluation questions will provide relevant information on several important aspects of the demonstration operations, for example: measures of beneficiary experience of care and provider engagement with Medicaid will feed into monitoring and policy development for network adequacy; and assessments of CCOs' actions to improve care coordination and integration will inform interpretation and resolution of grievances or appeals.

Table 1 shows the relevant formative research questions for the four topics listed above, as well as proposed measures and data sources. Note: rows shaded in light grey indicate research questions to be addressed in both the formative assessment and the midpoint assessment, described later in this section.

Table 1 – Formative Evaluation (shaded rows will be addressed in midpoint as well as formative)

Topic Area	Related Research Question(s)	Measures or data source(s)
OHA actions	To what extent has OHA effectively taken action to support transformation? For example: • Set expectations and monitor for care management • Develop global budget and quality incentive pool • Establish robust quality measurement and improvement strategy • Provide technical assistance and support, including Innovator Agent program • Patient-centered primary care home recognition, certification system for non-traditional health workers • Tracking method for flexible services	OHA documentation is the data source for most of these questions. Specific measures might include: • Incorporation of CCO transformation plans into individual contracts • Amount paid to CCOs in the form of quality incentives, vs. capitation • Attendance/participation rate at learning collaboratives • Measures of effectiveness from innovator agents document
CCO actions	To what extent have CCOs – in aggregate and individually – taken action to transform care delivery & payment? For example: • Encourage use of EHRs and participation in HIE • Use alternative payment mechanisms with providers • Maximize use of PCPCHs • Support and encourage providers to improve care coordination • Use quality metrics • Take action to reduce administrative waste • Provide flexible services where	• CCO Transformation plan tracking • Innovator agent contact database and monthly reports (see Innovator Agent document) • Office of Health IT tracking of EHR adoption and HIE participation (surveys) • Data from CCO quality assurance and oversight processes (monthly accountability team reviews, on-site operational reviews, etc., see Quality Strategy) • Surveys of CCO leadership and CCO Community Advisory members (see

Topic Area	Related Research Question(s)	
	appropriate • Engage meaningfully with communities	Innovator Agent document) • Tracking of flexible services • Qualitative information from independent evaluations – SHARE and McConnell NIH study
	• To the extent that some CCOs have not taken actions for transformation, what has prevented them from doing so? • To the extent that some CCOs have been successful in taking action, what have been their keys to their success?	As above
Levers for transformation	To what extent are CCO members experiencing improved care coordination, with emphasis on PCPCH?	• PCPCH enrollment by tier • Metrics from *Oregon Measures Matrix* related to integrating primary care and behavioral health, reducing preventable hospitalizations, and reducing preventable and costly utilization
	To what extent have OHA and CCOs implemented payment methods that focus on value not volume?	• Which CCOs do and which do not use alternative payment methods internally? • What is the distribution of available incentive funds across CCOs? (OHA admin data) • *Potentially:* measures from soon-to-Catalyst for Payment Reform scorecard
	To what extent have CCOs integrated physical, behavioral, and oral health services? Other services?	• CCO Transformation plan tracking • Metrics from *Oregon Measures Matrix* related to integration, e.g. SBIRT, follow-up after hospitalization for mental illness, etc.
	To what extent have CCOs achieved administrative efficiencies?	• CCO financial reporting requirements, including OHA-developed Exhibits (see CCO core contract) • Office of Health IT tracking of EHR adoption and HIE participation • CCO Transformation plan tracking • CCO participation in statewide administrative simplification efforts (e.g.

	Related Research Question(s)	
		common credentialing)
	To what extent are beneficiaries using flexible services?	• TBD – tracking method for flexible services is still in development • CCO Transformation plan tracking
	To what extent are best practices being tested and disseminated?	• CCO participation in learning collaboratives and other technical support opportunities • Innovator agent monthly reports; Number and success of innovations adopted by a CCO; rate at which CCOs test new ideas and improve (see Innovator Agent document) • Successful implementation of CCOs' transformation plans, the measures for which will be developed upon completion of the plans
Demonstration / Medicaid Transformation Goals	Have CCOs– in aggregate and individually • Improved quality of care for members? • Improved access to care? • Improved members' experience of care? • Improved members' health status?	See impact assessment table
	Has Oregon reduced per-member cost growth?	See summative assessment table

Midpoint Assessment

The midpoint assessment will analyze activity through the midpoint of calendar year 2014, with a report due to CMS no later than August 2015. In addition to summarizing findings to date on select research questions from the formative and summative evaluations (indicated by shaded rows in Table 1 and Table 2), the midpoint assessment will connect the two via an explicit examination of the coordinated care model on changes in access and quality. (Access and quality should be read here to include experience of care.) The report will also include a high-level summary of expenditure and cost data, based on 2 percent test reporting described in Attachment H, Section B. The state anticipates contracting with independent researchers (as described above) to perform a rigorous analysis of the association between state transformation activities and changes in access and quality, controlling for external forces.

For instance, a contractor could employ a difference-in-differences analysis, assessing the average changes in scores over time from the baseline year among CCO enrollees and

subtracting out the average changes among a comparison group of matched individuals from a non-CCO, fee-for-service comparison group in order to arrive at the "net" impact of transformation, as follows:

- **Measures**: Measures of access and quality (including care coordination and beneficiary experience of care) would be drawn from the *Oregon Measure Matrix* listed in Part III, below. Measures of access and quality for future consideration are also listed in Part III, below. Because this is an evaluative assessment rather than a “test,” there is no need to create an aggregate access or quality measure. The results of the formative evaluation to date will provide contextual information about the extent to which the transformation “levers” have been implemented.

- **Study Groups**: Contractors will provide for an adequate comparison group. Potential contractors will describe a plan for specifying the control group and specify criteria for case-matching or other adjustments to account for potential changes in group composition over time, as well as plans for the treatment of individuals who disenroll during the study period.

- **Data Years**: The contractor’s plan should also address the appropriate data years for both study and comparison groups to identify to the extent possible any underlying movement in the scores that was occurring prior to implementation.

- **Statistical Approach**: Contractors will describe a statistical plan that accounts for the distribution of the dependent variables and uses appropriate modeling techniques. The state will work with the contractor to insure that the model is appropriately pre-specified while being sensitive to model choices that must account for the distribution of the data.

- **Strategies to Account for Potential 2014 Expansion**: If the state expands its Medicaid program to 133 percent FPL in accordance with the Affordable Care Act in 2014, the contractors will describe specific strategies to account for the effects of this expansion on access and quality and separate them from the impacts of Medicaid system transformation. (A DiD design is robust against such changes provided the expansion impacts both groups in the same way, but if expansion impacts CCO and comparison group members differently, the model's ability to identify the specific impacts of Medicaid transformation will be compromised.) Contractors will propose methods to account for the impacts of the expansion (with respect to both expanded eligibility and the availability of more expansive coverage for some adults previously eligible for the demonstration) and extract those impacts from the estimates of CCO effects. Separate tracking of new eligibles, described in the analytic approach column of Table 1, will

produce information that may be of use to contractors in accounting for expansion effects.

- **Subgroup Analysis**: Contractors will describe a plan that provides results separately for vulnerable populations or subgroups of interest and compares those results to the overall trends to identify differences in effects by subgroup. Depending on the degree of variation across the state or among CCOs and the stability of enrollee populations, it may also be possible to compare trends in access and quality across beneficiaries experiencing "low-dose" and "high-dose" transformation.

The midpoint assessment will produce a more nuanced picture of trends than the summary scores of the DSHP quality and access "tests." It will also provide the state and CMS with a sophisticated assessment of the relationship between the state's actions and beneficiary outcomes well in advance of the end of the demonstration period.

Finally, the midpoint assessment will include a narrative section regarding the progress of Oregon towards streamlining its reporting processes, including whether there are reports and/or evaluations the state would recommend combining, and specifically regarding progress towards use of automated data systems that will support the transmission of data through data portals and other electronic reporting channels, and progress towards an HIE infrastructure.

Summative Assessment

The impact assessment focuses on the outcomes depicted in the theory of action: reduced PMPM cost growth (demonstration goal 1), improvement or maintenance of quality and access (demonstration goal 2), and improvement or maintenance of beneficiaries' experience of care and health status. Table 2 lists the research questions associated with each outcome, as well as proposed measures and data sources and analytic approaches for addressing the question. The research questions should be read as including both CCO enrollees and those beneficiaries for whom services will be provided on a fee-for-service basis even after January 2013. Note: rows shaded in light grey indicate research questions to be addressed in both the summative assessment and the midpoint assessment, described earlier in this section.

Table 2 – Summative Assessment (shaded rows will be addressed in midpoint as well as summative)

Outcome Area	Research Questions	Measures or Data Source	Analytic Approach
Per capita Medicaid spending	How does annual change in per-capita Medicaid spending during demonstration period compare to projected trend?	state Medicaid program expenditure data Presidents' budget for projected trend	Align with methodology for expenditures for 2% test (including adjustment for 2014).

Outcome Area	Research Questions	Measures or Data Source	
	Which beneficiary subpopulations* deviate from the statewide trends?	state Medicaid program expenditure data	Subpopulation analysis of expenditures by demonstration year.
	How does spending change for behavioral health compare to overall trends and physical health spending changes?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.
	How does spending change for primary care services compare?	state Medicaid program expenditure data	Analysis by expenditure or service category by demonstration year. McConnell NIH study will also address this question independently.
	Are "flexible services" deterring higher-cost care?	TBD – tracking method for flexible services is still in development.	Depending on tracking method, approach may include: Estimation of the value of flexible services provided, by category Estimation of costs deterred Case studies of variation by CCO in flexible services offered
Quality of care	Is quality of care for Medicaid beneficiaries improved or at least maintained over time?	Quality measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Is coordination of care for Medicaid beneficiaries improved or at least maintained over time?	Care coordination measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year. Trend analysis. Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in the quality of care or care coordination for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation

Outcome Area	Research Questions	Measures or Data Source	
	Did Medicaid system transformation result in improved quality of care or care coordination?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g. PQIs using HCUP data) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation assessing changes in quality for those enrolled in CCOs vs. not enrolled. Incorporate results of independent McConnell NIH study of changes in "contracted" and "non-contracted" quality measures For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group
Access to care	Has access to care for Medicaid beneficiaries improved or at least maintained over time?	Access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Has the rate of change in access to behavioral health kept pace with physical health access improvements?	Behavioral health access measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Comparison of change over time in access measures by service type
	Have there been variations in any of the access to care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved access to	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available (e.g.

Outcome Area	Research Questions	Measures or Data Source	
	care?		care delayed due to cost) Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of independent SHARE evaluation comparing changes in access for those enrolled in CCOs vs. not enrolled. Incorporate results of independent McConnell NIH study assessing impact to CCOs on probability of members accessing care, by provider type For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group and analysis of provider survey data on Medicaid acceptance by primary care v. subspecialty
Member experience of care	Has beneficiary experience of care improved or at least maintained over time?	Experience of care measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in experience of care measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved experience of care?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures) Incorporate results of externally-

Outcome Area	Research Questions	Measures or Data Source	
			conducted SHARE evaluation comparing changes in experience of care for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group
Health Status	Is beneficiary health status improved or at least maintained over time?	Health outcome or status measures from Oregon core set (STC 40b); CCO incentive measures, or CHIPRA or Adult Medicaid Core sets	Pre-post comparison (availability of data from pre-demonstration period varies by measure) by demonstration year Trend analysis Beginning in 2014, track new eligibles separately (as data sources allow)
	Have there been variations in health status measures for any beneficiary subpopulations*?	Measures as above	Pre-post comparison by subpopulation Trend analysis by subpopulation
	Did Medicaid system transformation result in improved health status?	Measures as above	Triangulation approach: Compare Oregon performance to national data, where available Compare Oregon performance to other state data, where available (e.g. Medicaid adult or CHIPRA quality measures, BRFSS) Incorporate results of externally-conducted SHARE evaluation comparing changes in health status for those enrolled in CCOs vs. not enrolled. For midpoint and summative evaluations: analysis comparing change from baseline among CCO enrollees to change in an appropriate comparison group

* Categories of interest for sub-population analysis include:

- Beneficiary race and ethnicity

- Beneficiary primary language
- Individuals eligible for Medicare and Medicaid
- Individuals with mental illness
- Disability status
- Rural vs. non-rural location

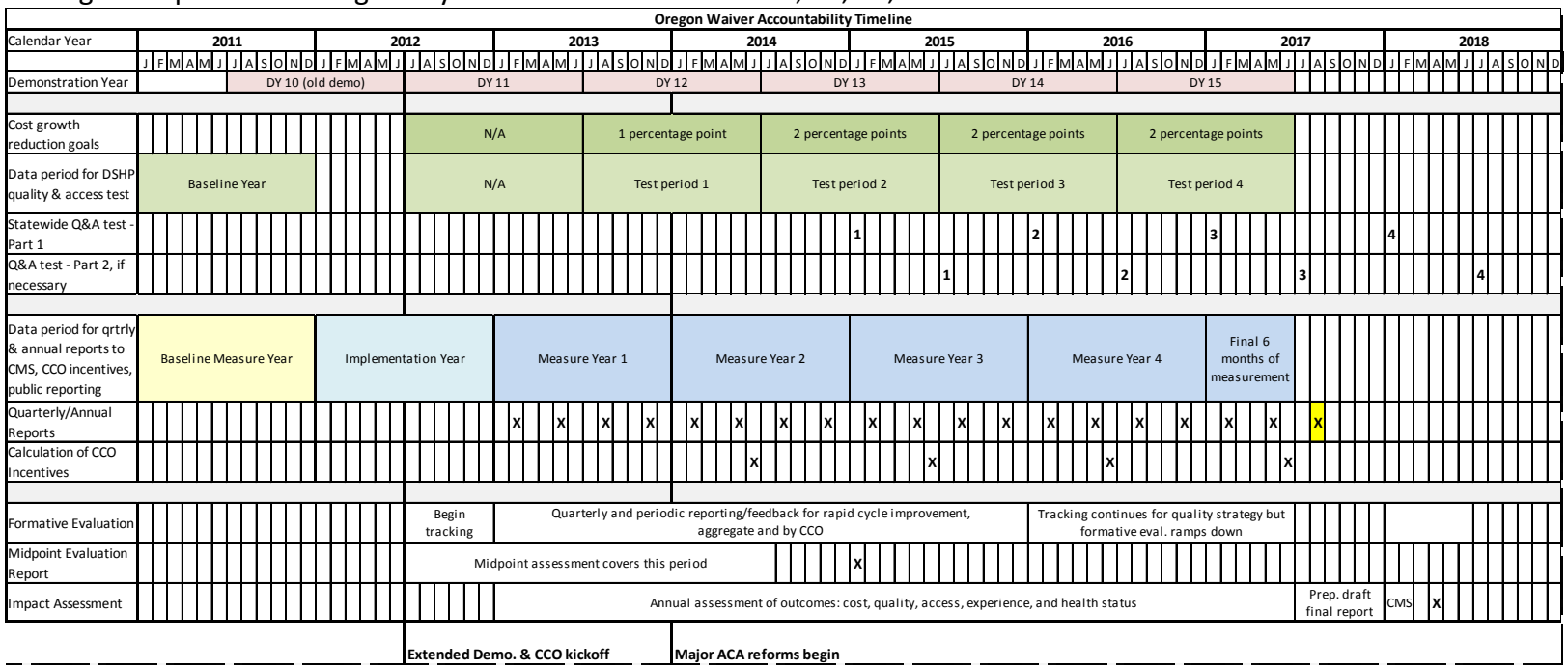
Ability to analyze outcomes by beneficiary sub-population will be dependent on the specific measure and data source. Provider measures for access will also be analyzed by subtype of provider.

Evaluation Plan Development

This plan was developed by a cross-division of OHA staff with experience in evaluation research and demonstration planning and reviewed by OHA leadership. External expertise and consultation was provided by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, as well as CMS staff. Because of the close connection between the formative evaluation plan described here and the state's Quality Strategy, the demonstration evaluation design will be reviewed annually along with the Quality Strategy.

Timeline

This figure depicts the timing of key deliverables under STCs 52, 54, 64, 86 and 88.



Part III: Oregon's Measurement Strategy 2012

Introduction

Oregon's Measurement Strategy (STCs 38, 39, 40, 42) outlines how the Oregon Health Authority will measure quality of care and access to care for individuals enrolled in Coordinated Care Organizations and for the Oregon Health Plan population as a whole. The metrics are also integral to the effort to monitor and correct pathways towards improvements in the quality of care and access to care for Medicaid beneficiaries under health system transformation efforts, as described in the Statewide Quality and Access Tests section above.

OHA Measurement Framework

Oregon has identified over 100 potential measures of cost, quality, access, patient experience, and health status that could be tracked over delivery settings and populations during the demonstration period. These measures come from several measure sets.

- Oregon CCO Incentive Measures
- Oregon Demonstration Core Performance Measures
- CMS Adult Core Set for Medicaid
- CMS Child Core Set for Medicaid and the Children's Health insurance Program

Oregon has committed to collecting and reporting on the CCO Incentive Measures and the Demonstration Core Performance Measures. Many of the CMS Adult Medicaid Quality Measures and CHIPRA Measures overlap with these measure sets, and Oregon has also committed to reporting on these two core sets even as they evolve to the extent feasible. *See Appendix 3.A for a listing of these measures by population and by domain.*

Oregon has submitted an application for an Adult Medicaid Quality Grant for the *Oregon CMS Adult Measures Project*, which would develop additional capacity for standardized collection and reporting of the CMS Adult Medicaid Quality Measures. Through this project, Oregon would test and evaluate methods for collection and reporting of the measures, improve measures so they are reliable, and develop capacity to report the data, analyze, and identify opportunities to improve health care quality for Medicaid beneficiaries. Work funded through this grant would inform the collection and reporting of the Demonstration Core Performance and CCO Incentive Measures.

Through participation in the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Program, Oregon has also collected all 24 CHIPRA measures and developed an understanding of standardization and comparability for these measures. Oregon will continue to participate in this program and collect and report on selected CHIPRA measures through 2015.

From these measure sets, Oregon has identified access measures, including CCO-level access improvement measures, and survey-based access measures. *These measures are also identified in the tables in Appendix 3.A.*

Incentive Measures

The Oregon Metrics and Scoring Committee have identified the year one incentive measures that will be tied to the quality pool as required by STC 37b.ii.[13] See Appendix 1.C: Quality Pool Structure above for a detailed description of the quality pool design and funding algorithm. Building on work completed by their predecessor committee, the Oregon Health Policy Board Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics[14], the Committee considered several core principles when selecting these measures. Among other principles, any selected measures should:

- Meet standard scientific criteria for reliability and face validity;
- Help drive system change;
- Successfully communicate to consumers what is expected of CCOs;
- Align with evidence-based or promising practices;
- Be nationally validated, a required reporting element in other health care quality initiatives, or align with national or other benchmarks for performance; and
- Usefully distinguish between different levels of CCO performance.

The majority of incentive measures selected overlap with Oregon's Demonstration Core Performance Measures, CMS Adult Medicaid Quality Measures, and CHIPRA Measures, ensuring that the incentive program is aligned with existing state and national quality measures. Selected incentive measures do strongly align with Oregon's quality improvement focus areas and all incentive measures have been included in the set of quality and access "test" measures. Specifications and data sources for the year one incentive measures can be found in Appendix 3.C and more detailed rationale for each of these incentive measures can be found in Appendix 3.D.

Through a public process, the Metrics and Scoring Committee established improvement and performance targets that a CCO must meet on the selected incentive metrics to be eligible for receiving funds from the quality pool. These targets are listed in Appendix 3.B.

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[13] http://www.oregon.gov/oha/pages/metrix.aspx

[14] http://www.oregon.gov/oha/OHPB/pages/health-reform/workgroups/outcomes-quality-efficiency.aspx

Oregon is also in the process of establishing benchmarks for the statewide quality and access test described below. Oregon's baseline data (2011) and those benchmarks that have already been identified are included in Appendix 3.B.

Ensuring Continuous Quality Improvement

Incentive Measures

The Metrics and Scoring Committee will likely consider additional measures, either as part of the Oregon Health Authority's overall measurement framework or as incentive metrics in future years. The Committee will be reviewing CCO performance data, improvement over baseline, and distribution of the quality pool to determine if the initial incentive metrics selected were the right combination of measures to improve quality and access for the Oregon Health Plan population. Incentive measures may be added in subsequent years and it is likely that other measures will be retired from the list, either due to measurement concerns or progress. CCO performance may improve significantly enough on select measures that the Committee refocuses efforts to different areas needing improvement.

The Committee is charged with revisiting not only the selected incentive measures, but also the performance and improvement targets. It is critical that these targets take future CCO improvement into account and continue to provide stretch goals that CCOs must meet to be eligible for the quality pool. CCOs will not be allowed to coast on early success, or demonstrate improvement in just one domain.

Specifically, the initial decision by the Metrics and Scoring Committee was to reward improvement in incentive metrics as compared to a historical baseline, rather than to the prior year's performance. This structure may not be adequate to provide ongoing incentives for continued improvement and may be reexamined by the Metrics and Scoring Committee in consultation with CMS and the state as part of the midpoint assessment.

Likewise, the Oregon Health Authority will be revisiting selected quality and access measures in future years of the demonstration to ensure that quality of care and access to care are being tracked appropriately. A subset of quality and access test measures has already been identified for consideration in demonstration year 3. These are listed in Appendix 3.E.

OHA will also be exploring National Quality Forum (NQF)-endorsed and other healthcare disparities and cultural competency measures for inclusion in the measurement framework. As new measures are identified, potentially through the CMS Adult Core Quality Measures Grant, or endorsed, through NQF or Meaningful Use Stage 2, OHA will add and retire measures from the overall measurement framework.

Modification of Metrics for Statewide Quality and Access Test

Consistent with the recognized need for flexibility to modify plans over time and take into account evidence and learning over time, as well as for unforeseen circumstances or other good cause, a CCO, CMS, or the state may request prospective changes to metrics or targets for any achievements that are well above or below the established targets based on progress to date through a modification process. CMS and the state must agree to modify the metrics; CMS retains the authority for final approval of such changes, which will be reflected in the quality strategy. Examples of when requests for changes may be appropriate are:

a. **Difficult metrics:** The CCO, CMS, or the state may suggest re-targeting of metrics in instances in which it appears that statewide targeted performance will not be achieved over the life of the demonstration.

b. **Topping out on metrics:** During any given year, the CCO, CMS, or the state may suggest re-targeting in instances in which targets have been achieved or surpassed. However, it appears that there is still substantial room for growth on selected projects (e.g., percentage improvement or volume metrics for subsequent years were already met because the original estimates were too low, but data suggest that more improvement could be done.)

c. **Mismatched metrics:** The CCO, CMS, or the state may suggest new metrics that better reflect local concerns when it is determined that the existing metrics are inadequate.

Data Collection

The Oregon Health Authority will be responsible for collecting data on all measures selected. Data sources for incentive measures are included in Appendix 3.B and descriptions of data sources are also included in section IV of the Quality Strategy. An external quality review organization (EQRO) will play a role in data collection and analysis where necessary, assisting with measures that require chart reviews and/or validation of information submitted by a CCO.

OHA will contract with the Oregon Health Care Quality Corporation (Quality Corp) for assistance in data cleaning and analysis, third party validation, and reporting. As a Robert Wood Johnson Foundation *Aligning Forces for Quality* grantee, Quality Corp is experienced in ensuring the production of transparent data and analytics that are highly valued and actionable.

Measurement Year

The first measurement year for the CCO incentive measures will be calendar year 2013. Results will be available in June 2014, in time for the first quality pool distribution by June 30, 2014. The

second measurement year for incentive measures will be 2014. Medicaid adult quality and CHIPRA measures will be calculated during the same period. A detailed timeline for the formative and summative assessments, and quarterly reporting as required by STC 64, is included in the Evaluation Plan above. Of note, the measurement period for the statewide quality and access tests will be the demonstration year, which runs from June to July, and so is offset from the measurement period for the CCO incentive measures by six months.

Data Analysis

OHA will also be responsible for conducting data analysis on these measures. Where possible, measures will be aggregated by the 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 vulnerable populations such as people experiencing homelessness and people with specific diagnoses (disabling conditions, SPMI, chronic conditions, addictions).

Where possible, measures will also be reported for the fee-for-service (FFS) population. For example, all measures from the Consumer Assessment of Health Plans and Systems (CAHPS) survey will be reported for the remaining FFS population.

Other subpopulations of interest for analysis include beneficiary primary language, individuals eligible for Medicare and Medicaid, and rural versus non-rural locations. OHA will involve data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders in clearly defining selected subpopulations for analysis before the measurement year begins in January 2013.

This 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 Part I (Oregon's CCO Quality Strategy). Data from selected measures will also be used to inform the evaluation questions described in Part II (Statewide Evaluations and Tests).

Data Reporting

The Oregon Health Authority has committed to transparency in health system transformation efforts: all selected measures will be reported publicly through reports made available on the Oregon Health Authority website. At a minimum, data will be reported publicly on an annual basis; however a subset of information will be reported more frequently to track patterns of utilization and highlight potential issues with performance. This will also allow OHA to work frequently with CCOs on metrics and possibly make course corrections prior to annual reports. Additional details on reporting are included in the Evaluation Plan timeline above.

Where possible and appropriate, measures will be reported by race and ethnicity, disability, and a where there is a diagnosis of serious and persistent mental illness (SPMI). Measures will be reported by CCO, and in aggregate. In addition, CCO dashboards will synthesize performance data for clear and understandable reporting to all stakeholders, most importantly Medicaid beneficiaries. OHA will not disclose any information otherwise protected by law.

Appendix 3.A: Measure Sets by Population and Domain

Table I: CCO Incentive Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient Experience	Systems
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√			√	√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√	√	√			
Mental and physical health assessment within 60 days for children in DHS custody (state measure)		√	√		√			
Follow up care for children on ADHD medication (NQF 0108)		√	√		√			
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Elective delivery before 39 weeks (NQF 0469)	√				√			
ED utilization without an admission per 1,000 member months (HEDIS)	√	√		√				
Colorectal cancer screening (HEDIS)	√		√		√			
Patient-Centered Primary Care Home (PCPCH) (state enrollment (state measure)	√	√	√	√				
Developmental screening by 36 months (NQF 1448)		√	√		√			
Adolescent well child visits (HEDIS)		√	√		√			
Controlling hypertension (NQF 0018)	√		√	√		√		
HemoglobinA1c poor control (NQF 0059)	√			√		√		
Access to Care: Getting Care Quickly (CAHPS Composites)	√	√	√				√	
Health Plan Satisfaction: Customer Service (CAHPS Composites)	√	√					√	
EHR adoption (composite – 3 questions)	√							√

Table II: Oregon Core Performance Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Getting needed care and getting care quickly (CAHPS Composites)	√	√	√				√	
Member health status, adults (CAHPS health status)	√	√				√		
Rate of tobacco use among CCO enrollees (Medicaid BRFFS, CAHPS)	√					√		
Rate of obesity among CCO enrollees (state measure)	√					√		
Ambulatory Care: Outpatient and emergency department visits (HEDIS)	√	√	√					
Potentially avoidable ED visits (Medi-Cal approach)	√	√		√				
Ambulatory-care sensitive hospital admissions (PQI #1: NQF 272; PQI #14: NQF 638)	√		√		√			
Medication reconciliation post-discharge (NQF 0554)	√				√			
All-cause readmissions (NQF 1789)	√			√				
Alcohol or other substance misuse (SBIRT)	√				√			
Initiation and engagement in alcohol and drug treatment (NQF 0004)	√		√		√			
Mental health assessment for children in DHS custody		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Effective contraceptive use among women who do not desire pregnancy (BRFFS)	√		√		√			
Low birth weight (NQF 0278, PQI 9)					√	√		
Developmental screening by 36 months (NQF 1448)		√	√		√			
Screening for clinical depression and follow-up plan (NQF 0418)	√		√		√			

Table III: CHIPRA Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517)	√		√	√	√			
Frequency of Ongoing Prenatal Care (NQF 1391)	√	√	√		√			
Low birth weight (NQF 1382)		√			√	√		
Childhood immunization status (NQF 0038)		√	√		√			
Immunizations for adolescents (NQF 1407)		√	√		√			
Developmental screening by 36 months (NQF 1448)		√	√		√			
Chlamydia screening for women (NQF 0033)	√		√		√			
Well-child visits in the first 15 months of life (NQF 1392)		√	√		√			
Well-child visits in the 3rd, 4th, 5th and 6th years of life (NQF 1516)		√	√		√			
Adolescent Well-Care Visit (NCQA)		√	√		√			
Child and adolescent access to Primary Care Practitioner (NCQA)		√	√		√			
Appropriate testing for children with pharyngitis (NQF 0002)		√			√			
Ambulatory Care: ED Visits (NCQA)	√	√	√	√	√			
Annual % of Asthma Patients with 1 or more Asthma-related ED visits (ages 2-20)		√	√	√	√			
Follow up Care for Children prescribed ADHD medication (NQF 0108)		√	√		√			
Annual pediatric hemoglobin A1C testing		√	√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√		√			
Mental health assessment for children in DHS custody		√	√		√			
CAHPS Health Plan Survey (child version with chronic conditions supplemental items)	√	√	√	√	√			

Table IV: Medicaid Adult Core Measures	Population		Domain					
Measures	Adult	Child	Access	Cost	Quality	Health Outcomes	Patient experience	Systems
Cervical cancer screening (NQF 0032)	√		√		√			
Medical assistance with smoking and tobacco use cessation (NQF 0027)	√		√	√	√			
Screening for clinical depression and f/u (NQF 0418)	√		√		√			
Plan All-Cause Readmissions (NCQA)	√	√	√	√	√			
Diabetes short-term complications admission rate (NQF 0272; PQI 01)	√		√	√	√			
COPD Admission Rate (NQF 0275, PQI 05)	√		√	√	√			
CHF Admission Rate (NQF 0277, PQI 08)	√		√	√	√			
Adult Asthma Admission Rate (NQF 0283, PQI 0283)	√		√	√	√			
Chlamydia Screening in Women age 21-24 (NQF 0033)	√		√		√			
Follow-up after hospitalization for mental illness (NQF 0576)	√				√			
Elective delivery before 39 weeks (NQF 0469, PC-01)	√			√	√			
Controlling hypertension (NQF 0018)	√			√	√	√		
Comprehensive Diabetes Care: LDL-C Screening (NQF 0063)	√		√	√	√			
Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF 0057)	√		√	√	√			
Antidepressant Medication Management (NQF 0105)	√		√		√			
Adherence to antipsychotics for individuals with schizophrenia (CMS-QMHAG)	√			√	√			
Annual monitoring of patients on persistent medications (NQF 0021)	√		√		√			
CAHPS Adult Survey (including NCQA Supplemental) (NQF 0006 and 0007)	√		√		√			
Prenatal and Postpartum Care: Postpartum Care Rate (NQF 1391)	√		√		√			

Appendix 3.B: Oregon Measures Matrix

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
Improving behavioral and physical health coordination	Alcohol or other substance misuse (SBIRT)	√	√			√	MN method[15] Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based	MN method Assume 0% baseline.	44% (SBIRT Oregon, OHSU Family medicine, SAMSHA-funded study. Accomplished 44% initial screen after 2 years of focused, evidence-based

[15] The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments. For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore, the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								intervention).		intervention).
	Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid 90th percentile. 2012 National Medicaid 90th percentile: 68%
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	TBD (baseline data will be available in April 2013)	TBD	Individual CCO baselines will be determined with 2011 data from predecessor organization.	TBD
	Mental and physical health assessment within 60 days for children in DHS custody	√	√				Oregon baseline (Mental Health): 58% Physical health baseline data will be available	90% (Note: Benchmark based on Metrics & Scoring	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data	90%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							by April 2013.	Committee consensus).	from predecessor organization.	
	Follow-up care for children prescribed ADHD meds (NQF 0108)	√			√	√	Oregon Medicaid baseline 2011: Initiation: 50% C&M: 57%	Medicaid 2012 NCQA National 90th percentile: Initiation: 51% C&M: 63%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	Medicaid NCQA National 90th percentile: Initiation: 51% C&M: 63%
Improving perinatal and maternity care	Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	Oregon baseline: 30.4% using admin data only.	2012 National Medicaid 75th percentile: 89% (prenatal care rate)	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 89%
	Prenatal and postpartum care: postpartum care rate (NQF 1517)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 66%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								90th percentile: 71%		
	PC-01: Elective delivery (NQF 0469)	√		√		√	Medicaid specific rate TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per Oregon Association of Hospitals and Health Systems (OAHHS), could also use the 16% rate publically available from Joint Commission)	5% or below.	MN method with 1% floor. Oregon Medicaid 2011: TBD (Oregon statewide rate was 20% in 2011 – March of Dimes. Per OAHHS, could also use the 16% rate publically available from Joint Commission)	5% or below.
Reducing preventable re-hospitalizations	Follow-up after hospitalization for mental illness	√	√	√	√	√	Oregon 2011 baseline: 51%	2012 National Medicaid 90th percentile: 68%	MN method with 3% floor. Individual CCO	2012 National Medicaid 90th percentile: 68%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	(NQF 0576)								baselines will be determined with 2011 data from predecessor organization.	
	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization baseline (2011): 56 / 1,000 mm	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm
	All-cause readmission (NQF 1789)		√		√	√	TBD	TBD	n/a	n/a
Ensuring appropriate care is delivered in appropriate settings	Ambulatory Care: Outpatient and ED utilization	√	√		√	√	TBD (baseline data available in Feb 2013) ED utilization	TBD 2011 National Medicaid 90th percentile (ED utilization): 44.1	MN method with 3% floor. Individual CCO baselines will be determined	2011 National Medicaid 90th percentile (ED utilization): 44.4/1,000mm

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
							baseline (2011): 56 / 1,000 mm	/ 1,000 mm	with 2011 data from predecessor organization.	
Improving primary care for all populations	Colorectal cancer screening (HEDIS)	√				√	Oregon 2011 baseline: 30.5% using admin data only.	49% (Note: this represents a realistic statewide increase for a 5-year period based on trends in Medicare and Commercial data).	MN method with 3% floor. Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National commercial data, unadjusted 75th percentile: 65.76 Adjustment factor for Medicaid: 4.42 Adjusted 75th percentile: 61.34 (Based on Metrics & Scoring Committee consensus)
	Patient-Centered Primary Care Home Enrollment	√				√	TBD (Baseline data available by February 2013)	100% (Tier 3)	The percentage of dollars available to each CCO for this measure will be tied to	The percentage of dollars available to each CCO for this measure will be tied to the

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
									the percentage of enrollees in PCPCH, based on measure formula.	percentage of enrollees in PCPCH, based on measure formula.
	Developmental screening in the first 36 months of life (NQF 1448)	√	√		√	√	Oregon baseline: 19.6% using admin data only.	50% (Metrics & Scoring Committee consensus)	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	50% (Metrics & Scoring Committee consensus)
	Well-child visits in the first 15 months of life (NQF 1392)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 77.3%	n/a	n/a
	Adolescent well-care visits (NCQA)	√			√	√	Oregon 2011 baseline: 26.7%	2011 National Medicaid 75th percentile:	MN method with 3% floor. Individual CCO	2011 National Medicaid 75th percentile: 56.9%

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
								56.9%	baselines will be determined with 2011 data from predecessor organization.	
	Childhood immunization status (NQF 0038)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 27.5%	n/a	n/a
	Immunization for adolescents (NQF 1407)				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 90th percentile: 80.9%	n/a	n/a
	Appropriate testing for children with pharyngitis (NQF				√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 76%	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0002)							90th percentile: 84%		
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√	1: 75% of adult tobacco users on Medicaid reported being advised to quit by their Dr; 2: 50% reported their Dr discussed or recommended medications with them; 3: 43% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)	2012 National Medicaid benchmark 90th percentile: Component 1: 81.4% Component 2: 50.7% Component 3: 56.6%	n/a	n/a
Deploying care teams to improve care and reduce	Ambulatory Care: Outpatient and	√	√		√	√	TBD (baseline data available in Feb	TBD 2011 National	MN method with 3% floor.	2011 National Medicaid 90th percentile (ED

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
preventable of unnecessarily costly utilization by super users	ED utilization						2013) ED utilization baseline (2011): 56 / 1,000 mm	Medicaid 90th percentile (ED utilization): 44.1 / 1,000 mm	Individual CCO baselines will be determined with 2011 data from predecessor organization.	utilization): 44.4/1,000mm
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and coordinating a broad set of resources, including CHW.	Controlling high blood pressure (NQF 0018)	√		√		√	TBD (baseline data will be available in April 2013)	2012 National Medicaid 75th percentile: 60%	Individual CCO baselines will be determined with 2011 data from predecessor organization.	2012 National Medicaid 75th percentile: 60%
	Comprehensive diabetes care: LDL-C Screening (NQF 0063)			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 80% 90th percentile: 84%	n/a	n/a
	Comprehensive diabetes care: Hemoglobin A1c testing (NQF			√		√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0057)							percentile: 86% 90th percentile: 90%		
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	TBD (baseline data available in Feb 2013)	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%	MN method. Individual CCO baselines will be determined with 2011 data from predecessor organization.	Pick percentile NCQA 2012 National Medicaid 90th percentile: 28% 75th percentile: 34%
	PQI 01: Diabetes, short term complication admission rate (NQF 0272)		√	√		√	201.2 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 05: Chronic obstructive pulmonary disease admission (NQF		√	√		√	416.9 (2011)	10% reduction from baseline Benchmark set based on	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0275)							Oregon's data (2002-2011)		
	PQI 08: Congestive heart failure admission rate (NQF 0277)		√	√		√	436.3 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
	PQI 15: Adult asthma admission rate (NQF 0283)		√	√		√	178.7 (2011)	10% reduction from baseline Benchmark set based on Oregon's data (2002-2011)	n/a	n/a
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy	√	√	√		√	**Access to Care** OR adult baseline: 79% OR child	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63%	MN method with 2% floor Access to Care OR adult	Average of the 2012 Medicaid 75th percentile for the adult and child rates.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	modules).						baseline 88% OR average: 83.5%	2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%	baseline: 79% OR child baseline 88% OR average: 83.5%	Access to Care 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√				
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	TBD (baseline data available in Feb 2013)	2012 National Medicaid benchmark 75th percentile: 63% 90th percentile: 69%	n/a	n/a
	Cervical cancer screening (NQF			√		√	TBD (baseline data available in Feb	2012 National Medicaid benchmark 75th	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	0032)						2013)	percentile: 74% 90th percentile: 79%		
	Child and adolescent access to primary care practitioners (NCQA)				√	√	TBD (baseline data available in Feb 2013)	TBD	n/a	n/a
	Provider Access Questions from the Physician Workforce Survey: 4) To what extent is your primary practice accepting new Medicaid/OHP patients? (include: completely					√	In 2009: 52.4% of Oregon's physicians accepted new Medicaid patients without limitations; 29.7% accepted with some limitations; and 17.9% were completely closed. 84% of	TBD	n/a	n/a

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	closed, open with limitations, and no limitations). 5) Do you currently have Medicaid/OHP patients under your care? 6) What is the current payer mix at your primary practice?						physicians have Medicaid patients. The statewide payer mix for Medicaid is 15%.			
	Screening for depression and follow up plan									

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	(see above)									
	SBIRT (see above)									
	Mental and physical health assessment for children in DHS custody (see above)									
	Follow-up care for children on ADHD medication (see above)									
	Timeliness of prenatal care (see above)									
	Colorectal cancer screening (see above)									
	PCPCH enrollment (see above)									

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	Developmental screening by 36 months (see above)									
	Adolescent well child visits (see above)									
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules)- report on identified Access to Care and Satisfaction with Care composites for incentive, waiver and test.	√	√	√		√	**Satisfaction with Care** OR adult baseline: 76% OR child baseline: 80% OR average: 78%	**Satisfaction with Care** 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71% National average: 83.95%	MN method with 2% floor. Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average: 78%	Average of the 2012 Medicaid 75th percentile for the adult and child rates. Satisfaction with Care 2012 National Medicaid adult 75th percentile: 83.19% 2012 National Medicaid child 75th percentile: 84.71%
	CAHPS 4.0H (child version including Medicaid and children with chronic	√	√		√	√				

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets	
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	Baseline	Benchmark	Improvement from Baseline Target	Benchmark Target
	conditions supplemental items)- report on identified Access to Care and Satisfaction with Care composites for incentive, waiver and test.									National average: 83.95%
Meaningful Use	EHR adoption (Meaningful Use 3 question composite)	√				√	TBD (Baseline data available in April 2013)	TBD	TBD (Baseline data available in April 2013)	TBD

Appendix 3.C: CCO Incentive Measure Specifications

Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) 329

Follow up after hospitalization for mental illness 330

Screening for depression and follow up plan 331

Mental and physical health assessment for children in DHS custody 333

Follow up care for children prescribed ADHD medication 334

Prenatal and Postpartum Care: Timeliness of prenatal care 336

Elective delivery before 39 weeks 337

Emergency Department Utilization 339

Colorectal cancer screening 340

Patient-Centered Primary Care Home (PCPCH) enrollment 342

Developmental screening in the first three years of life 343

Adolescent well child visits 345

Controlling high blood pressure 346

Diabetes: HbA1c Poor Control 347

Access to Care: Getting Care Quickly 348

Satisfaction with Care: Health plan information and customer service 348

Electronic Health Record (EHR) Adoption 349

Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)

This is a non-standard measure based on recommendations from SAMHSA and CMS. The measure is modeled after the screening for depression and follow up measure, without the chart review component.

Numerator

- Individuals screened using SBIRT as indicated by billing codes: 99408, 99409, and 99420

Denominator

- All individuals age 18+

Exclusions

- No exclusions noted.

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
A very low rate of claims submitted in a 12 month period (using CPT codes or H codes). Assume 0% baseline.	n/a	n/a

Follow up after hospitalization for mental illness

NQF Measure #0576. Measure Steward: National Committee for Quality Assurance.

This measure tracks the percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment (had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner) within seven days of discharge.

Numerator

- Clients seen for a non-inpatient visit for mental health services within seven days of discharge for a psychiatric hospitalization defined by relevant DRG codes.

Denominator

- Discharges for psychiatric hospitalization with principal mental health diagnosis.

Exclusions

- If discharge is followed up by another hospitalization for any cause within seven days of discharge, the discharge should be excluded from denominator.
- If it can be determined that the client was transferred to Oregon State Hospital or Blue Mountain Recovery Center, the discharge should be excluded from the denominator. This should be signified by disenrollment from OHP.

Notes

HEDIS specification also defines a metric for 30 day follow up. Continuous enrollment specifications in HEDIS metric take this longer follow up period into account. In addition, the clinics that qualify for follow up visits are too prescribed within HEDIS specifications. It is recommended that OHA adapts to include visits to any setting for mental health services. HEDIS calls for a mental health practitioner to see the person within 7 days. HEDIS definition for MH practitioner includes practically all practitioners allowed to encounter a mental health service in Oregon.

Data Source(s) Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
51%	68% (2012)	58% (2012)

Screening for depression and follow up plan

NQF Measure #0418. Measure Steward: Centers for Medicare and Medicaid Services

This measure tracks the percentage of clients age 18 and older screened for clinical depression using a standardized tool and with a documented follow-up plan

Numerator

- Individuals screened for clinical depression using an age appropriate tool with follow-up plan documented.

Denominator

- All individuals age 12+.

Exclusions

A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.

Notes

This is a metric that will have initial specifications for CMS Adult Quality Measures Grant. It is not currently defined in NQF, despite notation.

Data Source(s)

- Administrative data and chart review.

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
Assume 0% baseline.	n/a	n/a

Mental and physical health assessment for children in DHS custody

This is a non-standard measure that tracks the percentage of children in DHS custody who receive a mental and physical health assessment with 60 days of initial custody date

Numerator

- The number of children brought into DHS custody within a given quarter that received a mental health assessment within 60 days of custody date. Mental Health assessment is defined through the following procedure codes: H0031; H1011; 90801; 90802; 96101; and 96102.
- The number of children brought into DHS custody within a given quarter that received a physical health assessment (procedure codes to be defined) within 60 days of custody date.

Denominator

- The number of children age 4+ taken into custody within a given timeframe (month, quarter or year) who remained in DHS custody for 60 days.

Exclusions

- Children must be continuously enrolled for the 60 day follow up period.
  Notes

Current agreed upon procedure codes (with predecessor Mental Health Organizations) may need to be updated with CCOs.

Committee proposed expanding this measure to include oral health screening in future years

Data Source(s)

- Administrative data and child welfare records (ORKids)

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
58% (Mental Health assessment)	n/a	n/a

Follow up care for children prescribed ADHD medication

NQF #0108. Measure Steward: NCQA

The measure tracks the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

2. *Continuation and Maintenance (C&M) Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Numerator

- Rate 1: Members from the denominator with one face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date.

- Rate 2: The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Denominator

- Members 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an attention deficit/hyperactivity disorder (ADHD) medication during the 12-month Intake Period.

Exclusions

- Initiation Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis or DRG for mental health or substance abuse during the 30 days after the IPSD.

- Continuation and Management Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis of mental health substance abuse during the 300 days after the IPSD.
- Patients diagnosed with narcolepsy (ICD-9-CM Code: 347) should be excluded from the denominators.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
2011 rate 1: 49.96%	2012 rate 1: 51%	2012 rate 1: 44%
2011 rate 2: 57.09%	2012 rate 2: 63%	2012 rate 2: 53%

Prenatal and Postpartum Care: Timeliness of prenatal care

NQF #1517. Measure Steward: NCQA

This measure tracks the percentage of deliveries of live births that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Numerator

- Number of live birth deliveries that received a prenatal care visit as a member of the CCO in the first trimester or within 42 days or enrollment.

Denominator

- Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Exclusions

- None.

Notes

Must be enrolled for 43 days prior to delivery with no gaps.

From July 1, 2009, managed care plans received global payments for prenatal, delivery, and postpartum services in addition to capitation rates: a significant portion of ambulatory services may not generate a claim. This could be addressed through chart review.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
30.4% (administrative data only)	92% (2012)	89% (2012)

Elective delivery before 39 weeks

NQF #0469. Measure Steward: The Joint Commission

This measure tracks the percentage of patients with elective vaginal deliveries or elective cesarean sections at >=37 and <39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).

Numerator

- Individuals with elective deliveries with ICD-9-CM principal procedure code or ICD-9-CM other procedure codes for one or more of the following: Medical induction of labor, Cesarean section while not in active labor or experiencing spontaneous rupture of membranes.
- Procedure codes are defined in Appendix A, Table 11.05 and 11.06 available online at http://manual.jointcommission.org

Denominator

- Patients delivering newborns with >= 37 and < 39 weeks of gestation completed.

Exclusions

- ICD-9-CM Principal Diagnosis Code of ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07.
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
0.8% (2012)		

Emergency Department Utilization

This measure summarizes emergency department utilization and is half of the HEDIS measure "outpatient and ED utilization."

Numerator

- Number of ED visits (multiple visits on one day are counted as one visit).

Denominator

- Per 1,000 member months.

Exclusions

- Emergency Department visits that result in hospital admission.
- HEDIS does not include mental health or chemical dependency if diagnoses are listed as primary.

Notes

Recommend OHA reports total utilization for all covered diagnoses per 1,000 member months, as well as grouping for physical health, mental health, and chemical dependency.

Each group should be reported by recommended race and ethnicity categories. Each group should also be broken out by the following age categories: 0-12; 13-17; 18-20; 21-64; 65-74; and 75+.

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
56/1,000mm (2011)	44.4/1,000mm (2011)	55.2/1,000mm (2011)

Colorectal cancer screening

NQF #0034. Measure steward: NCQA

The measure tracks the percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Numerator

- Individual who had an appropriate screening if a submitted encounter / claim contains appropriate CPT code.

Codes used to identify (2012 HEDIS Specifications)

FOBT	CPT CODES: 82270, 82274 HCPCS: G0328 LOINC: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2
Flexible sigmoidoscopy	CPT CODES: 45330-45335, 45337-45342, 45345 HCPCS: G0104 ICD-9 CM PROCEDURE CODES: 45.24
Colonoscopy	CPT CODES: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 HCPCS: G0105, G0121 ICD-9 CM PROCEDURE CODES: 45.22, 45.23, 45.25, 45.42, 45.43

Denominator

- All eligible members meeting enrollment criteria and age 50-75 during measurement year.

Exclusions

- Continuous enrollment for measurement year and prior year. No more than one gap of up to 45 days.
- Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review.

Codes used to identify exclusions (2012 HEDIS specifications)

Colorectal cancer	HCPCS: G0213-G0215, G0231 ICD-9 CM DIAGNOSIS CODES: 153, 154.0, 154.1, 197.5, V10.0
Total colectomy	CPT CODES: 44150-44153, 44155-44158, 44210-44212 ICD-9 CM PROCEDURE CODE: 45.8

Notes

Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy. The diagnosis must have occurred by December 31 of the measurement year.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
30.5% (administrative data only)	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 90th percentile: 71.67.	National Medicaid data is not available. Using 2012 national commercial data, unadjusted 75th percentile: 65.76
	Adjustment factor for Medicaid: 4.12	Adjustment factor for Medicaid: 4.42
	Adjusted 90th percentile: 67.55	Adjusted 75th percentile: 61.34

Patient-Centered Primary Care Home (PCPCH) enrollment

This measure identifies the number of members enrolled in patient-centered primary care homes by tier.

Numerator

- The number of PCPCH enrolled members by tier:
    - # of enrollees in tier 1 x 1
    - # of enrollees in tier 2 x2
    - # of enrollees in tier 3 x 3

Denominator

- All enrolled members x 3

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	n/a	n/a

Developmental screening in the first three years of life

NQF #1448. Measure Steward: Oregon Health & Sciences University

This measure tracks the percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Numerator

- Children in the relevant denominator who had a claim/encounter with CPT code 96110 (developmental testing, with interpretation and report) by their birthday.

Denominator

- The children in the eligible population who turned one during the measurement period
- The children in the eligible population who turned two during the measurement period
- The children in the eligible population who turned three during the measurement period

Children must be covered by Medicaid/CHIP program continuously for 12 months between last birthdate and this birthdate, regardless if they had a medical/clinic visit or not during the measurement period.

Exclusions

- Children with more than one 45 day gap in enrollment for 12 months prior to birthday are excluded.

Notes

Measure could be collapsed into one across described denominators.

If using hybrid methodology, OHA may need to accept other forms of evidence. This would need to be defined and standardized across plans. Hybrid methodology would lose comparison to national benchmarks.

Data Source(s)

- Administrative data or chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
19.6% (administrative data only)		

Adolescent well child visits

This HEDIS measure tracks the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Numerator

- Members 12-21 years of age who received at least one comprehensive well-care visit during the measurement year.

Codes used to identify well-child visits (2012 HEDIS Specifications)

Well Child Visits	CPT CODES: 99381, 99382, 99391, 99392, 99432, 99461 HCPCS: G0438, G0439 ICD-9 CM DIAGNOSIS CODES: V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Denominator

- Members 12-21 years of age continuously enrolled in a specific health plan, FFS, or primary care management for the measurement year, with up to one 45-day gap in enrollment allowed.

Exclusions

Notes

Data Source(s)

- Administrative data

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
26.7%	64.1% (2011)	56.9% (2011)

Controlling high blood pressure

NQF #0018. Measure Steward: NCQA

This measure tracks the percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator

- The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.

Denominator

- Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Exclusions

- Exclude from the eligible population all patients with evidence of end-stage renal disease (ESRD) (including dialysis or renal transplant), all patients who are pregnant, and all patients who had an admission to a non-acute inpatient setting on or prior to December 31 of the measurement year.
- Individual must be continuously enrolled during the measurement year with no more than one month gap in coverage.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
	66% (2012)	60% (2012)

Diabetes: HbA1c Poor Control

NQF #0059. Measure Steward: NCQA

This measure tracks the percentage of adult patients with diabetes ages 18-75 years with most recent hemoglobin A1c level greater than 9.0% (poor control)

Numerator

- The number of patients in the denominator with HbA1c levels greater than 9.0% during the measurement year.

Denominator

- Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Exclusions

- Patients with a diagnosis of polycystic ovaries who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.
- Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who did not have a diagnosis of diabetes during the measurement year or year prior to the measurement year.

Notes

Data Source(s)

- Administrative data and chart review

Baseline Data

Oregon Medicaid	National Medicaid 90th percentile	National Medicaid 75th percentile
TBD	28% (2012)	34% (2012)

Access to Care: Getting Care Quickly

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: getting care quickly (adult) and getting care quickly (child).

The measure reports on the ease with which the members can access care quickly. The composite score is the overall percentage of members who responded “always” or “usually” to the following questions:

- In the last 6 months, when you needed care right away, how often did you get are as soon as you thought you needed? (Adult)
- In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor’s office or clinic as soon as you thought you needed? (Adult)
- In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed? (Child)
- In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor’s office or clinic as soon as you thought your child needed? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 79%	Adult (2012):85.59%	Adult (2012): 83.63%
Child (2011): 88%	Child (2012):92.16%	Child (2012): 90.31%
Average (2011): 83.5%	Average (2012): 88.88%	Average (2012): 86.97%

Satisfaction with Care: Health plan information and customer service

This measure is a composite of two CAHPS Health Plan Survey v4 composite measures: health plan information and customer service (adult) and health plan information and customer service (child).

This measure reports members' customer service experiencing when contacting the health plan. The composite score is the percentage of members who responded "always" or "usually" to the following questions:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed? (Adult)
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? (Adult)
- In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed? (Child)
- In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect? (Child)

Notes

Average adult and child composite scores.

Data Source(s)

- CAHPS

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
Adult (2011): 76%	Adult (2012):86.67%	Adult (2012): 83.19%
Child (2011): 80%	Child (2012): 88.99%	Child (2012): 84.71%
Average (2011): 78%	Average (2012): 87.83%	Average (2012): 83.95%

Electronic Health Record (EHR) Adoption

This measure is a composite of three Eligible Professional (EP) Meaningful Use Core Measures.

- #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)
- #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology).
- #5: Active Medicaid List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

Notes

Data Source(s)

Baseline Data

Oregon Medicaid	**National Medicaid 90th percentile**	**National Medicaid 75th percentile**
TBD	n/a	n/a

Appendix 3.D: Rationale for Incentive Measures

Incentive Measures[16]	Brief Description	Rationale for Measure
Screening for clinical depression and follow-up plan	Percent of members age 12+ screened for clinical depression using an age-appropriate standardized tool and follow-up plan documented in chart.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Alcohol and Drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	Percentage of members age 18+ with routine visit in the measurement year screened for substance abuse and referred as necessary.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health.
Bundled measure: mental health and physical health assessment for children in DHS custody	Percentage of children age 4+ who receive a mental health assessment and/or physical health assessment within 60 days of DHS custody date.	Oregon's baseline for mental health assessments for children in DHS custody is 58%. As this assessment is a requirement for the foster program, the rate should be much closer to 100%. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

[16] These measures will be publically reported by CCO, by race and ethnicity, and by other subpopulations where possible and appropriate, including people who are dually eligible, people with serious and persistent mental illness, people with disability, and people with special health care needs (e.g., chronic conditions, homelessness). Other analysis may include looking at beneficiary primary language, or rural versus non-rural locations.

Incentive Measures[16]	Brief Description	Rationale for Measure
Follow up care for children prescribed ADHD medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed	Oregon's baseline for follow-up care for children prescribed ADHD medication is 49.96% (rate 1) and 57.09% (rate 2). This is between the 2012 National Medicaid 75th and 90th percentiles. This measure addresses coordination of behavioral health and physical health care, as well as an emerging issue for children.
Follow-up after hospitalization for mental illness	Percentage of members age 6+ and mental health diagnosis with a follow-up visit within 7 days after hospitalization.	Oregon's baseline for follow-up after hospitalization for mental illness is 52%, between the 50th and 75th percentiles nationally (54% and 58%, respectively, 2012 Medicaid Benchmarks). Research has found patient access to follow-up care within 7 days of discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmissions.[17] In addition to potential cost savings from reducing readmissions, focusing on the integration between physical and behavioral health is a key component of Oregon's Health System Transformation. This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.

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

Incentive Measures[16]	Brief Description	Rationale for Measure
Prenatal care initiated in the first trimester	Percentage of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan.	Oregon's baseline for prenatal care is 30.4% based on administrative data, compared to the 25th percentile nationally of 77% (2012 Medicaid Benchmarks). However, ongoing measurement issues, including bundled payments for pre- and post-natal services, create an artificially low rate when just using administrative data. While Oregon's baseline is likely much higher than 30.4%, improving prenatal care is widely acknowledged as the most cost-effective way to improve the outcome of pregnancy for all women and infants.[18] As 43% of babies born in Oregon are covered by Medicaid (2009),[19]Oregon can achieve significant cost savings and better health outcomes by improving prenatal care. This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Reducing elective delivery before 39 weeks	Patients with elective vaginal deliveries or elective cesarean sections at >=37 and < 39 weeks of gestation completed.	The Leapfrog 2011 hospital survey indicates that rates of elective deliveries in Oregon range from 3.9 – 18.2%, compared to the recommended national benchmark of 5%. Complications for infants delivered by early cesareans include infections, five days or more of hospitalization, and the need for CPR. Additionally, babies born earlier average more visits during the first year of life compared to full-term babies (nine visits versus six, respectively). [20]

[18] A California Medi-Cal study found that women with no prenatal care were four times as likely to give birth to a baby of low birth weight and more than seven times as likely to give birth prematurely (2000). And a Missouri Medicaid study found a cost-savings of $1.49 for every $1 spent on prenatal care (1992).
[19] http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF
[20] http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Maternity_Care.pdf

Incentive Measures[16]	Brief Description	Rationale for Measure
		Total first year costs after initial hospitalization have been found on average to be three times higher for late preterm infants (>37weeks, <39 weeks) than for full-term infants. [21] This measure will help inform the quality improvement focus area: improving perinatal and maternity care.
Developmental screening by 36 months	The percentage of children with documentation that they were screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.	Oregon's baseline for developmental screening by 36 months is 19.6%. National survey for children's health indicates a range of 9% - 52% for developmental screening rates across the country. 52% was the highest performing state in the nation. Early developmental delays are often not identified until kindergarten entry or later – well beyond the period in which early intervention is most effective. Early identification and treatment of developmental delays leads to improved outcomes and reduced costs. This measure will help inform the quality improvement focus area: improving primary care for all populations.
Adolescent well care visits	The percentage of enrolled members age 12-21 who had at least on comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Oregon's baseline for adolescent well care visits is 26.3% (2010), well below the 25th percentile nationally of 39.7% (2011 Medicaid National Benchmark) and lower than the general population (in 2011, just over half of Oregon's 8th and 11th graders reported a well care visit in the past year – Oregon Healthy Teens). Youth who can easily access developmentally appropriate,

[21] McLaurin KK, Hall CB, Jackson EA, et al. Persistence of morbidity and cost differences between late-preterm and term infants during the first year of life. *Pediatrics*. 2009;123:653-659.

Incentive Measures[16]	Brief Description	Rationale for Measure
		evidenced-based preventive health services are more likely to be healthy.[22] This measure will help inform the quality improvement focus area: improving primary care for all populations.
Diabetes care: HemoglobinA1c poor control	Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control)	Addresses quality of care for a disease that impairs health and function in the individual and results in high costs due to complications and hospitalizations. By measuring HbA1c control, Oregon will assess the effectiveness of diabetes care. This measure will help inform the quality improvement focus area: Addressing discrete 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.
Controlling hypertension	Percentage of patients age 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year (2013).	According to 2010 BRFSS data, 39.4% of Oregon Health Plan adult enrollees have high blood pressure, compared to 31% of the general population. While baseline data for OHP members with controlled high blood pressure is not available, Oregon is likely below the 25th percentile nationally of 47% (2012 Medicaid Benchmarks) as studies indicate that as many as two thirds of those with hypertension are either undertreated or untreated.[23][24]

[22] Haas, S.A. & Fosse, N.E. (2008). Health and the educational attainment of adolescents: Evidence from the NLSY97.*Journal of Health and Social Behavior, 49,* (2), 178-92.

[23] *Trends in prevalence, awareness, treatment, and control of hypertension in the United States, 1988–2000.*JAMA.*2003; 290: 199–206*

Incentive Measures[16]	Brief Description	Rationale for Measure
		This measure will help inform the quality improvement focus area: Addressing discrete 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.
Colorectal cancer screening	Percentage of individuals age 50-75 who had appropriate screening for colorectal cancer, defined as: • Fecal occult blood test (FOBT) during the measurement year (2013); • Flexible sigmoidoscopy during the measurement year (2013) or the four years prior to the measurement year; or • Colonoscopy during the measurement year (2013) or the nine years prior to the measurement year.	Oregon's baseline for colorectal cancer screening is 30.5%, well below the 25th percentile of 51% (Regions 9 & 10, commercial population) and the overall screening rate in Oregon (63%)[25] Colorectal cancer is Oregon's second leading cause of cancer deaths.[26] Numerous studies have found that colorectal cancer screening is cost-effective or even cost-saving compared with no screening.[27] This measure will help inform the quality improvement focus area: improving primary care for all populations.
ED Utilization	Number of Emergency Department visits,	Oregon's baseline for Emergency Department utilization is 56 visits/1,000 member months (2011), close to the 75th

[24] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6135a3.htm?s_cid=mm6135a3_w
[25] 2008 BRFSS data. Screening is defined as fecal occult blood test within one year, sigmoidoscopy within 5 years, or colonoscopy within 10 years.
[26] www.oregon.gov/DHS/ph/oscar/arpt2006/colorectal06.pdf
[27] Cost-effectiveness of Colorectal Cancer Screening. *Epidemiol Rev (2011) doi: 10.1093/epirev/mxr004* First published online: June 1, 2011 http://epirev.oxfordjournals.org/content/early/2011/06/01/epirev.mxr004.full#abstract-1

Incentive Measures[16]	Brief Description	Rationale for Measure
	calculated per 1,000 member months	percentile nationally of 55.2/member months (2011 Medicaid Total Population National Benchmarks). Reducing ED utilization will result in cost savings.
Rate of PCPCH enrollment:	Percentage of members enrolled in patient-centered primary care homes, calculated by tier.	The Oregon Health Policy board estimates that up to $44 million in 3 years and up to $190 million in 10 years can be saved by implementing integrated health homes for Oregon Health Plan beneficiaries with chronic and/or comorbid conditions. Further savings will be possible when PCPCHs are expanded to public employees and other privately insured Oregonians.[28] This measure will help inform the quality improvement focus area: improving primary care for all populations.
CAHPS Composite: Getting Care Quickly Getting Needed Care	Percentage of members who responded "Always" or "Usually" to four CAHPS survey questions about getting needed care as soon as needed and getting appointments at a doctor's office or clinic as soon as needed. •	Improving access to effective and timely care has the potential to improve the overall quality of care and help reduce costs. [29] It is necessary to assess for the availability and proximity of providers, as well as barriers to access such as lack of transportation, or long waits to get an appointment.[30]Measuring access to care can also identify disparities based on race/ethnicity, gender, or geography.
CAHPS Composite:	Percentage of members who responded	Member satisfaction is a critical component of quality

[28]http://www.oregon.gov/OHA/OHPR/HFB/docs/Final_Report_12_2008.pdf

[29]Steinbrook R. Easing the shortage in adult primary care -- Is it all about money? N Engl J Med. 2009;360:2696-2699; Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff. April 7, 2004: w4.184-197.

[30] Hall A, Harris Lemak C, Steingraber H, et al. Expanding the definition of access: It isn't just about health insurance. J Health Care Poor Underserved. 2008;19:625-638

Incentive Measures[16]	Brief Description	Rationale for Measure
Health plan information and customer service	"Always" or "Usually" to four CAHPS survey questions about how often a health plan's customer service gave needed information or help and how often a health plan's customer service treated members with courtesy and respect.	analysis, from NCQA's HEDIS to the American Medical Association's Accreditation Program. Patient satisfaction is considered a key result of patient care. Healthier members tend to report better satisfaction with their health plan; although this has not been demonstrated conclusively, patient satisfaction could be used as a partial proxy for health status, particularly for managed care members.[31] Addressing patient satisfaction with health plans covers a number of variables, including patient interactions with individual providers, which may be less under the control of the health plan, but also the quality of communication of rules and benefits, and overall customer service provided by the plan.
EHR Composite (3Qs)	1. Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)	Creating a composite score from three Meaningful Use core measures will serve as a measure of EHR adoption across Oregon. The three MU measures selected address both quality and coordination of care, a critical component of the Coordinated Care model.

[31] http://www.dssresearch.com/Download/PSATwithHCHP_RG.pdf

Incentive Measures[16]		
	2. Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.) 3. Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	

Appendix 3.E: Measures for Consideration in Demonstration Year 3

Quality Improvement Focus Area	Measures
Reducing preventable rehospitalizations	• Pediatric central line associated bloodstream infections – Neonatal intensive care unit and pediatric intensive care unit
Addressing discrete health issues	
Reduce preventable and costly utilization	• Medication reconciliation post-discharge (NQF 0054) • Care transition – transition record transmitted to health care professional (NQF 0648)
Integrate primary care and behavioral health	• Antidepressant medication management (NQF 0105) • Behavioral health risk assessment for pregnant women (AMA PCPC1) • Depression remission at 12 months (NQF 710)
Improving access to timely and effective care	• Total eligible who received dental treatment services (ages 1-20) • Total eligible who received preventive dental services (ages 1-20) (NQF 1334)
Improving perinatal and maternity care	• Percentage of live births weighing less than 2500 grams (NQF 1382) • Prenatal and postpartum care: postpartum care rate (NQF 1391) • Behavioral health risk assessment for pregnant women (AMA PCPC1)
Improving primary care for all populations	• Annual monitoring of patients on persistent medications (NQF 0021)

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 46, 47, 48, and 49.

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 separately documented on the Tab entitled New FQHC/RHC and included in Level 2 tracking. In addition, any incremental increases in wrap payments associated with a change in scope after July 1, 2011 will also be tracked in this Tab and included as part of Level 2 tracking.

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.

Level 3: The per-member-per-month total expenditure to the state to provide care under Health System Transformation in Oregon.

On the tracking template, there are three administrative cost categories. For the first two on HIT and internal IT costs, specifically the costs funded by Medicaid AND undertaken exclusively to help make CCOs successful are included. The third, the transformation center and related supports, OHA will report the full budget and parse out the Medicaid funding share of that work. This will provide a full picture of the funds needed to support transformation directly. The following provides a more detailed description of the three administrative cost categories and what would be included:

1. **HIT/Interoperability Costs**

    - This category would include administrative expenditures by the state to implement and further statewide HIT/Interoperability *specific to CCOs*.
    - These expenditures would not include anything activities that are the responsibility of the CCOs and providers paid through the CCO global budget.
    - A couple examples of these state costs could include:
        - State monitoring and measuring the CCO progress in increasing EHR adoption rates within their networks
        - State evaluation of the HIT/HIE portions of the CCO Transformation Plans and measuring progress of those plans in those areas

2. **Internal IT system changes**

    - This category would include administrative costs to implement health system transformation that are above and beyond the intensity, frequency, or complexity of normal system changes and are undertaken for the sole purpose to successfully implement CCOs.
    - Examples would include:
        - Personal services focused on HST project direction, management, coordination.

- Hardware and software purchased to establish a new function or service (such as SharePoint for the CCO portal and collaboration)
- Contracted resources to assist with workload (such as documentation of business requirements, making system changes, implementation of new function/service, etc.)
- System changes needed to accommodate both transfer of pertinent data between the state and the CCOs, but also the changes required to support metrics, performance and quality measures and the payment processing attached to those requirements.

3. Transformation Center costs

- This would include the full cost of the transformation center, with Medicaid's share delineated.
- Medicaid's share could include analytic support, staff training, and other related administrative costs that are not funded by other grant funds.

Other Cost Treatment

- **Long-Term Care services**: Oregon has agreed to conduct an exploratory stakeholder process that would result in a report to CMS regarding the integration of DHS Medicaid-funded long-term care for the aged or people with disabilities into CCO global budgets. The report will identify opportunities, barriers, and strategies for integrating long term care, and address issues of scope, process and timeline for integration. The report will be submitted to CMS no later than December 31, 2013.
- **Uncompensated Care Costs:** CMS and OHA acknowledged that DSH audit reports have a significant lag between the review year and date of the actual audit report. State and CMS agree to use data from the most recently filed Medicare cost reports to evaluate the year-to-year trend in hospital uncompensated care. Most recently filed Medicare cost reports are available through the Healthcare Cost Report Information System (HCRIS) maintained by CMS. Six months following the end of the state fiscal year (beginning with SFY 2013), the state would extract HCRIS data for each of the two previous state fiscal years, calculate an aggregate year-to-year trend of uncompensated care and report it to CMS as a component of the quarterly report ending March 31 of each year.

To the extent uncompensated care is increasing more quickly than other health care costs, the state and CMS will attempt to identify underlying factors for the increase and to what extent the state and CMS have influence to affect such factors in the future.

Treatment of Populations Within the Workbook after January 1, 2014

The attached spending growth reduction template is now populated with actual expenditure data and caseload for CY 2011. Expenditure data is extracted from the OHA accounting system based on date of payment.

CMS has proposed a methodology for accounting for the influx of new enrollees in 2014 with the ACA Medicaid expansion. In discussions with the state, CMS has identified three particular populations that are identified in the waiver and subject to the two percent test for some portion of the expenditures for health care (also known as Level 1 service expenditures). The populations are:

A. State plan eligibles currently receiving the OHP Plus benefit package

B. Demonstration population that currently receives the OHP Standard benefit package but will move to the OHP Plus package on January 1, 2014 (approximately 60-70k enrolled individuals)

C. Newly covered individuals in the new section 1902(a)(10)(A)(i)(VIII) group (estimated at 220k individuals)

The current STCs require that the state begin achieving savings in state fiscal year 2014 (July 1, 2013 – June 30, 2014) for populations A and B based on calendar year 2011 base year expenditures for services identified as in the global budget. By June 30, 2014, the state is required to document a one percent savings for all groups covered in the demonstration. However, populations B and C will have major expenditure effects associated with mid-year changes attributable to implementation of ACA Medicaid expansions.

- Population A will not be affected as their benefit package will remain the same and the base year expenditures are still the relevant measure against which savings are determined.

- Population B will experience an increase in expenditures as of January 1, 2014, due to the expansion of their benefit package. CMS proposes that the state measure savings at the two percent level for the OHP Standard benefit package for the full 2014 period. The contracts in place with the CCOs would identify the capitated rate paid for the first half of the year. The state should document the proportion of the rate for the remainder of the demonstration year that is associated with the expanded (Plus) benefit package. The additional benefits available after January 1, 2014, are not subject to the spending growth reduction test for this demonstration year. For the subsequent demonstration year, the expenditures incurred over the final 6 months of the SFY 2014 demonstration year will be

used to develop a new SFY 2014 base (full expanded benefit package) against which SFY 2015 demonstration year (DY 13) will be measured.

- Population C will be new as of January 1, 2014 and therefore, expenditures from January 1 – June 30, 2014 will become the base against which SFY 2015 demonstration year (DY 13) expenditures are measured. The first year that the two percent will be applied is 2015 expenditures.

- If during demonstration year 2015 or 2016, the state is required to modify the rates for the expansion population based on actual experience of the CCOs due to a demonstrable difference in health status or a significant and identifiable increased pattern of utilization, the state will need to provide both of the following:

    1. Analyses that indicate population C has a higher case mix acuity requiring rates that are increased to reflect this higher "sicker population". The state will use the Chronic Illness and Disability Payment System Model (CDPS) to document this case mix and acuity differential and modify the base against which savings will be measured. The documentation must clearly demonstrate that the new population is clearly more expensive due to actual differences in population acuity (health) rather than simply increased utilization of services, poor management in CCOs, or other volume and care management issues.

    2. Analysis that population C has a significantly higher pattern of utilization when compared to the other Medicaid populations (rate groups). Significant increases in utilization that can be isolated to the expansion population are the result of either missed assumptions in the rate setting process or the result of untreated pent up demand. This state will demonstrate this discrepancy by documenting the base utilization assumptions used in setting the capitation rates for the expansion population and then compare those assumptions to the actual experienced utilization for specific services and activities identified prior to the population receiving services in 2014.

The state must provide the actual baseline service data, utilization assumptions, and health status indicators being targeted for review and analysis within the models employed under (1) and (2) for CMS approval prior to the population being enrolled in 2014. CMS understands that the contracts for this population will be negotiated between June and September of 2013 and would expect that the state would begin sharing this information during that period. If the detailed information described in this paragraph is not provided to CMS for review and approval, the state will not be able to request a change in the base for these populations.

Any modification to the base year would need to be agreed upon by CMS and Oregon through the underlying documentation and only for this specific population.

Return on Investment: The return on investment analysis focused on the federal investment represented by total federal financial participation (FFP) in DSHP claims plus additional FFP drawn by the state because it has additional state dollars in the same amount as the FFP drawn against the DSHP claims. This amount represents the total new federal investment into Oregon to support their delivery system transformation under the 1115 demonstration. This amount will be measured against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Description of Elements in the Work Book

Tab 1: PMPM Target – includes 2011 base year per member per month expenditures as developed using OHA expenditure information based on actual date of payment expenditure for 2011. 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. 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 2011 base year aggregate expenditures derived from Tab 8. CY 2011. Subsequent year expenditures for Tab 2 will be 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. Annual estimates will be updated quarterly based on the combination of actual and projections available each quarter.

Tab 4: Expenditure Actuals – includes actual aggregate expenditures derived from Tabs 8 through 13 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/Standard) for calculation of PMPMs.

Tab 6: New FQHC-RHC – provides a tracker of wrap payments made to FQHCs/RHCs established after 7/01/2011 and incremental increases in wrap payments due to increases in scope of service made after 7/01/2011. These calculations then feed into the FQHC/RHC wrap line items in Tabs 10-14.

Tab 7: ROI – includes calculations for the return on investment analysis outlined in STC 50 and above measuring the total DSHP investment against annual actual medical care savings generated for all beneficiaries mandatorily and voluntarily enrolled in CCOs. The savings are for all expenditures in levels 1 and 2 spending and are simply an analysis of total investment against total savings.

Tabs 8-13: Yearly tabs that track actuals for the CY 2011 base year and 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. For each current demonstration year, the full year will be estimated, updated with actuals as they are available.

PMPM WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGET

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
	Without HST Baseline Growth (Per ST&Cs)	Base Year	5.40%	5.40%	5.40%	5.40%	5.40%
	Without HST Baseline Growth PMPM	$ 400	$ 421	$ 444	$ 468	$ 493	$ 520
	With HST Spending Reduction Growth Target	Base Year	5.40%	4.40%	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	$ 368					
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						
	Youth residential alcohol and drug treatment (OHP carve out)						
	Adult residential alcohol and drug treatment (OHP carve out)						
	Nurse Home Visiting program: Babies First! And CaCoon						
	Non-Emergent Medical Transportation						
	Adult Residential Mental Health Services						
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
	Young Adults in Transition Mental Health Residential						
	Targeted Case Management						
	Federally Qualified Health Center Wrap						
	Primary Care Case Management						
	Global Budget PMPM	$ 400	$ 421	$ 440	$ 459	$ 484	$ 510
Level 2: Total Expenditu	**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 Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system costs						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

TOTAL EXPENDITURES WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGETS

	TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget						
Capitation:						
Total Managed Care	$ 2,140,213,391					
Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
Incentive Payment Pool						
Total Capitation	**$ 2,519,153,853**	**$ -**				
Services Outside of Capitation + Subject to Evaluation						
ADDITIONAL SERVICES:						
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030.00					
Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
Non-Emergent Medical Transportation	$ 43,416,273					
Adult Residential Mental Health Services	$ 71,019,309					
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
Young Adults in Transition Mental Health Residential	$ 376,116					
Targeted Case Management	$ 9,846,177					
Federally Qualified Health Center Wrap	$ 67,458,838					
Primary Care Case Management	$ 153,133					
Total Global Budget - No HST	**$ 2,733,284,427**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
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 Wrap for new centers and change of scope after 7/01/2011						
Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin						
Administrative Expenses						
HIT/Interoperability costs						
Internal IT system changes						
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
Total Administrative Expenses						

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

PMPM ACTUALS UNDER HEALTH SYSTEM TRANSFORMATION

		TOTAL CY 2011	TOTAL SFY 2013	TOTAL SFY 2014	TOTAL SFY 2015	TOTAL SFY 2016	TOTAL SFY 2017
Level 1: Global Budget	**Capitation:**						
	Total Managed Care						
	Total Fee For Service (for equivalent CCO services)						
	Incentive Payment Pool						
	Total Capitation PMPM	$ 368.32					
	Services Outside of Capitation + Subject to Evaluation						
	ADDITIONAL SERVICES:						
	Substance Abusing Pregnant Women and Substance Abusing						
	Parents with Children under Age 18 (Targeted Case Management)						
	Youth residential alcohol and drug treatment (OHP carve out)						
	Adult residential alcohol and drug treatment (OHP carve out)						
	Nurse Home Visiting program: Babies First! And CaCoon						
	Non-Emergent Medical Transportation						
	Adult Residential Mental Health Services						
	Cost-sharing for Medicare skilled nursing facility care (day 21-100)						
	Young Adults in Transition Mental Health Residential						
	Targeted Case Management						
	Federally Qualified Health Center Wrap						
	Primary Care Case Management						
	Global Budget PMPM	$ 399.63					
Level 2: Total Expendit	**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 Wrap for new centers and change of scope after 7/01/2011						
	Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin	**Administrative Expenses**						
	HIT/Interoperability costs						
	Internal IT system changes						
	New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)						
	Administrative Expenses PMPM						

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

3. PMPM Actuals 12/14/2012 3

TOTAL ACTUAL EXPENDITURES UNDER HEALTH SYSTEM TRANSFORMATION

	BASE TOTAL CY 2011	TOTAL SFY 2013	3.4% TOTAL SFY 2014	3.4% TOTAL SFY 2015	3.4% TOTAL SFY 2016	3.4% TOTAL SFY 2017
Level 1: Global Budget						
Capitation:						
Total Managed Care	$ 2,140,213,391					
Total Fee For Service (for equivalent CCO services)	$ 378,940,462					
Incentive Payment Pool	$ -					
Total Capitation	**$ 2,519,153,853**					
Services Outside of Capitation + Subject to Evaluation						
ADDITIONAL SERVICES:						
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	$ 1,206,030					
Youth residential alcohol and drug treatment (OHP carve out)	$ 3,010,303					
Adult residential alcohol and drug treatment (OHP carve out)	$ 9,982,229					
Nurse Home Visiting program: Babies First! And CaCoon	$ 227,973					
Non-Emergent Medical Transportation	$ 43,416,273					
Adult Residential Mental Health Services	$ 71,019,309					
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	$ 7,434,193					
Young Adults in Transition Mental Health Residential	$ 376,116					
Targeted Case Management	$ 9,846,177					
Federally Qualified Health Center Wrap	$ 67,458,838					
Primary Care Case Management	$ 153,133					
Total Global Budget	**$ 2,733,284,427**					
Level 2: Total Expendit						
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 Wrap for new centers and change of scope after 7/01/2011						
Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Level 3: Admin						
Administrative Expenses						
HIT/Interoperability costs	$ -					
Internal IT system changes	$ -					
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Ar	$ -					
Total Administrative Expenses	**$ -**					

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

Base Year Caseload and Projected Caseload

	HST Population Groups	Base CY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Total PLUS		5,533,161						
Total Standard	ACA/OHP Standard	838,738						
Total ACA Expansion	ACA/OHP Standard							
Total CHIP	Child	816,558						
Total Plus, Standard, ACA and CHIP		**7,188,457**						
Cawem Prenatal	Non-disabled adult	16,324						
Breast and Cervical Cancer Program	Non-disabled adult	6,309						

Footnote for discussion:

[1]AB/AD w/o Medicare and AB/AD w/Medicare populations include disabled children

Less Duals Non-enrollees	**286,450**
Less TPL Caseload	**68,761**
Total Caseload not including Cawem Prenatal	**6,839,555**

TPL Caseload:

kids	**9896**
Non-Dis	**4571**
Dis	**2842**
Duals	**50306**
Standard	**1146**
Total TPL	**68761**

FQHCs and RHCs who were either established after 7/01/2012 or have a change of scope since the CY 2011 baseyear

Note: these calculations will be fleshed out and linked to expenditure pages for FQHC payments lines.

Health Centers Established after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

DMAP Provider ID	FQHC/RHC Name	Type	Began	PPS Rate	CY 2011 Wrap	SFY 2012 Wrap	SFY 2013	SFY 2014
500637389	Women's Health Center	RHC	7/13/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637337	Ocean Medical Clinic	RHC	8/17/2011	$125.70	$0.00	$0.00	$0.00	$0.00
500637480	Naselle Clinic	RHC	8/17/2011	$86.32	$0.00	$0.00	$0.00	$0.00
544642552	MMoreCare	RHC	11/1/2011	$206.70	$0.00	$0.00	$0.00	$0.00
500640302	Centennial Medical Group	RHC	12/1/2011	$128.11	$0.00	$63,358.13	$0.00	$0.00
500642552	St. Charles Health Sys. Inc.	RHC	1/1/2012	$207.53	$0.00	$0.00	$0.00	$0.00
500646533	Firwood- Legacy Clinic	RHC	8/1/2012	$193.46	$0.00	$0.00	$0.00	$0.00
	Total				$0.00	$63,358.13	$0.00	$0.00

Incremental increases in wrap payments due to rate change effective after 7/1/2011 and excluded from Tier 1 Per Capital Spending Test

							SFY 2013		SFY 2014	
DMAP Provider ID	FQHC/RHC Name	Type	Pre-7/1/12 PPS Rate	New PPS Rate	Incremental Rate Change	Effective Date for New Rate	Total	Incremental Increase	Total	Incremental Increase
xxxxxxxxxxx	Example	FQHC	$ 200	$ 225	$ 25	1/1/2013	$ 2,250,000	$ 250,000		
	Total						$ 2,250,000	$ 250,000		

ROI Analysis

	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17
FFP DSHP Claimed (FMAP X TC)					
a. High Risk Pool					
b. Higher Education					
c. State identify Health Programs					
Total Claimed					
New FFP Available on Non-Federal Share {Total DSHP Claimed (line 7)/(1-FMAP)}-DSHP claimed					
Total Federal Investment (Line 7 + Line 9)					
Total Actual Savings (% reduction in Level I & 2 savings realized by the state X Level 1 & 2 spending)					
ROI (line 12/line 14)					

	CY 2011 DETAIL						
	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care	$ 647,342,558	$ 489,607,766	$ 530,789,880	$ 105,277,560	$ 367,195,627		$ 2,140,213,391
Total Fee For Service (for CCO equivalent services)	$ 115,182,230	$ 48,275,516	$ 165,007,384		$ 50,475,332		$ 378,940,462
Incentive Payment Pool							$ -
Total Capitation	$ 762,524,788	$ 537,883,283	$ 695,797,264	$ 105,277,560	$ 417,670,958	$ -	$ 2,519,153,853
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)						$ 1,206,030	$ 1,206,030
Youth residential alcohol and drug treatment (OHP carve out)						$ 3,010,303	$ 3,010,303
Adult residential alcohol and drug treatment (OHP carve out)						$ 9,982,229	$ 9,982,229
Nurse Home Visiting program: Babies First! And CaCoon						$ 227,973	$ 227,973
Non-Emergent Medical Transportation						$ 43,416,273	$ 43,416,273
Adult Residential Mental Health Services						$ 71,019,309	$ 71,019,309
Cost-sharing for Medicare skilled nursing facility care (day 21-100)						$ 7,434,193	$ 7,434,193
Young Adults in Transition Mental Health Residential						$ 376,116	$ 376,116
Taregeted Case Management						$ 9,846,177	$ 9,846,177
Federally Qualified Health Center Wrap						$ 67,458,838	$ 67,458,838
Primary Care Case Management						$ 153,133	$ 153,133
Total Global Expenditures	**$ 762,524,788**	**$ 537,883,283**	**$ 695,797,264**	**$ 105,277,560**	**$ 417,670,958**	**$ 214,130,575**	**$ 2,733,284,427**
Total Caseload	**4,146,385**	**858,410**	**603,435**	**393,733**	**837,592**		**6,839,555**
PMPM	**$ 183.90**	**$ 626.60**	**$ 1,153.06**	**$ 267.38**	**$ 498.66**		**$ 399.63**
Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation							
Mental health remaining in fee-for-service	$ 13,891,529	$ 8,376,740	$ 61,414,236	$ 816,989	$ 10,748,475		$ 95,247,969
Long Term Care						$ 812,827,021	$ 812,827,021
School Based Health Services						$ 25,174,125	$ 25,174,125
Behavioral Rehabilitative Services (BRS)						$ 3,663,118	$ 3,663,118
Personal Care 20 Client Employed Provider						$ 988,176	$ 988,176
FQHC Wrap for new centers and change of scope after 7/01/2011						$ -	$ -
Total Services Outside of Capitation + NOT Subject to	**$ 13,891,529**	**$ 8,376,740**	**$ 61,414,236**	**$ 816,989**	**$ 10,748,475**	**$ 842,652,439**	**$ 937,900,408**
Administrative Expenses							
HIT/Interoperability costs							$ -
Internal IT system changes							$ -
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							$ -
Total Administrative Expenses							$ -

Global Budget

Footnote:

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

C:\Documents and Settings\OR0181264\Local Settings\Temporary Internet Files\Content.Outlook\N9G5S3E3\[Attach H Exp Trend Review Template 121412.xls]1. PMPM Targets

SFY 2013 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2014 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2015 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:

[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2016 DETAIL	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

SFY 2017 DETAIL

	Children	Non-disabled adults	Disabled/elderly	Dual eligibles	ACA/OHP Standard	Services Not Identified by Population	Total
Capitation:							
Total Managed Care							
Total Fee For Service (for CCO equivalent services)							
Incentive Payment Pool							
Total Capitation							
Services Outside of Capitation + Subject to Evaluation							
ADDITIONAL SERVICES:							
Substance Abusing Pregnant Women and Substance Abusing							
Youth residential alcohol and drug treatment (OHP carve out)							
Adult residential alcohol and drug treatment (OHP carve out)							
Nurse Home Visiting program: Babies First! And CaCoon							
Non-Emergent Medical Transportation							
Adult Residential Mental Health Services							
Cost-sharing for Medicare skilled nursing facility care (day 21-100)							
Young Adults in Transition Mental Health Residential							
Targeted Case Management							
Federally Qualified Health Center Wrap							
Primary Care Case Management							
Total Global Budget							
Total Caseload							
PMPM							
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 Wrap for new centers and change of scope after 7/01/2011							
Total Services Outside of Capitation + NOT Subject to Evaluation							
Administrative Expenses							
HIT/Interoperability costs							
Internal IT system changes							
New staff (Transformation Ctr., Innovator Agents, Quality Oversight, Analytics)							
Total Administrative Expenses							$ -

Global Budget

Footnote:
[1] QMB, CAWEM, TPL, Duals & Tribal members now enrolled in CCOs are excluded from expenditures.

APPLICATION FOR AMENDMENT AND RENEWAL
Oregon Health Plan
1115 Demonstration Project
Appendices

APPENDICES	
Title	**Appendix**
CCO Application Timelines	A
Oregon Health Plan Transformation Public Process	B
CCO implementation proposal	C
CCO populations and schedule for inclusion in global budget	D
State Fund Only Program List	E
Initial Proposed CCO Accountability Metrics	F
CCO Proposed Measures--Crosswalk to Medicaid Adult, CHIPRA and Medicare ACO Measures	G
Summary of federal authority matrix	H
Federal authority matrix	I
Budget neutrality – Base	J
Budget neutrality – Change	K
Budget neutrality – Combined	L
Inventory of Medicaid services and timeline for inclusion in global budget	M

Appendix A

CCO Application Timeline

Event	1st Application Date	2nd Application Date	3rd Application Date	4th Application Date
CCO Request for Applications and Model Contract to CMS/Review Draft Posted on OHA and DMAP Websites	March 5, 2012	NA	NA	NA
CCO RFA Posted	March 19, 2012	March 19, 2012	March 19, 2012	March 19, 2012
CCO Letter of Intent Due to OHA Notice of Intent to Apply Due to CMS*	April 2, 2012	April 2, 2012	April 2, 2012	April 2, 2012
Part D Formulary Due to CMS*	April 30/May 14, 2012	April 30/May 14, 2012	April 30/May 14, 2012	***
CCO Technical Application Due	April 30, 2012	June 4, 2012	July 2, 2012	August 1, 2012
Medication Therapy Management Program Due to CMS*	May 7, 2012	May 7, 2012	May 7, 2012	***
CCO Financial Application Due	May 14, 2012	June 11, 2012	July 9, 2012	August 8, 2012
Award of Certification	May 28, 2012	July 2, 2012	August 6, 2012	September 5, 2012
Duals Benefit Package Due to CMS*	June 4, 2012	June 4, 2012	June 4, 2012	***
CCO-Medicaid Contract Signed	June 29, 2012	July 30, 2012	August 29, 2012	September 28, 2012
CCO-Medicaid Contract to CMS	July 3, 2012	August 1, 2012	August 31, 2012	October 1, 2012
CCO-Medicaid Contract Effective	**August 1, 2012**	**September 1, 2012**	**October 1, 2012**	**November 1, 2012**
CMS and OHA Certification for Duals*	July 31, 2012	July 31, 2012	August 6, 2012**	***
Three-Way Contract Signed*	Sept. 20, 2012	Sept. 20, 2012	Sept. 20, 2012	***
Dual Eligible Benefits Effective*	**January 1, 2013**	**January 1, 2013**	**January 1, 2013**	***

*Required for participation in CMS Financial Alignment Demonstration for Integrating Care for Individuals who are Dually Eligible. *See RFA Appendix F for more information.* Note, new Part D formularies are due April 30, and previously submitted formularies are due May 14.

**Currently under discussion with CMS due to risk that joint CMS/OHA readiness review for participation in CMS Financial Alignment Demonstration will not be completed in time to sign three-way contracts by Sept. 20, 2012.

***OHA is requesting that CMS allow CCOs to enter three-way contracts after Sept. 20, 2012, with details to be determined during the CMS/OHA Memorandum of Understanding process. Plans on later timelines may risk losing the ability to passively enroll individuals dually eligible for Medicare and Medicaid or other advantages.

Appendix B

Oregon Health System Transformation Public Process
2011-2012

Date	Meeting
Jan. 18, 2011, 9 am–4 pm	Oregon Health Policy Board meeting; public comment accepted[1]
Feb. 2, 2011, 6-9 pm	Public meeting: Weekly Health System Transformation Team [2]
Feb. 8, 2011, 1-3:30 pm	Oregon Health Policy Board meeting; public comment accepted
Feb. 9, 2011, 6-9 pm	Public meeting: Weekly Health System Transformation Team
Feb. 11, 2011, 9:30 am–2:30 pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 16, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Feb. 23, 2011, 6-9 pm	Tribal Health Services: SB 770 Meeting
Feb. 23, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 2, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 8, 2011, 8:30 am-noon:	Oregon Health Policy Board meeting; public comment accepted
Mar. 9, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 16, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 9 am-noon	Medicaid Advisory Committee
April 12, 2011, 12:30-4:30 pm	Oregon Health Policy Board meeting; public comment accepted
May 5, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
May 10, 2011, 8:30 am-noon	Oregon Health Policy Board meeting; public comment accepted
April 27, 2011, 9 am - noon	Medicaid Advisory Committee
April 29, 2011, 9 - 10 am	Tribal Consultation
May 16, 2011 9 - 10 am	Tribal Consultation
May 25, 2011, 9:30 am–2:30 pm	Tribal Health Services: SB 770 Meeting
June 2, 2011, 9-10 am	Tribal Consultation
June 2, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
June 23, 2011, 10-11 am	Oregon Health Policy Board meeting; public comment accepted
June 29, 2011	Senate passes House Bill 3650 by a vote of 22-7
June 30, 2011	House passes House Bill 3650 by a vote of 59-1
July 1, 2011	Governor Kitzhaber signs House Bill 3650, providing a framework for Coordinated Care Organizations and launching four workgroups and next round of public comments
July 12, 2011, 8 am-1 pm	Oregon Health Policy Board meeting; public comment accepted
July 19, 2011, 2 to 3 pm	Tribal Consultation
July 27, 2011, 9 am - noon	Medicaid Advisory Committee
Aug.4, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Aug. 9, 2011, 1-4:30 pm	Oregon Health Policy Board meeting; public comment accepted

[1] All OHPB meetings are live web-streamed statewide. All work papers and materials publicly posted for review.
[2] Appointed by Governor. All work papers and materials publicly posted for review. Members include stakeholders of all types and lawmakers of both parties

Aug. 16, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration[3]
Aug. 17, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Aug. 18, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Aug. 22, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Aug. 24, 2011, 9:30 am–2:30 pm	Tribal Health Services: SB 770 Meeting
Sept. 1, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Sep. 13, 2011, 8-12:30 pm	Oregon Health Policy Board meeting; public comment accepted
Sep. 20, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Sep. 21, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Sep. 22, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Sept. 22, 2011, 8-11 am	Legislature: Interim Joint Health Care Committee hearing
Sep. 26, 2011, 9 am-noon	Public Work Group: Metrics
Sep. 26, 2011, 6-8 pm	Community meeting: Roseburg
Sep. 27, 2011, 6-8 pm	Community meeting: Medford
Sept. 28, 2011, 9 am-noon	Medicaid Advisory Committee
Oct. 3, 2011, 6-8 pm	Community meeting: Pendleton
Oct. 5, 2011, 6-8 pm	Community meeting: Florence
Oct. 6, 2011, 6-8 pm	**C**ommunity meeting: Bend
Oct. 10, 2011, 6-8 pm	Community meeting: Portland
Oct. 11, 2011, 1-5 pm	Oregon Health Policy Board meeting; public comment accepted
Oct. 12, 2011, 6-8 pm	Community meeting: Eugene
Oct. 13, 2011, 6-8 pm	Community meeting: Astoria
Oct. 17, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Oct. 17, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Oct. 18, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Oct. 19, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Oct. 26, 2011, 9 am-noon	Medicaid Advisory Committee
Nov.3, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Nov. 8, 2011, 8:30 am-noon	Oregon Health Policy Board meeting; public comment accepted
Nov. 9, 2011 3:30-4:30 pm	Tribal Consultation
Nov. 14, 2011 1-5 pm	Tribal Health Services: SB 770 Meeting
Nov. 14, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Nov. 14, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Nov. 15, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Nov. 16, 2011, 8-11 am	Legislature: Interim Joint Health Care Committee hearing
Nov. 17, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Nov. 30, 2011 10:30-11:30 am	Tribal Consultation
Dec. 1, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Dec. 13, 2011, 1-6 pm	Oregon Health Policy Board meeting; public comment accepted
Dec. 20, 2011, all day	Legislature: Interim Joint Health Care Committee hearing
Dec. 20, 2011 9 am-12 pm	Tribal Consultation

[3] All work papers and materials publicly posted for review for all groups.

Jan. 10, 2012, 10 am-12 pm	Tribal Consultation
Jan. 10, 2012, 8:30 am-3 pm	Oregon Health Policy Board meeting; public comment accepted
Jan. 18, 2012, 8-11 am	Legislature: House Health Care Committee hearing
Jan. 20, 2012, 1-3 pm	Legislature: Senate Health Care and Human Services Committee hearing
Jan. 24, 2012, 8 am-noon	Oregon Health Policy Board meeting; public comment accepted
Jan. 25, 2012, 10 am-12 pm	Tribal Consultation
Jan. 25, 2012, 9-11 am	Medicaid Advisory Committee
Feb. 2, 2012, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Feb. 12, 2012, 9:30 am–2:30 pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 14, 2012, 1-4 pm	Oregon Health Policy Board meeting, public comment accepted
Feb. 14, 2012	Senate passes Senate Bill 1580 by a vote of 18-12
Feb. 16, 2012, 2-3 pm	Tribal Consultation
Feb. 23, 2012:	House passes Senate Bill 1580 by a vote of 53-7

Oregon Health Authority

Coordinated Care Organizations

Implementation Proposal

House Bill 3650
Health System Transformation
January 24, 2012

www.health.oregon.gov

Oregon Health Policy Board

The Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for the Oregon Health Authority. The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health. Board members are nominated by the Governor and are confirmed by the Senate. Board members serve a four-year term of office.

Eric Parsons
Chair, Portland

Lillian Shirley, BSN, MPH, MPA
Vice Chair, Portland

Mike Bonetto, PhD, MPH, MS
Bend

Carlos Crespo, MS, DrPH
Portland

Felisa Hagins
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Chuck Hofmann, MD, MACP
Baker City

Joe Robertson, MD, MBA
Portland

Nita Werner, MBA
Beaverton

Table of contents

1. **Executive summary** ..... **I**
2. **Existing market environment and industry analysis** **2**
   - *Target population* *2*
   - *Current delivery system for target population* *3*
   - *Population characteristics and health status* *4*
3. **Opportunities for achieving the Triple Aim: improving health, improving health care and reducing cost** **9**
   - *Financial projections for greater system efficiency and value* *9*
4. **Coordinated Care Organization (CCO) certification process** **12**
   - *Alternative dispute resolution* *13*
5. **Coordinated Care Organization (CCO) criteria** **15**
   - *Governance and organizational relationships* *15*
   - *Patient rights and responsibilities, engagement and choice* *18*
   - *Health equity and eliminating health disparities* *23*
   - *Payment methodologies that support the Triple Aim* *24*
   - *Health information technology* *26*
6. **Global budget methodology** **28**
   - *Populations included in global budget calculations* *29*
   - *Service/program inclusion and alignment* *29*
   - *Global budget development* *30*
7. **Accountability** **34**
   - *OHA accountability in supporting the success of CCOs* *34*
   - *CCO accountability* *35*
   - *Shared accountability for long-term care* *37*
8. **Financial reporting requirements to ensure against risk of insolvency** **38**
   - *Audited statements of financial position and guarantees of ultimate financial risk* *38*
   - *Financial solvency* *39*
   - *OHA monitoring and oversight* *41*
   - *Public disclosure of information* *42*

CCO licensure *42*

Corporate assets and financial management *43*

9. Medical liability 44

10. Implementation plan 46

Transition strategy *46*

Transitional provisions in HB 3650 ..... *46*

Implementation timeline *47*

11. Appendices 48

Coordinated Care Organization (CCO) Implementation Proposal
House Bill 3650 Health Care Transformation

1. Executive summary

Health care costs are increasingly unaffordable — to businesses, individuals, as well as the federal and state government. The growth in Medicaid expenditures far outpaces the growth in General Fund revenue, yet there has not been a correlating improvement in health outcomes.

In 2011 the Oregon Legislature and Governor John Kitzhaber created CCOs in House Bill 3650, aimed at achieving the Triple Aim of improving health, improving health care and lowering costs by transforming the delivery of health care. The legislation builds on the work of the Oregon Health Policy Board since 2009. Essential elements of that transformation are:

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care; and
- A global Medicaid budget tied to a sustainable rate of growth.

CCOs are community-based organizations governed by a partnership among providers of care, community members and those taking financial risk. A CCO will have a single global Medicaid budget that grows at a fixed rate, and will be responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid or dually eligible for both Medicaid and Medicare. CCOs will be the single point of accountability for the health quality and outcomes for the Medicaid population they serve. They will also be given the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

CCOs are the next step forward for Oregon's health reform efforts that began in 1989 with the creation of the Oregon Health Plan. Today's managed care organizations, mental health organizations and dental care organizations that serve our state's Medicaid population have done a good job in keeping health care costs down, but the current structure limits their ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. Additionally, the current payment system provides little incentive for the prevention or disease management actions that can lower costs, and OHP clients face a sometimes dizzying array of plans and rules while health care costs continue to outpace growth in income or state revenues.

Conventional wisdom is that there are three approaches to controlling what is spent on health care: reduce provider payments; reduce the number of people covered; or reduce covered benefits. Over the years these approaches have proven unsuccessful in reducing the actual cost of care and can squelch investments in health improvement that lead to lower future costs.

In the creation of CCOs, HB 3650 lays the foundation for a fourth pathway: Rather than spending less into an inefficient system, change the system for better efficiency, value and health outcomes.

To implement CCOs in our state, lawmakers called on the Oregon Health Authority to develop a proposal for governance, budgeting and metrics. This proposal has been developed through the Oregon Health Policy Board and is the result of the work of the board and four work groups comprising 133 people who met over four months, a series of eight community meetings around the state that brought input from more than 1,200 people, and public comment at the monthly Oregon Health Policy Board meetings.

Financial projections for greater system efficiency and value
There is ample evidence from initiatives in our local communities that the kind of transformation pointed to by HB 3650 can improve health outcomes and lower costs. National efforts show the same results.

Included in the proposal is work conducted on behalf of OHA and the Oregon Health Policy Board by Health Management Associates (HMA) that estimates total Medicaid spending in Oregon can be reduced by over $1 billion in the next three years and $3.1 billion over the next five years. In year one, the savings equate to $155 million to $308 million in total fund ($58 million to $115 million general fund) cost reductions, net of new investment. HMA believes these projections are conservative as there are certain opportunities that would move the system beyond what we currently understand as well-managed. It is also possible that greater potential savings could be achieved with faster implementation. Full details of HMA's analysis are included in the proposal.

This proposal outlines operational and key qualification guidelines for CCOs as recommended by the Oregon Health Policy Board, including:

- *Global budget*: CCO global budgets will be developed by OHA to cover the broadest range of funded services for the largest number of beneficiaries possible. OHA will construct the CCO global budgets starting with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets will include services that are currently provided under managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

  Once CCOs are phased in, quality incentives will be incorporated in the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

- *Accountability*: CCOs will be accountable for outcomes that bring better health and more sustainable costs. HB 3650 directed that CCOs be held accountable for their performance through public reporting of metrics and contractual quality measures that function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the direction of HB 3650. Accountability measures and performance expectations for CCOs will be introduced in phases to allow CCOs to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards.

  An external stakeholder group established a set of principles and recommendations for dimensions of measurement for OHA to use as a guide when establishing outcomes and quality metrics. Upon legislative approval to go forward, the next step is to establish a committee of technical experts from health plans and health systems to further define these metrics and a reporting schedule. The technical work group will be asked to establish both minimum expectations for accountability as well as targets for outstanding performance. *(See Appendix G.)*

- *Application process*: Beginning in spring/early summer of 2012, prospective CCOs will respond to a non-competitive request for applications (RFA) much like the process developed by the federal government for Medicare Advantage plans. The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

- *Governance*: CCOs will have a governing board with a majority interest consisting of representation by entities that share financial risk as well as representation from the major components of the health care delivery system. CCOs will also convene community advisory councils (CAC) to assure a community perspective; a member of the CAC will serve on the CCO governing board.

- *CCO criteria*: In their applications for certification, CCOs will demonstrate how they intend to carry out the functions outlined in HB 3650 including *(See Appendix D)*:
  - Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;
  - Ensuring member rights and responsibilities;
  - Working to eliminate health disparities among their member populations and communities;
  - Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;

- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency.

Assuming legislative approval, CCO criteria, the request for applications (RFA), and a model CCO contract will be publicly posted in spring 2012 so that communities interested in forming CCOs can begin preparing applications.

The Oregon Health Authority and the Oregon Health Policy Board are poised to begin implementation of the transformational change represented in HB3650.

Timeline

Federal permissions submitted	March 2012
CCO criteria publicly posted	Spring 2012
Request for application (RFA) and model contract posted	Spring 2012
Letters of intent submitted to OHA	Spring 2012
Evaluation of initial CCO applications	Spring/early summer 2012
First CCOs certified	June 2012
First CCOs begin enrolling Medicaid members	July 2012

Additional information and resources about Medicaid transformation and CCOs can be found at: www.health.oregon.gov.

2. Existing market environment and industry analysis

Target population

Projected enrollment

The target population includes all current and future Oregon Health Plan (OHP) enrollees. Between 2010 and 2011, enrollment grew rapidly, due primarily to growth within the expansion group. OHP staff estimates project modest (3%) annual enrollment growth through state fiscal year 2014, followed by a rapid increase between 2014 and 2015 when the Affordable Care Act Medicaid expansion goes into effect. (See Figure 1) While the vast majority of new enrollees are expected to be non-disabled adults, OHP is projecting that the annual rate of growth among the disabled and dual-eligibles, which is approximately 6 percent (excluding the year of the Medicaid expansion), will be roughly three times that of the TANF-related population's 2 percent. This trend is critical, as the disabled and dually eligible populations are, on average, far more costly than their TANF-related counterparts, and also stand to benefit most from effective care management.

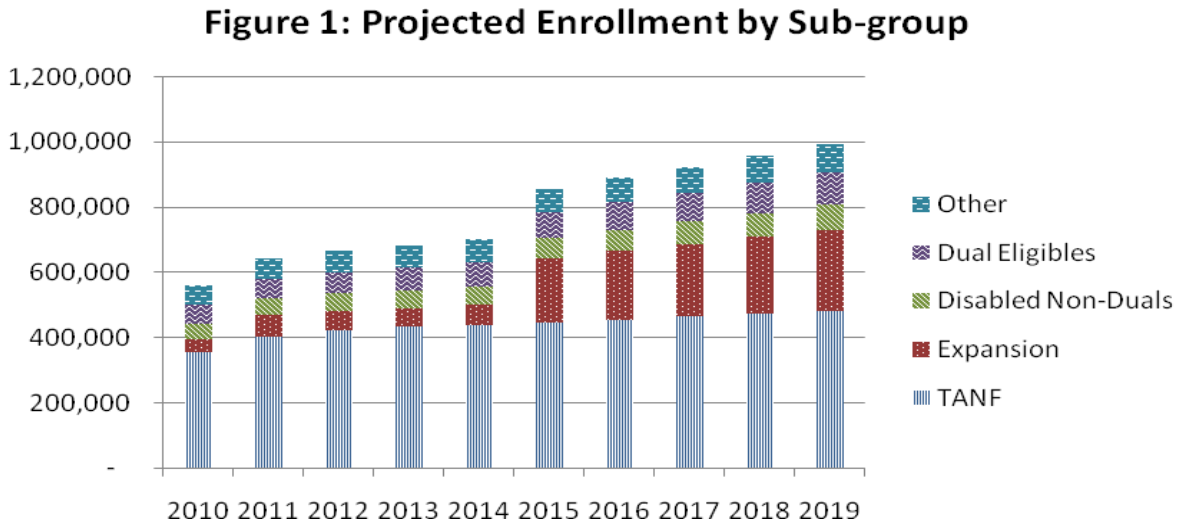

Table 1 shows the demographic distribution of the Oregon Medicaid population in 2011. The racial/ethnic makeup of the population has remained virtually unchanged over the last three years. The age profile of the Oregon Medicaid population has also remained stable over the last three years, though there has been a slight shift from the 0–18 age group to the adult group. This trend is expected to be much larger beginning in 2014, as the majority of new Medicaid enrollees will be previously uninsured adults. Approximately 56 percent of Medicaid enrollees are women and 44 percent are men. While this distribution has remained constant over the last several years, it is expected to shift somewhat toward men when the 2014 expansion is implemented.

Table 1: Oregon Medicaid Demographics (2011)

Demographic	%
Race/Ethnicity	
White	61%
African American	4%
Hispanic or Latino	22%
Asian, Native Hawaiian or Other Pacific Islander	3%
American Indian or Alaska Native	2%
Other/Unknown	8%
Age (in years)	
0-18	56%
19-64	37%
65+	7%
Gender	
Male	44%
Female	56%

Table 1: Data were extracted from the demographic reports published by the Oregon Health Plan, July 2011.

Current delivery system for target population

The current OHP program is fragmented, resulting in diluted accountability for patient care and likely duplication of infrastructure and services. Care is delivered through a system that includes three kinds of health plans (16 physical health organizations, 10 mental health organizations and eight dental care organizations), while some individuals continue to receive care on a fee-for-service basis. Specifically:[1]

- Approximately 78 percent of OHP clients are enrolled in physical health managed care.
- Nearly 90 percent of OHP clients are enrolled in managed dental care.
- Approximately 148,000 clients not enrolled in managed care receive services on a fee-for-service (FFS) arrangement — providers bill the state directly for their services based on a set fee schedule. Some providers receiving FFS also get a case management fee (in areas where there are no managed care plans).
- Approximately 88 percent of OHP enrollees are enrolled in capitated mental health organizations (MHOs). In many cases, the state provides capitated mental health organization (MHO) payments to the counties and the counties administer the programs. The counties function as the MHO, bearing full risk for the services and contract with panels of providers for direct services to enrollees. Addiction services for Medicaid clients are covered in fully capitated health plans, not through MHOs or counties.

Please see Appendix A for detailed information on current plan types and service areas.

[1] Oregon Health Authority. Oregon Health Policy Board meeting slides, Jan. 18, 2011

Population characteristics and health status

The need for more effective service integration and care management for OHP enrollees is evident in statewide and Medicaid-specific data. This section provides an overview of several key indicators of population health. Many of these indicators are also reflective of major cost-drivers within the Medicaid program.

- *Perinatal indicators.* Maternal and child health indicators are important factors in assessing the relative health of a community. Risk factors for poor birth outcomes such as low birth weight, short gestation, maternal smoking, inadequate maternal weight gain during pregnancy and substance abuse can often be addressed as a woman receives prenatal care.
- *Chronic conditions.* Experts estimate that chronic diseases are responsible for 83 percent of all health care spending.[2] Health care spending for a person with one chronic condition on average is 2-1/2 times greater than spending for someone without any chronic conditions.[3]
- *Smoking.* Direct Oregon Medicaid costs related to smoking are an estimated $287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon.[4] While overall tobacco use rates in Oregon are below national levels and trending downward, adult Medicaid clients are nearly twice as likely to smoke as Oregon adults in general.[5] Specifically, 37 percent of adult Medicaid clients smoke, compared to 17 percent of Oregon adults. In addition, studies have shown that economic status is the single greatest predictor of tobacco use.[6]
- *Obesity.* Similarly, Medicaid payments for obesity-related care accounted for nearly nine percent of Medicaid costs between 2004 and 2006, a figure that has likely grown as obesity rates have increased.[7]

Figure 2 shows statewide trends in perinatal indicator rates for the Medicaid population. Teen birth rates and low birth rate babies have remained relatively constant over the past 10 years. However, rates of late prenatal care have shown a troubling increase, and the percentage of Medicaid enrollees who smoke during their pregnancy has increased after dropping off in 2007.

[2] Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update.
[3] Ibid
[4] Oregon Health Plan, Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations. May 2011.
[5] Ibid.
[6] Ibid.
[7] Portland Pulse, from 2007 Oregon DHS data. See: http://www.portlandpulse.org/node/37.

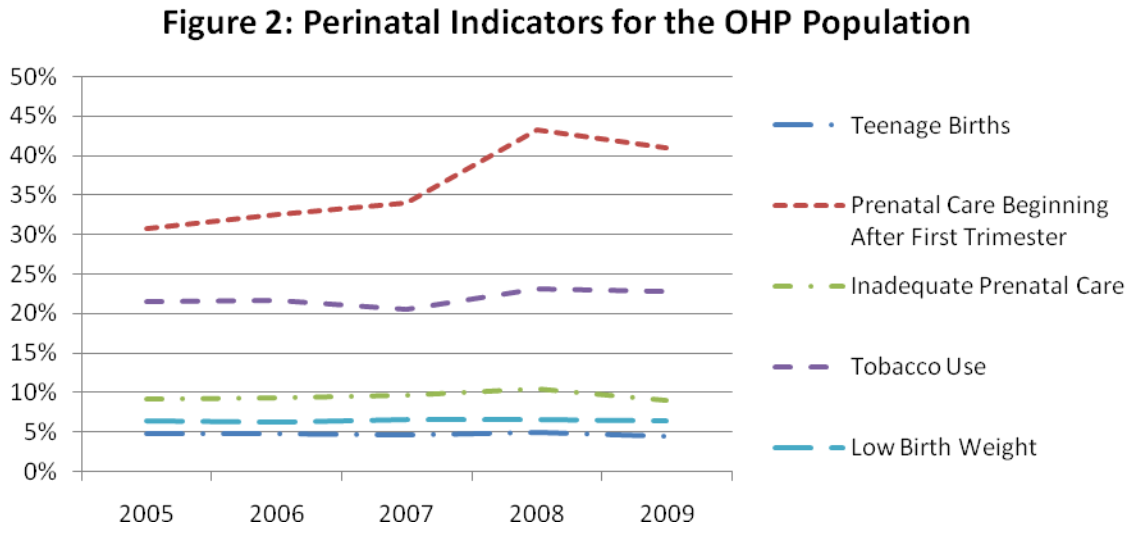

Figure 2: Oregon Vital Statistics Annual Reports 2005-2009

Figure 3 shows the variation across the state when looking at the prevalence of chronic conditions among current OHP enrollees based on diagnosis codes. The statewide bar shows the average across all seven regions for each of the seven chronic conditions. The regions are defined as follows:

- Region 1: Clatsop, Columbia, Tillamook, Lincoln
- Region 2: Coos, Curry
- Region 3: Benton, Clackamas, Linn, Marion, Multnomah, Polk, Washington, Yamhill
- Region 4: Douglas, Jackson, Josephine, Lane
- Region 5: Crook, Deschutes, Gilliam, Grant, Hood River, Jefferson, Morrow, Sherman, Wasco, Wheeler
- Region 6: Baker, Umatilla, Union, Wallowa
- Region 7: Klamath, Lake, Harney, Malheur

In many instances, there are large disparities across regions. For example, Region 2's population has a diabetes prevalence rate that exceeds the statewide average by more than 55 percent and exceeds the Region 5 prevalence rate by 96 percent. Similarly, Region 2's population has an asthma prevalence rate that exceeds the statewide average by 14 percent and the Region 6 rate by 25 percent.

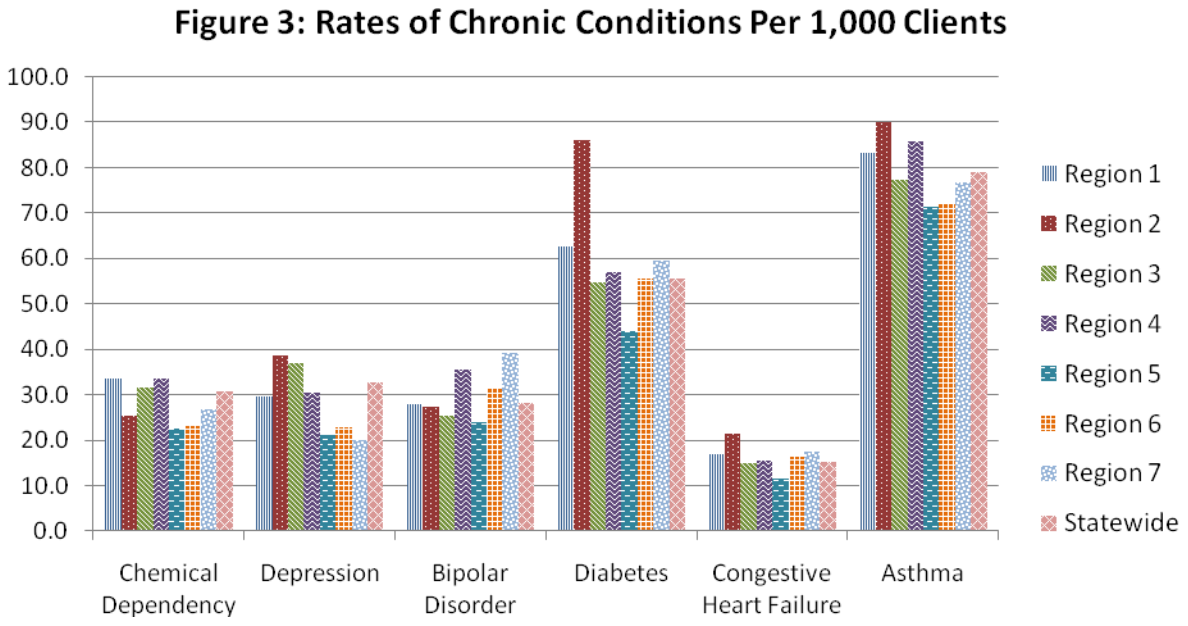

Figure 3: Oregon Health Authority Division of Medical Assistance Programs 8/15/2011.

Figure 4 illustrates the overweight/obesity trend in Oregon and nationally. The lower portion of each stack represents the percent of the population considered "obese" according to their body mass index (BMI). The total stack represents the percentage of the population considered "overweight or obese." While the percentage of the Oregon population considered "overweight or obese" has stayed relatively stable from 2002–2009, the portion that are classified as "obese" has grown. While overall rates of obesity in Oregon are below national levels, this is a troubling trend, as obesity is one of the most important risk factors for developing diabetes, as well as numerous other chronic conditions and certain types of cancer.

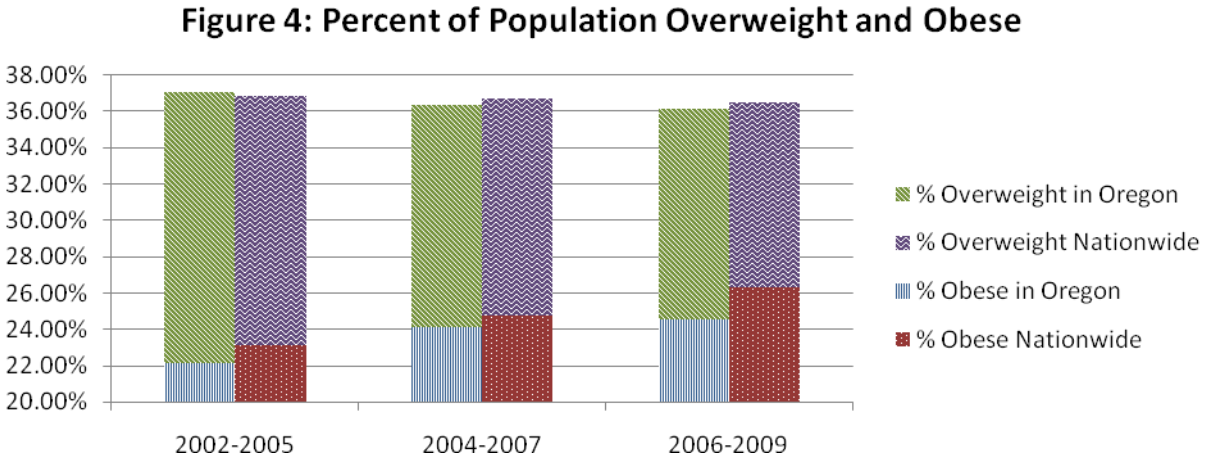

Figure 4: The lower stacks represent the percentage of the population classified as "obese." The total stacks represent the percentage of the population considered "overweight." The data comes from the Behavioral Risk Factor Surveillance System, accessed 12/2011.

Racial and ethnic disparities

In addition to overall rates of chronic disease and utilization of preventive services, it is important to look at disparities among racial and ethnic groups. A 2008 study by the Oregon Division of Medical Assistance Programs compared racial and ethnic disparities in Oregon and in the Oregon Health Plan and found that disparities exist but vary by race/ethnic group.[8] The prevalence of chronic disease is worse among certain minority groups compared to whites. For Oregon Health Plan clients, asthma prevalence was higher for American Indians and Alaska Natives than for any other group — and other minority groups' prevalence was lower than whites'. For Oregon Health Plan clients, all minority groups had a higher prevalence of diabetes, except for African Americans, where the prevalence was the same as for whites.

In its 2011 "State of Equity Report," the Department of Human Services and the Oregon Health Authority identified two disparities in key performance measures across race and ethnicity. For the first measure, the utilization rate of preventative services for children from birth to 10 years of age covered by the Oregon Health Plan, a higher rate is favorable. When comparing across the benchmark of non-Hispanic Whites, Figure 5 shows Native Americans utilizing preventive services at a rate of less than 75 percent of the utilization seen in the White population.

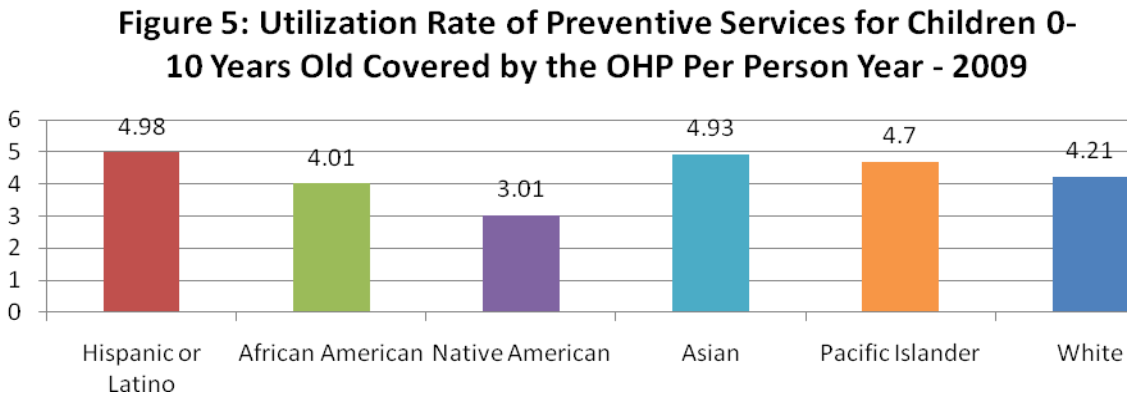

Figure 5: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011. Rates reflect the number of preventive services provided per person year.

In the second measure, the rate of ambulatory care sensitive condition hospitalizations of OHP clients, a lower rate is more favorable. As Figure 6 shows, when comparing rates to the benchmark of non-Hispanic Whites, the Native American population has a higher rate of potentially avoidable hospitalizations. . High rates of hospitalization for ambulatory care sensitive conditions indicate that a condition is not being properly managed. These two disparities together highlight a population in which there is a lack of health care needs being met and indicate a need for outreach and interventions targeted to specific groups.

[8] Division of Medical Assistance Programs and the Public Health Division, Oregon Department of Human Services' Efforts to Reduce Racial and Ethnic Health Care Disparities. May 23, 2008.

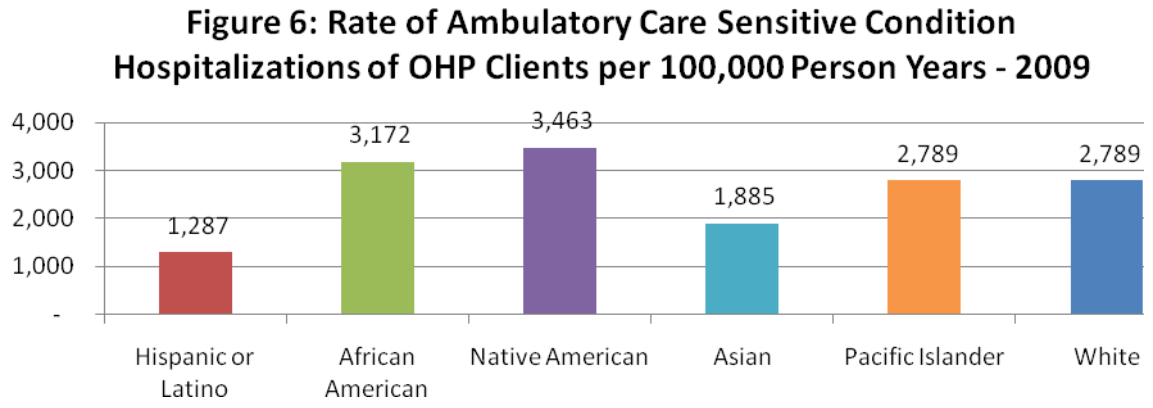

Figure 6: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011.

Unsustainable cost growth

Without implementing transformation, Health Management Associates estimates that Oregon's Medicaid costs will continue to surge at an average of 10 percent annual growth over the next seven years due to a combination of enrollment growth, increased utilization and inflation in the cost of medical products and services. This greatly exceeds the projected growth rate of General Fund revenue.

3. Opportunities for achieving the Triple Aim: improving health, improving health care and reducing cost

Financial projections for greater system efficiency and value

Current state

For the year ending June 30, 2013, total Oregon Medicaid expenditures are expected to approach $3.2 billion. Oregon's Medicaid enrollment has been growing in recent years and the base cost for services has increased historically and is expected to continue to do so. Inflationary factors include higher wages for care providers, changes in medical practice, and the introduction of new treatment protocols and new drugs and technology.

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as $11.7 billion in the FY 2017-2019 biennium with more than 950,000 individuals enrolled in the program. This figure includes approximately 250,000 newly eligible under federal health reform expansion provisions that take effect in 2014.

HB 3650 directs OHA to "prepare financial models and analyses to demonstrate the feasibility of a coordinated care organization being able to realize health care cost savings." OHA contracted with Health Management Associates to conduct this analysis.

Estimates of health transformation savings provided by Health Management Associates

The HMA analysis projects potential savings in six areas. The savings figures in parentheses represent anticipated percentage reductions in expenditures for that component that would take place after implementation is complete and fully scaled, which HMA estimates will take approximately three to five years. *(See Appendix B for more detailed tables)*:

- Improved management of the population (11–15% savings);
- Integration of physical and mental health (10–20% savings);
- Implementation of the Mental Health Preferred Drug List ($0 in the 2011–2013 biennium, $16 million in the 2013–2015 biennium);
- Increased payment recovery efforts (2% savings);
- Patient-centered primary care homes (4–7% savings);
- Administrative savings from MCO reductions (0.2–0.4% savings).

Improve to a well-managed system of care

In 2011, a report by Milliman for the Portland area Oregon Health Leadership Council projected savings for a well-managed Medicaid sub-population (Temporary Assistance for Needy Families, which is largely pregnant women and children) between $118 million and $141 million statewide. According to Milliman, well-managed status reflects attainment of utilization at defined levels equal to optimal benchmarks. Savings reflect the difference between existing service levels and those benchmarks. HMA

projected those findings to the entire Medicaid population by extending Milliman projections to the additional Medicaid groups: the aged, blind and disabled population as well as the expansion population. HMA considers these projections conservative because the complexity and level of chronic disease in these groups is higher and generally yields higher savings.

HMA states that the overall integration of care and payment mechanisms would reduce costs primarily on the Medicare side for dually eligible individuals. Based upon a study by the Lewin Group and in conjunction with the report from Milliman, HMA has estimated this rate at 8.5 percent. These savings come primarily from Medicare expenditures; a shared savings arrangement with Medicare is essential to obtaining a benefit to the state.

Integration of physical and mental health

A key strategy in Oregon's health system transformation efforts includes the integration of mental health and physical health. A study of integration savings projected results as high as 20 percent to 40 percent; however, HMA assumed a lower figure of 10 percent to 20 percent given the extent of other savings already applied in Oregon. This includes both the integration of physical health with certain mental health settings as well as the addition of mental health with physical health settings. Further, while HMA did not estimate the benefit of integrating dental health into the overall system, increased coordination should also reduce costs and increase the quality of the consumer's experience.

Implementation of Mental Health Preferred Drug List

This strategy will require legislative approval, so no savings are projected for year one. Clear evidence exists to demonstrate savings while maintaining the same level of treatment outcomes.

Increased payment recovery efforts

CCOs will audit claims to review Medicaid coverage criteria, inappropriate coding assignments, medical necessity, third party liability, coordination of benefits and other targeted areas, and recoup of overpayments.

Patient-centered primary care homes

The statewide implementation of the patient-centered primary care home model can further reduce costs. Early implementation of similar models has been shown to reduce total expenditures by up to 7 percent. By further enhancing the abilities of these homes through connections to specialty care and improving care transitions between levels of care, HMA believes Oregon can go beyond well-managed.

Administrative savings from MCO reductions

CCOs will be larger and more comprehensive than existing MCOs and MHOs. Consequently, economies of scale are available from the consolidation and redesign of current administrative functions.

Electronic health records and health information exchange

While not included in the table below, the savings from electronic connectivity and reduction in duplicate testing should be noted. Witter & Associates, LLC, estimate avoided services savings at $16

million a year from the widespread adoption and use of health information exchange (HIE). While implementation of statewide HIE is projected to take four to five years, the resultant savings over time are substantial. These estimates are not net of implementation costs. However, the federal investment in provider incentive payments is providing considerable financial support for these efforts. Additionally, we believe that the savings would be measurable if the costs of implementation could be shared across other payers.

HMA Estimates of Achievable Medicaid Savings Due to Health System Transformation
(each column represents expenditures and savings for that period only)

Low Savings – Total Funds	**7/12 to 6/13**	**7/13 to 6/15**	**7/15 to 6/17**	**7/17 to 6/19**
Average Enrolled	672,430	733,522	887,750	955,475
Projected Expenditures	**$3,178,000,000**	**$7,439,550,000**	**$10,018,650,000**	**$11,680,350,000**
Improve to "Well Managed"	($43,700,000)	($311,050,000)	($972,900,000)	($1,282,700,000)
Integration of Physical and Mental Health	($31,300,000)	($285,100,000)	($678,400,000)	($1,039,800,000)
Mental Health Preferred Drug List	$0	($16,000,000)	($27,000,000)	($53,100,000)
Program Integrity	($62,700,000)	($142,600,000)	($180,900,000)	($208,000,000)
Patient Centered Primary Care Homes	($11,000,000)	($99,800,000)	($237,500,000)	($363,900,000)
Admin Savings from MCO Reductions	($6,300,000)	($14,300,000)	($18,100,000)	($20,800,000)
Savings from Redesign	**($155,000,000)**	**($868,850,000)**	**($2,114,800,000)**	**($2,968,300,000)**
Projected Expenditures with Redesign	**$3,023,000,000**	**$6,570,700,000**	**$7,903,850,000**	**$8,712,050,000**
Percentage Change in Expenditures	-4.9%	-11.7%	-21.1%	-25.4%

High Savings – Total Funds	**7/12 to 6/13**	**7/13 to 6/15**	**7/15 to 6/17**	**7/17 to 6/19**
Average Enrolled	672,430	733,522	887,750	955,475
Projected Expenditures	**$3,178,000,000**	**$7,439,550,000**	**$10,018,650,000**	**$11,680,350,000**
Improve to "Well Managed"	($65,500,000)	($401,050,000)	($1,113,400,000)	($1,603,850,000)
Integration of Physical and Mental Health	($124,500,000)	($703,900,000)	($1,781,100,000)	($2,015,300,000)
Mental Health Preferred Drug List	$0	($16,000,000)	($27,000,000)	($51,800,000)
Program Integrity	($62,300,000)	($140,800,000)	($178,100,000)	($201,500,000)
Patient Centered Primary Care Homes	($43,600,000)	($246,300,000)	($623,400,000)	($705,400,000)
Admin Savings from MCO Reductions	($12,500,000)	($28,200,000)	($35,600,000)	($40,300,000)
Savings from Redesign	**($308,400,000)**	**($1,536,250,000)**	**($3,758,600,000)**	**($4,618,150,000)**
Projected Expenditures with Redesign	**$2,869,600,000**	**$5,903,300,000**	**$6,260,050,000**	**$7,062,200,000**
Percentage Change in Expenditures	-9.7%	-20.6%	-37.5%	-39.5%

4. Coordinated Care Organization (CCO) certification process

Pending direction and approval by the Legislature during the February 2012 session, the Oregon Health Authority will begin a non-competitive request for applications (RFA) procurement process that specifies the criteria organizations must meet to be certified as a CCO. Prospective CCOs will be asked to submit applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650, including being prepared to enroll all eligible persons within the CCO's proposed service area. Contracts with certified CCOs will be for multi-year periods, with annual renewal based on CCO compliance with DCBS and OHA requirements; this is similar to Medicare Advantage contract renewals. Health insurers certified by the Oregon Department of Consumer and Business Services Insurance Division retain their certification as long as they are in compliance with DCBS and OHA requirements, including financial solvency. For CCOs, OHA will establish a public recertification process in administrative rule.

In early spring 2012, OHA will promulgate administrative rules describing the CCO application process and criteria. Once the criteria have been finalized, the application process for prospective CCOs is planned as follows (see Section 9 of this document for a timeline):

- CCO criteria will be posted online by OHA.
- OHA will release a "Request for CCO Application."
- CCO applicants will submit letters of intent to OHA.
- CCO applicants will submit applications to OHA.
- OHA will evaluate CCO applications with a public review process.
- OHA will certify CCOs.
- CMS will collaborate with OHA evaluation of applications and certification of CCOs, or may follow with a separate certification with respect to individuals who are dually eligible.

Because CCOs will be responsible for integrating and coordinating care for individuals who are dually eligible for Medicare and Medicaid, the application will include the relevant Medicare plan requirements that will build on the existing CMS Medicare Advantage application process, streamlining the process for any plans that have previously submitted Medicare Advantage applications. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

Evaluation of CCO applications will account for the developmental nature of the CCO system. CCOs, OHA and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by HB 3650. Particular attention will be paid to community involvement in the governance of the CCO, and to the CCO's community needs assessment conducted with its community partners. In all cases, CCOs will be expected to have plans in place for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by HB 3650.

Alternative dispute resolution

HB 3650:

- ***Section 8(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.***
- ***Section 8 (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.***
- ***Section 8 (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.***
- ***Section 8 (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.***

HB 3650 requires the development of a dispute resolution process in establishing CCOs. If a health care entity (HCE) is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization, a process will be available to those parties that includes the use of an independent third-party arbitrator. Because "reasonable cost" is not defined, OHA will clarify in the rule-making process, to the best extent possible, the definition of reasonable cost.

A more complete description of the proposed process is provided in Appendix C. A summary of the primary objectives and components of the process is provided here.

A dispute resolution process using an arbitrator will follow after a good faith effort between the parties to agree to mutually satisfactory contract terms. If there is a question about whether the HCE is "necessary" for the certification of the CCO, the parties can consult with OHA. If there are technical questions that OHA can assist the parties with concerning the certification process, this consultation will be available. However, the primary goal is for the parties necessary to the certification of a CCO work together to agree upon the terms of a contract. Evidence of good faith negotiations should include at least one face-to-face meeting between the chief executive officer and/or chief financial officer of the HCE and of the organization applying for CCO certification, to discuss the contract offer that has been made and the reasons why the HCE has not accepted the offer. If that process does not result in a contract, either party can request the use of an arbitrator.

This dispute resolution process using an arbitrator applies when (and only when) an HCE is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization. This process is designed to be completed within 60 calendar days. When one party initiates the dispute resolution process, the other party and OHA will receive written notification. The parties will then identify a mutually acceptable arbitrator, who must be familiar with health care issues and HB 3650, and who agrees to follow the dispute resolution process described in Appendix C. In the first 10 days, both parties

must send their most reasonable contract offer to each other and the arbitrator, or an explanation of why no contract is desired; in the next 10 days, the parties can file a written explanation for why the offer or refusal to contract is reasonable or unreasonable. The arbitrator has 15 days to review these materials and issue a decision about whether the HCE refusal to contract is reasonable or unreasonable. Having received the decision, the parties have an additional 10 days to resolve their dispute and agree on a contract. At any point in the process, the parties can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

OHA realizes that occasions may arise when a CCO refuses to contract with an HCE. As part of implementation planning, a dispute resolution process will be developed to evaluate the reasonableness of such a refusal and to facilitate review of the dispute.

5. Coordinated Care Organization (CCO) criteria

In order to be certified as a CCO, an organization will be asked to address the criteria outlined in Sections 4 through 13 of HB 3650 and to illustrate how the organization and its systems support the Triple Aim. OHPB recommendations for CCO criteria, outlined below, were developed from a combination of stakeholder work group input, public comment, OHPB-sponsored community meetings held throughout the state, and public and invited testimony at board meetings, as well as board deliberations. Appendix D contains a consolidated list of the proposed CCO criteria along with minimum and transformational expectations for each criterion.

Governance and organizational relationships

HB 3650:

- ***Section 4(1)(o)(A-C): (o) Each CCO has a governance structure that includes: (A) a majority interest consisting of persons that share the financial risk of the organization; (B) the major components of the health care delivery system, and (C) the community at large to ensure that the organization's decision-making is consistent with the values of the members of the community.***
- ***Section 4(1)(i) Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met.***
- ***Section 4(2) The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.***
- ***Section 4(3) On or before July 1, 2014, each CCO will have a formal contractual relationship with any DCO in its service area.***
- ***Section 24(1-4): CCOs shall have agreements in place with publicly funded providers to allow payment for point of contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.***

<u>Governing board</u>

CCO organizational structures will vary to meet the needs of the communities they will serve. There is no single governance solution, and there is risk in being too prescriptive beyond the statutory definition of a CCO governing board. Instead, governing board criteria will support a sustainable, successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim. HB3650 requires that CCOs have a governance structure that includes a majority interest consisting of persons that share the financial risk of the organization. In the context of CCO governance, an entity has financial risk when it assumes risk for Medicaid health care expenses or service delivery either through contractual agreements or resulting from the administration of a global

budget. Entities are also considered at financial risk if they have provided funds that have a demonstrated risk of loss.

As part of the certification process, a CCO should articulate:

- How entities bearing financial risk for the organization make up the governing board's majority interest;
- How the governing board includes members representing major components of the health care delivery system;
- How consumers will be represented in the portion of the governing board that is not composed of those with financial risk in the organization;
- How the governing board makeup reflects the community needs and supports the goals of health care transformation; and
- The criteria and process for selecting members on the governing board, CAC and any other councils or committees of the governing board.

Community advisory council (CAC)

HB 3650 requires that each CCO convene a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership. It further requires that the CAC meets regularly to ensure that the health care needs of the consumers and the community are being met.

At least one member from the community advisory council (chair or co-chairs) will also serve on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations. There must be transparency and accountability for the governing board's consideration and decision making regarding recommendations from the CAC.

Clinical advisory panel

Potential CCOs will establish an approach to assuring best clinical practices. This approach will be subject to OHA approval, and may include a clinical advisory panel. If the CCO convenes a clinical advisory panel, this group should have representation on the governing board.

In addition, the CCO will need to address the following in its application:

- How will the CAC and any other councils or committees of the governing board support and augment the effectiveness of governing board decision making?
- What are the structures initially and over time that will support meaningful engagement and participation of CAC members, and how will they address barriers to participation?

Partnerships

HB 3650 encourages partnerships between CCOs and local mental health authorities and county governments in order to take advantage of and support the critical safety net services available through county health departments and other publicly supported programs. Unless it can be shown why such arrangements would not be feasible, HB 3650 requires CCOs to have agreements with the local mental health authority regarding maintenance of the mental health safety net and community mental health

needs of CCOs members, and with county health departments and other publicly funded providers for payment for certain point-of-contact services. OHPB directs OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.

Community needs assessment

CCOs should partner with their local public health authority and hospital system to develop a shared community needs assessment that includes a focus on health disparities in the community. The needs assessment will be transparent and public in both process and result. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, OHA is expected to work with communities and other relevant bodies such as the OHA Office of Equity and Inclusion and the Health Information Technology Oversight Council (HITOC) to create as much standardization as possible in the components of the assessment and data collection so that CCO service areas can be meaningfully compared, recognizing that there will be some differences due to unique geographic settings and community circumstances.

In developing a needs assessment, CCOs should meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community need that builds on community resources and skills and emphasizes innovation. OHA will define the minimum parameters of the community needs assessment with the expectation that CCOs will expand those as necessary to identify the needs of the diverse communities in the CCO service area. The Public Health Institute's "Advancing the State of the Art in Community Benefit" offers a set of principles that provide guidance for this work[9]:

- Emphasis on disproportionate unmet, health-related need, including disparities;
- Emphasis on primary prevention;
- Building a seamless continuum of care;
- Building community capacity;
- Emphasis on collaborative governance of community benefit.

[9] Public Health Institute, Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability. November, 2004.

Patient rights and responsibilities, engagement and choice

HB3650:

- ***Section 4(1)(a) Each member of the CCO receives integrated person-centered care and services designed to provide choice, independence and dignity.***
- ***Section 4(1)(h) Each CCO complies with safeguards for members as described in Section 8, Consumer and Provider Protections of HB 3650:***
  - ***Section 8(1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:***

  (a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

  (b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

  (c) Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

  (d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

  (e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

- ***Section 4(1)(k) Members have a choice of providers within the CCOs network and that providers participating in the CCO: (A) work together to develop best practices for care and delivery to reduce waste and improve health and well-being of members, (B) are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history, (C) emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication, (D) are permitted to participate in networks of multiple CCOs, (E) include providers of specialty care, (F) are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards, (G) work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members.***

Members enrolled in CCOs should be actively engaged partners in the design and, where applicable, implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices should be reflected in the development of treatment plans; member dignity will be respected. Under this definition, members will

be better positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against under-utilization of services and inappropriate denials of services.

In addition to any other consumer rights and responsibilities established by law, each CCO should demonstrate how it will:

- Use community input and the community needs assessment process to help determine the best methods for patient activation, with the goal of ensuring that patients act as equal partners in their own care;
- Encourage members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members;
- Engage members in culturally appropriate ways;
- Educate members on how to navigate the coordinated care approach;
- Encourage members to use wellness and prevention resources and to make healthy lifestyle choices;
- Meaningfully engage the community advisory council to monitor patient engagement and activation;
- Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities.

None of the patient rights and responsibilities identified above is intended to supplant Medicaid or Medicare law or rule.

Delivery system: access, patient-centered primary care homes, care coordination and provider network requirements
HB3650:

- ***Section 4(1)(b) Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings.***
- ***Section 4(1)(c) Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible.***
- ***Section 4(1)(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.***
- ***Section 4(1)(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health interpreters, community health workers, and personal health navigators who meet competency standards developed by the Authority.***
- ***Section 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.***

- ***Section 4(1)(j) Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.***
- ***Sec 4(1)(k)(G) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Section 4(1)(n) Each CCO participates in the learning collaborative described in ORS 442.210(3).Section 6(2) Each CCO shall implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology***.
- ***Section 6(3) Standards established by the authority for the utilization of patient centered primary care homes by CCOs may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.***
- ***Sec 20(4) 'Community health worker' means an individual who:***
  - ***c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;***
  - ***d) Assists members of the community to improve their health and increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness;***
  - ***e) Provides health education and information that is culturally appropriate to the individuals being served;***

Transformation relies on ensuring that CCO members have access to high-quality care. This will be accomplished by the CCO through a provider network capable of meeting health systems' transformation objectives. The following criteria focus on elements of a transformed delivery system critical to improving the member's experience of care as a partner in care rather than as a passive recipient of care.

<u>Patient-centered primary care homes</u>

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon's statewide standards. These standards were developed through a public process as directed by HB 2009 to advance the Triple Aim goals of better health, better care, lower costs by focusing on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's (and family's) physical and behavioral health care needs.

Building on this work, each CCO will demonstrate how it will use PCPCH capacity to achieve the goals of health system transformation including:

- How the CCO will partner with and/or implement a network of patient-centered primary care homes as defined by Oregon's standards to the maximum extent feasible, as required by HB 3650.;
- How the CCOs will require their other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, as required by HB 3650;
- How the CCO will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650, and members' experience of care and outcomes are improved (coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation);
- How the CCO's patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and services, as described in the bill, and that members are fully informed partners in transitioning to this model of care;
- How members will be informed about access to non-traditional providers, if available through the CCO. As described in HB 3650, these providers may include personal health navigators, peer wellness specialists where appropriate, and community health workers who, as part of the care team, provide culturally and linguistically appropriate assistance to members to access needed services and participate fully in all processes of care.

<u>Care coordination</u>

Care coordination is a key activity of health system transformation. Without it, the health system suffers costly duplication of services, conflicting care recommendations, medication errors and member dissatisfaction, which contribute to poorer health outcomes and unnecessary increases in medical costs.

CCOs should demonstrate the following elements of care coordination in their applications for certification:

- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care and, in the absence of full health information technology capabilities, how they will implement a standardized approach to patient follow-up;
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services;
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication;
- How they will meet state goals and expectations for coordination of care for individuals receiving Medicaid-funded long-term care services given the exclusion of Medicaid-funded long-term services from CCO global budgets.

CCO applicants should be able to describe the evidence-based or innovative strategies they will use within their delivery system networks to ensure coordinated care, especially for members with intensive care coordination needs, as follows:

- *Assignment of responsibility and accountability:* CCOs must demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions, as required by HB 3650.
- *Individual care plans:* As required by HB 3650, CCOs will use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.
- *Communication*: CCOs will demonstrate that providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities ((e.g., addressing issues of health literacy, language interpretation, having electronic health record (her) capabilities, etc.)).

Effective transformation requires the development of a coordinated and integrated delivery system provider network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. OHPB understands this work will occur over time. As each CCO develops, it will be expected to demonstrate the following:

- The CCO will ensure a network of providers to serve members' health care and service needs, meet access-to-care standards, and allow for appropriate choice for members as required by HB 3650. The bill also requires that services and supports should be geographically as close to where members reside as possible and, to the extent necessary, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.
- The CCO will build on existing provider networks and transform them into a cohesive network of providers.
- The CCO will work to develop formal relationships with providers, community health partners, and state and local government support services in its service area(s), as required by HB 3650, and how it will participate in the development of coordination agreements among those groups.

<u>Care integration</u>

- *Mental health and chemical dependency treatment:* Outpatient mental health and chemical dependency treatment will be integrated in the person-centered care model and delivered through and coordinated with physical health care services by the CCO. HB 3650 requires OHA to continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a CCO, but no later than July 1, 2013.
- *Oral health:* By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside. Shared financial accountability will encourage aligned financial incentives for cost-effectiveness and to discourage cost shifting.

- *Hospital and specialty services:* Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes and that specify the following: processes for requesting hospital admission or specialty services; and performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care.

Quality assurance and improvement

It is a continued goal of the OHA to require contracted Medicaid providers to meet established standards for quality assessment and improvement. As part of the certification process, CCOs will describe planned or established mechanisms for:

- A complaint/grievance and appeals resolution process, including how that process will be for communicated to members and providers;
- Establishing and supporting an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops;
- Participating in data collection and/or reporting for OHA accountability metrics;
- Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.

Health equity and eliminating health disparities

HB 3650:

- ***Section 2(2). The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.***
- ***Section 2(3)(b). The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including progress toward eliminating health disparities.***
- ***Sec 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.***
- ***Section 4(1)(k)(G). [Providers participating in a Coordinated Care Organization] work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Sec 19(1)(L) The authority shall: Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).***

- ***Sec 30(1)(a) Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:***
  (a) Demographics, including race and ethnicity.
  (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.

Health equity means reaching the highest possible level of health for all people. Historically, health inequities result from health, economic and social policies that have disadvantaged communities. These disadvantages result in tragic health consequences for vulnerable populations and increased health care costs to the entire system; these costs are borne by taxpayers, employers, workers and the uninsured. CCOs will ensure that everyone is valued and health improvement strategies are tailored to meet the individual needs of all members, with the ultimate goal of eliminating health disparities.

HB 3650 encourages CCOs and their associated providers to work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of members. Through their community needs assessment, CCOs will be expected to identify health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography or other factors in their service areas. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, the OHA Office of Equity and Inclusion should assist in identifying standard components (e.g., workforce) that CCOs should address in the assessment to ensure that all CCOs have a strong and comparable set of baseline data on health disparities.

CCOs will be expected to collect or maintain race, ethnicity and primary language for all members on an ongoing basis in accordance with standards jointly established by OHA and the Oregon Department of Human Services. CCOs can then track and report on any quality measure by these demographic factors and will be expected to develop, implement and evaluate strategies to improve health equity among members.

Payment methodologies that support the Triple Aim

HB 3650:

- ***Section 5(1). The OHA shall encourage CCOs to use alternative payment methodologies that: (a) reimburse providers on the basis of health outcomes and quality instead of the volume of care; (b) hold organizations and providers responsible for the efficient delivery of quality care; (c) reward good performance; (d) limit increases in medical costs; (e) use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination.***

To achieve improvements in quality and efficiency in the delivery system, it will be necessary for CCOs to move from a traditionally fee-for-service payment system to alternative methods that link payment to desired outcomes, promote patient-centered care, and compensate providers for prevention, care coordination, and other activities necessary for keeping people healthy. These methods should include transparent measurement of outcomes aligned with the Triple Aim and be guided by the principles outlined by the OHPB Incentives and Outcomes Committee in 2010:

- *Equity* - Payment for health care should provide incentives for delivering evidence-based care (or emerging best practices) to all people.
- *Accountability* - Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals.
- *Simplicity* - Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse.
- *Transparency* - Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers.
- *Affordability* (cost containment) - Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency.

In their applications for certification, CCOs will be expected to describe how they will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for their members. Examples include but are not limited to:

- Per-member per-month or other payments designed to support patient-centered primary care homes;
- Bundled payments (case rates, fee-for-service rates with risk sharing, or other) for acute episodes, or for episodes of chronic care defined by a calendar period;
- Incentives for service agreements between specialty and primary care physicians;
- Gain-sharing arrangements with providers, if volume is sufficient;
- Quality bonuses or other payment incentives for performance improvement on Triple Aim-focused quality, efficiency and outcomes metrics; and
- Incentives for the use of evidence-based and emerging best practices and health information technology.

While CCOs will have flexibility in the payment methodologies they choose to use, CCOs are encouraged to rely on previously developed and tested payment approaches where available. Efforts to create incentives for evidence-based and best practices will be expected to increase health care quality and patient safety and to result in more efficient use of health care services. To ensure successful transition to new payment methods, it will be necessary for CCOs to build network capacity and to help restructure systems and workflows to be able to respond effectively to new payment incentives.

Health information technology

HB 3650:

- ***Section 4(1)(g) Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent possible.***

OHPB requested that the Health Information Technology Oversight Council (HITOC) provide advice on appropriate health information technology (HIT) certification criteria for CCOs. In order to ensure that coordinated care delivery is enabled through the availability of electronic information to all participants, HITOC suggests that CCOs will need to develop the HIT capabilities described below. CCOs will span different provider types across the continuum of care and different geographic regions across the state, each of which is at different stages of HIT adoption and maturity. The proposed approach for achieving advanced HIT capability is to meet providers and communities where they are and require improvement over time. CCOs will ultimately need to achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and to develop their own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement and other health IT).

Electronic health records systems (EHRs)

CCOs should facilitate providers' adoption and meaningful use of EHRs. EHRs are a foundational component of care coordination because they enable providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to achieve advanced EHR adoption and meaningful use, CCOs will be expected to:

- Identify EHR adoption rates (rates may be divided by provider type and/or geographic region);
- Develop and implement strategies to increase adoption rates of certified EHRs;
- Consider establishing minimum requirements for EHR adoption over time (requirements may vary by region or provider type).

Health information exchange (HIE)

CCOs will facilitate electronic health information exchange in a way that allows all providers to exchange patients' health information with any other provider in that CCO. HIE is a foundational component of care coordination because it enables providers to access pertinent health information when and where it is needed to provide the best care possible and to avoid performing duplicative services. CCOs will be expected to ensure that every provider is:

- **Either** registered with a statewide or local direct-enabled health information service provider (HISP);
    - Direct is a way for one provider to send secure information directly to another provider without using sophisticated information systems. Direct secure messaging will be available to all providers as a statewide service. While EHR vendors will continue to develop products with increasingly advanced direct functionality, using direct secure messaging does not require an EHR system. Registration will ensure the proper identification of participants and secure routing of health care messages, and the email address provided with direct secure

messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time.

- **Or** is a member of an existing health information organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

CCOs should also consider establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

CCOs will leverage HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, CCOs should initially identify their current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in the following areas:

- Analytics (to assess provider performance, effectiveness and cost-efficiency of treatment, etc.);
- Quality reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the performance of the CCO);
- Patient engagement through HIT (using existing tools such as email, etc.);
- Other HIT (telehealth, mobile devices, etc.).

6. Global budget methodology

HB 3650:

- **Section 13(2)(b) Using a meaningful public process, the Oregon Health Authority shall develop…a global budgeting process for determining payments to CCOs and for revising required outcomes with any changes to global budgets.**

CCO global budgets are designed to cover the broadest range of funded services for the most beneficiaries possible. The construction of global budgets start with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets should include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

Once CCOs are phased in, quality incentives will be incorporated into the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

CCO global budgets will be comprised of two major components: capitated and non-capitated. The capitated portion will include funding for all services that can be disbursed to CCOs in a prospective per-member per-month payment. Initially, the capitated portion should include all services currently provided by physical health, mental health and — by 2014 if not before — dental care organizations. The non-capitated portion of the global budget calculation will be for programs and services that are currently provided outside of managed care. The CCO will receive payment and be accountable for the provision of those services.

This approach provides a flexible format that recognizes that not all current Medicaid funding lends itself neatly to a per-member per-month calculation. As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

Primary components of the CCO global budgets and shared accountability arrangements:

Medicaid services currently capitated under managed care	**Medicaid services <u>not</u> currently capitated under managed care**	**Exclusions from CCO global budgets**
Physical health services	Physical health services	Long-term care services
+ Mental health services	+ Mental health services	+ Mental health drugs
+ Oral health services (if included)	+ Medicaid-funded public health services	+ Services postponed from inclusion
Per-member per-month capitated payment	*Non-capitated portion; payment basis may vary.*	*Shared accountability for outcomes and costs may be possible.*

CCO Global Budget

Populations included in global budget calculations

With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. An overview of the eligible CCO populations and their current managed care enrollment can be found in Appendix E. Approximately, 78 percent of people who are eligible for Medicaid are enrolled in a capitated physical health plan, 88 percent in a mental health organization, and 90 percent in a dental care organization.[10] HB 3650 directs OHA to enroll as many of the remaining eligible individuals (including those who are currently in fee-for-service Medicaid) into a CCO as possible. Section 28 of HB 3650 specifically exempts American Indians, Alaska Natives and related groups from mandatory enrollment in CCOs.

Service/program inclusion and alignment

One of the primary goals of the global budget concept is to allow CCOs flexibility to invest in care that may decrease costs and achieve better outcomes. The more programs, services and funding streams that are included in CCO global budgets, the more flexibility and room for innovation exist for CCOs to provide comprehensive, person-centered care. In addition, leaving necessary care outside of the global budget creates conflicting incentives where the action of payers outside of the CCO, who have little reason to contribute to CCO efficiencies, may have an undue effect on costs and outcomes within the CCO.

In considering which Medicaid funding streams should be included in the global budget, the budget will start with the presumption that all Medicaid dollars are in the global budget (with the exception of the services explicitly excluded by HB 3650.) See Appendix F for a list of the services funded by Medicaid funds. Without exception, funding and responsibility for all current services provided by managed physical and mental health organizations as well as non-emergent transportation will be included in each CCO's global budget. The services that are currently capitated under physical and mental health organizations account for approximately 80 percent of Oregon's non-long-term care Medicaid expenditures. Non-emergent transportation represents another 2 percent of expenditures.

Currently, 5 percent of Oregon's non-long-term care Medicaid expenditures are associated with payments for dental care through DCOs. Dental expenditures will be included in global budgets based on individual CCO determination, as HB 3650 allows until July 1, 2014 to incorporate these services.

With respect to the remaining 13 percent of non-long-term care Medicaid expenditures, OHPB believes exceptions to service or program inclusion in the global budgets should be minimal. However, consideration could be given to CCO requests to postpone inclusion of one or more services or programs on the grounds that their inclusion would negatively affect health outcomes by reducing available funding, access or quality. CCOs are strongly encouraged to develop strategic partnerships within their communities in order to successfully manage comprehensive global budgets.

[10] Citizen Alien Waived Emergent Medical (CAWEM) beneficiaries and individuals who are partially dual eligible for Medicaid and Medicare—including qualified Medicare beneficiaries (QMB) and specified low-Income Medicare beneficiaries (SLMB)—are not included in this calculation.

In the case of services that are postponed or excluded from CCO global budgets, it is anticipated that CCOs will enter into shared accountability arrangements for the cost and health outcomes of these services in order to ensure that incentives are aligned in a manner that facilitates optimal coordination. HB 3650 excludes mental health drugs and long-term-care services from CCO global budgets. As described in the Accountability section below, these and other exclusions from CCO global budgets weaken incentives for coordinated care, which must be addressed.

Global budget development

The overall global budget strategy will hold CCOs accountable for costs but not enrollment growth. This strategy suggests an overall budgeting process that builds off of the current capitation rate methodology, but also includes a broader array of Medicaid services and/or programs. CCOs' first-year global budgets will include two Medicaid components:

A capitated portion that includes the per-member per-month payments for services currently provided through the OHP physical health plans, mental health organizations and (if included) dental care organizations; and,

An add-on component to the capitated portion for the remaining Medicaid services or programs not currently included in capitation payments.

Additionally, CCO global budgets will also include Medicare funding to blend with their Medicaid funding to care for individuals eligible for both programs. After the development of an initial baseline of quality and outcome data, OHA will develop a quality incentive component to the global budget methodology to reward CCOs for improved health care outcomes and controlling costs.

<u>Capitated portion of the global budget methodology</u>

At least initially, the capitated portion of CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011–13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the communities the CCOs serve.
Under this approach, potential CCOs will submit a completed base cost template using internal cost data that is representative of a minimum base population. This will not be a competitive bidding process, but OHA actuaries will review the submission for completeness and soundness in order to establish a base rate. Once a base rate is established, the state actuaries will use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

More specifically, in order to establish rates, OHA will gather estimated costs that use the most reliable cost data from potential CCOs in order to produce a base cost while addressing actuarial soundness, CCO viability and access to appropriate care. This cost data will indicate the lowest rate a CCO can accept in its base region, based on current population, geographic coverage and benefit package (the CCO Base Cost Template referenced above). OHA will use the CCO Base Cost Template as the foundation

for the CCO capitation rates. If CCOs propose to operate in geographic areas where they have little or no experience, state actuaries will use a population-based risk adjustment methodology based on the currently used Chronic Illness and Disability Payment System (CDPS), to develop the rates in these new areas.

It is anticipated that initial CCO global budget amounts be established for one year, but that stakeholders and OHA will explore the possibility of establishing global budgets that could be enacted on a biennial or multi-year basis thereafter. For subsequent years, stakeholders have indicated support for continuing to adjust payments to CCOs based on member risk profiles under the current CDPS process. Stakeholders have encouraged OHA to investigate the possibility of including pharmacy data and expanded demographic data into CDPS.

Pending direction and approval by the Legislature during the February 2012 session, it is expected that OHA carry out the following process for prospective CCOs (see Section 10 of this document for a timeline):

- Finalize CCO definition/scope and process;
- Release CCO estimated cost submission process document;
- Collect comments on estimated cost submission process document;
- Make final changes to estimated cost submission process;
- Release of CCO base cost template;
- Release notice of intent to contract as CCO;
- Collect base cost template from prospective CCOs;
- Review and certification of CCO rates;
- Conduct final review of CCO capitation rates;
- Submit CCO capitation rates to CMS;
- Submit contracts to CCOs.

CCO contractors will provide a notice of intent to contract as a CCO followed by a submission of base costs to OHA not later than the beginning of May 2012. OHA's Actuarial Services Unit will be available for technical assistance and work closely with potential CCOs to help them prepare and submit their base cost estimates. If a potential CCO declines to provide a base cost template, OHPB does not recommend certifying a capitation rate for the CCO or issuing the CCO a contract.

The CCO's submitted rates will be reviewed by OHA's actuary and assessed for reasonableness based on documentation that the CCO is capable of:

- Attaining identified efficiencies without endangering its financial solvency;
- Providing adequate access to services for its enrollees; and
- Meeting all necessary federal standards, including but not limited to explanatory notes detailing planned actions, such as initiatives to increase efficiency.

OHA's actuary will assess actuarial soundness at the CCO and region level, and will confer with the CCO regarding any questions or issues that need to be resolved. Additional calculations may be required to ensure that CCO rates in aggregate meet the 2011–2013 legislatively approved budget.

Non-capitated or supplemental portion of the Global Budget Methodology

As previously stated, the OHPB recommended approach to global budgets starts with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. The non-capitated portion of the global budget calculation will encompass programs and services that are currently provided outside of managed care. The CCO will now receive payment and be accountable for the provision of those services.

However, the board recognizes that it may not be feasible or optimal to initially wrap all Medicaid services that have been traditionally outside of managed care capitation into a per-member per-month payment calculation. This may be the case when communities provide the state matching funds for certain Medicaid services. New financing arrangements between the state, CCO and county will be needed to ensure the ability to match local funds is not compromised. In other cases, there may not be adequate experience to comfortably base a per-member per-month calculation, at least initially.

As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

Blended funding for individuals who are dually eligible for Medicare and Medicaid

In HB 3650, the Legislature directed OHA to seek federal waivers and permissions necessary to allow CCOs to provide Medicare and Medicaid services to individuals who are eligible for both programs. Inclusion of dually eligible enrollees in the CCOs and the associated Medicare funding in the global budget is important for a number of reasons. Medicare spending covers the majority of the costs for individuals who are dually eligible, and the vast majority of costs not associated with long-term care. Medicare is the primary payer for dually eligible beneficiaries, and therefore covers the preponderance of medical services. Including Medicare funding in the global budget creates a larger pool of funding to leverage and will allow CCOs to find economies of scope and scale. Including Medicare funding also will provide a significant opportunity to use these funding streams more flexibly and integrate care more effectively. Better coordination of care for Oregon's dually eligible population holds promise for better health and health care for them and lower Medicare and Medicaid spending.

Quality incentive payments

CCO global budget payments should be connected to quality metrics for both clinical processes and health outcomes. However, the board recognizes such an incentive structure will be difficult to initiate in the first year of CCO operation. So initially, metrics will be used to ensure adequate CCO performance for all programs or funding streams in the global budget and to create a data baseline. After the initial period, metrics should be used to determine exceptional performers who would qualify for incentive rewards. The board supports Oregon's discussions with CMS on developing an incentive program as early as possible and is following the progress of the Massachusetts Blue Cross/Blue Shield Alternative

Quality Contract and other new incentive models such as the Five-Star Quality Rating for Medicare Advantage plans to garner lessons that may be applied to CCO global budget development. The board has emphasized that any incentive design should include shared savings approaches so that CCOs are not penalized for successfully lowering costs.

7. Accountability

OHA accountability in supporting the success of CCOs

OHA will be an active partner in health care transformation and support CCOs by:

- Providing accurate and timely data and feedback to CCOs.
- Implementing and supporting learning collaboratives in partnership with CCOs, as required by HB 3650.
- Identifying and sharing information on evidence-based best practices, emerging best practices and innovative strategies in all areas of health care transformation, including patient engagement and activation.
- Providing technical assistance to CCOs to develop and share their own best practice approaches. OHA should develop a system to monitor the development of best practices and the accumulation of evidence supporting new practices or innovations, and should then support widespread adoption of the innovations or best practices.
- Reducing and streamlining administrative requirements.

Further, HB 3650 requires that OHA report back to the Legislature regularly on the progress of payment reform and delivery system change. It further directs OHA to publish data on quality, costs and outcomes at the CCO level.

HB 3650:

- ***Sec 2(3)(b) The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including:***
  - ***a) The achievement of benchmarks;***
  - ***b) Progress toward eliminating health disparities;***
  - ***c) Results of evaluations;***
  - ***d) Rules adopted;***
  - ***e) Customer satisfaction;***
  - ***f) Use of patient-centered primary care homes;***
  - ***g) The involvement of local governments in governance and service delivery; and***
  - ***h) Other developments with respect to coordinated care organizations.***
- ***Section 10(2) The authority shall evaluate on a regular and ongoing basis key quality measures, including health status, experience of care and patient activation, along with key demographic variables including race and ethnicity, for members in each coordinated care organization and for members statewide.***
- ***Section 10(3) Quality measures identified by the authority under this section must be consistent with existing state and national quality measures. The authority shall utilize available data systems for reporting and take actions to eliminate any redundant reporting or reporting of limited value.***
- ***Section 10(4) The authority shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, by coordinated care organization:***
  (a) Quality measures;

(b) Costs;
(c) Outcomes; and
(d) Other information, as specified by the contract between the coordinated care organization and the authority, that is necessary for the authority, members and the public to evaluate the value of health services delivered by a coordinated care organization.

CCO accountability

HB 3650:

- ***Section 10(1) The Oregon Health Authority through a public process shall identify objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCO contracts to hold the organizations accountable for performance and customer satisfaction requirements.***

Accountability for each aspect of the Triple Aim — better health, better care and lower costs — is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality and efficiency measures identified by OHA through a robust public process and in collaboration with stakeholders. CCO accountability metrics will function both to ensure that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650. Further, members and the public deserve to know about the quality and efficiency of their health care so metrics of outcomes, quality and efficiency will be publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of their community CCO.

Accountability measures for CCOs will build on OHPB committee work during the past two years, beginning with the Incentives and Outcomes Committee and followed by the Outcomes, Quality and Efficiency Metrics Work Group. The next stage of metrics development will be for OHA to establish a technical advisory group of experts from health plans, health systems and to include consumers to build measure specifications, including data sources, and to finalize a reporting schedule. This stage of the work will be completed by May 2012. Further technical work, such as establishing benchmarks based on initial data, will follow as outlined below.

<u>Measurement and reporting requirements</u>

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. In the first year, accountability will be for reporting only. In future years, CCOs will be accountable for meeting specified performance benchmarks (see accountability standards below). Initially, years will be based on the effective date of each CCO's contract; that is, year one for a CCO that starts operation in July 2012 run through June 2013 and year one for a CCO that is certified in November 2012 will run through October 2013. However, all CCOs must meet performance benchmarks by January 2014. CCOs that begin operation less than a year before that date will have a shorter reporting-only accountability period and CCOs that start on or after January 2014 will have no phase-in period at all.

Depending on the measure and data source, reports may flow from CCOs to OHA or the reverse. For example, it may be advantageous for OHA to collect member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs. While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, OHA will assess performance more frequently (e.g., quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections and rapid improvement.

Specific areas of CCO accountability metrics

Based on input from OHPB-sponsored stakeholder workgroups, CCO metrics will include both core and transformational measures of quality and outcomes:

- Core measures will be Triple-Aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. They will be uniform across CCOs and will encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health, etc.).
- Transformational metrics will assess CCOs' progress toward the broad goals of health systems transformation and will therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

The initial set of CCO accountability metrics and data sources will be established in consultation with the CMS and the technical advisory group in early 2012, in advance of the request for CCO applications. See Appendix G for examples of potential CCO accountability metrics and an example of how accountability for transformation can be shared across the system.

Accountability standards, monitoring and oversight

With the assistance of the technical advisory work group, OHA will establish two levels of CCO performance standards: minimum expectations for accountability and targets for outstanding performance. Performance relative to targets will affect CCOs' eligibility for financial and non-financial rewards. CCOs' performance with respect to minimum expectations will be assessed as part of OHA monitoring and oversight; subpar performance will lead to progressive remediation building on current accountability mechanisms for MCOs including technical assistance, corrective action plans, financial and non-financial sanctions, and, ultimately, non-renewal of contracts. (See OHA Monitoring and Oversight in the next section.) As outlined in proposed CCO criteria, CCOs will be expected to assess their own performance, to develop quality improvement plans and goals, and to demonstrate progress toward those goals over time. However, OHA will facilitate the provision of technical assistance to assist CCOs to improve their performance with respect to accountability metrics.

As with the reporting expectations, accountability standards will be introduced over time. During every phase of reporting:

- Year one — accountability for reporting only, reporting without budgetary or contractual consequences;
- Years two and three — CCOs expected to meet or exceed minimum performance expectations set for core measures and to improve on past performance for transformational measures.

Quality incentive payments may be offered after year one. The board supports Oregon's discussions with CMS to develop an incentive program as early as possible.

OHA, in cooperation with the technical advisory group described above, will use data from CCOs' first reporting periods to establish baselines and to set benchmarks for both minimum and outstanding performance using those baselines. The technical work group will also advise OHA on adopting and retiring measures or on moving "transformational" measures to the core set.

Annual review of CCO accountability metrics

The board expects that CCO accountability metrics will evolve over time based on ongoing evaluation of the metrics' appropriateness and effectiveness. OHA will establish an annual review process that draws on technical work group expertise and ensures participation from representatives of CCOs and other stakeholders, including consumers and community partners.

Shared accountability for long-term care

Medicaid-funded long-term care services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the state, creating the possibility of misaligned incentives and cost-shifting between the CCOs and the long-term care (LTC) system. Cost-shifting is a sign that the best care for a beneficiary's needs is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTC system. Other elements of shared accountability between CCOs and the LTC system will include: contractual elements, such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems through a memorandum of understanding, a contract or other mechanism; and reporting of metrics related to better coordination between the two systems.

Further, since individuals receiving Medicaid-funded LTC services and supports represent a significant population served by CCOs, CCOs should include these individuals and the LTC delivery system in the community needs assessment processes and policy development structure.

8. Financial reporting requirements to ensure against risk of insolvency

HB 3650:

- ***Section 13(3) The Authority, in consultation with the Department of Consumer and Business Services shall develop a proposal for the financial reporting requirements for CCOs to be implemented under ORS 414.725(1)(c) to ensure against the organization's risk of insolvency. The proposal must include, but need not be limited to recommendations on:***
  - ***a) The filing of quarterly [statements] and annual audited statements of financial position, including reserves and retrospective cash flows, and the filing of quarterly and annual statements of projected cash flows;***
  - ***b) Guidance for plain-language narrative explanation of the financial statements required in paragraph a) of this subsection;***
  - ***c) The filing by a CCO of a statement of whether the organization or another entity, such as a state or local government agency or a reinsurer, will guarantee the organization's ultimate financial risk;***
  - ***d) The disclosure of a CCO's holdings of real property and its 20 largest investment holdings, if any;***
  - ***e) The disclosure by category of administrative expenses related to the provision of health services under the CCO's contract with the authority;***
  - ***f) The disclosure of the three highest executive salary and benefit packages of each CCO;***
  - ***g) The process by which a CCO will be evaluated or audited for financial soundness and stability and the organization's ability to accept financial risk under its contracts, which process may include the use of employed or retained actuaries;***
  - ***h) A description of how the required statements and the final results of evaluations and audits will be made available to the public over the Internet at no cost to the public;***
  - ***i) A range of sanctions that may be imposed on a CCO deemed to be financially unsound and the process for determining the sanctions, and;***
  - ***j) Whether a new category of license should be created for CCOs recognizing their unique role but avoiding duplicative requirements by Department of Consumer and Business Services (DCBS).***

OHA will collaborate with DCBS, as required by HB 3650, to review CCO financial reports and evaluate financial solvency. HB 3650 specifies that CCOs should not be required to file financial reports with both OHA and DCBS; DCBS will be the recipient of these reporting requirements. The following section provides an overview of proposed requirements related to the above items and addresses additional information on organizational structure, corporate status and structure, existing contracts and books of business, and risk management capacities that CCOs shall report.

Audited statements of financial position and guarantees of ultimate financial risk

The Department of Consumer and Business Services defines the purpose of financial regulations of insurers as being to:

> "[E]nsure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of $2.5 million of capital and surplus for an insurer to be authorized to transact insurance. This floor increases as the company assumes more insurance risk. Capital and surplus is the amount a company's assets exceed liabilities." "Health Insurance in Oregon," DCBS; January 2009; p8

CCOs will submit financial information consistent with that required for insurers, including the use of statutory accounting principles (SAP). Application of these principles would allow for standardization of accountability and solvency assurances across health plans enrolling Medicaid, Medicare and commercial populations, and will address the CMS's interest in having organizations that enroll Medicare beneficiaries regulated by the state's Insurance Division. The filing requirements include: quarterly and annual statements of financial position using the form developed by the National Association of Insurance Commissioners (NAIC); annual actuarial certification of unpaid claim reserves, annual calculation of risk-based capital; and annual audited financial statements (using SAP). Included in the NAIC form is a schedule of retrospective cash flows and quarterly and annual statements of projected cash flows. A plain language narrative explanation of the required statements of financial position, statements of projected cash flow, and statements of the sources and uses of public funds will be developed and made publicly available as required by statue (HB 3650 Section 13(3)(b)).

A key element for monitoring financial solvency is an understanding of a CCO's relationship and transactions with its parent, subsidiaries and affiliates. CCOs will be required to submit holding company information consistent with that required for insurers. Such information would include description of any management, service or cost-sharing arrangements and an annual consolidated audited financial statement.

Further, to the extent permissible, financial information collected as required by HB 3650 should be transparent and made available online. This kind of transparency will enable the community to evaluate the financial condition of the CCO and increase confidence in the effectiveness of its governance. A high level of transparency also will enable the CCO board to take early corrective actions. It is critical that CCOs provide understandable, comprehensive and reliable information about their financial status and performance.

Financial solvency

It is expected that information from the NAIC financial reports will be used by financial analysts from DCBS and the Division of Medical Assistance Programs and by OHA's Actuarial Services Unit to track the financial solvency of CCOs as they gain (or lose) enrollment over time and build their financial reserves and other risk management measures commensurately. In addition, CCOs will be subject to periodic on-site financial examinations consistent with those performed on insurers. The factors below have been identified as gauges of a CCO's financial solvency; final financial reporting and solvency terms will be negotiated with CMS, which will participate regarding inclusion of Medicare funding for individuals who are dually eligible:

- *Risk-bearing entity*: As required by HB 3650, the CCO will identify whether the CCO itself or some other entity (such as a state or local government agency, or a reinsurer) will guarantee the CCO's ultimate financial risk, in full or in part. In some cases, CCOs may enter into contracts with hospitals, physician groups, or other providers to share in the financial risk (and rewards) associated with the difference between targeted or projected expenditures and actual expenditures. The extent to which these arrangements reduce the risk borne by the CCO itself will be factored into an actuary's determination of the CCO's reserves.
- *Reinsurance*: Provided through the state or purchased individually by CCOs, reinsurance will act to limit the financial risk of the CCO by capping its risk exposure on either a case-by-case or aggregate basis.
- *Claims reserves*: An adequate amount of liquid assets to satisfy claims liability is required of health plans providing commercial, Medicare and Medicaid coverage in Oregon. Claims reserve requirements for CCOs will be actuarially determined to reflect the CCO's enrollment level and its mix of covered lives based on rate category.
    - *Medical loss ratio*: This is the ratio of expenditures (or claims) incurred for the provision of health care services divided by total health care service revenue. Expenditure incurred for health care services is the amount paid plus the change in the unpaid claim liability. The unpaid claim liability is an estimate for claims already reported but not yet paid and an estimate of the claims for health care services used by a member that have not yet been submitted for payment.
    - *Size of the organization and risk characteristics*: Total number of insured lives and the risk characteristics across all lines of business will be considered ("risk-based capital").
    - *Enrollment level*: The predictability of CCO expenditures and the ability of the CCO to bear risk are reduced at lower enrollment levels. CMS currently requires that Medicare Advantage Plans have a minimum enrollment level of 5,000 beneficiaries. OHPB recommends that CCOs be required to file their actual and projected enrollment levels by rate category.
    - *Organizational liability*: As required by HB 3650, CCOs will be required to file a statement identifying the entity that will be the guarantor of the CCO's ultimate financial risk and any other entities or persons sharing in that risk (in addition to identifying contracting providers bound by risk-sharing agreements with the CCO).
    - *Real property, investments and executive compensation*: As required by HB 3650, each CCO will be required to disclose their real property holdings, their 20 largest investment holdings, and executive compensation. The NAIC form for annual statements includes schedules that provide details on each of these items.
    - *Operating budget*: As described below, OHPB recommends that each CCO be required to describe an annual operating budget including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting any alternative payment methodologies implemented. This operating budget will serve both to indicate the financial soundness of the CCO and to demonstrate that the CCO has developed its budget to reflect the requirements and objectives of health systems transformation.

- *Administrative expenses*: As required by HB 3650, each CCO will be required to outline, by category, administrative expenses relating to provision of services under its CCO contract. The NAIC form for annual statements includes a schedule of expenses by expense category. The expense schedule would show CCO expenses for all of its populations — those incurred under its CCO contract as well as contracts for other populations, including Medicare, PEBB, OEBB and other commercial insurance. Other schedules and note disclosures required by the NAIC form will provide information about expense arrangements with a parent or affiliate organization and detail amounts paid for such service arrangements. A comprehensive understanding of CCO administrative expenses will make possible a more accurate evaluation of the CCO's overall sustainability.

OHA monitoring and oversight

OHA must work in partnership with CCOs to ensure health system transformation success. OHA will institute a system of progressive accountability that maximizes the opportunity to succeed but also protects the public interest. Actions taken when access, quality or financial performance are jeopardizing members should be aligned with the categories that currently exist with DCBS. These categories reflect that OHA would become increasingly involved over time if an entity continues to miss performance guidelines with increased monitoring, technical assistance and supervision. To the extent permissible, OHA monitoring and oversight efforts and documents will be made public.

<u>Quality, access and financial monitoring</u>

Measures for monitoring and oversight in these areas should be aimed initially at root cause analysis and assisting the CCO in developing improvement strategies. Technical assistance for performance improvement will be the primary strategy in the first year of CCOs' operation, when their accountability will be for reporting only. Informal interim reporting (quarterly or semi-annually) will facilitate timely feedback and allow for mid-course corrections such that CCOs will be prepared to meet specified quality standards in year two, whether those standards are absolute benchmarks or expected improvement on past performance. When the evidence indicates that a CCO is not meeting performance standards, steps taken should be progressive, building on current accountability mechanism for MCOs, and may include:

- Technical assistance to identify root causes and strategies to improve;
- Increased frequency of monitoring efforts;
- Corrective action plan;
- Restricting enrollment;
- Financial penalties;
- Non-renewal of contracts.

Conversely, OHA may choose to offer a simplified, streamlined recertification or contracting process to high performing CCOs, in addition to the possibility of financial performance incentives.

If quarterly reports or other evidence suggest that a CCO's financial solvency is in jeopardy, OHA and DCBS will act as necessary to protect the public interest. These measures have two objectives: first, to

restore financial solvency as expeditiously as possible; and second, to identify the causes of the threat to solvency and implement measures to prevent such threats in the future. Actions may include:

- Increased reinsurance requirements;
- Increased reserve requirements;
- Market conduct constraints;
- Financial examinations.

The ultimate action, if no effective remedy is feasible, will be loss of licensure and liquidation of assets as necessary to meet financial obligations.

Public disclosure of information

Current DCBS rules require the public disclosure of information pertaining to licensed insurers. As required by HB 3650, OHA will ensure that CCO financial information is transparent and made available online.

CCO licensure

A new licensure category will be created for CCOs by DCBS in collaboration with OHA. This new licensure category will reflect the unique requirements and objectives of health systems transformation. This will also allow the application of certain insurance code provisions to CCOs that will allow for consistency of reporting and financial solvency and comparability among CCOs and insurers but will not subject CCOs to insurance code provisions that are not necessary given their unique contracting relationship with OHA. A separate licensure category also will facilitate the blend of flexibility and accountability that will be needed for successful implementation and operation of CCOs. DCBS and OHA staff will determine whether statutory changes are required to implement a licensure category specific to CCOs, and propose such changes through the 2012 legislative process. In the interim, existing licensure categories will be used as appropriate to the populations covered.

CCOs will be expected to provide information on corporate status, participation in the Oregon Health Plan, and other contracts:

- Corporate status: where incorporated; affiliated corporate entity or entities involved under potential CCO contract; current Department of Consumer and Business Services (DCBS) licensure/certification;
- Oregon Health Plan MCO or MHO status: current OHA MCO or MHO contractor status; organizational changes involved in CCO application; whether CCO is formed through MCO or MHO partnership; and MCO or MHO service area vs. CCO service area;
- Other state contracts: Oregon Medical Insurance Pool (OMIP); Healthy Kids/Kids Connect; PEBB; OEBB;
- Medicare contracts: CMS contracts with CCO to provide Medicare services;
- Commercial contracts: both group and individual markets;
- Administrative services or other management contracts.

Corporate assets and financial management

As part of the certification process, CCOs will provide information relating to assets and financial and risk management capabilities, including:

- Tangible net equity and other assets;
- Risk reserves, current and scheduled, based on enrollment and projected utilization;
- Risk management measures;
- Delegated risk;
- Reinsurance and stop-loss;
- Incurred but not reported (IBNR) tracking;
- Claims payment;
- Participation in the All Payer All Claims reporting program as required by Section 4(k)(L);
- Internal auditing and financial performance monitoring;
- Administrative cost allocation across books of business (including Medicaid, Medicare and commercial).

9. Medical liability

HB 3650:

- ***SECTION 16. Health care cost containment. (1) The Oregon Health Authority shall conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures, while protecting access to health care services for those in need and protecting their access to seek redress through the judicial system for harms caused by medical malpractice. The study and recommendations should address but are not limited to:***
  - ***(a) An analysis of the cost of defensive medicine within the Oregon health care delivery system and its potential budget impact, and containment and savings that would result from recommended changes.***
  - ***(b) Identification of costs within the health care delivery system, including costs to taxpayers and consumers related to care and utilization rates impacted by defensive medical procedures or medical malpractice concerns.***
  - ***(c) An analysis of utilization, testing, services ordered, prescribed or delivered through centers or facilities in which there is a financial interest between the provider requesting a test or service and the entity or individual providing the test or service, including an examination of Stark laws exceptions and exemptions.***
  - ***(d) Establishment of criteria for evaluation and reduced utilization of services and procedures where the health of those served is not negatively impacted or necessarily improved.***
  - ***(e) Identification and analysis of the benefits and impact of caps on medical liability insurance premiums as well as the benefits and potential cost saving from the extension of coverage through the Oregon Tort Claims Act to those who serve or act as agents of the state.***
  - ***(f) A path for a cap on damages for those acting on behalf of the state and serving individuals who receive medical assistance or have medical coverage through other publicly funded programs.***
  - ***(g) An examination of the possible clarifications and limitations on joint and several liability requirements for coordinated care organizations so that these organizations can assume the risk of their actions but are not liable for the actions of others within the coordinated care organization or its contracted services.***
  - ***(h) The effectiveness of binding and nonbinding medical panels in addressing claims of medical malpractice.***

(2) The authority shall coordinate with the Department of Consumer and Business Services and other appropriate agencies, including nongovernmental agencies, in order to collect and analyze the data generated by the study and to make complete recommendations to the Legislative Assembly.

(3) The authority shall secure assistance and input from stakeholder organizations in an effort to secure the best information available relevant to the impacts on administrative costs resulting from litigation, as well as to identify cost containment or cost reduction mechanisms.

(4) The authority shall focus its efforts on the medical malpractice marketplace and coverage throughout Oregon and the impact of implementing medical malpractice liability caps, in order to provide complete information to the Legislative Assembly as it studies the collective elements of health system transformation.

(5) The authority shall present the study and recommendations for addressing health care cost containment and cost reductions to the Legislative Assembly at the same time that the coordinated care organization qualification criteria and global budgeting process are presented to the Legislative Assembly for approval under section 13 of this 2011 Act.

Section 16 of HB 3650 directed the Oregon Health Authority (OHA) to conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures. Specifically, Section 16 directed the OHA to explore the costs, benefits and impacts of defensive medicine and consider several types of medical liability reform options.

To accomplish this work, OHA contracted with consultants with expertise in the areas of medical liability reform and health care data analysis and worked with the Oregon Department of Justice (DOJ) on a legal analysis of related policy. OHA also solicited input from stakeholders regarding medical liability reform options in the Oregon marketplace. Final reports for each of the analyses can be viewed at www.oregon.gov/OHA/OHPR/ by clicking on the "Documents, Reports, Presentations" page.

These analyses do not suggest that there is any single solution that will solve all the issues of the health care system. The medical liability system is a critical aspect of an efficient health care system, but it also has an impact on Oregon's work force as it relates to provider education, retention and recruitment. Further, it strains work force capacity when time is spent providing unnecessary lab or X-ray studies, or hospital stays ordered for defensive medicine purposes.

Ultimately, any reforms chosen need to balance three key factors: reduction of costs, improved patient safety, and equity for those individuals who are injured as a result of medical errors.

Therefore, OHA recommends that the appropriate body or — in the case that no appropriate body is identified, the Oregon Health Policy Board— review these studies in detail, outline advantages and disadvantages as to how options meet the desired policy goals and, as appropriate, draft legislative concepts for the 2013 Legislature. Such suggestions may include:

- Consider the key next steps for an Administrative Compensation System (ACS) in Oregon. This evaluation should include assessing the best design for such a system and include an actuarial evaluation, specifically estimating the premiums paid and the potential number of injured, including a definition of "fault" vs. "no-fault," and setting payment thresholds.
- Evaluate the suggested refinements to Oregon's Joint and Several Liability statutes and assess the feasibility of making those changes in the 2013 legislative session.
- Evaluate the feasibility and affordability of extending the OTCA or another type of liability funding arrangement for Oregon providers.
- Evaluate the viability of pursuing caps on non-economic damages, considering our current partial caps for wrongful death, prenatal and perinatal injury.
- Evaluate how CCOs could partner with hospitals in their community to adopt optimal apology and offer arrangements among their networks, and assess any needed statutory changes or other barriers to implementation.
- Evaluate the use of safe harbors through establishing a standard of care, with consideration of the results of Oregon's AHRQ grant-funded analysis of safe harbor closed-claims analysis.

10. Implementation plan

Transition strategy

In addition to accommodation through appropriate levels of flexibility, incentives to form CCOs as early as possible should be integrated into the CCO certification process. OHPB recommendations for such incentives include, but are not limited to, the following options:

- *Financial incentives*: Global budget adjustments, annual trend rates, and incentive payments or enhanced federal financial payments, if available, could be structured to support CCOs, providing financial incentives to form the new organization early. This approach provides not only strong incentives and resources for CCOs, but also underscores the urgency and priority of health system transformation.

- *Enrollment incentives*: Building sufficient enrollment to mitigate risk is essential for CCO start-up. New eligibles and those due for annual redetermination should be automatically enrolled in CCOs. This strategy will need to take into account the choice and notification of enrollees, including those eligible for both Medicare and Medicaid.

- *Flexibility incentives*: Efforts to provide flexibility in service delivery and administration should be directed first and foremost to CCOs.

- *Technical assistance and training incentives*: CCOs will benefit from the learning collaborative that OHA will establish, as required by HB 3650, and from state-level work to accumulate evidence about and disseminate information on innovative service delivery practices. If OHA successfully applies for and receives enhanced federal financial contributions for workforce training, then these funds would also be made available to CCOs that invest in developing the alternative workforce identified in HB 3650, including community health workers, peer wellness specialists, and personal health navigators.

Transitional provisions in HB 3650

In the case of an area of the state where a CCO has not been certified, Sections 13 and 14 of HB 3650 require continued contracting with one or more prepaid managed care health services organizations in good standing and already serving that area. In addition, HB 3650 requires these organizations to fulfill a substantial portion of CCO responsibilities including specific service offerings, organizational structure, patient-centered primary care homes and other system delivery reforms, consumer protections, and quality measures. Continued contracting with prepaid managed care health services organizations will reflect these statutory requirements. MCO contracts will be amended to reflect the requirements of HB 3650 parallel to the certification process for CCOs.

Implementation timeline

The sequence below indicates key time frames for MCOs and MHOs transitioning to CCO status (dates are approximate and subject to legislative and CMS approval):

Rules:

March 2012	OHA will release temporary administrative rules defining CCO criteria and other administrative rule changes as necessary.
June-September 2012	OHA administrative rules process to finalize CCO/MCO changes that include the required Rules Advisory Committee.

CCO applications:

March 2012	OHA will release CCO application, with Letter of Intent.
April 2012	CCO applicants will submit applications to demonstrate that they meet CCO criteria to OHA.
April-May 2012	OHA will evaluate CCO applications.
June 2012	OHA will certify CCOs (CMS will approve CCOs for enrollment of the dually eligible).

Contracts:

March 2012	CCO estimated cost submission process defined (including public comment process) and release of CCO Base Cost template.
April 2012	CCO applicants will submit notices of intent to contract and, subsequently, base cost estimates.
April-July 2012	State to negotiate CCO contracts and budget (CMS will participate regarding inclusion of Medicare funding for the dually eligible).
April-May:	OHA review and certification of CCO rates
May:	Final review of CCO budget
June:	CCO budget submitted to CMS
June:	Contract to CCO
July 1:	Effective date of CCO contract
July 31:	Three-way contracts signed between CCO/state/CMS (may come behind OHA contracts, as a contract amendment or rider)

Implementation:

June-August 2012	State and CMS conduct “readiness review” of certified CCOs for inclusion of the dually eligible (CMS will participate regarding inclusion of Medicare funding for the dually eligible).
July-September 2012	CCOs passing Medicare “readiness review” can begin preparing for enrolling dually eligible individuals for Medicare services.
July 2012	First CCOs enroll Medicaid beneficiaries.
July 2012	HB 3650 Sections 4, 6, 8, 10 and 12 take effect for MCOs.
Sept. 30, 2012	Current MCO contracts due for renewal.
January 2013	CCOs begin providing Medicare services to dually eligible beneficiaries.

11. Appendices

A. Managed care plan types and service areas
B. Financial projections and potential savings tables
C. Proposed Alternative Dispute Resolution (ADR) process
D. CCO Criteria Detail Matrix
E. Table of eligibles for CCO enrollment and current managed care enrollment status
F. Program list
G. Accountability framework and examples

Appendix A: Current managed care plans and service areas

Fully capitated health plans (FCHP) and physician care organizations (PCO)

Plan	Organization type	Counties served
Care Oregon, Inc.	FCHP	Clackamas, Clatsop, Columbia, Coos, Douglas, Jackson, Klamath, Lincoln, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Washington, Yamhill
Cascade Comprehensive Care, Inc.	FCHP	Klamath
DCIPA, LLC	FCHP	Douglas
Docs of the Coast South	FCHP	Coos, Curry
Family Care, Inc.	FCHP	Clackamas, Clatsop, Jackson, Josephine, Marion, Morrow, Multnomah, Umatilla, Washington
Intercommunity Health Network	FCHP	Benton, Lincoln, Linn, Tillamook
Kaiser Permanente or Plus, LLC	PCO	Clackamas, Marion, Multnomah, Polk
Lane Individual Practice Association	FCHP	Benton, Lane, Linn
Marion Polk Community	FCHP	Benton, Clackamas, Linn, Marion, Polk, Yamhill
Mid-Rogue Holding Company	FCHP	Curry, Douglas, Jackson, Josephine
ODS Community Health, Inc.	FCHP	Baker, Clatsop, Columbia, Jackson, Malheur, Union, Wallowa, Yamhill
Oregon Health Management Services	FCHP	Douglas, Jackson, Josephine
Pacific Source Community Solutions, Inc.	FCHP	Crook, Deschutes, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Sherman, Wasco, Wheeler
Providence Health Assurance	FCHP	Clackamas, Multnomah, Washington, Yamhill
Tuality Health Alliance	FCHP	Washington

Mental health organizations (MHO) and dental care organizations (DCO)

Plan	Organization type	Counties served
Access Dental Plan, LLC	DCO	Clackamas, Multnomah, Washington
Accountable Behavioral Health	MHO	Benton, Lincoln
Advantage Dental	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Malheur, Morrow, Multnomah, Polk, Sherman, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Capitol Dental Care, Inc.	DCO	Benton, Clackamas, Clatsop, Columbia, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Umatilla, Wasco, Washington, Yamhill
Clackamas Mental Health Organization	MHO	Clackamas, Hood River, Sherman, Wasco
Family Care, Inc.	MHO	Clackamas, Multnomah, Washington
Family Dental Care	DCO	Clackamas, Multnomah, Washington
Greater Oregon Behavioral Health, Inc.	MHO	Baker, Clatsop, Columbia, Douglas, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler
Jefferson Behavioral Health	MHO	Coos, Curry, Jackson, Josephine, Klamath
Lane Care	MHO	Lane
Managed Dental Care of Oregon	DCO	Clackamas, Multnomah, Washington
Mid Valley Behavioral Care Network	MHO	Linn, Marion, Polk, Tillamook, Yamhill
Multicare Dental	DCO	Clackamas, Multnomah, Washington

Plan	Organization type	Counties served
Verity Integrated Behavioral Healthcare Systems	MHO	Multnomah
ODS Community Health, Inc.	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Crook, Deschutes, Hood River, Jackson, Jefferson, Josephine, Lane, Linn, Marion, Malheur, Multnomah, Polk, Tillamook, Wallowa, Wasco, Washington, Yamhill
Pacific Source Community Solutions, Inc.	MHO	Crook, Deschutes, Jefferson, Klamath
Washington County Department of Mental Health	MHO	Washington
Willamette Dental Group	DCO	Benton, Clackamas, Clatsop, Columbia, Deschutes, Douglas, Jackson, Josephine, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Washington, Yamhill

Appendix B: HMA financial projections and savings estimates implementation of "well-managed" by program

Data are by calendar year but were prorated and accumulated into state fiscal years for the summary report.

TANF

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	351,738	$1,312,400,000	$0	$1,312,400,000	$0	$1,312,400,000	$0
2011	398,997	$1,528,000,000	$0	$1,528,000,000	$0	$1,528,000,000	$0
2012	422,055	$1,658,900,000	($12,200,000)	$1,646,700,000	($24,700,000)	$1,634,200,000	($12,500,000)
2013	430,829	$1,738,200,000	($38,900,000)	$1,699,300,000	($51,800,000)	$1,686,400,000	($12,900,000)
2014	435,565	$1,803,600,000	($67,100,000)	$1,736,500,000	($94,000,000)	$1,709,600,000	($26,900,000)
2015	444,300	$1,888,300,000	($140,600,000)	$1,747,700,000	($168,600,000)	$1,719,700,000	($28,000,000)
2016	453,200	$1,977,300,000	($220,700,000)	$1,756,600,000	($235,500,000)	$1,741,800,000	($14,800,000)
2017	462,300	$2,070,300,000	($246,500,000)	$1,823,800,000	($308,100,000)	$1,762,200,000	($61,600,000)
2018	471,500	$2,167,800,000	($258,100,000)	$1,909,700,000	($322,800,000)	$1,845,000,000	($64,700,000)
2019	480,900	$2,270,100,000	($270,300,000)	$1,999,800,000	($338,000,000)	$1,932,100,000	($67,700,000)

Disabled Non-dual

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	49,000	$745,800,000	$0	$745,800,000	$0	$745,800,000	$0
2011	50,300	$800,100,000	$0	$800,100,000	$0	$800,100,000	$0
2012	53,500	$872,300,000	($4,800,000)	$867,500,000	($9,800,000)	$862,500,000	($5,000,000)
2013	55,100	$946,200,000	($15,900,000)	$930,300,000	($21,300,000)	$924,900,000	($5,400,000)
2014	56,700	$1,024,800,000	($28,800,000)	$996,000,000	($40,200,000)	$984,600,000	($11,400,000)
2015	60,700	$1,115,600,000	($62,600,000)	$1,053,000,000	($75,100,000)	$1,040,500,000	($12,500,000)
2016	64,300	$1,214,700,000	($102,200,000)	$1,112,500,000	($108,900,000)	$1,105,800,000	($6,700,000)
2017	68,100	$1,322,500,000	($118,500,000)	$1,204,000,000	($148,300,000)	$1,174,200,000	($29,800,000)
2018	72,100	$1,440,100,000	($129,200,000)	$1,310,900,000	($161,400,000)	$1,278,700,000	($32,200,000)
2019	76,400	$1,568,000,000	($140,700,000)	$1,427,300,000	($175,800,000)	$1,392,200,000	($35,100,000)

Expansion

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	40,572	$219,500,000	$0	$219,500,000	$0	$219,500,000	$0
2011	68,806	$389,400,000	$0	$389,400,000	$0	$389,400,000	$0
2012	58,851	$348,400,000	($2,600,000)	$345,800,000	($5,200,000)	$343,200,000	($2,600,000)
2013	58,550	$362,600,000	($8,100,000)	$354,500,000	($10,800,000)	$351,800,000	($2,700,000)
2014	62,199	$402,900,000	($15,000,000)	$387,900,000	($21,000,000)	$381,900,000	($6,000,000)
2015	198,550	$1,345,300,000	($100,200,000)	$1,245,100,000	($120,100,000)	$1,225,200,000	($19,900,000)
2016	211,050	$1,495,800,000	($167,000,000)	$1,328,800,000	($178,200,000)	$1,317,600,000	($11,200,000)
2017	223,550	$1,657,300,000	($197,300,000)	$1,460,000,000	($246,600,000)	$1,410,700,000	($49,300,000)
2018	236,050	$1,830,500,000	($217,900,000)	$1,612,600,000	($272,600,000)	$1,557,900,000	($54,700,000)
2019	248,550	$2,016,100,000	($240,100,000)	$1,776,000,000	($300,200,000)	$1,715,900,000	($60,100,000)

Dual-eligibles -- Medicaid data

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	58,100	$168,300,000	$0	$168,300,000	$0	$168,300,000	$0
2011	61,600	$182,300,000	$0	$182,300,000	$0	$182,300,000	$0
2012	65,200	$201,800,000	($1,100,000)	$200,700,000	($2,300,000)	$199,500,000	($1,200,000)
2013	70,300	$227,600,000	($3,800,000)	$223,800,000	($5,100,000)	$222,500,000	($1,300,000)
2014	75,500	$255,700,000	($7,200,000)	$248,500,000	($10,000,000)	$245,700,000	($2,800,000)
2015	79,400	$281,300,000	($15,800,000)	$265,500,000	($18,900,000)	$262,400,000	($3,100,000)
2016	84,200	$314,600,000	($26,500,000)	$288,100,000	($28,200,000)	$286,400,000	($1,700,000)
2017	89,300	$351,900,000	($31,500,000)	$320,400,000	($39,500,000)	$312,400,000	($8,000,000)
2018	94,700	$393,600,000	($35,300,000)	$358,300,000	($44,100,000)	$349,500,000	($8,800,000)
2019	100,400	$440,500,000	($39,500,000)	$401,000,000	($49,400,000)	$391,100,000	($9,900,000)

Appendix C:
Alternative dispute resolution (ADR) process outline

HB 3650 required the development of a process that involves the use of an independent third party arbitrator to resolve disputes when a necessary health care entity (HCE) refuses to contract with an organization seeking to form a coordinated care organization (CCO). The process must be presented to the Legislative Assembly for approval. This outline was developed by the Oregon Health Authority (OHA), with input from an external stakeholder work group.

HB 3650 Section 8(4) to (7) provides as follows:

> (4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.
>
> (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.
>
> (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.
>
> (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.

Scope: Section 4 shows that this statutory process applies when an organization is seeking to form a CCO and participation by a health care entity (HCE) is necessary for the organization to qualify as a CCO. As a result, the proposed process is limited to the certification of CCOs and only when the HCE is necessary for the organization to qualify as a CCO. This limited scope also is consistent with the substantial statutory remedy in subsection (6) for an unreasonable refusal to contract by an HCE.

Who is qualified to serve as an arbitrator? Statute is silent about who is qualified to serve as an arbitrator in this process, except to require the "use of an independent third party arbitrator." OHA recommends that the CCO applicant and the HCE use any qualified independent third party arbitrator that they agree upon. The proposed process provides some minimal recommendations for the qualifications of the arbitrator. The arbitrator must:

- Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
- Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650.

Length of time for the arbitration process: Since Section 8 establishes this arbitration process when an organization is seeking to become qualified as a CCO, a dispute with a necessary HCE should be resolved

promptly. A timeline of 60 calendar days is recommended once an arbitration process is initiated by one of the parties. Extending the time should require the written agreement of both parties.

Process for resolving disputes under Section 8(4) to (7)

Preliminary good faith negotiations: GOAL – the parties voluntarily agree on terms and enter into contracts.

1. Organization is seeking to become certified as a CCO (Applicant) and:
   a. Applicant asserts that a health care entity (HCE) is necessary for Applicant to qualify as a CCO;
   b. An HCE asserts that its inclusion is necessary for Applicant to be certified as a CCO; or
   c. OHA, in reviewing Applicant information, identifies the HCE as necessary for Applicant to qualify as a CCO.
2. If there is disagreement between an Applicant and HCE regarding whether the HCE is "necessary," the Applicant or HCE can request review from OHA about whether the HCE may be considered "necessary" for an Applicant to qualify as a CCO.
   a. If the specific HCE is deemed by OHA as not "necessary" for Applicant to be certified as a CCO, then this specific process does not apply per Section 8.
   b. The process described below only applies where an HCE is deemed by OHA as "necessary" for the Applicant to be certified as a CCO (or the parties agree that the HCE is "necessary" for an Applicant to qualify as a CCO), in accordance with Section 8.
3. If deemed by OHA as "necessary" or the parties agree that the HCE is "necessary," the HCE and Applicant participate in contract negotiations.
   a. Goal: Applicant and HCE agree on terms and enter into a contract.
4. Request for technical assistance from OHA – voluntary.
   a. Either Applicant or HCE may request OHA technical assistance.
   b. OHA may offer technical assistance. OHA assistance will be confined to clarification of the CCO certification process and criteria, and other program requirements.
5. Before requesting referral to this dispute resolution process, the parties should take the following actions in an attempt to reach a good faith resolution between the Applicant and the HCE:
   a. The Applicant has provided a written offer of terms and conditions to the HCE and the HCE has explained to the Applicant the source of disagreement, if any.
   b. Before referral, the CFO or CEO of each organization has had at least one face-to-face meeting in a good faith effort to resolve the source of disagreement.
   c. Goal: Applicant and HCE agree on terms and enter into a contract.
6. If the Applicant and HCE are unable to reach agreement on contract terms within 10 calendar days of the HCE and Applicant face-to-face meeting in 5(b), either party can notify the other party in writing to initiate referral to an independent third party arbitrator. (At that time, the party initiating the referral will provide a copy of the notification to the OHA.) The arbitrator must:

a. Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
b. Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650.

Arbitration process: NOTE – At any point in this process, the CCO and HCE can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

1. After notification that arbitration is being initiated, the parties agree upon the arbitrator and complete paperwork required to secure the arbitrator's services – costs for arbitration to be borne by the parties. (Estimated 15 calendar days.)
    a. In consideration of potentially varied financial resources as between the parties that should not pose a barrier to the use of this process, the arbitrator should be permitted to respond to requests to allocate costs among the parties.
    b. Any changes to the time periods described in this process will require the written agreement of both parties.
2. Once referral is completed (step 1), the Applicant and HCE have 10 days to submit to each other and the arbitrator their most reasonable contract offer (10 calendar days) or submit a statement from the HCE that no contract is desired and why this is reasonable.
3. The parties then have 10 days from receipt of the other party's offer, or HCE statement that no contract is desired, to submit to the arbitrator and the other party their advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the Applicant. (10 calendar days.)
    a. Legal standards for arbitration:
        i. An HCE may reasonably "refuse to contract with a CCO if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service" – per Section 8(5).
        NOTE: Where federal or state statute or regulation establishes particular reimbursement requirements (e.g., Type A and B hospitals, federally qualified health centers, rural health centers, providers of Indian health services), those laws shall be applied.
        ii. In addition to subparagraph (i), an HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the legislative policies described in HB 3650. Some examples of facts or circumstances pertinent to what is a "reasonable" or "unreasonable" refusal to contract include, but are not limited to:

            1. Whether participation in the CCO contract imposes demands on the HCE that the HCE cannot reasonably meet without significant negative impact on HCE costs, or HCE obligations or structure, in the context of the proposed reimbursement arrangement or other CCO requirements, including, but not limited to, use of electronic health records, service delivery requirements, or quality or performance requirements.
            2. Whether refusal to contract by the HCE impacts access to covered services in the community that should be provided by the CCO. This factor alone should not be used to find a refusal to contract unreasonable, but it is recognized that HCEs and

CCOs should be encouraged to make a good faith effort to work out differences in order to achieve beneficial community objectives and the policy objectives of HB 3650.

3. Whether the HCE has entered into a binding obligation to participate in the network of a different CCO, and that HCE participation significantly reduces HCE capacity to participate in the Applicant's CCO.

4. Arbitrator determination and final opportunity to settle:
   a. The arbitrator must evaluate the final offers/statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' arguments about whether the refusal to contract is reasonable or unreasonable. (15 calendar days.)
   b. The arbitrator's determination will be provided to the parties and not disclosed publicly to the OHA for a period of 10 calendar days, to allow the parties an opportunity to resolve the contract issue themselves. (10 calendar days.)
   c. If the parties have not voluntarily reached an agreement regarding contract terms after the 10-day period, the arbitrator's decision must be released to OHA. Once released to OHA, the arbitrator's decision will be a public record, subject to protection of trade secret information if identified by one of the parties prior to submission to OHA.
   (Total time = 60 calendar days.)

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

This document reflects the statement of work and certification criteria for Coordinated Care Organizations (CCOs) that will contract with OHA under HB 3650 and has been developed through the work of the Oregon Health Policy Board and its four work groups, a series of eight community meetings around the state, public comment at the monthly Oregon Health Policy Board meetings, and comment from the legislature. **This is a working document and is for discussion purposes only.**

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Governance structure: **Each CCO has a governance structure that includes:** • **A majority interest consisting of the persons that share the financial risk of the organization;** • **The major components of the health care delivery system; and** • **The community at large, to ensure that the organization's decision making is consistent with the values of the members of the community.**	CCO will clearly articulate: • How it will meet governance structure criteria from HB 3650; • How the governing board makeup reflects community needs and supports the goals of health care transformation; • What criteria will are/were used to select for governing members; • How it will assure transparency in governance.	NA
Community advisory council: **Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of the membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met**	• A member of the CAC must sit on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations.	
Dental care organizations: **On or before 7/1/14, each CCO will have a formal contractual relationship with any DCO in its service area.**	• CCO adheres to HB 3650 requirements regarding DCOs.	• CCO enters into shared financial accountability arrangement with DCOs before 2014, to encourage aligned financial incentives for cost-effectiveness and discourage cost shifting.

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Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Partnerships: **CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.**	• OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.	
Person-centered care: **Each member receives integrated person-centered care and services designed to provide choice, independence and dignity.**	• CCO describes how it will use PCPCH capacity to deliver person-centered care per HB 3650 and ensure members are fully informed partners in transitioning to this model of care.	
Safeguards for members: **OHA shall adopt rules for member safeguards including: protections against underutilization of services and inappropriate denials; access to qualified advocates; education and engagement to help members be active partners in their own care.**	• CCO adheres to HB 3650 requirements regarding member safeguards, including access to qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers, and to applicable Medicare and Medicaid regulations not waived. • CCOs will describe planned or established mechanisms for a complaint/grievance and appeals resolution process, including how that process will be for communicated to members and providers.	

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Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Patient engagement: **CCO operates in a manner that encourages patient engagement, activation and accountability for the member's own health.**	• CCO actively engages members in the design and, where applicable, implementation of their treatment and care plans • CCO ensures that member choices are reflected in the development of treatment plans and member dignity is respected.	• CCO uses community input and the community needs assessment process to help determine the best methods for patient activation • CCO develops approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members • CCO meaningfully engages the community advisory council to monitor patient engagement and activation.
Member access and provider responsibilities: **Members have *access* to a choice of providers within the CCO's network and providers in the network:** • **Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members;** • **Are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history;** • **Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision making and communication;** • **Are permitted to participate in networks of multiple CCOs;** • **Include providers of specialty care;** • **Are selected by CCOs using universal**	CCO describes: • How it will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services; • How it will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication; • How members will be informed about access to non-traditional providers, if available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and community health workers.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
application and credentialing procedures, objective quality information; are removed if providers fail to meet objective quality standards; • **Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members.**		
<u>Member and care team</u>: **Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings.**	• CCO demonstrates how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.	
<u>Holistic care through primary care homes</u>: **Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible.**	• CCO adheres to HB 3650 requirements regarding individualized care plans, particularly for members with intensive care coordination needs. • Care plans reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.	
<u>Transitional care</u>: **Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.**	• CCO demonstrates how it will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650, and members' experience of care and outcomes are improved. Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation. • CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes.	

Appendix D: Draft matrix of suggested CCO criteria
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Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Navigating the system: **Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, community health workers and personal health navigators who meet competency standards established by the Oregon Health Authority.**	• CCO demonstrates how members will be informed about access to non-traditional providers, if available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and community health workers.	
Accessibility: **Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.**	• CCO adheres to HB 3650 requirements for access to services and supports.	
High need members: **Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency; CCO involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions.**	• CCO uses individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.	
Learning collaborative: **Each CCO participates in the learning collaborative described in ORS 442.210.**	• CCO adheres to HB 3650 requirements for participation in learning collaborative.	
Patient-centered primary care homes: **Each CCO shall implement, to the maximum extent feasible, patient-centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse**	• CCO adheres to HB 3650 requirements for patient-centered primary care homes. • CCO demonstrates how the patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and	• All members enrolled in a PCPCH; member experience of care exceeds benchmarks; PCPCH's in advanced tiers.

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.	services, as described in the bill, and that members are fully informed partners in transitioning to this model of care.	
Health equity: **Health care services focus on improving health equity and reducing health disparities.** Ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors.	• CCO identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, or other factors through community needs assessment. • CCO collects or maintains race, ethnicity and primary language for all members on an ongoing basis in accordance with standards jointly established by OHA and Oregon Department of Human Services.	
Alternative payment methodologies: **OHA encourages CCOs to use alternative payment methodologies that:** • **Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;** • **Hold organizations and providers responsible for the efficient delivery of quality care;** • **Reward good performance;** • **Limit increases in medical costs;** • **Use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination.**	• CCO describes how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for members.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Health information technology: **Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable.**	• CCO documents level of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and develops a HIT improvement plan for meeting transformation expectations. • CCO participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.	• CCO providers have EHR/HIE capacity to send and receive patient information in real time, and CCOs have the analytic capacity to assess patient outcomes of care coordination.
Outcome and quality measures: **Each CCO reports on outcome and quality measures identified by the Oregon Health Authority under Section 10 and participates in the All Payer All Claims data reporting system.**	• CCO reports and demonstrates an acceptable level of performance with respect to OHA-identified metrics. • CCO submits APAC data in a timely manner according to program specifications.	• CCO demonstrates exceptional performance with respect to identified metrics.
Transparency: **CCO is transparent in reporting progress and outcomes.**	• CCO will clearly articulate how it will assure transparency in governance. • Financial, outcomes, quality and efficiency metrics will be transparent and publicly reported and available on the internet for each CCO.	
Best practices: **Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.**	• CCO describes capacity and plans for ensuring best practices in areas identified by HB 3650. • CCO establishes a clinical advisory panel (CAP) or uses other means to ensure clinical best practices. The CAP, if one is formed, should be represented on the CCO governing board, similar to the CAC. • CCO describes plans for: an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops; and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.	

Appendix E: Overview of CCO eligible populations

Oregon Medicaid caseload for inclusion in Coordinated Care Organization (CCO) global budgets (includes managed care and fee-for-service)

Populations included in CCO global budgets	Total eligibles	Medical		Dental		Mental health	
		FCHP + PCO*	FFS	DCO	FFS	MHO	FFS
OHP Plus (categorical pops)	**362,182**	287,049	75,132	320,790	41,392	314,177	48,005
SCHIP (ages 0-18)	**58,473**	52,236	6,237	55,721	2,753	55,314	3,160
OHP Standard (1115 expansion population)	**46,206**	38,471	7,735	42,084	4,122	42,058	4,148
Fully dual-eligible	**58,675**	33,967	24,709	52,080	6,595	50,532	8,143
Subtotal	**525,537**	**411,723**	**113,813**	**470,674**	**54,862**	**462,080**	**63,456**
To be decided							
Citizen Alien Waived Emergent Medical - Prenatal	**1,138**	-	1,138	-	1,138	-	1,138
Citizen Alien Waived Emergent Medical	**22,558**	-	22,558	-	-	-	-
Breast and Cervical Cancer Program - Medical	**444**	-	444	-	444	-	444
Subtotal	**24,140**	**-**	**24,140**	**-**	**1,582**	**-**	**1,582**
Grand total	***549,677***	***411,723***	***137,954***	***470,674***	***56,445***	***462,080***	***65,039***

* FCHP - Fully capitated health plan
PCO - Physician care organization

Notes:
· Medical, dental and mental health eligibles should *not* be added together to reach totals. Rather, most beneficiaries are eligible for all three types of services and are therefore counted separately under each.
· OHP Plus includes: Temporary Assistance to Needy Families-Medical, Poverty Level Medical Adults, Poverty Level Medical Children, Aid to the Blind and Aid to the Disabled, Old Age Assistance, and Foster Care, Substitute or Adoptive Care Children.
· SCHIP includes ages 0 to 18, excludes CAWEM Prenatal.
· Eligibility categories do not include Family Health Insurance Assistance Program, Healthy KidsConnect, CHIP employer-sponsored insurance.

Staff reference:
09-11 Dec Rebal; includes FFS and managed care.

Appendix F: Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid program/services	Description	Current intermediate entity, if any (e.g., counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Physical health programs*				
Physical health coverage, including emergency transport, FCHP administrative, hospital reimbursement allowances, FQHC wraparound, and pass through.	Depending on benefit package, includes medical care from a physician, nurse practitioner or physician assistant; hospital care; hospice care; laboratory and x-ray; medical equipment and supplies; emergency medical transportation; physical, occupational and speech therapy; prescription drugs (excluding mental health drugs); vision services and other covered services.	Fully capitated health plans, physician care organizations	Y	52%
		FFS only		18%
Dental coverage, including DCO administrative**	Includes basic dental services, urgent/immediate treatment and other services.	Dental care organizations	Y	5%
Non-emergency medical transportation	Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation for Medicaid eligibles to access OHP covered services when no alternative transportation is available.	Transportation brokerages and FFS		2%
Citizen Alien Waived Emergent Medical (CAWEM)	Emergency medical services to non-citizens who are eligible for medical assistance except they do not meet the Medicaid citizenship and immigration status requirements.	FFS only		1%
Citizen Alien Waived Emergent Medical (CAWEM) Prenatal Program	Prenatal care to pregnant women who are currently only eligible for CAWEM Emergency Medical (only in select counties; voluntary enrollment only).	FFS only		<1%
Breast and Cervical Cancer Program - Medical	Provides access to medical care for low-income, uninsured, and medically underserved women diagnosed with breast or cervical cancers	FFS only		<1%
Behavioral Rehabilitation Services (leverage)	Services provided by a child care agency in a shelter, residential or therapeutic foster care placement setting to remediate psychosocial, emotional and behavioral disorders.	FFS only		<1%
Targeted Case Management (leverage)	Assists eligible clients in gaining access and effectively using medical, social, educational and other services.	FFS only		<1%

* Class 7 and 11 mental health drugs are not included in this list because House Bill 3650 excludes them from CCO global budgets. However, they are included in the total expenditures used to calculated percentages in this table.
** Dental care organizations are not required to enter into contracts with CCOs until July 1, 2014, but may do so at an earlier date.

Appendix F: Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid program/services	Description	Current intermediate entity, if any (e.g., counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Addictions and Mental Health programs				
Mental health coverage including MHO administrative	Medicaid-funded ambulatory assessment and treatments (based on the prioritized list) of mental health conditions provided in community-based settings by licensed practitioners or non-licensed personnel employed by agencies with a certificate of approval by OHA/AMH.	Mental health organizations	Y	8%
		FFS only		1%
Adult community residential mental health services	Mental health services provided in a residential setting.	CMHP		3%
Addiction health coverage	Ambulatory assessment and treatments (based on the prioritized list) of substance use disorders provided by licensed professionals or non-licensed personnel employed by agencies.	FCHPS and PCOs	Y	1%
		FFS only		<1%
Adult residential alcohol and drug treatment***	Alcohol and drug treatment provided in a residential setting.	CMHP and direct contracts w/providers		<1%
Residential mental health for non-forensic children	Mental health services provided in a residential setting.	MHO plus provider direct billing to DMAP for non-MHO enrolled children	Y	<1%
Youth residential alcohol and drug treatment ***	Alcohol and drug treatment services provided in a residential setting	None - direct contracts with all providers		<1%
Psychiatric day treatment service for children	Psychiatric day treatment service delivered in a facility-based setting.	MHO-provider direct billing to DMAP for non-MHO enrolled kids	Y	<1%
Statewide Children's Wraparound	Services and supports for children with complex behavioral health needs and their families.	MHO	Y	<1%
Personal Care 20 client-employed provider for people with mental illness	Intensive community or in-home supports to assist Medicaid-eligible, disabled individuals with activities of community living.	Client employs provider		<1%

*** Residential alcohol and drug treatment providers are not required to enter into contracts with CCOs until July 1, 2013, but may do so at an earlier date.

Appendix F: Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid program/services	Description	Current intermediate entity, if any (e.g., counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Aging and People with Disabilities	**Descriptions**			
Payment of Medicare premiums for dual-eligibles	Medicare premium payments for dual-eligibles paid by Medicaid	N/A	Y	4%
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Applicable deductibles, coinsurance and copayment amounts for dually eligible enrollees.	N/A		<1%
OHP Post-Hospital Extended Care	Provides a stay of up to 20 days in a nursing facility to allow for discharge from a hospital to a nursing facility	FFS Only	Y	<1%
Public Health	**Descriptions**			
School-Based Health Center services	Comprehensive primary care clinics that provide physical, mental and preventive health services to school-aged children in a school-based setting.	Local public health authority (LPHA)		1%
Babies First!	A Medicaid-funded nurse home visiting program for families with babies and young children up to 5, with significant health and social risks. Provides health assessments, aligns community resources, strengthens parenting skills, and improves infant health outcomes.	Local health departments		<1%
Maternity Case Management	An education and support program for pregnant women on Medicaid with social or health concerns during pregnancy to improve health outcomes.	Local health departments (DMAP provides reimbursement for MCM services to a broader community of prenatal care providers not under the public health program)		<1%

Appendix G: Principles, domains and example CCO accountability metrics

OHPB Stakeholder Work Group on Outcomes, Quality and Efficiency Metrics

Potential CCO performance measures

At a minimum, any selected performance measure should meet standard scientific criteria for reliability and face validity. Potential measures also should be evaluated against the principles below, with the goal of establishing a set of CCO performance measures that reasonably balances the various criteria. OHA should re-examine selected measures on a regular basis to ensure that they continue to meet the criteria.

Principle	Selection criteria	Change criteria
Transformative potential	○ Measure would help drive system change	○ Measure reinforces the status quo rather than prompting change
Consumer engagement	○ Measure successfully communicates to consumers what is expected of CCOs	○ Measure is not understandable or not meaningful to consumers
Relevance	○ Condition or practice being measured has a significant impact on issues of concern or focus* ○ Measure aligns with evidence-based or promising practices	○ Lack of currency — measure no longer addresses issues of concern or focus*
Consistency with existing state and national quality measures, with room for innovation when needed	○ Measure is nationally validated (e.g., NQF endorsed) ○ Measure is a required reporting element in other health care quality or purchasing initiative(s) ○ National or other benchmarks exist for performance on this measure	○ Measure loses national endorsement ○ Measure is unique to OHA when similar standard measures are available
Attainability	○ It is reasonable to expect improved performance on this measure (can move the meter)	○ CCO or entity performance is “topped out” ○ Measure is too ambitious
Accuracy	○ Changes in CCO performance will be visible in the measure ○ Measure usefully distinguishes between different levels of CCO performance	○ Measure is not sensitive enough to capture improved performance ○ Measure is not sensitive enough to reflect variation between CCOs

Feasibility of measurement	○ Measure allows CCOs and OHA to capitalize on existing data flows (e.g., state All Payer All Claims reporting program or other established quality reporting systems) ○ Data collection for measure will be supported by upcoming HIT and HIE developments	○ Burden of data collection and reporting outweighs the measure's value
Reasonable accountability	○ CCO has some degree of control over the health practice or outcome captured in the measure	○ Measure reflects an area of practice or a health outcome over which CCO has little influence
Range/diversity of measures	○ Collectively, the set of CCO performance measures covers the range of topics, health services, operations and outcomes, and populations of interest	○ There is a surplus of measures for a given service area or topic ○ Measure is duplicative ○ Measure is too specialized

* These issues include, but are not limited to: health status, health disparities, health care costs and cost-effectiveness, access, quality of care, delivery system functioning, prevention, patient experience/engagement, and social determinants of health.

Domains of measurement

OHA should assess CCO performance in these domains:

- Accountability for system performance in all service areas for which the CCO is responsible:
  - Adult mental health;
  - Children's mental health;
  - Addictions;
  - Outpatient physical;
  - Inpatient physical;
  - Women's health;
  - Dental;
  - Prevention;
  - End-of-life care.

- Accountability for transformation:
  - Care coordination and integration;
  - Patient experience and activation;
  - Access;
  - Equity;
  - Efficiency and cost control;
  - Community orientation.

Potential CCO performance measures

Examples only

Measure	Data Type	Other initiatives that use the measure
Rate of tobacco use among CCO enrollees	Survey or medical record	7
Obesity rate among CCO enrollees	Survey or medical record	
Low birth weight	Vital statistics /medical record	2
Well child visits	Claims/encounter data	2, 5, 6
Dental visits (% of members with any visit in past year)	Claims/encounter data	6, 7
Depression screening	Medical record	1, 3, 4, 5
Initiation and engagement in drug, alcohol, and mental health treatment	Claims/encounter data	3, 5, 6
Penetration rate for mental health and chemical dependence treatment	Survey and administrative data	
Cholesterol control for patients with diabetes	Medical record	5
Glucose control for diabetics	Medical record	4
Cancer screening (1 of: cervical, breast or colorectal)	Claims/encounter data	1, 2, 4, 5, 6
Effective contraceptive use and unintended pregnancy	Survey	
Chlamydia screening	Claims/encounter data	1, 2, 5, 6
Fall risk screening (older adults)	Claims/encounter data	4, 6
Service engagement (% members who received no health services at all in x period)	Claims/encounter and administrative data	
Member or patient experience with: · Getting needed care and getting care quickly · Shared decision making and participation in care planning · Care coordination · Chronic disease self-management support · Primary provider or provider team · Overall experience of care	Survey	1, 2, 4, 5, 6
Primary care-sensitive hospital admissions (AHRQ PQIs)	Claims/encounter data	1, 4
ED visits by primary diagnosis (e.g. mental health, substance abuse, dental, other)	Claims/encounter data	
Hospital acquired infection rates	CDC reporting system	
Medication management (e.g., % discharges where medications were reconciled within 7 days)		4, 6
Follow-up after hospitalization (visit within 7 days of discharge for physical or mental health diagnosis)	Claims/encounter data	1, 2, 6
Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)	Claims/encounter data	1, 4, 6
End of life care preferences (e.g. % dual eligibles or age-specified members who have a POLST form on file)	Administrative data	
Health/functional status improvement	Survey	4

1 – Medicaid Adult Core Measures
2 – CHIPRA Core Measures
3 – Medicaid Health Home Core Measures
4 – Medicare ACO Quality Measures
5 – Oregon PCPCH
6 - HEDIS
7 – National Quality Strategy

Accountability by level

Illustrative examples for discussion purposes only

Example domain: Care coordination

	CCO criteria (structure)	Process metrics	Outcome metrics	Triple Aim
Macro: **OHA**	Establish recognition process for PCPCHs Administer EHR incentive program; facilitate HIE (e.g., connect regional HIOs, Direct Project)	• # of PCPCHs recognized • % of eligible providers and hospitals meeting Meaningful Use	• % of OHA-covered lives with access to PCPCH • OHA roll-up: ambulatory care-sensitive hospital admissions • Statewide EHR adoption • Statewide HIE participation • OHA roll-up: Medication errors, duplicate testing	Better care, lower costs
Meta: **CCO**	Incorporate OHA-recognized PCPCHs into CCO network Support clinical information exchange among CCO providers (e.g., act as or participate in regional HIO; use Direct)	• Member experience of care coordination (e.g., shared decision making composite) • % members with individual care plan • Medication management — % members with medications reconciled within 7 days of hospital discharge	• Rate of ambulatory care-sensitive hospital admissions • Member experience of care overall • Medication errors • Duplicate testing	Better health, lower costs Better care
Micro: **Practice or provider**	Implement PCPCH standards, seek recognition Identify, track and proactively manage patient care electronically using up-to-date information	• % members assigned to personal provider or team • Screening for depression and follow-up plan	• Benchmark for continuity of care • % patients showing improvement on clinically valid depression tool	Better care Better care, lower costs

Collected by OHA

Forecasted Average Monthly Caseload for 2011-2013 Biennium; Includes Managed Care and Fee-For-Service

	Total	Medical		Dental		Mental Health	
Populations Included in CCO Global Budgets	**Eligibles**	**FCHP + PCO***	**FFS**	**DCO**	**FFS**	**MHO**	**FFS**
OHP Plus (Categorical Pops)	**419,390**	345,012	74,378	389,398	29,992	371,350	48,040
SCHIP (ages 0-18)	**72,713**	63,410	9,303	67,845	4,868	61,584	11,129
OHP Standard (1115 Expansion Population)	**59,612**	50,680	8,932	54,211	5,401	54,056	5,556
Fully Dual Eligible	**65,360**	35,024	30,336	58,906	6,454	57,888	7,472
Breast and Cervical Cancer Program - Medical	**638**	-	638	-	638	-	638
Subtotal	**617,713**	**494,126**	**123,587**	**570,360**	**47,353**	**544,878**	**72,835**
Optional Populations							
Citizen Alien Waived Emergent Medical - Prenatal	**1,728**	-	**1,728**	-	**1,728**	-	**1,728**
Subtotal	**1,728**	**-**	**1,728**	**-**	**1,728**	**-**	**1,728**
Grand Total	***619,441***	***494,126***	***125,316***	***570,360***	***49,082***	***544,878***	***74,563***

* FCHP - Fully Capitated Health Plan
PCO - Physician Care Organization

Notes:

- Medical, Dental and Mental Health eligibles should *not* be added together to reach totals. Rather, most beneficiaries are eligible for all three types of services and are therefore counted separately under each.
- OHP Plus includes: Temporary Assistance to Needy Families-Medical, Poverty Level Medical Adults, Poverty Level Medical Children, Aid to the Blind and Aid to the Disabled (without Medicare), Old Age Assistance (without Medicare), and Foster Care, Substitute or Adoptive Care Children.
- SCHIP includes ages 0 to 18, excludes CAWEM Prenatal.
- Eligibility categories do not include Family Health Insurance Assistance Program, Healthy Kids Connect, CHIP Employer-Sponsored Insurance.

Staff reference:
11-13 Fall 2011 Rebal; includes FFS and Managed Care.

Appendix E State Fund Only Program List

Community Mental Health Program	
20 Non-Residential Adult	$8,106,392
22 Child and Adolescent	$680,649
24 Regional Acute Psychiatric Inpatient	$14,185,239
25 Community Crisis	$10,208,134
27 Residential Treatment for Youth	$241,446
34 Adult Foster Care	$406,568
35 Older/Disabled Adult	$587,176
37 Special Projects	$4,323,061
38 Support Employment	$723,108
39 Homeless	$500,000
28 Residential Treatment	$15,010,022
201 Non-Residential Adult (Designated)	$560,803
Total CMH Program	**$55,532,595**
Alcohol and Drug Treatment Program	
01 Local Admin	
60 A & D-Special Projects	$1,902,603
61 A & D Residential Treatment - Adult	$4,049,316
66 Continuum of Care	$10,397,186
Total A&D Treatment Program	**$16,349,105**
State Hospitals (OSH and BMRC)	
- Civil	31,845,689
- Forensic	94,397,533
- Gero-Neuro	13,687,590
Total Oregon State Hospital	**$139,930,811**
Children, Adults and Families	
System of Care	$ 1,162,626
Community Based Sexual Assault	$ 36,600
Community Based Domestic Violence	$ 198,966
Youth Investment Program	$ 194,075
Family Based Services	$ 3,687,007
Foster Care Prevention	$ 261,272
Regular Foster Care	$ 5,339,250
Enhanced Supervision	$ 2,219,528
Client Transportation	$ 1,331,619
Independent Living Services	$ 224,058
Nursing Assessments	$ 8,348
Foster Family Shelter Care	$ 1,220,850
Other Medical	$ 1,449,526

IV-E Waiver (Demo Project for Parenting, mentoring, enhanced superv	$	33,995
Contracted Foster Care	$	79,133
Interstate Compacts	$	139,801
Personal Care	$	419,306
Tribal	$	25,869
Residential Treatment	$	4,229,340
Target Children	$	1,200,382
Total CAF	**$**	**23,461,546**
Seniors and Persons with Disabilities:		
Oregon Project Independence	$	4,592,500
Oregon Supplemental Income Program	$	2,895,000
SE #150 Family Support	$	1,254,500
SE #151 Children Long-Term Support	$	2,732,880
SE #45 Nursing Facility Special Services	$	83,608
Total SPD	**$**	**11,558,488**
Public health services vital for healthy communities		
Emergency Medical Services	$	1,950,000
Vaccine Purchase	$	2,250,000
General Microbiology	$	420,863
Virology	$	440,229
Lab Compliance	$	11,467
Chlamydia	$	800,000
Other Test Fees	$	150,000
Newborn Screening	$	2,400,000
Prescription Drug Monitoring Program	$	800,000
HIV Community Services	$	575,000
HST (HIV/Sexually Transmitted Disease/Tuberculosis)	$	1,488,042
Sexually Transmitted Disease	$	60,000
Total Public Health	**$**	**12,695,600**
Other Programs Supporting Transformation		
Oregon Medical Insurance Pool	$	219,947,958
Undergraduate and graduate education -OHSU		27,989,281
Department of Community Colleges and Workforce Development:		
One-year health services certificates	$	18,760,000
AAS (two-year) health services degrees	$	47,400,000
Oregon University System:		

Enrollment Funding for Health Professions		$7,932,612
Health Professions - Targeted Program		$2,933,018
Collaborative Nursing - Targeted Program		$88,610
Department of Corrections:		
Drug and Alcohol Treatment	$	6,841,106
Mental Health Treatment	$	15,044,154
Oregon Youth Authority:		
Drug and Alcohol Treatment	$	2,900,000
Mental Health Treatment	$	5,500,000
Total Other Programs Supporting Transformation	**$**	**107,399,499**

TOTAL STATE FUND ONLY PROGRAMS	**$**	**446,944,790**

Appendix F **Initial Proposed CCO Accountability Metrics (transparency metrics also listed)**

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
1. Experience of Care*^ – Key domains TBD from member experience survey (version TBD and may alternate by year) *Domain(s):Member experience & activation* *Data type: Survey (collected by OHA)* *Also part of:* Medicaid Adult Core, CHIPRA, Medicare ACOs, Medicare Part C, OR PCPCH, others 2. Rate of tobacco use among CCO enrollees*^ *Domain(s): Prevention, outpatient physical, overall health status, cost control* *Data type: Survey* *Also part of: Nat'l Quality Strategy* 3. Access – Outpatient and ED utilization per member-month*^ *Domain(s):Access, community engagement* *Data type: Claims/encounter* *Also part of: CHIPRA Core, NCQA HEDIS* 4. BMI assessment & follow-up plan*^ / Weight assessment and counseling for children and adolescents *Domain(s): Prevention, outpatient physical* *Data type: Medical record* *Also part of: Medicare ACOs, OR PCPCH, CHIPRA* 5. Screening for clinical depression and follow-up plan^ *Domain(s):Mental health* *Data type: medical record* *Also part of: Adult Medicaid Core, Medicare ACOs*	1. Rate of early childhood caries *Domain(s):Oral health* *Data type: Medical record* *Also part of: HP 2020* 2. Wrap-around care for children – **TBD** (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure) *Domain(s):Care coordination, mental health* *Data type: TBD* *Also part of: TBD* 3. Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method *Domain(s):Women's health, prevention* *Data type: Survey* *Also part of:* 4. Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined) *Domain(s):End-of-life care, care coordination* *Data type: Administrative or medical record* *Also part of: Pending* 5. Health and functional status – (1) % members who report the same or better mental and physical health	CMS Adult Core Measures including: · Flu shots for adults 50-64 · Breast & cervical cancer screening · Chlamydia screening · Elective delivery & antenatal steroids, prenatal and post-partum care · Annual HIV visits · Controlling high BP, comprehensive diabetes care · Antidepressant and antipsychotic medication management or adherence · Annual monitoring and for patients on persistent medications · Transition of care record CHIPRA Core Measures including: · Childhood & adolescent immunizations · Developmental screening · Well child visits · Appropriate treatment for children with pharyngitis and otitis media · Annual HbA1C testing · Utilization of dental, ED care (including ED visits for asthma) · Pediatric CLABSI · Follow up for children prescribed

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
6. Alcohol misuse - Screening, brief intervention, referral for treatment (SBIRT)^ *Domain(s):Addictions* *Data type: medical record* *Also part of: OR PCPCH* 7. Initiation & engagement in of alcohol and drug treatment^ *Domain(s):Addictions* *Data type: Claims/encounter* *Also part of: Medicaid Adult Core, HEDIS, Meaningful Use, OR PCPCH* 8. Low birth weight <u>or</u> adequacy of prenatal care *Domain(s):Overall health status, MCH* *Data type: Claims/encounter* *Also part of: CHIPRA* 9. Primary-care sensitive hospital admissions (PQIs) for chronic conditions like diabetes, asthma, CHF, and COPD*^ *Domain(s): Outpatient physical, prevention, cost control* *Data type: Encounter/hospital discharge* *Also part of: Adult Medicaid Core, Medicare ACOs* 10. Healthcare-acquired conditions – TBD *Domain(s):Inpatient care* *Data type: Clinical* *Also part of: CDC and OR HAI reporting, Medicare value-*	status than 1 year ago*; (2) % members with Medicaid LTC benefit with improvement or stabilization in functional status *Domain(s): overall health outcomes* *Data type: Survey* *Also part of: Medicare ACOs, MA star ratings(1), SNP(2)* 6. ED visits – Potentially avoidable or other categorization TBD (*^) *Domain(s):Outpatient physical, care coordination, cost control* *Data type: Claims/encounter* *Also part of: TBD* 7. Access - % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members *Domain(s):Access, coordination and integration* *Data type: Survey* *Also part of: Unknown* 8. Improvement on disparities in health status or quality of health care identified by CCO in community needs assessment *Domain(s):Equity, cost control, potentially others* *Data type: mixed* *Also part of: Unknown* 9. Community Orientation - TBD	ADHD medications SAMSHA National Outcome Measures including: · Improvement in housing (adults) · Improvement in employment (adults) · Improvement in school attendance (youth) · Decrease in criminal justice involvement (youth) Others TBD, for example: · Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc. · Initiation and engagement of mental health treatment

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
based purchasing, CHIPRA 11. Follow-up after hospitalization^ - % of members with follow-up visit within 7 days after hospitalization for mental illness *Domain(s):Care coordination* *Data type: Claims/encounter* *Also part of: Adult Medicaid Core* 12. Readmission rates: (1) Plan all-cause readmissions*^; (2) readmissions to psychiatric care^ *Domain(s):Care coordination, cost control* *Data type: Claims/encounter* *Also part of: Adult Medicaid Core, Medicare ACOs* 13. High needs care coordination – TBD (e.g. % of members identified as high need assigned to intensive care coordination) *Domain(s):Care coordination* *Data type: TBD* *Also part of: TBD* 14. Medication management –TBD *Domain(s):Care coordination* *Data type: TBD* *Also part of: TBD* 15. MLR - % of global budget spent on health care and services *Domain(s):Efficiency, cost control*	*Domain(s):TBD* *Data type: TBD* *Also part of: TBD* 10. Timely transmission of transition record - % of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours *Domain(s):Care coordination* *Data type: Attestation* *Also part of: Adult Medicaid Core*	

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting , evaluation, etc.
Core Measures	**Transformational Measures**	
Data type: Administrative *Also part of: Unknown*		
CCO-LTC System Joint Accountability Measures		
1. Care planning - % of members with Medicaid-funded LTC benefits who have a care plan in place. *Domain(s):Care coordination* *Data type: Administrative* *Also part of: Pending*	1. Transitions of care - % of LTC patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the care manager or AAA/APD within 1 business day *Domain(s):Care coordination* *Data type: Administrative* *Also part of: Unknown*	

* Report separately for members with severe and persistent mental illness

^ Report separately for individuals with Medicaid-funded Long-Term Care (LTC) benefit

Duals / Medicare 3-way Contract Accountability Measures – TBD pending negotiation with CMS

- Additional measures may apply related to quality and experience, outcomes, etc. for dually eligible individuals
- These measures will be determined in consultation with CMS by June 2012.
- Rewards for strong performance on these measures would come in part from the incentives that CMS has specified as part of the state demonstration to integrate care for dually eligible individuals, possibly in the form of a quality withhold.

Appendix G **CCO Proposed Measures--Crosswalk to Medicaid Adult Core Set, CHIPRA Core Set, and Medicare ACO Set**

NQF ID	Measure owner	Measure name	CCO Measures		Medicaid Adult Core	Medicare ACOs	CHIPRA Core
			Core	Transform-ational			
Access / Availability							
	NCQA/ HEDIS	% of children & adolescents (12 mo - 19 yrs) with visit to primary care pracitioner (4 breakdowns)					X
	NCQA/ HEDIS	Ambulatory care: Outpatient and ED visits per member month	X				X
		ED visits – Potentially avoidable or other categorization TBD		X			
		Access to specialty care: % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members		X			
		Measure of community orientation TBD		X			
Experience of Care, Patient & Family Engagement							
0007	AHRQ	CAHPS Health Plan Survey (adult, child, children with special healthcare conditions, etc.)	X - (Specific instrument and domains TBD)		X		X
0005	NCQA	CG CAHPS - Timeliness - Doctor Communication - Rating of Doctor - Access to specialists - Health promotion & education - Shared decision-making				X	
0006		Self-reported Health Status/Functional Status from Medicare Advantage HOS	Under consideration -			X	
		Improvement in functional status	Under consideration - Transformatio				
Care Coordination, including transitions & medication management							
0097	NCQA	Medication Reconciliation: Reconciliation after discharge from an inpatient facility (acute inpatient or psychiatric)	Under consideration			X	
0021	NCQA	Annual Monitoring for Patients on Persistent Medications (ACE inhibitors or ARBs, digoxin, dieuretics, anti-convulsants)			X		
0648	AMA-PCPI	Timely Transmission of Transition Record to Health Professional (Inpatient Discharges to Home/ Self-Care or Any Other Site of Care).		Under consideration	X		
	NCQA/ HEDIS	Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase)					X
0576	NCQA	Followup After Hospitalization for Mental Illness	X		X		X
NA ...	NCQA	Plan All-Cause Readmission rate (also report separately for psychiatric)	X		X	X	
		High needs care coordination TBD - e.g. % of members identified as high need assigned to intensive care coordination	X				
		Wrap-around care for children – TBD (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure)		X			
Physical Health Screenings, Immunizations, Prevention							
Children							
0038		Childhood immunization status at 2 years (incl Tdap, polio, MMR, HiB, Hep A, Hep B, chicken pox, pneumococcal, rotavirus, and flu)					X
NA	NCQA	Adolescent immunizations - 13 year olds (incl meningococcal, Tdap or Td)					X
NA	NCQA/ HEDIS	% patients with all recommended well child visits to 15 mos					X
NA	NCQA/ HEDIS	Well-child visits years 3-6 (% 3-6 year olds with a well-child visit during measurement year)					X
NA	NCQA/ HEDIS	Adolescent well-care: % patients age 12-21 with at least on well-case visit to PCP or OB-GYN during measurement year					X
NA	CAHMI	% of patients w/ at least one validated developmental screening tool (ASQ, MCHAT, etc) by 36 mos					X

NQF ID	Measure owner	Measure name	Core	Transform-ational	Medicaid Adult Core	Medicare ACOs	CHIPRA Core
0024		Child/Adolescent weight screening	X				X
Adults							
421/ other	CMS	Adult BMI/Weight Screening (and follow-up)	X		(X)	X	X
0039, 0041	NCQA	Flu Shots for Adults Ages 50 and above			X	X	
0043, 0044		Pneumococcal Vaccination (ages 65 and over)				X	
0027, 0028	NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (age 18+)			X	X	
		Rate of tobacco use among members	X				
0031	NCQA	Breast Cancer Screening (women 40-69; mammography within last 24 months)			X	X	
0032	NCQA	Cervical Cancer Screening			X		
0034		Colorectal cancer screening (50-75 years)				X	
0033		Chlamydia screening			X		X
0101	NCQA/ HEDIS	Fall risk screening - % patients age 65 and older screened for fall risk within 12 months				X	
Behavioral Health Screening and Treatment							
NA ...	RAND	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment (SBIRT)	X				
0418	CMS	Screening for Clinical Depression and Follow-up Plan	X		X	X	
0004	NCQA/ HEDIS	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X		X		
0105	NCQA	Antidepression Medication Management			X		
NA ...	CMS-QMHAG	Adherence to antipsychotics for individuals with schizophrenia			X		
Maternal & Child Health							
		Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method		X			
	NCQA/ HEDIS	Frequency of ongoing prental care (% distribution of pregnancies in previous year by completion of expected prenatal visits)	Under consideration				X
	NCQA/ HEDIS	Prenantal and Post-partum care: Timeliness of prenatal care (% live births where prenatal care started in first trimester OR within 43 days of enrollment)					X
0469	Hospital Corp. of America	Elective delivery prior to 39 completed weeks gestation			X		
	CA	Cesarean rate: % of women with first, live, singleton birth (not breach) who had cesarean					X
	CDC	Low birth weight (<2,500g) births as % of total	Under consideration				X
0476	Providenc e	Appropriate Use of Antenatal Steroids.			X		
1391	NCQA/ HEDIS	Prenatal and Postpartum Care: Postpartum Care Rate			X		
Management of Chronic Conditions							
Ambulatory-care sensitive hospital admissions							
0272	AHRQ	PQI 01: Diabetes, short-term complications	X (tentative)		X		
0273	AHRQ	PQI 02: Perforated appendicitis					
0274	AHRQ	PQI 03: Diabetes, long-term complications					
0275	AHRQ	PQI 05: Chronic obstructive pulmonary disease	X (tentative)		X	X	
0276	AHRQ	PQI 07: Hypertension					
0277	AHRQ	PQI 08: Congestive heart failure	X (tentative)		X	X	
0280	AHRQ	PQI 10: Dehydration					
0279	AHRQ	PQI 11: Bacterial pneumonia					
0281	AHRQ	PQI 12: Urinary Tract Infection Admission Rate					
0282	AHRQ	PQI 13: Angina without procedure.					
0638	AHRQ	PQI 14: Uncontrolled Diabetes Admission Rate					
0283	AHRQ	PQI 15: Adult asthma.	X (tentative)		X		
0285	AHRQ	PQI 16: Lower extremity amputations among patients with diabetes					
Cardiovascular Disease, Diabetes, Asthma, Heart Failure, Etc.							
	CMS	BP Screening - % adults 18+ with BP measured in last 2 years				X	

NQF ID	Measure owner	Measure name	Core	Transform-ational	Medicaid Adult Core	Medicare ACOs	CHIPRA Core
0018	NCQA	Controlling High Blood Pressure (% 18-85 years with hypertension diagnosis whose blood pressure is < 140/90 mm Hg)			X	X	
0074	AMA-PCPI	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol.				X	
0075	NCQA	Comprehensive Ischemic Vascular Disease Care: Complete Lipid Profile and LDL-C control rates.				X	
0068		Use of aspirin or other antithrombotic for Ischemic Vascular Disease				X	
0066		ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)				X	
0063	NCQA	Diabetes: Lipid profile.			X		
0057/ other	NCQA	Hemoglobin A1c testing			X		X
0059	NCQA	Diabetes: poor control (HbA1C > 9)				X	
0729		Diabetes composite (Hemoglobin A1c Control (<8%); Low Density Lipoprotein (<100); Tobacco Non Use; Blood Pressure <140/90; Aspirin Use)				X	
0083	AMA-PCPI	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)				X	
		Annual number of asthma patients (> 1 year-old) with > 1 asthma related ER visit					X
Other							
0403	NCQA	HIV/AIDS: Annual medical visit.			X		
Management of Acute Conditions + Safety							
0002	NCQA	Appropriate testing for kids with pharyngitis: % of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode					X
	AMA-PCPI	Otitis Media with Effusion - avoidance of inappropriate use of systemic antimicrobials					X
0298		Health Care Acquired Conditions - TBD	X				X (CLABSI)
Dental							
	CMS (EPSDT)	Preventive dental services: % of eligibles age 1-20 who received preventive service					X
	CMS (EPSDT)	Dental Tx: % of eligibles age 1-20 who received dental treatment services					X
		Rate of early childhood caries		X			
HIT Use / Capacity							
	CMS	% of PCPs who successfully qualify for Meaningful Use incentive				X	
Efficiency							
		MLR - % of global budget spent on health care and services	X				
Equity							
		Improvement on disparities (# TBD) in health status or quality of health care identified by CCO in community needs assessment		X			
End-of-Life Care							
		Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined)		X			

Federal authority to implement Coordinated Care Organizations (CCO) and Transform Managed Care Organizations (MCO) in Oregon
Summary

In addition to Oregon's existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow the following:

Potential new waiver authorities

Issue	CFR/SSA Reference
• Flexibility to make payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement • Alternative provider payment methodologies to reimburse on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care, and comprehensive care coordination • Flexibility to create PMPM payments to support Patient Centered Primary Care Homes for the remaining FFS Medicaid/SCHIP populations that do not meet the ACA sec. 2703 multiple chronic condition requirements. *(Oregon has submitted a SPA for the ACA Sec. 2703 population)* • Latitude to set rates inclusive of non-encounterable medical services (1902(a)(30)) • Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community • Latitude to set a sustainable fixed rate of per capita cost growth within CCO global budgets • Flexibility in design, implementation and scoring of performance improvement plans (PIPS) to align with Medicare processes	42 CFR § 438.6
• An alternative payment methodology for FQHCs to allow a unique FQHC prospective payment system (PPS)/alternative payment methodology (APM)	SSA § 1902(bb)
• Expansion of definition of "health care professional" expansion to include naturopathic physicians and other state-licensed providers	42 CFR § 438.2
• Flexibility for the state to optimize the use of electronic communications to OHP members where written materials are required, at member's request, as well as contractors and providers	42 CFR §422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230, CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708,

Issue	CFR/SSA Reference
	722; 42 CFR § 455.1; 42 CFR § 489
• Flexibility in marketing requirements for CCOs that serve Medicaid, Medicare, and commercial populations	42 CFR § 438.104
• Ability to streamline and simplify due process rights to reflect person-centered primary care and to align Medicaid and Medicare consumer protection processes to the greatest extent possible (1902(a)(3))	42 CFR § 438.400-424 42 CFR § 431.244
• Ability to fold non-emergency medical transportation into global budget in first contract year. This program is under a 1915(b) waiver.	42 CFR § 431.53; SSA § 1915(b)

Potential new expenditure authorities

Issue	CFR/SSA Reference
Federal financial participation (FFP) for designated state-funded health care programs (DSHP)	
An additional 6 percentage points in federal medical assistance percentage (FMAP) for current HCBS waivers	
County intergovernmental transfers as partial state match	

Potential changes to 1115 Demonstration Special Terms and Conditions (STC) narrative where no waivers are necessary

- Changes in selection and contracting policies and procedures
- Description of integrated delivery system elements such as coordinated care teams that include non-traditional providers and other workers, and streamlined referral and prior authorization procedures for those who use specialty care
- Network adequacy criteria
- Medicaid enrollment processes applicable to clients eligible for both Medicaid and Medicare under current waiver authority
- Changes in Medicaid appeals and other consumer protections processes to integrate with Medicare protections
- The Medicaid impact of the streamlining of Medicare/Medicaid EQRO reviews

Medicaid State Plan Amendments related to Health Systems Transformation

- Non-traditional workforce – e.g. CHW, personal health navigators, peer wellness specialists and doulas
- Patient-centered primary care homes (PCPCH)
- To restructure the FQHC alternative payment system (APM) under the CCO structure

Appendix I Federal authority to implement Coordinated Care Organizations (CCO) and Transform Managed Care Organizations (MCO) in Oregon[1]

Issue	Change needed- Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
CCO selection and contracting	• Request for Applications (RFA) much like the process developed by the federal government for Medicare Advantage plans • Ability to contract with CCO entity, adding the CCO delivery system to the State's current managed care delivery system	• 42 CFR 431.50– Statewide-ness and uniformity • 42 CFR § 431.51– freedom of choice	• State has a *waiver in place* (of 42 CFR 431.50) for contracting with managed care entities and other insurers. • State believes this would apply to CCOs. • State has a *waiver in place* (of 42 CFR 431.50) to allow local variation in service delivery.	• *State's 1115 Demonstration Special Terms and Conditions will reflect* changes in selection and contracting policies and procedures.		State will address selection and contracting provisions in Request for Application (RFA) approval process.

[1] The preamble to 42 CFR, part 438, specifies that states that had 1115 Demonstrations in place prior to the passage of the Balanced Budget Act (1997) and part 438, and whose waivers have continued to be renewed, will have continuing waiver authority under the ongoing demonstrations. Thus, Oregon will not need additional waivers of part 438 provisions that are covered by previous waiver authority under the SSA or parts other than 438 of the Code of Federal Regulations (CFR). The state must act in accordance with provisions in part 438 that are not currently waived, or seek additional waivers if necessary.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Delivery systems • Inclusive physical, • Integrated care, ○ Hospital care ○ Specialty care ○ Services provided ○ Patient-centered	• Single integrated, inclusive systems • CCO prioritizes working with members with high health care needs, multiple chronic conditions, mental illness or chemical dependency. • Patient-centered primary care homes (PCPCH) • Ability to establish per member/per month (pm/pm) payment for care coordination under PCPCH for clients who do not experience multiple chronic conditions (as described in the ACA, section 2703) • Use of non-traditional workforce	• 42 CFR 431.51– Freedom of choice • SSA § 1902(a)(10)– services required • 42 CFR § 438.12 provider discrimination prohibited • 42 CFR §438.608 and §610– program integrity • 42 CFR § 438.2– definitions	• State has a *waiver in place* (of 42 CFR 431.51) to allow: ○ Mandatory enrollment and auto-enrollment in managed care delivery system; ○ State to define the types of insurers to include in the delivery system; and ○ State to offer Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services only where available	• *Potential 1115 Demonstration amendment* to allow PMPM payments to support Patient Centered Primary Care Homes for Medicaid/SCHIP populations that do not meet the ACA sec. 2703 multiple chronic condition requirements as described in the ACA, section 2703 • as described in the ACA, section 2703. • *State's 1115 Demonstration Special Terms and Conditions will reflect*	• Patient-centered primary care homes (PCPCH) – (SPA submitted) • Non-traditional workforce – e.g. CHW, personal health navigators, peer wellness specialists and doulas (SPA in progress)	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
(PCPCH) ○ Care coordination ○ Special continuity of care services for vulnerable populations	• Flexibility for local system design elements and local governance based on community needs assessments	• 42 CFR § 438.214– provider selection, credentialing and non-discrimination • 42 CFR § 440.168– Primary care case management	through managed care providers. • State has a *waiver in place* (of 42 CFR 431.50) to allow local variation in service delivery.	the description of integrated delivery system elements such as coordinated care teams that include non-traditional providers and other workers and streamlined referral and prior authorization procedures for those needing specialty care.		
Global budget • Integrated funding for physical, dental, mental health and chemical dependency, possibly to include other Medical Assistance programs– e.g. School-Based	• Development of rates in tandem with CCOs based on spending and anticipated shared savings • Plan and provider accountability • Multiple integrated	• 42 CFR § 438.6– actuarial soundness– Capitation rates must not include		• *Potential 1115 Demonstration amendment* to integrate funding • *Potential 1115 Demonstration amendment* due to	• State has a SPA in progress to restructure the	• Pre-approval of rate-setting methodology would serve as the basis for the Global Budget.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Health Center Services, Babies First!, Maternity Case Management, non-emergency medical transportation	funding sources • Ability to pay for non-encounterable medical services – expanded understanding of *actuarial soundness* • Blended Medicare and Medicaid funding through 3-way contract for dually eligible individuals • Ability to establish per member/per month (pm/pm) payment for care coordination under PCPCH for clients who do not experience multiple chronic conditions as described in the ACA, section 2703	services plans perform outside contract. • 42 CFR § 436.6– certification of MCO data for rate setting • SSA § 1905(a)– services eligible for reimburse-ment • SSA § 1902(bb)– payments to FQHCs/RHCs • 42 CFR § 433.51–funds		unique FQHC Prospective payment system (PPS) and Alternative payment methodology (APM) • *Potential 1115 Demonstration amendment* to allow PM/PM care coordination payments to PCPCH providers (outside of PCCM regulations) for providers serving PCPCH clients who do not experience multiple chronic conditions as described in the ACA, section 2703	FQHC Alternative Payment System (APM) under the CCO structure.	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		from units of government				
Global budget • Financial solvency, including reinsurance and reserves	• Financial solvency requirements–State is considering brokering re-insurance or stop-loss insurance.	• 42 C.F.R. § 434.50–protection against insolvency • 42 CFR § 438.116–solvency standards	• No new federal authority necessary • State will require CCOs to comply with federal solvency standards.			• State will address financial solvency provisions in CCO contracts for approval by CMS.
Global budget Risk arrangements	• CCOs are expected to have comprehensive risk contracts. • State is considering potential options for risk-sharing arrangements.	• 42 CFR § 434.20 and 21–basic HMO and PHP rules and contract requirements • SSA §	State has current federal CNOM (costs not otherwise matchable) authority under 42 CFR § 434.20 and 21 for State to contract for comprehensive services on a prepaid *or other risk*			

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		1902(a)(30): Payments must be consistent with efficiency, economy, and quality of care. • 42 CFR § 438.6(b)– comprehen-sive risk contracts	basis.			
Global Budget Incentive payments to CCOs for performance of infrastructure development, measurement and reporting of clinical practices and quality measures, and	• Ability to provide existing MCOs and potential CCOs with the incentive and resources to operationalize the CCO care model • Ability to shift the basis	42 CFR § 438.6		*Potential 1115 Demonstration amendment* to allow for payment in excess of 105 percent of the approved capitation payments attributable to the		

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
enrollee health outcomes	of payment over time from the provision of service to the attainment of health outcomes. •			enrollees or services covered by the incentive arrangement. *State's Special Terms and Conditions will reflect* the principles for CCO incentives and procedures for developing benchmarks and incentive payments.		
Global Budget Alternative payment methodologies – CCOs to providers	• Alternative provider payment methodologies to reimburse on the basis of outcomes and quality • Payment structures that incentivize prevention, person-centered care, and comprehensive care coordination	• SSA § 1902(a)(30) • 42 CFR § 430–grants to states for Medical Assistance • 42 CFR § 438.6–		• *Potential 1115 Demonstration amendment* to allow flexibility in alternative payment methodologies • *State's 1115 Demonstration*		

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		contract requirements		*Special Terms and Conditions will reflect* new methodologies.		
Global Budget Non-emergency medical transportation (NEMT)	Explore the possibility of folding NEMT into global budget in first contract year	• 42 CFR § 431.53 • SSA § 1915(b This program is under a 1915(b) waiver.				*The state would like to explore with CMS* the possibility of folding NEMT into the global budget during the first contract year.
Network adequacy	• Revised criteria for network adequacy to more closely align with Medicare and use of team-based person-centered primary care • Fully integrated care across physical, dental, mental health and chemical dependency. • Inclusion of non-traditional workforce e.g.	• 42 CFR § 438.206– availability of services and credentialed providers; responsibili-ties of health care professionals		• *State's 1115 Demonstration Special Terms and Conditions will reflect* network adequacy criteria.	• Patient-centered primary care homes (PCPCH) – (SPA submitted) • Non-traditional workforce – e.g. Community Health Workers (CHW) (SPA in progress)	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
	Community Health Workers and Healthcare Navigators					
Eligibility/enrollment • Mandatory • Auto • Choice of plan • Lock-in	No changes to current eligibility and enrollment policies and procedures	• 42 CFR § 431.51– freedom of choice • 42 § 438.52– choice of plan • 42 CFR § 438.50(f)(2)– equitable distribution of enrollees • 42 CFR §438.6– contract requirements • 42 CFR §438.10– required	• State has a w*aiver in place (of 42 CFR 431.51)* to allow mandatory managed care enrollment, auto-enrollment without choice of plan, and lock-in for Medicaid-eligible populations, including for those dually eligible for Medicaid and Medicare. • State will continue to provide choice among providers in plan.	• *State's 1115 Demonstration Special Terms and Conditions will describe* Medicaid enrollment processes applicable to clients eligible for both Medicaid and Medicare.		• Medicare enrollment will be addressed in duals demonstration MOU/3-way contracts

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		information, including available providers				
Consumer protections • Access • Grievances, Appeals, • Hearings • Accessibility • Cultural/linguistic appropriateness	• Ability to streamline and simplify due process rights such as complaints, appeals, and grievances to reflect person-centered primary care • Ability to have Medicaid consumer protection processes come more in line with the Medicare process–e.g. require clients to go through plan-level appeal prior to seeking a state fair hearing	• 42 CFR § 431.244–hearing decisions • 42 CFR § 438 Part F • 42 CFR § 438.206–availability of services and credentialed providers • § 438.207–assurances of adequate capacity • § 438.208–coordination/		• *Potential 1115 Demonstration amendment* to allow state to integrate Medicaid and Medicare processes • *State's 1115 Demonstration Special Terms and Conditions will reflect* changes in Medicaid appeals and other consumer protections processes to more closely align with Medicare.		• State will make internal modifications to the Medicaid program's grievance and appeals processes to align with Medicare. • State will continue to comply with 42 CFR § 438 Part F.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		continuity of care • § 438.209– direct access to specialists • § 438.210– coverage and authorization • § 438.228– grievance systems				
Benefits • Benefit package that integrates physical, dental , mental health and chemical dependency services [2]	• Latitude to include non-encounterable medical services	• SSA § 1902(a)(10)(A); 1902(B) • 42 CFR § 440.230-250– sufficiency of amount,	State has a w*aiver in place* (of 42 CFR 440.230-250) to: • Use the Prioritized List of Health Services. • Offer different	• *Potential 1115 Demonstration amendment* to include non-encounterable medical services in capitation rates.		

[2] There will be a separate long-term care benefit that will not be under CCO)s.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		duration, and scope • 42 CFR § 400-424- grievances and appeals • 42 CFR § 438.6(c)– services in addition to those covered under the State Plan that cannot be included when determining payment rates	benefits to different populations.	• *State's 1115 Demonstration Special Terms and Conditions will reflect* changes in scope of capitation payments.		
Quality improvement/assu-	• Ability to streamline and consolidate, including alignment of Medicaid	• 42 CFR § 438.206 • 42 CFR §§		• *State's 1115 Demonstration Special Terms and*		PIP requirements will be included in the 3-way contract to

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
rance reporting • Performance improvement plans (PIP) • Quality incentives, including physician incentives	and Medicare requirements for quality assurance and performance improvement, including performance incentives • Flexibility in validation of performance improvement plans (PIP) and required protocols used by External Quality Review Organizations (EQRO)	438.200-204, 438.240 (a)(2) and (d), 438.364 and 438.358– validation of PIPs and protocols for EQROs • 42 CFR § 438.240 (a)(2)–PIP topics • 42 CFR § 438.310– EQRO requirements • 42 CFR § 417.479(i)– physician incentive requirements		*Conditions will reflect* State flexibility in establishing an integrated quality/ performance improvement program for CCOs with efficient and effective EQRO protocols and standards that meet Medicare and Medicaid requirements for external quality reviews. • *State's 1115 Demonstration Special Terms and Conditions will reflect* the Medicaid impact of the streamlining of		combine the Medicare and state review of PIPs in order to streamline quality administration.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)	State Plan Amendments (SPA)	
		(422.208-Medicare)		Medicare/ Medicaid PIP reviews.		
Workforce • Non-traditional	• Ability to use a non-traditional workforce such as Community health workers, personal health navigators, peer wellness specialists and doulas • Ability for State to determine qualification and certification standards. • Expand definition of "health care professional" to include naturopathic physicians, acupuncturists, and other licensed providers.	• SSA §1905(a) 42 USC § 1396–services • 42 CFR § 438.2– definition of health care professional • 42 CFR § 438.6 and § 438.206-210 health care professional • 42 CFR § 38.12– provider non-discrimination		*Potential 1115 Demonstration amendment* to expand the definition of "health care professional" in 42 CFR § 438.2 to include naturopathic physicians and other state-licensed providers	SPA to provide authority for payment for non-traditional workforce – e.g. CHW, personal health navigators, peer wellness specialists and doulas – (SPA in progress)	

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Administrative Simplification and regulatory relief	**Fraud and Abuse** • Ability for CCOs and their provider networks to work within antitrust, Stark, anti-kickback and Civil Monetary Penalty Laws • Ability to implement administrative simplification and streamlining strategies in areas such as reporting requirements, coordination of managed care reporting to multiple state regulatory agencies and encounter data	• SSA § 1877 • 42 CFR §411–Stark physician referral law • 41 U.S.C. § 51–anti-kickback law • 42 CFR § 438.416–managed care reporting requirements • 42 CFR § 438.210–managed care communica-tion with clients				Pursuant to Section 17 of HB 3650, State may seek from the DHHS OIG: • Waivers or expansion of safe harbors related to the anti-kickback statutes, and • Waiver of or exemption from Stark laws as necessary to permit certain physician referrals related to integrated care and formation of CCOs.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Communications and Marketing	Flexibility in marketing requirements for CCOs that serve Medicaid, Medicare and commercial populations.	Marketing activities: 42 CFR § 438.104— restrictions on marketing by MCOs Communications: 42 CFR §422.128, 208, 210 42 CFR § 431. 200, 211, 213, 214, 220, 230, 42 CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708	*Potential 1115 Demonstration amendment* to provide marketing latitude for CCOs that would not violate Medicaid restrictions.	• *State's 1115 Demonstration Special Terms and Conditions will reflect* CCO marketing protocols. • *State's 1115 Demonstration Special Terms and Conditions will reflect* optimal use of electronic communications, including to OHP consumers, with consumer's permission.		The MOU and 3-way contract will determine marketing rules.

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Federal Financial Participation (FFP) Selected state designated health programs (DSHP)	Ability to receive federal financial participation (FFP) for certain state-funded health care programs	SSA § 1115(a)		*Costs not otherwise matchable authority (CNOM)* under SSA § 1115(a) for federal financial participation (FFP)		

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Federal Financial Participation (FFP) Home and Community Based Services (HCBS) programs	An additional 6 percentage points in federal medical assistance percentage (FMAP) for current HCBS waivers, including: • Aged and physically disabled waiver • DD comprehensive services waiver • DD support services waiver • DD children's model waivers					

Issue	Change needed-Medicaid	Applicable federal Medicaid law or regulation	Medicaid authority			Other/ Comments
			Current 1115 Demonstration	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**State Plan Amendments (SPA)**	
Financial Participation County funds to be used for portion of state' matchable funds	Flexibility to accept local county funds for state match					

Citations from the Code of Federal Regulations (CFR) and the Social Security Act

References to 42 CFR § 438	Other CFR references	Social Security Act references
• 42 CFR § 438.2–Definitions • 42 CFR § 438.6– Contract requirements; actuarial soundness; entities eligible for comprehensive risk contracts; certification of MCO data for rate setting; services not covered under state plan • 42 CFR §438.10–Required information, including available providers • 42 CFR § 438.12 Provider discrimination prohibited • 42 CFR § 438.50(f)(2)–Equitable distribution of enrollees • 42 § 438.104–Marketing activities • 42 CFR § 438.116–Solvency standards • 42 CFR §§ 438.204–Elements of state quality strategies • 42 CFR § 438.206 – Availability of services and credentialed providers; responsibili-ties of health care professionals • 42 CFR § 438.207–Assurances of adequate capacity • 42 CFR § 438.208–Coordination/ continuity of care • 42 CFR § 438.209–Direct access to specialists • 42 CFR § 438.210–Coverage and authorization; communications with clients; EQRO requirements • 42 CFR § 438.240 (a)(2)–PIP topics • 42 CFR §§ 438.608 and 610–program integrity • 42 CFR § 438.228–Grievance systems • 42 CFR § 438.240–Quality assessment and program performance improvement • 42 CFR § 438.416–Managed care reporting requirements • 42 CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708–Member communications	• 42 C.F.R. § 430– Grants to states for Medical Assistance programs • 42 CFR § 431.51–Freedom of choice; funds from units of government • 42 CFR § 434.20 and 21–Basic HMO and PHP rules and contract requirements • 42 C.F.R. § 434.50–Protection against insolvency • 42 CFR § 417.479(i)–Physician incentive requirements (422.208-Medicare) • 42 CFR §422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230–Communications • 42 CFR § 431.53	• SSA § 1902(a)(10)(A)–Services required • SSA § 1902(a)(10)(B)–Amount, duration and scope • SSA § 1902(bb)–Payments to FQHCs/RHCs • SSA § 1905(a)–Services eligible for reimbursement • SSA § 1115(a)–costs not otherwise matchable (CNOM) authorities • SSA § 1915(b

Exhibit 2.1
Base Model
OHP Section 1115 Demonstration
Summary In Total Funds

Federal Fiscal Year		Neutrality Ceiling		Actual/Projected Expenditures		Surplus/Deficit
Original Waiver Period						
1994 Actual	$	390,951,750	$	346,190,634	$	44,761,116
1995 Actual	$	818,988,036	$	827,254,935	$	(8,266,899)
1996 Actual	$	892,465,451	$	885,011,152	$	7,454,299
1997 Actual	$	1,040,624,108	$	895,762,310	$	144,861,798
1998 Actual	$	1,224,165,720	$	1,051,592,807	$	172,572,913
Jan-99	$	112,450,962	$	95,260,442	$	17,190,520
Total Original Waiver	$	4,479,646,027	$	4,101,072,280	$	378,573,747
First Waiver Extension (beginning February 1999)						
1999 Actual (Feb - Dec)	$	1,236,961,227	$	1,071,151,312	$	165,809,915
2000 Actual	$	1,448,108,685	$	1,275,376,104	$	172,732,581
2001 Projection (1)	$	1,602,109,256	$	1,398,528,881	$	203,580,375
Jan-02	$	152,138,992	$	132,715,597	$	19,423,395
Total First Waiver Extension	$	4,439,318,160	$	3,877,771,894	$	561,546,266
Second Waiver Extension (beginning February 2002)						
2002 Actuals (Feb to Sept)	$	1,253,756,577	$	1,051,310,479	$	202,446,098
OHP2 Waiver Amendment						
DY 1 (FFY 03 Actual)	$	1,987,913,110	$	1,542,201,604	$	445,711,506
DY 2 (FFY 04 Actual)	$	2,093,044,450	$	1,494,082,316	$	598,962,134
DY 3 (FFY 05 Actual)	$	2,278,562,238	$	1,733,929,530	$	544,632,708
DY 4 (FFY 06 Actual)	$	2,454,368,136	$	1,558,038,076	$	896,330,060
DY 5 (FFY 07 Actual)	$	2,588,680,697	$	1,488,456,119	$	1,100,224,578
Total Second Waiver	$	11,402,568,631	$	7,816,707,645	$	3,585,860,986
OHP2 Waiver Extension						
DY 6 (FFY 08 Actual)	$	3,047,303,332	$	1,980,350,291	$	1,066,953,041
DY 7 (FFY 09 Actual)	$	3,210,937,225	$	1,857,765,840	$	1,353,171,385
DY 8 (FFY 10 Actual)	$	3,882,351,591	$	2,275,008,353	$	1,607,343,238
DY 9 (FFY 11 Actual)	$	4,521,446,161	$	2,847,833,594	$	1,673,612,567
DY 10 (FFY 12 Actual/Projection-9 mos)	$	3,761,911,867	$	2,075,993,645	$	1,685,918,222
Total OHP2 Waiver Extension	$	18,423,950,176	$	11,036,951,723	$	7,386,998,453
OHP2 Waiver - Health System Transformation						
DY 10 (FFY 12 Projection-3 mos)	$	1,253,970,622	$	691,997,882	$	561,972,741
DY 11 (FFY 13 Projection)	$	5,484,794,646	$	3,101,031,746	$	2,383,762,900
DY 12 (FFY 14 Projection)	$	7,144,866,029	$	4,031,369,406	$	3,113,496,623
DY 13 (FFY 15Projection)	$	8,206,432,253	$	4,736,820,942	$	3,469,611,311
DY 14 (FFY 16 Projection)	$	9,109,244,685	$	5,227,654,170	$	3,881,590,515
DY 15 (FFY 17Projection)	$	10,084,599,193	$	5,756,796,180	$	4,327,803,013
Total Waiver Extension	$	41,283,907,428	$	23,545,670,326	$	17,738,237,103
Cumulative Total	**$**	**81,283,146,999**	**$**	**51,429,484,347**	**$**	**29,853,662,652**

Exhibit 2.2
Base Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disabled	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance						
Parents	249,052	268,092				
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Total Member Months	**6,041,305**	**6,198,002**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)						
National Health Expenditures Growth Rate	CMS Approved PMPM	CMS Approved PMPM	*8.30%*	*5.90%*	*6.30%*	*6.00%*
Base Population PMPM						
AFDC	$ 474.53	$ 503.95	$ 545.78	$ 577.98	$ 614.39	$ 651.25
PLM-W	$ 1,806.87	$ 1,917.09	$ 2,076.21	$ 2,198.70	$ 2,337.22	$ 2,477.46
PLM-C	$ 691.61	$ 734.48	$ 795.44	$ 842.37	$ 895.44	$ 949.17
Old Age Assistance	$ 602.15	$ 632.26	$ 684.74	$ 725.14	$ 770.82	$ 817.07
Aid to Blind/Disabled	$ 1,959.64	$ 2,073.30	$ 2,245.38	$ 2,377.86	$ 2,527.67	$ 2,679.33
Foster Care & SAC	$ 830.04	$ 881.50	$ 954.66	$ 1,010.99	$ 1,074.68	$ 1,139.16
New Mandatory Adults (ACA)	$ -	$ -	$ 531.05	$ 562.38	$ 597.81	$ 633.68

Exhibit 2.2
Base Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Expansion Population PMPM						
General Assistance						
Parents	$ 367.33	$ 389.74				
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	$ 332.13	$ 352.72	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)						
Base Population Expenditures						
AFDC	1,055,604,797	$ 1,145,222,847	$ 1,204,826,435	$ 1,301,416,819	$ 1,411,060,450	$ 1,525,623,840
PLM-W	287,863,302	$ 295,435,072	$ 327,272,741	$ 355,948,315	$ 388,600,748	$ 423,050,482
PLM-C	1,230,418,455	$ 1,319,552,078	$ 1,431,795,312	$ 1,516,271,235	$ 1,611,796,323	$ 1,708,504,103
Old Age Assistance	256,213,019	$ 282,923,705	$ 320,879,671	$ 354,855,265	$ 393,911,749	$ 436,032,662
Aid to Blind/Disabled	1,908,221,005	$ 2,142,788,723	$ 2,712,946,926	$ 3,080,296,119	$ 3,510,595,572	$ 3,989,715,931
Foster Care & SAC	182,806,348	$ 191,318,116	$ 229,492,754	$ 247,931,071	$ 268,862,882	$ 290,738,315
New Mandatory Adults (ACA)	-	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Base	4,921,126,926	$ 5,377,240,541	$ 7,144,866,029	$ 8,206,432,253	$ 9,109,244,685	$ 10,084,599,193
Expansion Population Expenditures						
General Assistance	-	$ -	$ -	$ -	$ -	$ -
Parents	$ 91,484,271	$ 104,486,176	$ -	$ -	$ -	$ -
Adults/Couples	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - All Title XIX	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Existing	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Medicaid	$ 3,271,292	$ 3,067,929	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid		$ -	$ -	$ -	$ -	$ -
Total Expansion	$ 94,755,563	$ 107,554,105	$ -	$ -	$ -	$ -
Additional Health Services Expenditures						
Total Base + Expansion Allowable Expenditures	**$ 5,015,882,489**	**$ 5,484,794,646**	**$ 7,144,866,029**	**$ 8,206,432,253**	**$ 9,109,244,685**	**$ 10,084,599,193**

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

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disables	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance (3)						
Parents	249,052	268,092				
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Non-Allowable Expansion Population Member Months						
General Assistance		-	-	-	-	-
Adults/Couples	491,298	420,011	-	-	-	-
FHIAP - Existing	2,995	2,777	-	-	-	-
FHIAP - Non-Medicaid	54,564	40,767	-	-	-	-
Total Non-Allowable Expansion	548,857	463,555	-	-	-	-
Total Member Months	**6,590,164**	**6,661,557**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
PER MEMBER PER MONTH COSTS (PMPM) (1)						
National Health Expenditures Growth Rate			*8.3%*	*5.9%*	*6.3%*	*6.0%*
Base Populations PMPM						
AFDC	286.08	$ 285.12	$ 308.78	$ 327.00	$ 347.60	$ 368.46
PLM-W	1,164.12	$ 1,162.29	$ 1,258.76	$ 1,333.03	$ 1,417.01	$ 1,502.03
PLM-C	210.06	$ 214.85	$ 232.68	$ 246.41	$ 261.93	$ 277.65
Old Age Assistance	188.01	$ 177.43	$ 192.16	$ 203.49	$ 216.31	$ 229.29
Aid to Blind/Disables	916.92	$ 888.43	$ 962.17	$ 1,018.94	$ 1,083.13	$ 1,148.12
Foster Care & SAC	456.23	$ 463.64	$ 502.12	$ 531.75	$ 565.25	$ 599.16
New Mandatory Adults (ACA)			$ 531.05	$ 562.38	$ 597.81	$ 633.68
Expansion Population PMPM						
General Assistance (3)	$ -	$ -	$ -	$ -	$ -	$ -
Parents	$ 353.24	$ 353.09	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 23.41	$ 31.02	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Non-Allowable Expansion Population PMPM						
General Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	$ 579.63	$ 577.96	$ -	$ -	$ -	$ -
FHIAP - Existing	$ 97.21	$ 74.79	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 217.09	$ 253.35	$ -	$ -	$ -	$ -

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL EXPENDITURES (1)						
Base Populations Expenditures						
AFDC	636,388,175	$ 647,930,520	$ 681,655,182	$ 736,303,130	$ 798,336,264	$ 863,152,770
PLM-W	185,462,153	$ 179,115,146	$ 198,418,428	$ 215,804,384	$ 235,600,292	$ 256,486,190
PLM-C	373,710,983	$ 386,003,322	$ 418,828,590	$ 443,539,477	$ 471,482,464	$ 499,771,412
Old Age Assistance	79,999,681	$ 79,394,194	$ 90,047,799	$ 99,582,496	$ 110,542,738	$ 122,362,975
Aid to Blind/Disables	892,858,666	$ 918,208,416	$ 1,162,525,171	$ 1,319,937,991	$ 1,504,326,124	$ 1,709,633,687
Foster Care & SAC	100,478,248	$ 100,626,869	$ 120,705,784	$ 130,403,773	$ 141,413,065	$ 152,919,024
New Mandatory Adults (ACA)	-	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Leverages	113,980,333	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262
Total Base	$ 2,382,878,239	$ 2,752,814,729	$ 4,031,369,406	$ 4,736,820,942	$ 5,227,654,170	$ 5,756,796,180
Expansion Population Expenditures						
General Assistance (3)						
Parents	87,974,422	94,660,351	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 230,587	$ 269,837	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Total Expansion	$ 88,205,009	$ 94,930,188	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures						
General Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	284,771,824	$ 242,750,746	-	-	-	-
FHIAP - Existing	$ 291,175	$ 207,723	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 11,845,280	$ 10,328,360	$ -	$ -	$ -	$ -
Total Non-Allowable Expansion	$ 296,908,279	$ 253,286,829	$ -	$ -	$ -	$ -

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Additional Health Services Expenditures						
Health System Transformation Expenditures						
DSHP						
Total Base + Expansion Expenditures	**$ 2,767,991,527**	**$ 3,101,031,746**	**$ 4,031,369,406**	**$ 4,736,820,942**	**$ 5,227,654,170**	**$ 5,756,796,180**

Exhibit 2.3
Base Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17

	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
NHE Growth Rate		8.30%	5.90%	6.30%	6.00%

Exhibit 2.1
Change Model
OHP Section 1115 Demonstration
Summary In Total Funds

Federal Fiscal Year	Neutrality Ceiling	Actual/Projected Expenditures	Surplus/Deficit
Original Waiver Period			
1994 Actual			
1995 Actual			
1996 Actual			
1997 Actual			
1998 Actual			
Jan-99			
Total Original Waiver	$ -	$ -	$ -
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)			
2000 Actual			
2001 Projection (1)			
Jan-02			
Total First Waiver Extension	$ -	$ -	$ -
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)			
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)			
DY 2 (FFY 04 Actual)			
DY 3 (FFY 05 Actual)			
DY 4 (FFY 06 Actual)			
DY 5 (FFY 07 Actual)			
Total Second Waiver	$ -	$ -	$ -
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)			
DY 7 (FFY 09 Actual)			
DY 8 (FFY 10 Actual)			
DY 9 (FFY 11 Actual)			
DY 10 (FFY 12 Actual/Projection)			
DY 11 (FFY 13 Projection)			
DY 12 (FFY 14 Projection)			
DY 13 (FFY 15 Projection)			
DY 14 (FFY 16 Projection)			
DY 15 (FFY 17 Projection)			
Total OHP2 Waiver Extension	$ -	$ -	$ -
OHP2 Waiver - Health System Transformation			
DY 10 (FFY 12 Projection)	$ 10,688,104	$ 231,535,785	$ (220,847,681)
DY 11 (FFY 13 Projection)	$ 140,907,240	$ 1,033,271,771	$ (892,364,531)
DY 12 (FFY 14 Projection)	$ 235,873,371	$ 740,715,774	$ (504,842,403)
DY 13 (FFY 15 Projection)	$ 258,774,969	$ 435,293,949	$ (176,518,980)
DY 14 (FFY 16 Projection)	$ 262,333,774	$ (467,652,851)	$ 729,986,625
DY 15 (FFY 17 Projection)	$ 263,142,134	$ (801,444,836)	$ 1,064,586,970
Total Waiver Extension	$ 1,171,719,592	$ 1,171,719,592	$ (0)
Cumulative Total	**$ 1,171,719,592**	**$ 1,171,719,592**	**$ -**

Exhibit 2.2
Change Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disabled						
Foster Care & SAC						
New Mandatory Adults (ACA)						
Total Base	-	-	-	-	-	-
Expansion Member Months (2)						
General Assistance						
Parents						
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Total Expansion	-	-	-	-	-	-
Total Member Months	**-**	**-**	**-**	**-**	**-**	**-**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)						
Base Population PMPM						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disabled						
Foster Care & SAC						
New Mandatory Adults (ACA)						

Exhibit 2.2
Change Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Expansion Population PMPM						
General Assistance						
Parents						
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)						
Base Population Expenditures						
AFDC	$ -	$ -	$ -	$ -	$ -	$ -
PLM-W	$ -	$ -	$ -	$ -	$ -	$ -
PLM-C	$ -	$ -	$ -	$ -	$ -	$ -
Old Age Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Aid to Blind/Disabled	$ -	$ -	$ -	$ -	$ -	$ -
Foster Care & SAC	$ -	$ -	$ -	$ -	$ -	$ -
New Mandatory Adults (ACA)	$ -	$ -	$ -	$ -	$ -	$ -
Total Base	$ -	$ -	$ -	$ -	$ -	$ -
Expansion Population Expenditures						
General Assistance						
Parents	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - All Title XIX	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Existing	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Medicaid	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ -	$ -	$ -	$ -	$ -	$ -
Total Expansion	$ -	$ -	$ -	$ -	$ -	$ -
Additional Health Services Expenditures	$ 10,688,104	$ 140,907,240	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Total Base + Expansion Allowable Expenditures	**$ 10,688,104**	**$ 140,907,240**	**$ 235,873,371**	**$ 258,774,969**	**$ 262,333,774**	**$ 263,142,134**

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

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disables						
Foster Care & SAC						
New Mandatory Adults (ACA)						
Total Base	-	-	-	-	-	-
Expansion Member Months (2)						
General Assistance (3)						
Parents						
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Total Expansion	-	-	-	-	-	-
Non-Allowable Expansion Population Member Months						
General Assistance						
Adults/Couples						
FHIAP - Existing						
FHIAP - Non-Medicaid						
Total Non-Allowable Expansion	-	-	-	-	-	-
Total Member Months	**1,510,326**	**6,198,002**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
PER MEMBER PER MONTH COSTS (PMPM) (1)						
Base Populations PMPM						
AFDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disables						
Foster Care & SAC						
New Mandatory Adults (ACA)						
Expansion Population PMPM						
General Assistance (3)						
Parents						
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Non-Allowable Expansion Population PMPM						
General Assistance						
Adults/Couples						
FHIAP - Existing						
FHIAP - Non-Medicaid						
HEALTH SYSTEM TRANSFORMATION PMPM	$ (51.11)	$ (49.82)	$ (89.37)	$ (119.53)	$ (216.41)	$ (244.77)

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL EXPENDITURES (1)						
Base Populations Expenditures						
AHDC						
PLM-W						
PLM-C						
Old Age Assistance						
Aid to Blind/Disables						
Foster Care & SAC						
New Mandatory Adults (ACA)			$ -	$ -	$ -	$ -
Total Base	$ -	$ -	$ -	$ -	$ -	$ -
Expansion Population Expenditures						
General Assistance (3)						
Parents						
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid						
FHIAP - Non-Medicaid						
Total Expansion	$ -	$ -	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures						
General Assistance						
Adults/Couples						
FHIAP - Existing						
FHIAP - Non-Medicaid						
Total Non-Allowable Expansion	$ -	$ -	$ -	$ -	$ -	$ -

Exhibit 2.3
Change Model
OHP Section 1115 Demonstration
Actual and Projected Demonstration Expenditures

	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Additional Health Services Expenditures	$ 10,688,104	$ 140,907,240	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Health System Transformation Expenditures	$ (77,197,144)	$ (308,788,576)	$ (698,044,526)	$ (1,033,158,439)	$ (1,939,664,045)	$ (2,274,264,390)
DSHP	$ 298,044,826	$ 1,201,153,107	$ 1,202,886,929	$ 1,209,677,419	$ 1,209,677,419	$ 1,209,677,419
Total Base + Expansion Expenditures	**$ 231,535,785**	**$ 1,033,271,771**	**$ 740,715,774**	**$ 435,293,949**	**$ (467,652,851)**	**$ (801,444,836)**

Exhibit 2.1
Combined Model
OHP Section 1115 Demonstration
Summary In Total Funds

Federal Fiscal Year	Neutrality Ceiling	Actual/Projected Expenditures	Surplus/Deficit
Original Waiver Period			
1994 Actual	$ 390,951,750	$ 346,190,634	$ 44,761,116
1995 Actual	$ 818,988,036	$ 827,254,935	$ (8,266,899)
1996 Actual	$ 892,465,451	$ 885,011,152	$ 7,454,299
1997 Actual	$ 1,040,624,108	$ 895,762,310	$ 144,861,798
1998 Actual	$ 1,224,165,720	$ 1,051,592,807	$ 172,572,913
Jan-99	$ 112,450,962	$ 95,260,442	$ 17,190,520
Total Original Waiver	$ 4,479,646,027	$ 4,101,072,280	$ 378,573,747
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)	$ 1,236,961,227	$ 1,071,151,312	$ 165,809,915
2000 Actual	$ 1,448,108,685	$ 1,275,376,104	$ 172,732,581
2001 Projection (1)	$ 1,602,109,256	$ 1,398,528,881	$ 203,580,375
Jan-02	$ 152,138,992	$ 132,715,597	$ 19,423,395
Total First Waiver Extension	$ 4,439,318,160	$ 3,877,771,894	$ 561,546,266
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)	$ 1,253,756,577	$ 1,051,310,479	$ 202,446,098
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)	$ 1,987,913,110	$ 1,542,201,604	$ 445,711,506
DY 2 (FFY 04 Actual)	$ 2,093,044,450	$ 1,494,082,316	$ 598,962,134
DY 3 (FFY 05 Actual)	$ 2,278,562,238	$ 1,733,929,530	$ 544,632,708
DY 4 (FFY 06 Actual)	$ 2,454,368,136	$ 1,558,038,076	$ 896,330,060
DY 5 (FFY 07 Actual)	$ 2,588,680,697	$ 1,488,456,119	$ 1,100,224,578
Total Second Waiver	$ 11,402,568,631	$ 7,816,707,645	$ 3,585,860,986
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)	$ 3,047,303,332	$ 1,980,350,291	$ 1,066,953,041
DY 7 (FFY 09 Actual)	$ 3,210,937,225	$ 1,857,765,840	$ 1,353,171,385
DY 8 (FFY 10 Actual)	$ 3,882,351,591	$ 2,275,008,353	$ 1,607,343,238
DY 9 (FFY 11 Actual/)	$ 4,521,446,161	$ 2,847,833,594	$ 1,673,612,567
DY 10 (FFY 12 Actual/Projection-9 mos)	$ 3,769,927,946	$ 2,075,993,647	$ 1,693,934,299
Total OHP2 Waiver Extension	$ 18,431,966,255	$ 11,036,951,725	$ 7,395,014,530
OHP2 Waiver - Health System Transformation			
DY 10 (FFY 12 Projection-3 mos)	$ 1,256,642,649	$ 923,533,666	$ 333,108,982
DY 11 (FFY 13 Projection)	$ 5,633,570,577	$ 4,142,172,208	$ 1,491,398,369
DY 12 (FFY 14 Projection)	$ 7,380,739,399	$ 4,772,085,180	$ 2,608,654,219
DY 13 (FFY 15 Projection)	$ 8,465,207,222	$ 5,172,114,891	$ 3,293,092,331
DY 14 (FFY 16 Projection)	$ 9,371,578,459	$ 4,760,001,319	$ 4,611,577,140
DY 15 (FFY 17 Projection)	$ 10,347,741,327	$ 4,955,351,344	$ 5,392,389,983
Total Waiver Extension	$ 42,455,479,633	$ 24,725,258,608	$ 17,730,221,024
Cumulative Total	**$ 82,462,735,282**	**$ 52,609,072,631**	**$ 29,853,662,651**

Exhibit 2.2
Combined Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10	Projection DY 11	Projection DY 12	Projection DY 13	Projection DY 14	Projection DY 15
	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disabled	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance						
Parents	249,052	268,092				
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Total Member Months	**6,041,304**	**6,198,002**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)						
	CMS Approved PMPM	CMS Approved PMPM				
Base Population PMPM						
AFDC	$ 474.53	$ 503.95	$ 545.78	$ 577.98	$ 614.39	$ 651.25
PLM-W	$ 1,806.87	$ 1,917.09	$ 2,076.21	$ 2,198.70	$ 2,337.22	$ 2,477.46
PLM-C	$ 691.61	$ 734.48	$ 795.44	$ 842.37	$ 895.44	$ 949.17
Old Age Assistance	$ 602.15	$ 632.26	$ 684.74	$ 725.14	$ 770.82	$ 817.07
Aid to Blind/Disabled	$ 1,959.64	$ 2,073.30	$ 2,245.38	$ 2,377.86	$ 2,527.67	$ 2,679.33
Foster Care & SAC	$ 830.04	$ 881.50	$ 954.66	$ 1,010.99	$ 1,074.68	$ 1,139.16
New Mandatory Adults (ACA)	$ -	$ -	$ 531.05	$ 562.38	$ 597.81	$ 633.68
Expansion Population PMPM						
General Assistance						
Parents	$ 367.33	$ 389.74	$ -	$ -	$ -	$ -
Adults/Couples						
FHIAP - All Title XIX						
FHIAP - Existing						
FHIAP - Medicaid	$ 332.13	$ 352.72	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						

Exhibit 2.2
Combined Model
OHP Section 1115 Demonstration
Allowable Expenditures
In Total Funds

With Requested Trends Using Actual and Projected Member Months	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL ALLOWABLE EXPENDITURES (Member Months x PMPM)						
Base Population Expenditures						
AFDC	$ 1,055,604,797	$ 1,145,222,847	$ 1,204,826,435	$ 1,301,416,819	$ 1,411,060,450	$ 1,525,623,840
PLM-W	$ 287,863,301	$ 295,435,072	$ 327,272,741	$ 355,948,315	$ 388,600,748	$ 423,050,482
PLM-C	$ 1,230,418,453	$ 1,319,552,078	$ 1,431,795,312	$ 1,516,271,235	$ 1,611,796,323	$ 1,708,504,103
Old Age Assistance	$ 256,213,019	$ 282,923,705	$ 320,879,671	$ 354,855,265	$ 393,911,749	$ 436,032,662
Aid to Blind/Disabled	$ 1,908,221,006	$ 2,142,788,723	$ 2,712,946,925	$ 3,080,296,119	$ 3,510,595,572	$ 3,989,715,931
Foster Care & SAC	$ 182,806,350	$ 191,318,116	$ 229,492,754	$ 247,931,071	$ 268,862,882	$ 290,738,315
New Mandatory Adults (ACA)	$ -	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Base	$ 4,921,126,926	$ 5,377,240,541	$ 7,144,866,028	$ 8,206,432,253	$ 9,109,244,685	$ 10,084,599,193
Expansion Population Expenditures						
General Assistance						
Parents	$ 91,484,272	$ 104,486,176	$ -	$ -	$ -	$ -
Adults/Couples	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - All Title XIX	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Existing	$ -	$ -	$ -	$ -	$ -	$ -
FHIAP - Medicaid	$ 3,271,292	$ 3,067,929	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid		$ -	$ -	$ -	$ -	$ -
Total Expansion	$ 94,755,564	$ 107,554,105	$ -	$ -	$ -	$ -
Additional Health Services Expenditures	$ 10,688,104	$ 148,775,931	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Total Base + Expansion Allowable Expenditures	**$ 5,026,570,594**	**$ 5,633,570,577**	**$ 7,380,739,399**	**$ 8,465,207,222**	**$ 9,371,578,459**	**$ 10,347,741,327**

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

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
MEMBER MONTHS						
Base Populations Member Months (1)						
AFDC	2,224,527	2,272,493	2,207,540	2,251,669	2,296,680	2,342,591
PLM-W	159,316	154,106	157,630	161,890	166,266	170,760
PLM-C	1,779,064	1,796,580	1,800,000	1,800,000	1,800,000	1,800,000
Old Age Assistance	425,497	447,480	468,617	489,363	511,029	533,654
Aid to Blind/Disables	973,761	1,033,516	1,208,233	1,295,406	1,388,868	1,489,074
Foster Care & SAC	220,238	217,037	240,391	245,236	250,179	255,221
New Mandatory Adults (ACA)	-	-	1,728,000	2,400,000	2,550,000	2,700,000
Total Base	5,782,403	5,921,212	7,810,411	8,643,564	8,963,022	9,291,300
Expansion Member Months (2)						
General Assistance (3)						
Parents	249,052	268,092	-	-	-	-
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	9,849	8,698	-	-	-	-
FHIAP - Non-Medicaid						
Total Expansion	258,901	276,790	-	-	-	-
Non-Allowable Expansion Population Member Months						
General Assistance						
Adults/Couples	491,298	420,011	-	-	-	-
FHIAP - Existing	2,995	2,777	-	-	-	-
FHIAP - Non-Medicaid	54,564	40,767	-	-	-	-
Total Non-Allowable Expansion	548,857	463,555	-	-	-	-
Total Member Months	**6,590,161**	**6,661,557**	**7,810,411**	**8,643,564**	**8,963,022**	**9,291,300**

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
PER MEMBER PER MONTH COSTS (PMPM) (1)						
National Health Expenditures Growth Rate			8.3%	5.9%	6.3%	6.0%
Base Populations PMPM						
AFDC	$ 286.08	$ 285.12	$ 308.78	$ 327.00	$ 347.60	$ 368.46
PLM-W	$ 1,164.12	$ 1,162.29	$ 1,258.76	$ 1,333.03	$ 1,417.01	$ 1,502.03
PLM-C	$ 210.06	$ 214.85	$ 232.68	$ 246.41	$ 261.93	$ 277.65
Old Age Assistance	$ 188.01	$ 177.43	$ 192.16	$ 203.49	$ 216.31	$ 229.29
Aid to Blind/Disables	$ 916.92	$ 888.43	$ 962.17	$ 1,018.94	$ 1,083.13	$ 1,148.12
Foster Care & SAC	$ 456.23	$ 463.64	$ 502.12	$ 531.75	$ 565.25	$ 599.16
New Mandatory Adults (ACA)			$ 531.05	$ 562.38	$ 597.81	$ 633.68
Expansion Population PMPM						
General Assistance (3)						
Parents	$ 353.24	$ 353.09	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 23.41	$ 31.02	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Non-Allowable Expansion Population PMPM						
General Assistance	$ -	$ -	$ -	$ -	$ -	$ -
Adults/Couples	$ 579.63	$ 577.96	$ -	$ -	$ -	$ -
FHIAP - Existing	$ 97.21	$ 74.79	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 217.09	$ 253.35	$ -	$ -	$ -	$ -
HEALTH SYSTEM TRANSFORMATION PMPM	$ (51.11)	$ (49.82)	$ (89.37)	$ (119.53)	$ (216.41)	$ (244.77)

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
TOTAL EXPENDITURES (1)						
Base Populations Expenditures						
AFDC	$ 636,388,175	$ 647,930,520	$ 681,655,182	$ 736,303,130	$ 798,336,264	$ 863,152,770
PLM-W	$ 185,462,153	$ 179,115,146	$ 198,418,428	$ 215,804,384	$ 235,600,292	$ 256,486,190
PLM-C	$ 373,710,983	$ 386,003,322	$ 418,828,590	$ 443,539,477	$ 471,482,464	$ 499,771,412
Old Age Assistance	$ 79,999,681	$ 79,394,194	$ 90,047,799	$ 99,582,496	$ 110,542,738	$ 122,362,975
Aid to Blind/Disables	$ 892,858,667	$ 918,208,416	$ 1,162,525,171	$ 1,319,937,991	$ 1,504,326,124	$ 1,709,633,687
Foster Care & SAC	$ 100,478,249	$ 100,626,869	$ 120,705,784	$ 130,403,773	$ 141,413,065	$ 152,919,024
New Mandatory Adults (ACA)	$ -	$ -	$ 917,652,190	$ 1,349,713,429	$ 1,524,416,961	$ 1,710,933,860
Total Leverages	$ 113,980,333	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262	$ 441,536,262
Total Base	$ 2,382,878,241	$ 2,752,814,729	$ 4,031,369,406	$ 4,736,820,942	$ 5,227,654,170	$ 5,756,796,180
Expansion Population Expenditures						
General Assistance (3)						
Parents	$ 87,974,422	$ 94,660,351	$ -	$ -	$ -	$ -
Adults/Couples (3)						
FHIAP - All Title XIX						
FHIAP - Existing (3)						
FHIAP - Medicaid	$ 230,587	$ 269,837	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid						
Total Expansion	$ 88,205,009	$ 94,930,188	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures						
General Assistance						
Adults/Couples	$ 284,771,824	$ 242,750,746	$ -	$ -	$ -	$ -
FHIAP - Existing	$ 291,175	$ 207,723	$ -	$ -	$ -	$ -
FHIAP - Non-Medicaid	$ 11,845,280	$ 10,328,360	$ -	$ -	$ -	$ -
Total Non-Allowable Expansion	$ 296,908,279	$ 253,286,829	$ -	$ -	$ -	$ -

Appendix L	Actual/Projection DY 10 FFY 12	Projection DY 11 FFY 13	Projection DY 12 FFY 14	Projection DY 13 FFY 15	Projection DY 14 FFY 16	Projection DY 15 FFY 17
Additional Health Services Expenditures	$ 10,688,104	$ 148,775,931	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134
Health System Transformation Expenditures	$ (77,197,144)	$ (308,788,576)	$ (698,044,526)	$ (1,033,158,439)	$ (1,939,664,045)	$ (2,274,264,390)
DSHP	$ 298,044,826	$ 1,201,153,107	$ 1,202,886,929	$ 1,209,677,419	$ 1,209,677,419	$ 1,209,677,419
Total Base + Expansion Expenditures	**$ 2,999,527,315**	**$ 4,142,172,208**	**$ 4,772,085,180**	**$ 5,172,114,891**	**$ 4,760,001,319**	**$ 4,955,351,344**

JOHN A. KITZHABER, MD
Governor

February 29, 2012

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Sebelius,

I am pleased to share with you the State of Oregon's request of the federal government to approve amendments to the Oregon Health Plan Waiver Demonstration under Section 1115(a) of the Social Security Act. With these amendments, the Demonstration will serve to transform and improve the health care delivery system for Oregonians for years to come by improving health, improving health care and containing costs.

As Oregon forges ahead to implement its most ambitious health care transformation plan to date, focusing on integrated, coordinated care and alignment of incentives, we are also requesting approval to use federal savings earned under the OHP waiver to help launch our initiatives. Specifically, Oregon is requesting an amendment to our OHP 1115 Demonstration to authorize federal financial participation (FFP) for selected state designated health programs (DSHP). These programs would be authorized by Section 1115(a) cost not otherwise matchable authority (CNOM).

Since established in 1994, the Oregon Health Plan Waiver Demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth, saving the federal and state government more than $15 billion over the life of the waiver.

As we look to the future, Oregon is ready to build on that success and to take it further to meet three goals:

1. Transform Oregon's Medicaid delivery system to focus on prevention, integration, and coordination of health care across the continuum of care with the goal of improving outcomes and bending the cost curve;
2. Promote the Triple Aim of better health, better health care, and lower per capita costs; and
3. Establish supportive partnerships with CMS to implement innovative strategies for providing high-quality, cost-effective, person-centered health care under Medicaid and Medicare.

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We estimate that there will be approximately 200,000 additional Oregonians eligible for Medicaid with the implementation of federal health reform in 2014. This proposal envisions a system anchored by the creation of community-based Coordinated Care Organizations (CCOs) that focus on prevention and primary care and the needs of their particular communities. With these reforms, we believe Oregon will be well-positioned to provide access to health care for newly eligible people, meet the three goals outlined above, and, at the same time, effectively use federal and state resources to support integrated care.

CCOs will integrate and coordinate care across physical, behavioral, and oral health care services through a strong focus on primary and preventive care, evidence-based services, and more effective management of care. The CCOs will not directly provide long-term services and supports (LTSS) at this time; however, in order to reduce cost-shifting and ensure shared responsibility for delivering high-quality, person-centered care, the CCOs and LTSS system will coordinate care and share both programmatic and financial accountability.

With this waiver amendment, Oregon is requesting, first, that all of the state's existing 1115 Demonstration authorities remain in place. These authorities will allow the State to implement a significant portion of the transformed system, including contracting with CCOs; enrolling individuals, including those eligible for Medicaid and Medicare, in managed care and establishing integrated benefit packages. Specific new flexibilities are outlined in our attached request. The State also requests approval of a three-year extension through October 31, 2016. The current Demonstration is scheduled to expire October 31, 2013.

Our desire is to continue to work collaboratively with CMS in moving these requests forward as expeditiously as possible. Oregon expects to contract with the first CCOs in July 2012. In order to accomplish that, we respectfully request expedited CMS review and approval. Our target date for approval of our DSHP request is April 1, 2012 and of the overall waiver amendments and extension, June 1, 2012.

The State of Oregon looks forward to your support and to working with you as we implement health system transformation and enter a new 1115 Demonstration renewal period and as we continue to fulfill the mission of the Oregon Health Authority: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Thank you for your consideration of these amendment and extension requests. If you have any questions or would like further information, please do not hesitate to contact our Medicaid Director, Judy Mohr Peterson at (503) 945-5768.

Sincerely,

John A. Kitzhaber, M.D.
Governor

C:
The Honorable Jeff Merkley, U.S. Senator
The Honorable Ron Wyden, U.S. Senator
The Honorable Earl Blumenauer, U.S. Representative
The Honorable Peter DeFazio, U.S. Representative
The Honorable Kurt Schrader, U.S. Representative
The Honorable Greg Walden, U.S. Representative
The Honorable Suzanne Bonamici, U.S. Representative
Bruce Goldberg, Director, Oregon Health Authority
Michael Bonetto, Office of Governor John Kitzhaber, Senior Health Policy Advisor
Sean Kolmer, Office of Governor John Kitzhaber, Assistant Health Policy Advisor
Judy Mohr Peterson, Director, Division of Medical Assistance Programs, Oregon Health Authority
Bruce Hanna, Speaker, House of Representatives
Arnie Roblan, Speaker, House of Representatives
Peter Courtney, Senate President
Cindy Mann, Director, CMCS
Terri Fraser, CMCS
Carol Peverly, CMS Region X Administrator
Cecile Greenway, CMS, Region X
Wendy Hill-Petras, CMS, Region X

Appendix M

Proposed CCO Global Budget Inclusion/Exclusion of Oregon Medicaid Services Programs

Program Area	Program/Service/Function	Notes	% of non-LTC Medicaid Expenditures (based on 09-11)	Timeline for Inclusion in Global Budgets				Payment Methodology		New to Budget Neutrality in Waiver Amendme						
				July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned	Pre-CCO Global Budget	Under CCO Global Budget		FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	58%	X				Capitation/FFS	Capitation	No						
Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	9%	X				Capitation/FFS	Capitation	No						
Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities) and Medicare Advantage premiums for dual eligibles	Basis of payment currently depends on whether or not a beneficiary is enrolled in a Medicare Advantage plan, Medicaid physical health managed care plan.	Included in OHP physical health coverage above	X				FFS/Capitation	Capitation	No						
Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	2%	X				Capitation/FFS	Capitation	No						
Additional Enrollees	Breast and Cervical Cancer Medical (BCCM) (not inclusive of screening)	Clients currently receive care on a FFS basis, but would benefit from coordinated care. Benefits mirror those currently paid through capitation.	< 1%	X				FFS	Capitated? Specifics under development	Yes	$ 4,004,905	$ 16,756,501	$ 16,756,501	$ 16,756,501	$ 16,756,501	$ 16,756,501
Additional Enrollees	Eligible clients with third party insurance	Approach under development	< 1%	X				FFS	Capitation portion? Specifics under development	No						
Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Cost sharing for Medicare eligibles also eligible for a full Medicaid benefit and enrolled in a CCO will be included in blended capitation rates under CMS demonstration.	< 1%	X				FFS	Capitation portion	Yes	$ 1,946,099	$ 7,806,803	$ 8,179,617	$ 8,453,716	$ 8,791,864	$ 9,197,643
Mental Health	Children's Statewide Wraparound Projects	Services and supports for children with complex behavioral health needs and their families. Paid in the capitation rate for 3 MHOs currently.	< 1%	X				Capitation	Capitation	No						
Mental Health	Exceptional Needs Care Coordinators	Specialized case management service provided to clients identified as aged, blind or disabled who have complex medical needs. Currently paid through capitation	< 1%	X				Capitation	Capitation portion	No						
Mental Health	Non-forensic intensive treatment services for children	Currently paid through capitation for managed care enrolled clients and FFS for eligible clients not enrolled in managed care.	< 1%	x				Capitation/FFS	Capitation portion	No						
Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	Currently in the capitation rate for those in managed care for the first 20 days of care.	< 1%	X				Capitation/FFS	Capitation portion	No						
Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Program currently operates in a limited number of counties.	< 1%	Optional in counties where currently operating	X			Invoiced	TBD	Yes	$ -	$ 2,192,325	$ 2,961,100	$ 2,996,634	$ 3,044,580	$ 3,050,573
Addictions	Youth residential alcohol and drug treatment (OHP carve out)	HB 3650 states that OHA shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.	< 1%	Optional	Optional until July 1, 2013			FFS	Capitation?	Yes	$ 939,800	$ 3,823,106	$ 3,872,807	$ 3,919,280	$ 3,981,989	$ 3,989,828
Mental Health	Adult residential alcohol and drug treatment (OHP carve out)	HB 3650 states that OHA shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.	< 1%	Optional	Optional until July 1, 2013			FFS	Capitation?	Yes	$ 3,797,300	$ 15,447,416	$ 15,648,233	$ 15,836,012	$ 16,089,388	$ 16,121,060

Appendix M

Proposed CCO Global Budget Inclusion/Exclusion of Oregon Medicaid Services Programs

Program Area	Program/Service/Function	Notes	% of non-LTC Medicaid Expenditures (based on 09-11)	July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned	Pre-CCO Global Budget	Under CCO Global Budget	Budget Neutrality in Waiver Amendme	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Program is only one year old and has only operated in one county, with one additional county likely to begin operation soon.	< 1%	Optional in counties where currently operating	X			Invoiced	TBD	No						
Transportation	Non-Emergent Medical Transportation	Not currently in capitated rates, but inclusion necessary for coordination and access to care. Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation.	2%		X			Payment to brokerages on per ride basis	Methodology TBD	Yes	$ -	$ 23,606,072	$ 31,474,762	$ 31,474,762	$ 31,474,762	$ 31,474,762
Mental Health	Adult Residential Mental Health Services	High-cost, low-frequency services linked to management of census at state hospitals. CCOs will need to manage utilization and develop alternative services such as access to housing with necessary supports for independent living.	2%		X			FFS	Methodology TBD	Yes	$ -	$ 70,675,805	$ 95,459,454	$ 96,604,967	$ 98,150,647	$ 98,343,857
Targeted Case Management	HIV/AIDS Targeted Case Management	Overall services supported by Medicaid and CDC block grant funds.	< 1%		X			Invoiced	TBD	No						
Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon	Considering inclusion in second year of CCO operation or later in order to determine how to best integrate public health nurses into transformation.	< 1%		X			Invoiced	TBD	Yes	$ -	$ 599,213	$ 798,950	$ 798,950	$ 798,950	$ 798,950
Targeted Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)	Considering inclusion in second year of CCO operation or later in order to determine how to best integrate public health nurses into transformation.	< 1%		X			Invoiced	TBD	No						
Dental	OHP dental coverage	HB 3650 states that dental care organizations may choose to operate until 7/1/14 or opt to become part of a CCO sooner.	5%	Optional	Optional	Optional Until July 1, 2014		Capitation	Capitation	No						
Additional Enrollees	Citizen Alien-Waived Emergency Medical (CAWEM) Prenatal	Program currently operates in a limited number of counties.	1%	Optional	Optional	X		FFS	TBD	No						
Mental Health	Community crisis services, immediate mental health crisis assessment, triage, and intervention services available 24/7	Services are delivered by community mental health programs and are paid on a monthly basis to the counties. Excluded initially to avoid service disruption.	< 1%			X		Monthly allotment	TBD	Yes	$ -	$ -	$ 9,381,089	$ 12,658,217	$ 12,860,748	$ 12,886,065
Mental Health	Young Adults in Transition Mental Health Residential	Clients age 15-26 yrs. Eligibility currently determined by state. Integration with non-Medicaid funding sources and limited number of providers make it difficult to include in GB initially.	< 1%			X		FFS	TBD	Yes	$ -	$ -	$ 1,766,314	$ 2,383,346	$ 2,421,480	$ 2,426,246
Mental Health	Personal Care 20 Client Employed Provider	Providers are individuals selected by service recipient who require minimal ADL assistance (no more than 20 hours per month); Small volume makes inclusion initially in GB difficult.	< 1%			X		FFS	TBD	Yes	$ -	$ -	$ 902,783	$ 1,218,155	$ 1,237,645	$ 1,240,082
Mental Health	Community adult outpatient MH treatment services, case management, vocational and social services, locating housing, peer delivered services	A mix of county, Medicaid, general fund, and federal block grant funding.	1%			X		Monthly allotment	TBD	Yes	$ -	$ -	$ 32,264,667	$ 43,535,791	$ 44,232,364	$ 44,319,435
Mental Health	Mental health support services including supported employment, community geriatric psych specialists, preadmission screening/resident review (PASRR), housing renovations, homelessness supports, housing development	County funding that is a mix of Medicaid, general fund, and federal block grant. Difficult to put into GB initially due to this complexity.	1%			X		Monthly allotment	TBD	No	$ -	$ -	$ 16,407,094	$ 22,138,638	$ 22,492,857	$ 22,537,134
Long Term Care	Long term care institutional and community supports	Specifically excluded from CCO global budgets by statute	N/A				X	Varies		No						
Mental Health	OHP-covered mental health drugs	Specifically excluded from CCO global budgets by statute	3%				X	FFS		No						

Appendix M

Proposed CCO Global Budget Inclusion/Exclusion of Oregon Medicaid Services Programs

Program Area	Program/Service/Function	Notes	% of non-LTC Medicaid Expenditures (based on 09-11)	July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned	Pre-CCO Global Budget	Under CCO Global Budget	Budget Neutrality in Waiver Amendme	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
Other	Hospital Leverages: DSH, GME, Pro-Share, and UMG		3%				X	FFS/reconciliation		No						
Other	FQHC Full-Cost Settlements		2%				X	FFS/reconciliation		No						
Additional Enrollees	Citizen Alien-Waived Emergency Medical (emergency only, excludes CAWEM prenatal)	Emergency services only. Not predictable enough to forecast.	1%				X	FFS		No						
Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)	Program provides assessments, care plans, referrals and related activities specific to the developmentally disabled population, which CCOs may not have the experience to manage at this time.	< 1%				X	FFS		No						
Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)	Program provides assessments, care plans, referrals and related activities specific to the developmentally disabled population, which CCOs may not have the experience to manage at this time.	< 1%				X	FFS		No						
Mental Health	State Hospital Care - Forensic		< 1%				X	Direct Expenditure		No						
Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations		< 1%				X	Direct Expenditure		No						
Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)	This is a state hospital level of care. Low frequency-high cost utilization makes inclusion in cap difficult. The youth are court committed or transferred by OYA due to crisis.	< 1%				X	Direct Expenditure		No						
Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB	If determined necessary, care is provided at the state hospital and paid on a FFS basis. Low frequency - high cost utilization makes inclusion in capitation initially difficult.	< 1%				X	FFS		No						
Mental Health	Supervision services for persons under the jurisdiction of the Psychiatric Security Review Board (PSRB)	These are monitoring and reporting functions done by the community mental health programs on behalf of the PSRB and are paid monthly by AMH to the counties.	< 1%				X	Monthly payment		No						
Other	A & B Hospital Facilities Settlements		< 1%				X	Settlement		No						
Targeted Case Management	Child Welfare Youth (Targeted Case Management)	Difficult to initially put in CCO scope of work.	< 1%				X	Direct Expenditure		No						
Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)	Education based service provided by school or ESD staff.	< 1%				X	Invoiced?		No						
Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)	Difficult to initial put in CCO scope of work.	< 1%				X	Direct Expenditure		No						
Targeted Case Management	Tribal Targeted Case Management	Program is managed by tribes. State statute prohibits mandatory enrollment of tribal members into CCOs.	< 1%				X	Invoiced		No						
										Total	$ 10,688,104	$ 140,907,240	$ 235,873,371	$ 258,774,969	$ 262,333,774	$ 263,142,134

APPLICATION FOR AMENDMENT AND RENEWAL
Oregon Health Plan
1115 Demonstration Project

Medicaid and Children's Health Insurance Program

MARCH 1, 2012

Oregon Health Authority

APPLICATION FOR AMENDMENT AND RENEWAL
Oregon Health Plan
1115 Demonstration Project

Table of Contents

AMENDMENT AND RENEWAL REQUEST	
Topic	**Page**
I. Policy Context	4
II. Conditions on the Ground in Oregon - Legacy of OHP	6
III. Integration of Care for Medicare and Medicaid Enrollees	8
IV. Stakeholder and CMS Collaboration	10
V. Oregon's Medicare-Medicaid Demonstration Design Contract	12
VI. Certification of CCOs	13
VII. Design Elements of CCOs	13
VIII. Federal Authority Requests	20
IX. Budget Neutrality	24
X. Evaluation Plan	27

APPENDICES	
Title	**Appendix**
CCO Application Timelines	A
Oregon Health Plan Transformation Public Process	B
CCO implementation proposal	C
CCO populations and schedule for inclusion in global budget	D
State Fund Only Program List	E
Initial Proposed CCO Accountability Metrics	F
CCO Proposed Measures--Crosswalk to Medicaid Adult, CHIPRA and Medicare ACO Measures	G
Summary of federal authority matrix	H
Federal authority matrix	I
Budget neutrality – Base	J
Budget neutrality – Change	K
Budget neutrality – Combined	L
Inventory of Medicaid services and timeline for inclusion in global budget	M

RENEWAL AND AMENDMENTS TO
Oregon Health Plan
Medicaid and Children's Health Insurance Program
1115 Demonstration Project
February 2012

I. Policy Context

This document outlines proposed modifications to Oregon's existing Demonstration under Section 1115(a) of the Social Security Act. Since established in 1994, the Oregon Health Plan Demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth, saving the federal and state government more than $15 billion over the life of the waiver. With this renewal and amendment, Oregon seeks to build on our long history of demonstrated leadership and to meet three key goals:

1. Transform Oregon's Medicaid delivery system to focus on prevention, integration, and coordination of health care across the continuum of care with the goal of improving outcomes and bending the cost curve;
2. Promote the Triple Aim of better health, better health care, and lower per capita costs; and
3. Establish supportive partnerships with CMS to implement innovative strategies for providing high-quality, cost-effective, person-centered health care under Medicaid and Medicare.

We estimate that there will be approximately 200,000 additional Oregonians eligible for Medicaid with the implementation of federal health reform in 2014. This proposal envisions a system anchored by the creation of community-based Coordinated Care Organizations (CCOs) that focus on prevention and primary care and the needs of their particular communities. With these reforms, we believe Oregon will be well-positioned to provide access to health care for newly eligible people, meet the three goals outlined above, and, at the same time, effectively leverage federal and state resources to support integrated care. As Oregon forges ahead to implement its most ambitious health care transformation plan to date, focusing on integrated, coordinated care and alignment of incentives, we are also requesting approval to use federal savings earned under the OHP waiver to help launch our initiatives.

While Oregon will be requesting some new flexibilities, in addition to those in the state's current 1115 Demonstration authorities for the CCOs to effectively integrate and coordinate care, these flexibilities are not comprehensive and are not intended to supplant current federal and state statute governing health insurance and Medicaid managed care. Nor are the waivers requested in this application intended to reduce any current flexibilities under Oregon's 1115 Demonstration waivers.

The ultimate goal of the CCOs is to move from fragmentation to integration and deliver the right care in the right place at the right time within a patient-centered care model. CCOs will integrate and coordinate care across physical, behavioral, and oral health care services through a strong focus on primary and preventive care, evidence-based services, and more effective management of care. Not

only will CCOs change how services are delivered, but this new model will also serve a broader population by enrolling beneficiaries who would otherwise receive care on a fee-for-service basis, including those dually eligible for both Medicare and Medicaid. Experience in enrolling new beneficiary groups will help prepare CCOs to transform health care delivery for the expanded Medicaid population that will become eligible in 2014.

Oregon and its stakeholders are committed to transforming the delivery system without compromising the overall capacity to provide care. This will require a phased implementation of CCO requirements. However, the sustainability of Oregon's Medicaid program depends on successfully achieving system transformation in a timely manner. As outlined below, in order to proceed apace, Oregon may certify and contract with CCOs to provide care to Medicaid clients before the state's planning to integrate dually eligible beneficiaries is completed with CMS *(See Appendix A, CCO Application Timelines).* The Medicare-Medicaid Coordination Office is prepared to do the same with respect to integrated care for individuals who are dually eligible for Medicare and Medicaid beginning in January 2013. Regardless, Oregon will work with CMS to ensure that CCOs can successfully meet the needs enrollees, including those eligible for both Medicare and Medicaid.

Oregon's proposed health care transformation was initially outlined in the Oregon Legislature under House Bill 3650 of 2011,[1] which was passed with broad bipartisan support. The law creates a new delivery model for Oregon called the Integrated and Coordinated Health Care Delivery System in which CCOs are used to improve health; increase the quality, reliability, availability and continuity of care; and reduce the cost of care. Using alternative payment methodologies, and ongoing community needs assessments, CCOs will provide medical assistance recipients with integrated health care services that focus on prevention and use patient-centered primary care homes, evidence-based practices, health information technology and employ a broader use of non-traditional health care workers (e.g., community health workers, peer wellness specialists) to improve health and reduce health disparities. Within a fixed global budget, CCOs will be accountable for care management and provision of integrated and coordinated health care for their members. Care coordination will be an integral part of CCOs, which will provide services in a patient-centered primary care home setting to the maximum extent possible. Patients will choose or be assigned to a consistent provider/clinic or team to increase continuity and ensure individual responsibility for care coordination functions.

CCOs will developed a person-centered plan for beneficiaries with high or special health care needs, based both on their needs and personal preferences. Care plans will address key access, tracking, referral, and care coordination goals. There is a strong expectation that there will most likely be co-management for beneficiaries with mental health or substance abuse diagnoses and specialty services and supports for people with developmental disabilities and others who may need long term care and services and supports. Co-location of behavioral health and primary care is strongly encouraged. Patient-centered primary care homes (PCPCH)/health home services will function under the direction of a licensed health professionals, including physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

[1] http://www.leg.state.or.us/11reg/measpdf/hb3600.dir/hb3650.en.pdf

HB 3650 required OHA to submit specific proposals detailing CCO criteria for qualification and a CCO global budget methodology before the state would proceed with requests for federal flexibilities or implementation of the Medicaid delivery system transformation outlined in the legislation. Through a robust public process *(See Appendix B, Oregon Health System Transformation Public Process*), the Oregon Health Policy Board developed a detailed CCO Implementation Plan *(See Appendix C, CCO Implementation Proposal)* that included the CCO criteria for qualification and the CCO global budget methodology. The Implementation Plan was submitted to the legislature for consideration in late January 2012. Senate Bill 1580, which essentially approves the CCO criteria and global budget process and enables the creation of CCOs, was introduced by Governor John Kitzhaber, at the request of the Oregon Health Authority (OHA) on February 1, 2012. SB 1580 was passed with broad bipartisan support (53-7) on February 23, 2012.[2]

Building on the current managed care structure, Oregon's health system transformation efforts are the next stage of evolution for the state's Medicaid system. While there are similarities between CCOs and Medicare Accountable Care Organizations, Oregon's CCOs are risk-bearing entities. The CCO model emphasizes community-driven rather than provider-led governance; community needs assessments; person-centered care management; alternative payment methodologies; global budgets that increase at a fixed rate of growth, and a focus on metrics and outcomes. The key elements of the state's approach are patient-centered primary care homes, improved coordination of care, and aligned incentives that reward providers and beneficiaries for achieving good outcomes.

II. Conditions on the Ground in Oregon - Legacy of Oregon Health Plan

From 2009-2011, Oregon's Medicaid expenditures increased at an unsustainable annual rate that far outpaced the growth in general fund revenue. This growth in expenditures occurred despite the success of the Oregon Health Plan (OHP), which has saved the state and federal government an estimated $16 billion since its inception in 1994.

The Centers for Medicare & Medicaid Services (CMS) granted Oregon its initial section 1115 Demonstration to implement the innovative OHP nearly two decades ago, phasing in coverage under the initial Demonstration beginning in 1994. CMS approved Oregon's current section 1115 Demonstration, known as Oregon Health Plan 2 (OHP2), in 2002. The Demonstration has been renewed on several occasions and is currently scheduled to expire in October 2013. With this amendment, Oregon requests an extension of this Demonstration under Section 1115(a) of the Social Security Act, through October 31, 2016. Under the OHP2, the state currently provides coverage to more than 650,000 Oregonians and is available to individuals with incomes at or below 100 percent of the federal poverty level regardless of age, disability, or family status. The primary objectives of OHP2 are to achieve:

- Health care coverage for uninsured Oregonians;
- A basic benefit package of effective services;
- Broad participation by health care providers;
- Decreases in cost-shifting and charity care;

[2] http://www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.en.pdf

- A rational process for making decisions about resources and the provision of health care for Oregonians; and
- Control over health care costs.

Under OHP2, the majority of Oregonians covered through Medicaid and the Children's Health Insurance Program (CHIP) receive services through a combination of physical, behavioral, and dental managed care entities. Oregon's Demonstration is unique in its longstanding use of a prioritized list of health care conditions and treatments that enables the state to focus resources on prevention and use of the prioritized list as a method to control health care costs and assure accountability. It is envisioned that under this waiver modification, the prioritized list would continue to be used.

In 2009, Oregon established the Oregon Health Authority (OHA) as the guiding structure for the state's health and health care purchasing agencies, including the state employee's health program. OHA is overseen by the Oregon Health Policy Board (OHPB), a nine-member citizen board. OHA's mission focuses on "helping people and communities achieve optimum physical, mental and social well-being through partnership, prevention and access to quality, affordable health care." As part of a larger agency dedicated to the vision of a healthy Oregon, the Medicaid program and OHP2 are well-positioned to serve as an essential and leading component of the transformation of the Oregon health system.

As mentioned above, the OHP2 provides an important foundation to support the health system transformation to CCOs. Oregon's transformed system will leverage lessons learned from its managed care, behavioral health, and dental care organizations. The CCOs will build on the successes of current pilot programs focused on coordinating care for high-need, high-cost Medicaid beneficiaries. The state anticipates that CCOs will fundamentally reform the current delivery model by providing improved quality and benefits across all Oregon communities, paying providers for prevention and outcomes, and coordinating care for individuals with chronic conditions to achieve improved health outcomes and avoid preventable specialty care and unnecessary hospitalizations and emergency care.

While health plan performance is generally strong, there are still significant opportunities to enhance access to care, improve care delivery, and advance health outcomes at the community level. Although the number of children and adults served by the Oregon Health Plan who receive preventive services has increased annually, barriers still exist including health care providers that do not accept Medicaid and lack of knowledge among some beneficiaries and their families regarding the importance of routine health visits. Similarly, although appropriate prenatal visits have increased annually, there is still a lack of beneficiary understanding concerning the importance of prenatal visits, even when a pregnancy is going normally.

With the transition to CCOs, Oregon will be positioned to improve the satisfaction of beneficiaries with both their ability to get care and the quality of care they receive. At the same time, the CCOs will help the state achieve a sustainable level of health care spending through global payment strategies and reductions in unnecessary health care costs through better coordination of chronic care and a reduction of health disparities.

Economic conditions and revenue constraints

Oregon, like the rest of the United States, is experiencing a slow and tenuous economic recovery. The state's jobless rate has improved, showing a decline from 10.4 percent unemployment in January 2011, to 8.9 percent in December 2011, but it is still above the national unemployment rate of 8.5 percent during the same period. In addition, while Oregon is seeing slight increases in state revenues, overall revenues to the state have decreased, in part due to the expiration of the enhanced Medicaid Federal Medical Assistance Percentage (FMAP) funds. Oregon's budget reality is that state expenditures are outpacing revenues. This shortfall is driven in part by a rate of increase in Medicaid and public employees' health care expenditures, one area of spending that is growing faster than statewide general revenue. Without a change in its health care spending trajectory, Oregon is faced with making serious reductions in payments to Medicaid providers or adjustments to covered benefits to achieve its budget targets in FY2013.

This weak fiscal climate creates not only an imperative, but a unique opportunity for Oregon to do what it has done time and again – innovate. Through the CCO initiative, Oregon has developed an innovative redesign of the State's health care delivery system to achieve better value for all stakeholders while improving outcomes. With 80 percent of health care dollars spent on 20 percent of the patients, Oregon sees an opportunity to focus its health care transformation, in part, on improving coordination for patients with chronic health issues and increasing integration across physical, mental, dental and other health care services to enhance outcomes and reduced costs. If successful, this transformation will help Oregon reduce future costs to the OHP, stabilize the delivery system, and preserve available services.

III. Stakeholder and CMS Collaboration

OHA initiated discussions with CMS about the CCO model in early fall of 2011 and specifically addressed the state's desire to begin the transition to the CCO model beginning July 1, 2012. Through the CMS Medicaid State Technical Assistance Team (MSTAT) process, weekly calls and consultation have kept CMS officials informed of Oregon's progress, and a series of concept papers have more fully described components of Oregon's proposed health system transformation. Within Oregon, preparations and a robust stakeholder and public engagement process related to Oregon's waiver request began in the early days of the State's consideration of the new system. *(See Appendix B, Oregon Health Plan Transformation Public Process)*:

- In February, 2011, Governor Kitzhaber appointed 44 stakeholders to the "Health System Transformation Team." This group was made up of representatives of major components of the health care system, advocacy organizations and Oregon's tribes. It met every Wednesday evening in three-hour sessions over eight weeks to develop a conceptual framework for transformation of Oregon's health system. The work of this group resulted in the legislative concept that became HB 3650, which was signed by the Governor on July 1, 2011.
- In August 2011, Governor Kitzhaber selected 133 people—from nearly 500 applicants—to serve on four workgroups to inform the development of the CCO Implementation Proposal. The four work groups, chartered under the Oregon Health Policy Board (OHPB), included:

- CCO Criteria;
- Global Budget Methodology;
- Outcomes, Quality and Efficiency Metrics; and
- Medicare-Medicaid Integration of Care and Services.

The workgroups, which ranged in size from 35 to 40 members, were selected to represent the diversity of Oregon health care stakeholders. The workgroups met monthly for three-hour sessions, between August and November, each month providing input to the OHPB. All of the meetings were public, and the discussion topics and meeting materials were posted online for additional public comment.[3] Because of the size of the workgroups, the meetings were structured so that organizational and background information was presented in a large group setting, followed by structured, facilitated discussions in small group breakouts of 12 to 15 members each. The discussions from each of the workgroup meetings were summarized and presented to the OHPB along with a summary of public input.

- The Medicaid Advisory Committee considered issues related to Oregon's health system transformation in March, April, July, September and October 2011, and in January and February 2012.

- The Oregon Health Authority engaged with Oregon tribes about health system transformation in consultations and in regular meetings with tribal health care leadership in February, April, May, June, July, August, November, and December of 2011 and in January and February of 2012.

- The Oregon Health Authority engaged and held discussions of health system transformation with Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) representatives in May, June, August, September, November and December of 2011 and in February 2012.

- In late August and early September 2011, more than 1,200 Oregonians provided input through eight public meetings that were held around the state (Portland, Medford, Astoria, Bend, Roseburg, Eugene, Florence, and Pendleton; and through online surveys.

- Each month since the passage of HB 3650, the Oregon Health Policy Board meetings have focused on specific aspects of the CCO Implementation Proposal with both invited testimony and open public testimony. Two meetings were held in January 2012 to finalize the OHPB's recommendations to the legislature. These meetings are always live-streamed on the web.

- There were two open public comment periods on the Board's CCO Implementation Proposal in December 2011 and January 2012.

[3] http://health.oregon.gov/OHA/OHPB/health-reform/workgroups/index.shtml

IV. Integration of Care for Medicare and Medicaid Enrollees

Integration of Medicare and Medicaid services and financing for dually eligible Medicare-Medicaid enrollees is key to realizing Oregon's Triple Aim of better health, better health care, and lower costs. Medicare-Medicaid enrollees are a disproportionately high-cost population, making up 15 percent of the Medicaid population nationally, but accounting for 39 percent of Medicaid costs.[4] In Oregon, Medicare-Medicaid enrollees make up 17 percent of the Medicaid population, but account for 40 percent of the state's Medicaid expenditures for acute and long-term services and supports (LTSS). Similarly, Medicare-Medicaid enrollees make up 21 percent of the Medicare population nationally (15 percent in Oregon), but account for 36 percent of Medicare costs.[5] There are approximately 59,000 Medicare-Medicaid enrollees in Oregon.

Under the Demonstration authority for Medicare-Medicare enrollees (hereafter referred to as the "Medicare-Medicaid Demonstration"), financial alignment will result in savings for this population, for example, through:

- Reductions in avoidable hospitalizations and emergency room utilization;
- Reductions in avoidable specialty care
- Reductions in unnecessary or duplicative drug utilization; and
- Administrative efficiencies from new flexibilities to align Medicare and Medicaid regulatory and administrative requirements.

Enrollees participating in the Medicare-Medicaid Demonstration will receive primary, acute, mental health and chemical dependency care, and prescription drugs through their CCO. The CCOs will not directly provide long-term services and supports (LTSS); however, in order to reduce costs in both systems and ensure shared responsibility for delivering high-quality, person-centered care, the CCOs and LTSS system will coordinate care and share both programmatic and financial accountability.

Promising models and pilot projects exist in Oregon for better coordinating care between the medical and LTSS systems. Practices that are used in these projects (alone or in combination) are described below.

- *Co-Location or Team Approaches:* These models include co-location of staff such as LTSS case managers in medical settings (hospitals or primary care), care coordination positions jointly funded by the LTSS and medical systems, or team approaches such as a multi-disciplinary care team including LTSS representation.
- *Services in Congregate Settings:* In these models, a range of LTSS and medical services are provided in congregate settings to a group of common beneficiaries. Services can be limited to one type of service, such as personal care provided in an apartment complex.

[4] 2007 data - The Kaiser Family Foundation Program on Medicare Policy. (January 2011). *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*. Menlo Park. CA: Jacobson, Gretchen, Neuman, Tricia, Damico, Anthony, Lyons, Barbara. http://www.kff.org/medicare/upload/8138.pdf Oregon specific data: Kaiser Family Foundation, State Health Facts (2007 data). www.statehealthfacts.org

[5] Ibid.

- *Physician Extender/Home-Based Programs:* These models rely on the use of nurse practitioners, physician assistants or registered nurses who perform assessments, plan treatments, and provide interventions to the person in their home, or another community-based setting, or a nursing facility setting.

To achieve system-wide alignment, models such as these will be brought to scale under the Medicare-Medicaid Demonstration and supported by mechanisms that promote shared accountability. A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTSS system, including those that reflect better coordination between the two systems. Other elements of shared accountability between CCOs and the LTSS system will include:

- Contractual elements, including specific requirements for coordination between the two systems;
- Requirement to clearly define roles and responsibilities between the two systems through a memorandum of understanding, contract, or other mechanism between the CCO and the local Area Agency on Aging (AAA) or the state's Aged and People with Disabilities (APD) local office; and
- Reporting of metrics related to better coordination between the two systems.

As with the rest of the CCO development process, in establishing these structures for shared accountability across CCOs and the LTSS system, it will be important to balance prescriptiveness and local flexibility. OHA and Oregon's Department of Human Services (DHS) will set broad goals for integration of care for Medicare-Medicaid enrollees, and local entities interested in becoming CCOs will propose approaches within their individual capacity to address the needs of beneficiaries. OHA and DHS will approve proposals that reduce the cost-shifting and uncoordinated care that can result in fragmented care and poor outcomes for beneficiaries.

The CCO care delivery model is uniquely suited to meet the needs of complex populations through its patient-centered approach and community focus. It provides an ideal platform for development of the Medicare-Medicaid Demonstration. Oregon will work with CMS to align the CCO design and and model requirements with the Medicare Advantage Model of Care standards in order to ensure that the final three-way contract includes the elements necessary to meet the needs of Medicare-Medicaid enrollees. The final Memorandum of Understanding (MOU) will outline the clinical and non-clinical care elements to be provided through the Demonstration.

For example, in the MOU, CMS and the state will agree on how to align enrollment processes and beneficiary safeguards, such as appeals. In addition, guidelines for beneficiary information will be included in the Medicare-Medicaid Demonstration MOU and three-way contracts with CCOs. Beneficiary information about options for enrollment will be integrated with Medicare to the extent possible, and be accessible and understandable to beneficiaries, including those with disabilities or limited English proficiency. CMS and the state will prior approve all outreach and marketing materials, subject to a consistent and integrated single set of rules.

V. Oregon's Medicare-Medicaid Demonstration Design Contract

In April 2011, Oregon was selected to receive a $1 million contract from CMS for a 12-month planning process to design a new approach to integrate care for dually eligible Medicare and Medicaid enrollees. OHA is preparing a formal implementation proposal, through which CMS may offer additional funding for the Medicare-Medicaid Demonstration. This proposal is due in April 2012. This proposal will closely follow the Capitated Financial Alignment model, in order to take advantage of the new opportunity to pursue three-way contracts between health plans, the state, and CMS for blended Medicare and Medicaid payment to plans. The blended rates, which will be paid to CCOs, will reflect savings for both Medicare and Medicaid. However, as a design contract state, Oregon is not limited to proposing this model, and as such the proposal to CMS may also be an opportunity to pursue other promising models, such as housing with services and a more flexible Program of All-Inclusive Care for the Elderly (PACE) program.

Oregon will work with CMS to negotiate the terms and program structure for the Medicare-Medicaid enrollee population to ensure that its proposal meets Oregon's requirements and CMS standards and conditions for including Medicare funding for Medicare-Medicaid enrollees. After signing an MOU between the state and CMS, CMS will participate in the contracting process as relevant for Medicare funding, likely on a timeline following the state contracting process, leading to the signing of three-way contracts among CMS, the state, and CCOs.

Through the Medicare-Medicaid Demonstration, regular calls and meetings have kept CMS officials abreast of Oregon's progress. Oregon state officials have engaged internal and external stakeholders to gather feedback about the current system and how to most effectively structure the proposed new system. Staff attended focus groups organized by CMS that provided valuable insights into how consumers interact with and view the current system and areas of potential improvements. One of the external stakeholder workgroups established by Governor Kitzhaber to assist in developing the CCO framework focused specifically on integration of care and services for Medicare-Medicaid enrollees. This workgroup included participants from a variety of perspectives, including consumers, medical and LTSS providers, local AAAs, health insurance plans, unions, and advocates. The workgroup met four times to address:

- What is working and what needs to improve in the delivery of coordinated, integrated services for dually eligible individuals;
- Development of metrics that reflect the needs of this population;
- Strategies for structuring care coordination and transitions of care; and
- Strategies for shared accountability with long-term care

Staff also conducted listening groups with Medicare-Medicaid enrollees and participated in workgroups with state leadership and subject matter experts to analyze policy options and ensure that the needs of individuals who are dually eligible are addressed throughout Oregon's health system transformation effort.

VI. Certification of CCOs

Throughout the stakeholder process, OHPB received recommendations about the key certification requirements for CCOs. In March 2012, OHA will begin a non-competitive request for applications (RFA) procurement process that specifies the criteria that organizations must meet to be certified as a CCO (*See Appendix A, CCO Application Timelines*). Prospective CCOs will be asked to submit applications to OHA describing their capacity and plans for meeting the requirements established by HB 3650 and its successor laws, including being prepared to enroll all eligible persons within each CCO's proposed service area. Contracts with certified CCOs will be for multi-year periods, with annual renewal based on CCO compliance with OHA requirements; this is similar to Medicare Advantage contract renewals. Certification will be for six-year periods; CCOs will retain their certification between certification periods as long as they are in compliance with OHA requirements, and in the future, with Division of Insurance requirements. Recertification will include public process to be established in rule by OHA.

In mid spring 2012, OHA will promulgate administrative rules describing the CCO application process and criteria. Once the criteria have been finalized, the state will initiate the application process for prospective CCOs in March 2012. It is expected that CMS will provide guidance to OHA in its evaluation of applications and certification of CCOs in order to be certified to take Medicare risk.

Because CCOs will be responsible for integrating and coordinating care for Medicare-Medicaid enrollees, the application will build on the existing CMS Medicare Advantage application process, streamlining the process for any plans that have previously submitted Medicare Advantage applications. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas. Evaluation of CCO applications will account for the evolutionary nature of the CCO system. CCOs, OHA, and partner organizations will need time to develop capacity, relationships, systems, community needs assessments, and the experience necessary to fully comply with HB 3650.

VII. Design Elements of CCOs

In a final report in January 2012, OHPB made the following recommendations for the key design elements of the CCOs. *(See Appendix A, CCO Application Timelines)*

a. Global budget

CCO global budgets are designed to cover the broadest range of funded services for the most beneficiaries possible. The construction of global budgets start with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets will include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services, achieve economies of scale and scope and to contain per capita costs to a sustainable fixed rate of growth. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

Medicaid Populations Included in Global Budget Calculations. With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. An overview of the eligible CCO populations and their current managed care enrollment can be found in *Appendix D, CCO populations and schedule for inclusion in global budget*. Approximately, 78 percent of people who are eligible for Medicaid are enrolled in a capitated physical health plan, 88 percent in a mental health organization, and 90 percent in a dental care organization.[6] HB 3650 directs OHA to enroll as many of the remaining eligible individuals (including those who are currently in fee-for-service Medicaid) into a CCO as possible. Section 28 of HB 3650 specifically exempts American Indians, Alaska Natives and related groups from mandatory enrollment in CCOs.

Medicaid Service/Program Included in Global Budgets. One of the primary goals of the global budget concept is to allow CCOs flexibility to invest in care that may decrease costs and achieve better outcomes. The more programs, services and funding streams that are included in CCO global budgets, the more flexibility and room for innovation exist for CCOs to provide comprehensive, person-centered care. In addition, leaving necessary care outside of the global budget creates conflicting incentives where the action of payers outside of the CCO, who have little reason to contribute to CCO efficiencies, may have an undue effect on costs and outcomes within the CCO.

The inclusion of Medicaid services in CCO global budgets will be phased in to balance accountability, incentives, and enrollee care concerns. *Appendix M, Inventory of Medicaid services and timeline for inclusion in global budget*, provides an inventory of Medicaid funded services and the current plan for inclusion of those services in CCO global budgets.

Without exception, funding and responsibility for all current services provided by managed physical and mental health organizations will be included in each CCO's global budget. The services that are currently included in capitationunder physical and mental health organizations account for approximately 70 percent of Oregon's non-long-term care Medicaid expenditures.

Currently, five percent of Oregon's non-long-term care Medicaid expenditures are associated with payments for dental care through DCOs. Dental expenditures will be included in global budgets based on individual CCO determination, as HB 3650 allows until July 1, 2014 to incorporate these services.

With respect to the remaining non-long-term care Medicaid expenditures, *Appendix D* provides the schedule for inclusion in the global budget. Careful consideration needs to be given to when and how these services are folded in. CCOs are strongly encouraged to develop strategic partnerships within their communities in order to successfully manage comprehensive global budgets. While these partnerships are developing we do not want to fold in services that may reduce the quality or access of current high need or targeted services. Over time, the OHPB feels strongly that all exclusions need to be addressed to ensure a robust CCO global budget structure.

[6] Citizen Alien Waived Emergent Medical (CAWEM) beneficiaries and individuals who are partially dual eligible for Medicaid and Medicare—including qualified Medicare beneficiaries (QMB) and specified low-Income Medicare beneficiaries (SLMB)—are not included in this calculation.

Components of the Global Budgets. The overall global budget strategy will hold CCOs accountable for costs but not enrollment growth. This strategy suggests an overall budgeting process that builds on the current capitation rate methodology, but includes a broader array of Medicaid services and/or programs. After establishing the baseline global budget, the State proposes to contain CCO global budgets to a sustainable, fixed rate of per capita cost growth and would like to work with CMS to develop that methodology.

Major components of the CCO global budgets include:

A capitated portion that includes the per-member per-month payments for services currently provided through the OHP physical health plans, mental health organizations and (if included) dental care organizations.

At least initially, the capitated portion of CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011–13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the communities the CCOs serve. Under this approach, potential CCOs will submit a completed base cost template using internal cost data that is representative of a minimum base population. This will not be a competitive bidding process, but OHA actuaries will review the submission for completeness and soundness in order to establish a base rate. Once a base rate is established, the state actuaries will use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

CCO optional services that can be included in individual CCO global budgets if all integral community partners support the inclusion. These services include residential alcohol and drug treatment services, OHP dental coverage, and selected targeted case management programs that are offered in only one or a few counties. HB 3650 specifies that the first two are optional for inclusion until July 1, 2013 and July 1, 2014 respectively. We anticipate that they could be paid on a per member per month basis. The reimbursement methodology for the selected targeted case management programs is under development as local matching funds serve as the state Medicaid match. *Appendix D* provides a timeline for statewide inclusion of these and any remaining Medicaid funded services not listed here. In the interim, Medicaid services not included in the global budget initially will continue to be reimbursed as they are currently.

CCO transformation incentive payments that will be outside of the capitated portion to provide 1) infrastructure for metric reporting and delivery system transformation efforts in year 1 of the global budgets, and 2) incentive for continual transformation and improvement through meeting both cost and health outcomes metrics.

Additionally, CCO global budgets will include Medicare funding to blend with Medicaid funding to provide care and services to individuals eligible for both programs. Discussion of this methodology is addressed in the State's proposal for the Medicare-Medicaid Demonstration.

Finally, Oregon would like to explore with CMS the implications of phasing non-emergency medical transportation (NEMT) into the CCO global budgets during the first contract year. Oregon operates this program under a 1915(b) waiver.

b. Accountability

CCOs will be accountable for outcomes associated with better health and more sustainable costs. HB 3650 directed that CCOs be held accountable for their performance through public reporting of metrics and contractual quality measures. These strategies function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in accordance with HB 3650. Accountability measures and performance expectations for CCOs will be phased in to allow CCOs time to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards. An external stakeholder group established as part of Oregon's health system transformation developed a set of measurement recommendations for OHA to use as a guide. SB 1580 creates a nine-member Metrics and Scoring Committee within OHA, to be appointed by the Director. This group is directed to identify "objective outcome and quality measures including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations." It further requires that quality measures adopted by the committee must be consistent with existing state and national quality measures.[7]

i. Quality Measurement

OHA has distinguished CCO accountability metrics (including both core and transformational measures as described below) from measures and reporting requirements designed to promote CCO transparency and community engagement and to enable state and federal monitoring and evaluation of CCO structure and operations.

As defined by the OHPB and its Quality, Outcomes, and Efficiency workgroup, there are two types of CCO accountability measures:

- *Core Measures*: Triple-Aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes in the selected domains.
- *Transformational Measures*: Measures that assess CCO's progress toward the broad goals of health systems transformation, which may require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

To conduct this measurement, it will be important for reports and data to flow from CCOs to OHA and from OHA to CCOs. While annual reporting will serve as the basis for holding CCOs accountable to contractual

[7] http://www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.en.pdf

expectations, OHA will assess performance more frequently (e.g., quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

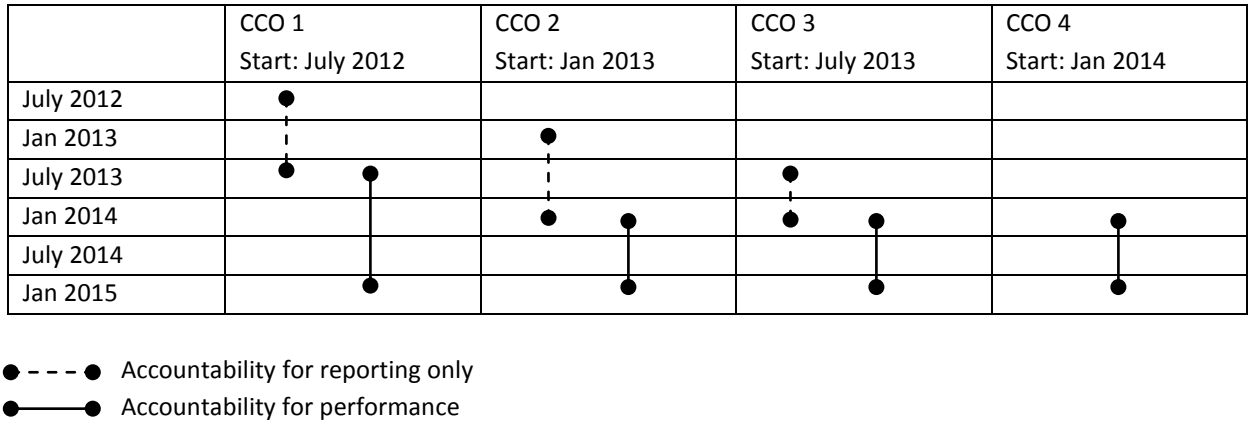
Initial core and transformational measures are shown in *Appendix F*, and, where applicable, alignment with national quality measure sets is also exhibited.[8] Many of the measures proposed for CCO accountability are the same as or closely aligned with items used in federal measurement initiatives including Medicaid Adult and CHIPRA core sets, Medicare Advantage reporting requirements, and Medicare's Shared Savings (ACO) and Hospital Value-based Purchasing programs. *Appendix G* exhibits both proposed core measures and transformational measures. In addition, Oregon will collect and report other measures, also shown in *Appendix G*, to satisfy federal reporting requirements and to provide communities with information about the performance of their CCO(s). Oregon will continue to work with CMS as part of the Medicare-Medicaid Demonstration to identify performance measures to promote joint accountability between CCOs and the long-term services and supports system (LTSS).

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. *(See Figure 1 below).* In year 1, CCO accountability will be for reporting only. In years 2 and 3, CCOs will be accountable for meeting minimum standards on core measures and improving on their past performance for transformational measures. OHA plans to offer incentives to reinforce these reporting and performance expectations, with the specific incentive design to be determined.

Initially, these accountability years will be based on the effective date of each CCO's contract; that is, year 1 for a CCO that starts operation in July 2012 will be July 2012-June 2013, and year 1 for a CCO that starts operation in November 2012 will be November 2012-October 2013. However, all CCOs will be required to meet minimum accountability standards by January 2014, regardless of their start date. CCOs that begin operation less than a year before that date will have a shorter reporting-only period and CCOs that start on or after January 2014 will have no phase-in period at all, as depicted in Figure 1 below.

[8]Appendix F represents measures currently under consideration, not a final list. The next stage of metrics development will be for OHA to establish a technical advisory group of internal and external experts (including consumers) to build measure specifications, including data sources, and to finalize a reporting schedule. Development of joint CCO-LTSS accountability measures will also be part of this task. Further technical work, such as establishing benchmarks based on initial data, will follow.

Figure1: Phasing in of CCO Accountability Measures



CCO accountability metrics will evolve over time based on ongoing evaluation of the metrics' appropriateness and effectiveness. OHA's Metrics and Scoring Committee will establish an annual review and revision process that draws on the expertise of the technical workgroup described above and that ensures participation from representatives of CCOs and other stakeholders, including consumers and community partners. To guide its annual review, OHA and the Committee will utilize the OHPB's Quality, Outcomes, and Efficiency workgroup principles for measure selection and revision along with national frameworks like the Institute of Medicine's stepwise approach to "measuring what matters."[9]

ii. Quality Assurance and Performance Improvement (QAPI)

CCOs will be required to maintain QAPI plans, as managed care organizations do today, including requirements for utilization guidelines and review, member protections, quality and access reporting, and fraud and abuse protections. In keeping with Oregon's goals for health system transformation and the proposed structural and operational criteria for CCOs, the following are likely focus areas for quality assurance and performance improvement (QAPI) at the state and CCO levels:

- *Person-(or patient) Centered Care* -- Patient engagement and activation including shared decision making; involvement of patients in developing a plan of care and planning for care transitions; and mechanisms for engaging patients outside the health care setting and improving self-management skills, including planning for end-of-life care.
- *Governance and Partnerships* – Collaboration with safety net providers, dental care organizations and residential chemical dependency service providers (if not incorporated into CCO initially), local public and mental health authorities, the long-term care system, and other systems or agencies like the Governor's Early Learning Council; and involvement of consumers (or beneficiaries) in CCO governance.

[9] Institute of Medicine. (April 2011). Child and Adolescent Health and Health Care Quality: Measuring What Matters. Available at: http://www.iom.edu/Reports/2011/Child-and-Adolescent-Health-and-Health-Care-Quality/Report-Brief.aspx

- *Care Coordination and Integration* – Use of OHA-recognized patient-centered primary care homes (PCPCHs); timely communication between PCPCHs and other services; providers using electronic health information technology where available; real or virtual co-location of services; use of alterative payment methodologies to encourage coordination and integration of care; and coordination of care for individuals receiving Medicaid-funded long term care services given the legislative exclusion of Medicaid funded long-term services from CCO global budgets.
- *Capacity and Access* – Adequacy of provider network in relation to member needs and choice of providers; use of non-traditional health workers and availability of care in non-traditional settings; timely and appropriate access to hospital and specialty services; and use of population health management tools and strategies.
- *Reduction of Health Disparities* – Development of a needs assessment process to identify community needs, and health disparities; prioritization of health disparities for reduction in the community action plan; use of best practices and provision of culturally and linguistically appropriate care; and maintenance of data on member race, ethnicity, and primary language in accordance with state standards.

The focus areas above reflect many service expectations for CCOs that cannot be tracked using traditional medical coding systems. The state's QAPI activities and QAPI requirements for CCOs will allow for strong oversight of these services without imposing new and potentially burdensome reporting mechanisms that run counter to the CCO model and the intent of transformation. Oregon will work with CMS to develop a process to identify QAPI focus areas that include Medicare quality improvement priorities for dual eligibles.

The CCO accountability measures described above and related incentives will be core elements of the state's Quality Strategy. The measures will allow OHA to set clear expectations for care delivery and health systems transformation and to monitor CCOs' performance against those expectations. The state will work with independent entities (QIO/EQRO) to review CCO performance. While Oregon plans to utilize the QIO/EQRO for audits, the state will retain the responsibility to monitor CCOs as they come into compliance after findings are presented and as they maintain compliance. OHA will institute a system of progressive accountability that maximizes the opportunity to succeed but also protects the public interest.

Technical assistance for performance improvement will be the primary strategy in the first year of CCOs' operation, when their accountability will be for reporting only. Informal interim reporting (quarterly or semi-annually) will facilitate timely feedback and allow for mid-course corrections such that CCOs will be prepared to meet specified quality standards in year 2, whether those standards are absolute benchmarks or expected improvement on past performance. When the evidence indicates that a CCO is not meeting performance standards, steps taken will build on current accountability mechanisms for Medicaid MCOs and Medicare Advantage plans, and may include:

- Technical assistance;
- Increased frequency of monitoring efforts;
- Corrective action plan;

- Restricting enrollment;
- Financial penalties; and
- Non-renewal of contracts.

These consequences would phase in over time if sub-standard performance continues. For CCOs that perform well on accountability metrics and meet other contractual expectations, OHA may choose to offer a simplified, streamlined recertification or contracting process in addition to the possibility of financial performance incentives.

c. Application process

Beginning in March 2012, prospective CCOs will respond to a non-competitive RFA. The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements to the extent that these are known at that time. The RFA will be open to all communities in Oregon and will not be limited to certain geographic areas. OHA is required to contract with all certified CCOs. (*See Appendix A, CCO Application Timelines*)

d. Governance

CCOs will be required to have a governing board with a majority interest consisting of representation by entities that share financial risk as well as representation from the major components of the health care delivery system. In addition, the governance structure must include at least two health care providers in active practice, at least one whose practice is primary care; and a mental health or chemical dependency treatment provider. At least two members must be from the community at large. CCOs will also convene community advisory councils to provide a community perspective and a member of the council will serve on the CCO governing board.

e. Criteria

In their applications for certification, CCOs will demonstrate how they intend to carry out the functions outlined in HB 3650 and SB 1580, including:

Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;

- Ensuring member rights and responsibilities within the context of patient-centered care with the member as part of the primary care team;
- Addressing health disparities among member populations and communities, both to improve outcomes and the health of the community, and as an investment in containing costs;
- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency through reporting of quality data; and

- Complying with financial reporting requirements and assuring financial solvency.

(*For detailed criteria, go to: health.oregon.gov for a draft copy of the Request for Applications*)

VIII. Federal Authority Requests

With this waiver amendment, Oregon requests that its existing Medicaid waiver authority remain in place, both to waive certain provisions of the Social Security Act and to maintain authority for Costs Not Otherwise Matchable (CNOM). Oregon is also requesting additional waiver authority, new requests for CNOM as outlined below.

a. Waiver Authority

As detailed in the attached matrix, *Appendix I, Federal Authority to Implement Coordinated Care Organizations (CCOs) and Transform Managed Care Organizations (MCOs) in Oregon*, there are several changes that will occur to the OHP based on this amendment, but the state believes that its existing authority already allows for many of the proposed changes to the OHP. The state does anticipate significant changes to its Special Terms and Conditions to reflect the proposed programmatic changes. In addition, as described in *Appendices H and I*, the state will also be requesting state plan amendments to implement some features of the transformation, including the ability to use a non-traditional workforce.
Specifically, Oregon's current waiver includes authority that the state wishes to maintain. This authority allows the state to:

- Contract with managed care entities and insurers;
- Mandatorily enroll and auto-enroll individuals within managed care, and lock-in enrollment;
- Define types of insurers;
- Offer Federally Qualified Health Centers (FQHCs) and Rural Health Clinic (RHC) services only where available through managed care providers;
- Use Oregon's Prioritized List of Health Services;
- Provide different benefits to different eligible populations; and,
- Contract for comprehensive services on a prepaid or other risk basis.

In addition to Oregon's existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow for:

Issue	CFR/SSA Reference
• Flexibility to make payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement • Alternative provider payment methodologies to reimburse on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care, and comprehensive care coordination • Flexibility to create PMPM payments to support Patient Centered Primary	42 CFR § 438.6

Issue	CFR/SSA Reference
Care Homes for the remaining FFS Medicaid/SCHIP populations that do not meet the ACA sec. 2703 multiple chronic condition requirements. *(Oregon has submitted a SPA for the ACA Sec. 2703 population)* • Latitude to set rates inclusive of non-encounterable medical services (1902(a)(30)) • Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community • Latitude to set a sustainable fixed rate of per capita cost growth within CCO global budgets • Flexibility in design, implementation and scoring of performance improvement plans (PIPS) to align with Medicare processes	
• An alternative payment methodology for FQHCs to allow a unique FQHC prospective payment system (PPS)/alternative payment methodology (APM)	SSA § 1902(bb)
• Expansion of definition of "health care professional" expansion to include naturopathic physicians and other state-licensed providers	42 CFR § 438.2
• Flexibility for the state to optimize the use of electronic communications to OHP members where written materials are required, at member's request, as well as contractors and providers	42 CFR § 422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230; 42 CFR § 438.6, 10. 56. 100,102, 104, 210, 224, 228, 400-424, 702, 706, 708, 722; 42 CFR § 455.1;42 CFR § 489
• Flexibility in marketing requirements for CCOs that serve Medicaid and Medicare, and commercial populations	42 CFR § 438.104
• Ability to streamline and simplify due process rights to reflect person-centered primary care and to align Medicaid and Medicare consumer protection processes to the greatest extent possible (1902(a)(3))	42 CFR § 438.400-424 42 CFR § 431.244
• Ability to fold non-emergency medical transportation into global budget in first contract year	42 CFR § 431.53

b. Expenditure Authority

Designated State Health Programs (DSHP). In addition to the additional waiver authorities outlined above, Oregon is requesting an amendment to our OHP 1115 Demonstration to authorize federal financial participation (FFP) for selected state designated health programs (DSHP). These programs would be

authorized by Section 1115(a) cost not otherwise matchable authority (CNOM). Our target request is approximately $450 million per year (which represents approximately $750 million (FFP) in approved DSHP programs.

A list of identified programs is included as *Appendix E, State Fund Only Program List*. These programs are vital for the success of health system transformation, spanning mental health, public health, community services, and child health services. Currently, state funds support these services and programs to meet health needs that Medicaid, as it is currently structured, does not. Many of the Oregonians served by these dollars receive services along side of people who are Medicaid eligible, and many of them are individuals who churn in and out of Medicaid eligibility, creating a confusing and inefficient system for consumers and communities to navigate. We ask for federal investment in these programs in recognition that they are vital to improving the health of Medicaid enrollees and the communities in which they live.

The additional expenditures outlined in *Appendix E* will serve as a down payment on health reform in Oregon that will yield results in support of the triple aim. Oregon's request to CMS is patterned after similar approved requests in other states (e.g., California, New York and Massachusetts), and Oregon hopes to be given the same opportunity. The state anticipates that this additional federal investment can be ramped down as we approach implementation of federal reform in 2014 and begin to realize the additional savings from health system transformation. CMS approval of this request will allow Oregon to move forward with our mutual reform goals without eroding services that are vital for transformation.

Finally, the State would also like to explore with CMS the mechanism for using county Intergovernmental Transfers (IGT).

Additional FFP for Oregon's Home and Community Based Services (HCBS) programs. Oregon would also like to pursue a request for an additional 6 percentage points FFP for our current HCBS waiver, increasing the opportunity to connect long term care and services to Oregon's health system transformation. Oregon has long been a leader in placing eligible beneficiaries in community-based settings and is therefore not eligible for the CMS rebalancing incentives. While long term care is not part of the global budget that will be paid to Coordinated Care Organizations, Oregon is pursuing the same management strategies that would exist if long term care was included. Oregon is partnering and establishing strong accountability expectations between the acute and long term care systems. This strategy is comprehensive and is presented with specifics in Oregon's Dual Design proposal.

Currently, Oregon is serving a remarkably low 16.2% of its aged and physically disabled long term care population in nursing facilities. Zero percent of our developmental disability population is served in institutions. While this is outstanding from a cost/ independence factor, it does make care coordination more challenging as care coordination is easier when residents are served in large institutional settings. Approval of this request will facilitate additional investment towards ensuring Oregon's initiatives are successful.

Specifically, we are requesting:

1) An additional 6 percent FF for the aged and physically disabled waiver.
2) An additional 6 percent FF for the DD comprehensive services waiver.
3) An additional 6 percent in FF for the DD support services waiver.
4) An additional 6 percent in FF for the DD children's model waivers.

IX. Budget Neutrality

Oregon understands that the state must demonstrate budget neutrality for the Oregon Health Plan (OHP) Demonstration. Budget neutrality means that Oregon may not receive more federal dollars under the Demonstration than it would have received without it. The state is requesting amendment to its Section 1115 Demonstration in order to implement Oregon's health system transformation (HST) initiative. This document discusses the budget neutrality tests for the Section 1115 Demonstration.

The Section 1115 budget neutrality test performed for this Demonstration amendment will build upon the methodology that was adopted for the OHP Demonstration approvals that were originally granted in 1993 and most recently extended in 2010.

When submitting a combined Section 1115, states are required to include an initial showing that the Demonstration is expected to be budget neutral. This is the state's best estimate of cost and caseload at the time it submits its request. The test for budget neutrality will be applied according to the terms and conditions for the Demonstration that have been agreed to by the state and CMS, and will be measured periodically throughout the course of the Demonstration approval period and will finally be measured at the conclusion of the Demonstration.

This section is organized into three parts:

- Oregon's management tools to manage budget neutrality;
- The components of the budget neutrality test; and,
- Oregon's cost and caseload estimates, the key assumptions that underlie those estimates.

Additional details of the cost and caseload estimates are reflected in a series of exhibits.

a. Budget Neutrality Management Tools

While the design of the Demonstration must satisfy the requirements for federal budget neutrality in order to be approved by CMS, it must also satisfy the requirements for state budget neutrality in order to be implemented by Oregon.

In order to provide for administrative efficiency and management flexibility, the Demonstration is designed so that the state may invoke any of the budget neutrality management strategies, with appropriate notice to CMS. Oregon requests continuation of this flexibility which has included two primary management tools:

- The adjustable enrollment cap used to limit the size of the OHP Standard and FHIAP Demonstration populations, and is established based on funding availability and/or budget neutrality capacity.
- An adjustable benefit level through moving the coverage line further up or down the Oregon Prioritized List of Health Care Services for both OHP Standard and OHP Plus populations, subject to Legislative direction and CMS approval. Additionally the state has the flexibility to add or remove services that are not part of the fixed set of OHP Standard services, depending on available state funds.

In addition to these two very important budget management tools, the state is working toward the implementation of global budgets that will provide certainty in funding over time for both the state and Coordinated Care Organizations. Please see "Global Budget" p. 10 for discussion of the global budget methodology.

b. Components of the Budget Neutrality Test

Oregon requests that the current Section 1115 Demonstration methodology be used for the purpose of evaluating budget neutrality for the five year HST extension period. This methodology uses a set of specified annual per capita costs multiplied by the actual or allowed enrollment for each year of the five year Demonstration. The result of this calculation is an aggregate allowable expenditure level. *Appendices J, K and L* contain all budget neutrality calculations.

Oregon proposes to continue use of the CMS approved DY 2010 per capita costs for the various eligibility groups under the current Demonstration extension for determination of the base year allowable costs.

Trending Factors. The base year allowable per capita rates are trended by CMS approved trend rates through Demonstration year (DY) 11 (FFY 2013). The proposed Demonstration extension is based on the Medicaid specific National Health Expenditure projected trend rates of 8.3 percent for DY 12 (FFY 2014), 5.9 percent for DY 13 (FFY 2015), 6.3 percent for DY 14 (FFY 2016), and 6.0 percent for DY 15 (FFY 2017).

With the implementation of health system transformation, Oregon anticipates savings over the five year waiver. These savings, based on recent modeling performed for the state by Health Management Associates (HMA), are incorporated into the budget neutrality calculations through a per member per month adjustment to the projected per capita spending estimates.

Beneficiaries and Services Included. In the implementation of health system transformation, Oregon proposes to include individuals diagnosed with breast and cervical cancer and Citizen/Alien-Waived Emergency Medical (CAWEM) pregnant women. Per capita calculations are included for these populations for both the allowable and actual spending estimates in *Appendices J, K and L*.

The budget neutrality test will be expanded beyond the historical Oregon acute care and behavioral health programs that have been included. *The State Fund Only Program List at Appendix E* outlines the additional services that Oregon expects to be affected under this HST extension period. Budget neutrality calculations provide a per capita adjustment applied equally to the allowable and actual waiver estimates to account for these additional services as a "pass through". Medicaid services and populations (e.g., QMB/SLMB, long-term care) for which the state has no immediate plans to move into CCO global budgets are excluded from budget neutrality calculations.

Historical Savings. Oregon is a demonstrated leader in delivering high quality care and containing spending growth in its Medicaid program. Oregon is requesting to continue use of the historical Demonstration savings (currently estimated at $16 billion total funds). This figure reflects the savings estimates identified by Oregon and CMS through the twenty year life of the OHP Demonstration.

Administrative costs will continue to be reimbursed based on the current federal matching rates of 50 percent, 75 percent and/or 90 percent of the administrative expense and are not subject to the budget neutrality test.

c. Caseload and Cost Estimates

This section describes the caseload and cost estimates for this Demonstration amendment request, as well as additional background information and key assumptions that underlie the estimates.

Demonstration Renewal Time Frame. The State also requests approval of a three-year extension through October 31, 2016. The current Demonstration is scheduled to expire October 31, 2013.

For purposes of budget neutrality, CMS has previously instructed Oregon to use Federal Fiscal Years ending September 30, 2013. This is how budget neutrality is presented for this waiver extension. The proposed flexibility policy options, for purposes of budget neutrality, are projected to begin on July 1, 2012. The cost and caseload estimates are based on these begin and end dates.

Caseload Estimates. All populations are reported as the average number of persons covered for the entire period. These estimates , were prepared by the Office of Forecasting, Research and Analysis, Department of Human Services, with the exception of the FHIAP caseload provided by the Office of Private Health Partnerships and initial estimates of enrollment increases attributable to federal reform in 2014 provided by the Office for Health Policy and Research.

Cost Estimates. Budget neutrality spreadsheets provide the forecast of expenditures for the Title XIX program and present the budget neutrality for the requested Section 1115 demonstration. These spreadsheets provide:

- the budget neutrality summary from the beginning of the OHP demonstration project through this extension request.
- the calculation of Oregon' budget neutrality ceiling using allowable per capita and projected populations; and,
- the state's actual and projected expenditures. At the end of the seventeen-year demonstration, the state is projecting a surplus of $16.3 billion total funds.

Designated State Health Programs. Oregon is requesting approval to use federal savings earned under the OHP demonstration to help launch health system transformation. Oregon proposes to receive Medicaid matching funds on certain state only funded programs to support the implementation of the state's health system transformation. That request of $750 million in federal funds a year for five years is included in

Appendices K and L. CMS can provide Oregon with a "down payment" on health reform that will yield results in support of the CMS triple aim.

X. Evaluation Plan

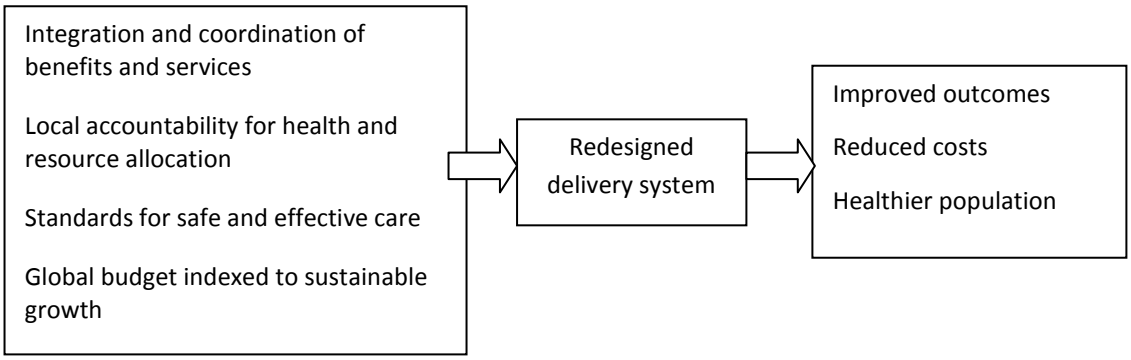
As described within this waiver amendment, Oregon's goal is to create a health care system that emphasizes prevention and integrates financing and care delivery for physical, behavioral, and oral health care services within community-based CCOs. Each community-based CCO will operate within a global budget such that the CCO has flexibility to achieve the greatest possible health within available resources and is held accountable for improved quality and outcomes. Oregon recognizes the importance of closely assessing the performance of the transformed delivery system. Thus, the state will maintain a robust monitoring of system performance and will continue to assure that standards of access, program operation, and quality are met and that standards evolve to match progress in achieving the policy objectives of health system transformation. Many oversight mechanisms used today will continue in the future; the transition from managed physical and mental health care organizations (and dental care organizations, over time) to CCOs probably has greater implications for QAPI focus areas than for methods of oversight.

Oregon is also committed to working with CMS and our local partners on a robust evaluation of the system transformation and its impact on patient experience and safety, improved care outcomes, and costs.

a. Evaluating the Transformation Initiative

While it is closely linked to performance measures and quality improvement, the evaluation component of Oregon's Demonstration will focus on the implementation and impact of Medicaid reform and of health system transformation as a whole. As mentioned throughout this waiver amendment, Oregon's Medicaid transformation initiative is firmly grounded in the Triple Aim of better health, better health care, and lower costs. Accordingly, the state expects that the proposed changes in financing and delivery will lead to improvements in health status and in the quality of care provided to Medicaid and dual eligible beneficiaries and that these improvements, along with greater efficiency and a sustainable growth rate for expenditures, will help bend the cost curve. The state also believes that these reforms can be expanded to commercial insurance through adoption by the PEBB and OEBB programs, which administer health insurance for state employees and for education districts, respectively.

Transformation Elements, System Change, Triple Aim Goals



Using the framework of the Triple Aim to assess the implementation and outcomes of Medicaid transformation suggests overall evaluation questions such as:

- *Better health*: What impact does the transition to CCOs have on health status, health equity, or health behaviors among Medicaid eligibles, including important subsets of members like dual eligibles or children with special healthcare needs? What elements of CCO design or operation are associated with improved health? How does the transition to CCOs impact the health of all communities within the CCO service area?
- *Better care*: What impact does the transition to CCOs have on care integration and coordination, as measured by care processes, utilization, client outcomes, member experience, and costs? What elements of CCO design or operation are associated with improved care integration and coordination?
- *Lower or controlled costs*: What impact does the transition to CCOs have on overall costs, cost growth, distribution of expenditures by service type or payor (Medicaid or Medicare), or costs for unnecessary or inappropriate care? What elements of CCO design or operation are associated with improved cost control (or reduced cost growth) and potential savings? Do savings or efficiencies lead to reinvestment in improved care? Do investments in improved care for Medicaid and dually eligible members improve care or improve health for the community at large?

Oregon will work with CMS and with local partners, including the active health services research community in Oregon that has led the Oregon Health Study, to produce a draft evaluation design in accordance with standard waiver Terms and Conditions within 120 days of the waiver's approval. The state will also collaborate with the Research Triangle Institute (RTI) and the Urban Institute to align the evaluation design with national plans for evaluating state Demonstrations to integrate care for dual eligibles.

b. Evaluation Plan for Medicare-Medicaid Demonstration

In addition to the state's own monitoring and evaluation activities, the Medicare-Medicaid Demonstration requires active participation in a national evaluation conducted by CMS' evaluation contractor. OHA will cooperate with all aspects of CMS' evaluation activities, including submitting required data to the contractor. The state will follow the preferred Medicare-Medicaid alignment process of an integrated quality and performance improvement process for CCOs and request an exemption from existing Medicaid standards for performance improvement projects as negotiated through the MOU and three-way contract process.