Oregon's State Innovation Model Project
End of Year Report
Demonstration Period Two
October 1, 2014–September 30, 2015

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Overview

As Oregon completes Demonstration Year 2, we want to thank the Centers for Medicare and Medicaid Innovation (CMMI) for the contributions the State Innovation Model (SIM) resources have made this past year. The CMMI investment in Oregon through the SIM award accelerates the pace of health transformation in our state. The SIM grant fuels the spread of the coordinated care model (CCM) from the Medicaid population to other payers and populations more quickly and effectively than if the SIM resources were not available to support these pioneering efforts. The CCM is proving to be effective in transforming how care is delivered in Oregon and the model continues to show improvements, even with the inclusion of the more than 434,000 additional Oregonians who have enrolled in the Oregon Health Plan (OHP) since January 1, 2014. Today, approximately 1.1 million Oregonians are enrolled in OHP.

Our 2014 Health System Transformation report[1] - the second report to show quality pool payments for our Medicaid Coordinated Care Organizations (CCOs)—continues to document improvements in areas such as enrollment in patient-centered primary care homes, emergency department visits, and hospital admissions from chronic diseases. All of Oregon's CCOs showed improvements in a number of quality measures and 13 of 16 CCOs earned 100 percent of their quality pool payments in 2014.

Financial data indicates that CCOs are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services (CMS) to reduce the growth in spending by two percentage points per member, per year. These metrics offer proof that Oregon's model of health system transformation is continuing to improve care for Oregonians who need it most.

Oregon SIM Accomplishments, Demonstration Period Two

SIM demonstration year two accomplishments, organized by driver, include:

Driver 1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care

Patient Centered Primary Care Home

The Oregon Legislature established the Patient-Centered Primary Care Home (PCPCH) Program in 2009 through passage of House Bill 2009 to create access to patient-centered high quality care and reduce costs by supporting practice transformation. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness, and managing chronic conditions. The key functions of the program are to recognize clinics meeting the PCPCH standards, refine and evaluate the standards over time, provide technical assistance and develop strategies for provider communication and engagement. The goals of the program are that all Oregon Health Authority (OHA)-covered lives, as well as 75% of all Oregonians, receive care through a recognized primary care home. Oregon SIM resources support the PCPCH program by providing technical assistance, learning collaboratives, compliance support and

[1] Full report can be found at http://www.oregon.gov/oha/metrics/Pages/index.aspx

clinical consultants to encourage primary care clinics to continue along the spectrum of practice transformation.

Since 2009, the program has worked with the PCPCH Standards Advisory Committee, a diverse group of stakeholders from across the state, to define what a primary care home looks like. The model is defined by six core attributes, each with a corresponding number of standards and measures. The committee is currently meeting to develop recommendations on standards for integration of primary physical health care in sites where the main focus is delivery of behavioral health care services.

PCPCH program achievements this period include:

- Almost 600 primary care homes are recognized statewide, representing over 50% of all eligible clinics in Oregon and serving over 2 million Oregonians, over half the state's population.
- As of Q3, 2015 the percentage of CCO members (Medicaid) receiving health care from a recognized PCPCH is now 83.6%. The increase in enrollment of CCO members in a PCPCH has been especially dramatic in rural Eastern Oregon where enrollment has increased from 3.7% in 2012 to 73.5% as of Q3 2015.
- In 2012, PCPCH program staff began conducting on-site visits to verify the clinic practice and patient experience in the practice accurately reflects the measures a clinic attested to on their PCPCH application as well as to provide practice coaching and other technical assistance to recognized clinics. To date, over 100 site visits have been completed in 23 out of 36 counties in Oregon.
- More than 95% of clinics recognized as PCPCHs chose to reapply for recognition to maintain their PCPCH status.
- PCPCH program evaluation suggests that, after the first year of implementation, there was a significant net increase in preventive procedures (5%) and significant net reductions in specialty visits (6.9%) and expenditures (6.6%) for PCPCH sites vs. non-PCPCH sites.

Health Information Technology and Exchange

Health information technology (HIT) and Health Information Exchange (HIE) tools are critical supports for coordinated care. Oregon's HIT/HIE efforts work to ensure the care Oregonians receive is optimized by health IT.

The largest success in HIT for Oregon stakeholders this year has been the increased adoption of PreManage, the HIT tool that brings real-time hospital notifications to health plans, CCO and primary care coordinators.

- OHA is a co-sponsor for this effort and is responsible for coordinating CCO use of the tool.
- All 59 Oregon hospitals are now contributing admit, discharge, transfer (ADT) data to the Emergency Department Information Exchange (EDIE).
- About 10 CCOs and health plans and over 100 provider clinics subscribe to PreManage to access the EDIE data and better manage their populations.
- SIM funds were instrumental in launching EDIE and supporting PreManage pilots for Assertive Community Treatment teams.

Additional accomplishments this reporting period include:

- House Bill 2294, passed in the most recent legislative session, updates Oregon's original HIT statute to account for changes since 2009 and has three major components:
    - Establishes the Oregon HIT Program within OHA.
    - Grants OHA flexibility for participation in partnerships or collaboratives that provide statewide HIT services.
    - Updates statute for Oregon's HIT Oversight Council (HITOC) for providing strategic and policy recommendations and oversight on the progress of Oregon HIT efforts.
- In partnership with the Office of Rural Health, five SIM-funded telehealth pilot grants have been executed in teledentistry, telepsychiatry, community paramedics, telepharmacy and distance cognitive testing for dementia patients.
- A new statewide inventory of telehealth services available in Oregon which includes information on vendors and the types of telehealth services they provide will be available by the end of the year.

Driver 2: Paying for value and improved outcomes

Quality Measures

The 2015 Health System Transformation report[2] lays out the progress of Oregon's CCOs on quality measures in 2014. This is the sixth such report since CCOs were launched in 2012. In addition, this is the second report to show a full calendar year of data, as well as results from the second year of Oregon's pay for performance program.

The final data show large improvements, including:

- Emergency department visits by people served by CCOs have decreased 22 percent since 2011 baseline data.
- The rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 26.9 percent since 2011 baseline data.
- The rate of adults (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 60 percent since 2011 baseline data.
- PCPCH enrollment has increased 56 percent since 2011. Primary care costs continue to increase, indicating more services are happening within primary care rather than emergency departments.
- Two CCOs exceeded the Screening, Brief Intervention, and Referral to Treatment (SBIRT) benchmark. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has held steady, indicating room for improvement.
- All of Oregon's CCOs showed improvements in a number of quality measures and 13 of 16 CCOs earned 100 percent of their quality pool payments in 2014.

[2] http://tinyurl.com/o7smu5a

Alternative Payment Models
Oregon has experienced progress in paying for value through the development of alternative payment models (APMs) over the course of this demonstration period. Many CCOs have implemented risk-based capitation APMs for their providers. For example, AllCare CCO has created a per member per month payment for all adult and pediatric primary care providers, which uses graduated risk tiers calculated for each provider based on patient acuity. In addition, Primary Health of Josephine County has piloted an APM for a maternal medical home whereby the CCO pays the clinic a per-member per-month allotment for all patients, using a risk-stratification model to allow higher payments for high-risk patients. Finally, PacificSource Community Solutions CCO, Central Oregon Region combines partial capitation and shared savings for all providers as well as inpatient and outpatient hospital services except for behavioral health.

OHA has contracted with Oregon Health Science University's (OHSU's) Center for Evidence-based Policy (CEbP) to provide continued support for APM implementation across Oregon. CEbP will develop an APM readiness assessment instrument for CCOs, conduct the assessment with CCOs and evaluate results. Two or three CCOs will be selected to receive intensive technical assistance to develop and implement at least one APM by September 2016. In addition, CCOs and stakeholders will receive support to improve readiness for implementation.

Oregon's 2015 legislative session also included Senate Bill (SB) 231, which requires major insurers and CCOs to report the percentage of their total health care expenditures that are directed toward primary care. The specific services to be counted as primary care, defined in rule by OHA and the Oregon Insurance Division. Further, the OHA will convene a voluntary payment reform collaborative, protected from anti-trust laws that are only applicable to conversations occurring in state-supervised public meetings, where insurers and providers will share best practices in primary care APMs and develop strategies for coordinated technical assistance. Please see the following for more information
https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB231/Enrolled

Driver 3: Integrating care across silos and with community health improvement

Behavioral Health Integration
In February 2015, the OHA Transformation Center, in collaboration with OHSU researchers, completed an environmental scan to determine the extent of behavioral and physical health integration activity across the state and how integration efforts could be further supported. Transformation Center representatives visited communities, interviewed integration leaders and provider teams, and participated in stakeholder meetings. The OHSU research team conducted semi-structured interviews with 4-10 key stakeholders in 5 CCOs that were selected on the basis of variation in size, organizational structure, geographic location, and experience delivering integrated care. Interviewees included CCO leaders, behavioral health and primary care providers. The findings were used to develop a technical assistance strategic plan.

The scan found some degree of behavioral health integration occurring in most communities, but there is significant variation in the manner, breadth and depth of integration. Although it is too early for significant outcome data to emerge, providers often cited examples for how care is

improving and patients' lives are being positively impacted. Similar concerns and challenges were raised across communities. These fell into three general categories: reimbursement and financial sustainability, information sharing, and workforce development. Providers are interested in learning how integration is being implemented in other communities and they are willing to share their experiences.

Based on the above, the Behavioral Health Technical Assistance Plan has nine components. Some strategies are underway, e.g. the Behavioral Health Information Sharing Advisory Group and the PCPCH Standards Advisory Committee. Some strategies are being further developed, e.g., podcast interviews with integration leaders and virtual site visits. The most impactful strategy for many smaller clinics will be the availability of onsite integration practice consultation and coaching.

As mentioned earlier, SB 832 requires OHA to prescribe, by rule, standards for behavioral health homes. This work had been planned before the legislation was introduced, and a series of advisory committee meetings on PCPCH standards—including standards for behavioral health integration and behavioral health-focused medical homes—began in June 2015. Please see: https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB832/Enrolled

In August 2014, OHA established the Behavioral Health Information Sharing Advisory Group (further described below). The group was formed to develop solutions that will further support care coordination and OHA's vision of integrated care and services. Some of their accomplishments in this reporting period include:

- Development of a web page with resources for providers, including federal and state resources and examples to assist CCOs and providers in understanding confidentiality issues and requirements governing the use and disclosure of personal health information. http://www.oregon.gov/oha/amh/Pages/bh-information.aspx
- Webinars to facilitate understanding of privacy laws for physical and behavioral health information sharing and applying 42 CFR Part 2 to behavioral health primary care providers.
- Identification of four priorities as the result of a provider survey that assessed the needs and challenges providers face when sharing behavioral health information. The priority areas include:
    - Outreach to internal and external partners, particularly those that will be directly impacted
    - Education to demystify common misconceptions
    - Leveraging existing IT solutions, as the survey revealed providers are unaware of existing IT solutions that might be helpful in exchanging personal health information (DSM)
    - Development of tools to facilitate information sharing

In the first quarter of 2016, OHA anticipates releasing a provider toolkit that will include an overview and comparison of federal and state privacy laws, case studies of allowable sharing, results and products from the Office of the National Coordinator for Health Information Technology grant work, model forms and FAQ is under development.

Population Health
Oregon made significant progress this reporting period with the completion of Oregon's State Health Improvement Plan (SHIP)[3], which includes seven priority areas and improvement strategies that are the foundation for improving health in Oregon over the next five years. The plan addresses the following priorities:

- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce harms associated with alcohol and substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable diseases

OHA's Public Health Division has utilized SIM funds to build a foundation for community health integration as a core component of Oregon's health system transformation. SIM community health initiatives facilitate the development of strong partnerships between CCOs and local public health authorities (LPHAs) and provide a better overall understanding of the leading health issues in the state and among the Medicaid population.

In September 2013, Oregon's Public Health Department released a competitive request for grant applications for CCO and LPHA partnerships to implement evidence-based population health initiatives in both the community and health system settings. Applicants were able to select from a range of health issues based on priorities identified in their community health assessments. Four grantees were selected for funding through the term of the SIM grant, collectively reaching six of 16 CCOs and 20 of 34 LPHAs. Grantees include:

- The Center for Human Development (LPHA for Union County), working in collaboration with Eastern Oregon CCO and 11 other LPHAs in the Eastern Oregon CCO region on developmental screening for children within the first 36 months of life;
- Intercommunity Health Network CCO, working in collaboration with Benton, Lincoln and Linn county LPHAs on tobacco prevention;
- Jackson County LPHA, working in collaboration with Josephine County LPHA, AllCare CCO, Jackson Care Connect CCO and PrimaryHealth of Josephine County CCO on preconception health;
- Multnomah County LPHA, working in collaboration with Health Share of Oregon CCO and Clackamas and Washington county LPHAs on the prevention of opioid overdose.

Regional Health Equity Coalitions
Six Regional Health Equity Coalitions (RHECs), have been fully established (3 with SIM support). These coalitions are coordinated, community-driven collaborative groups organized at a regional level to identify policy, system and environmental barriers to increase health equity. The RHECs build on the inherent strengths of their local communities while crafting and implementing policies to reduce health disparities and address the social determinants of health. RHECs help communities of color build their capacity to work with CCOs and other health promoting systems and serve as a bridge to underserved communities. Coalitions partner with

[3] https://public.health.oregon.gov/About/Pages/HealthImprovement.aspx

organizations and systems to promote health equity by sharing their expertise and providing representation of culturally and linguistically diverse communities.

The Office of Equity and Inclusion (OEI) has completed two rounds of site visits to each of the coalitions this year. Through a collaborative and participatory process, the OEI and the RHECs have identified evaluation questions, main outcomes resulting from RHEC activities and indicators for monitoring progress. OEI has identified successes associated with each indicator across the six RHECs, and some key milestones to highlight during this funding cycle include the following:

- RHECs now include members across sectors representing healthcare, transportation, housing, education, law enforcement, and juvenile justice. Health-related member organizations include oral health, behavioral health, physical health, and CCO administration.
- A RHEC engaged the newly elected Mayor of the largest city in their region on health equity issues disproportionately affecting Latino residents. The Mayor has now created a Latino Advisory Council and continues to meet with RHEC members.
- A RHEC sponsored a forum with the U.S. Representative in their region to discuss health equity issues facing their community members.
- One of the RHECs partnered with the Regional Health Equity Task Force to interview community members about their experiences accessing health services across three counties and produced a 35-minute video and 25-page report. These materials were presented to the CCO, resulting in an assessment of healthcare interpreter services in the region. Findings from the assessment led the CCO to contract with the RHEC to provide their providers with additional training on how to use healthcare interpreters appropriately.

Health Equity Leadership Training

This period saw the graduation of the second SIM-funded Developing Equity Leadership through Training and Coordination (DELTA) cohort. The twenty-five graduates will act as drivers of equity and inclusion within Oregon's health promoting systems, facilitating the development and institutionalization of health equity and inclusion strategies in a variety of settings in their communities.

Traditional Health Workers

During this period, OHA reached and exceeded its Medicaid waiver goal of training and certifying 300 traditional health workers (THWs). By March 2015, OHA had certified 354 THWs and approved 24 THW training programs.

Health Care Interpreter Learning Collaborative

The Health Care Interpreter (HCI) Learning Collaborative includes two strategies:

1. Increase the availability of training required to become qualified or certified in the practice of health care interpreting.
2. Increase the utilization of qualified and certified HCIs by educating providers and health systems on the value and importance of trained and skilled HCIs to increase health care access and quality.

Through these strategies, Oregon has increased the number of individuals ready to become qualified or certified. Particularly of note are the number of individuals from rural areas of the state where, in some cases, no qualified or certified interpreter were available.

Despite a delayed start of the program due to technical issues, OHA anticipates meeting the deliverables of the program within the grant period. There is a high degree of interest in the program and providers are increasingly recognizing the value of including the highest quality of health care interpreting in their practices. Additionally, strong partnerships with HCI training programs and the Oregon Health Care Interpreter Association have increased awareness and engagement of HCIs in the program.

Long Term Supports and Services
Long Term Services and Supports (LTSS) has had several accomplishments this period including their ongoing work with the CMS CCO Alignment group to share care coordination practices and outcomes as well as health promotion, prevention and self-management program partnerships between CCOs, Area Agencies on Aging (AAA) and the Agency for People with Disabilities (APD).

Progress has been achieved through updating 2015-2016 Memoranda of Understanding (MOUs) between CCOs and either Aging or People with Disabilities or Area Agency on Aging offices, whichever administers long-term services and supports in the geographic area. These agreements have five required domains of activity including establishing member care teams, individualized service plans, prioritization of high needs members, care transitions and member engagement and preferences.

Finally, using the recommendations of the LTSS-CCO integration study final report, APD has completed a draft LTSS MOU metrics proposal.

Housing with Services
Housing with Services was established as a limited liability company with a variety of agreements and contracts governing level of partnership, participation and service contracts with a wide range of health and social service organizations. From its initial plan of four buildings, it has grown to include eleven buildings serving 1400 low-income seniors and people with disabilities in Portland, Oregon. Accounting and family metrics software is in place to track costs and service utilization. The health and wellness center opened and includes a primary care clinic, an ElderPlace program and a variety of classes including health promotion/prevention and self-management classes on site. Some classes are designed for and specialize in serving members of ethnic and racial minority groups. Health navigation, referral and health care coordination services are provided on-site in the buildings by health care professionals and para-professionals. Mental health services are also now available on-site. A Resident Council is operating and advises on the Housing with Services program as well as a resident volunteer program and a food bank. Finally, a first round of evaluation including a self-reported needs assessment and a qualitative study of the Housing with Services consortium development was completed. In addition, APD has convened a Housing Policy Workgroup and legislation is pending to either define or convene an official Task Force on Housing with Services in Oregon. The intent is to

identify any regulatory or consumer protection needs as the model spreads. The SIM-funded Housing with Services pilot staff are participating in this workgroup.

Year 3 SIM funding for Housing with Services is solely for evaluation purposes. Housing with Services has successfully solicited a number of grants to provide funding for operations and to provide culturally responsive services in Year 3. Negotiations with the two CCOs serving the Portland Metro area are progressing to provide additional health supports and sustainable funding in Year 3 and beyond.

Medicaid/Medicare Dually Eligible

Oregon's Dual Eligibles program has had many noteworthy accomplishments. Enrollment of those dually eligible for Medicare/Medicaid and enrolled in CCOs remains above 50%. The program continues to strive to make systematic improvements, align with federal processes and support CCOs. Highlights of their activities include:

- Improving technology systems to provide Medicare-effective dates 90 days in advance rather than the current 30 days or fewer window. This will assist CCOs and their Medicare Advantage partners with CMS's "seamless conversion" alignment process.
- Producing and providing monthly enrollment reports through OHA's Office of Health Analytics since January 2015. These reports are now available at : http://www.oregon.gov/oha/healthplan/Pages/reports.aspx
- An updated duals fact sheet was produced in June 2015 to provide a statewide picture of dual eligible beneficiaries with Medicaid.
- Health Analytics and OHSU are examining the impact of the coordinated care model on Oregon dual eligible in CCOs and fee-for-service (FFS).
- OHA was selected in September 2015 to participate in CMS's Innovator Accelerator Program (IAP), aimed at providing support to state Medicaid agency efforts targeted to beneficiaries with complex needs and high costs (BCNs) for this project.
- A technical assistance tool for CCO Duals was developed which highlights a wide variety of best practice opportunities for CCOs and community partners for meeting duals' coordinated care objectives in areas such as communication, engagement, population health management, care coordination, care transitions, administrative policy, health promotion and health equity.
- A Fall Forum was held for coordinated care plans, Medicare Advantage plans, LTSS and other partners focused on the high-need dual eligible beneficiaries.

Coordination with Early Learning Efforts

Beginning in 2013, Oregon's Early Learning Council supported the development of 16 community-based Early Learning Hubs (EL hubs) which serve as coordinating bodies to make supports more available, more accessible and more effective for children and families. Currently all 16 EL Hubs have executed their contracts with the Early Learning Council. Across the state, coordination across EL hubs and CCOs has been rapidly evolving in order to ensure improved outcomes for Oregon's children and prevent future, chronic health conditions.

Driver 4: Standards for safe and effective care

Health Evidence Review Commission (HERC)

A key component of Oregon's transformation is translating evidence to ensure the right care is being delivered at the right time in order to achieve the Triple Aim. In the second demonstration year, OHSU's CEbP continued their work with HERC to improve the clinical evidence synthesis and translational work to aid the spread of the coordinated care model and in July they completed a needs assessment to determine how best to develop a guide targeted to CCO Medical Directors on the use of such tools.

A draft report of a review of the evidence in support of shared decision-making tools, as well as the best practices to encourage their use at the point of care, was then completed in August to help inform content of the final guide.

Aligning standards and metrics across payers

Aligning metrics across payers is critical to send consistent signals to providers and reduce the measurement burden on all parties. Oregon signaled its continued support for these efforts in the passing of Senate Bill (SB) 440 in its last legislative session (2015). SB 440 requires the Oregon Health Policy Board (OHPB), the policy-making and oversight body for the OHA, to develop a strategic plan for the collection and use of health care data by September 2016 and, beginning in 2017, creates a new Health Plan Quality Metrics Committee under the OHPB to adopt and report on quality measure for CCOs, PEBB, OEBB and state-regulated commercial plans. Please see: https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB440/Enrolled

Oregon is one of 11 states with an all-payer claims database. Legislatively created, Oregon's major health payers began reporting payments made to providers to OHA's All-Payer, All-Claims Reporting Program (APAC) in 2010. As of June 2014, APAC contains information about enrollment, utilization, and spending for 81 percent of Oregon's four million residents and will continue to guide policy makers with data on leading health system indicators. It will help Oregonians understand where we are and where we are heading as health system transformation progresses and the CCM spreads across the health care system.

In September 2014, the second report in a series presenting leading indicators for Oregon's health system transformation was released. It uses data from the APAC to examine how well Oregon's health system transformation is achieving its goals.

This report builds on the first Leading Indicators for Health Care Transformation report with more complete enrollment data and a first look at health care utilization and spending under the ACA. It focuses on changes in enrollment, utilization, and spending between 2013 and 2014, the first year of expanded coverage under the ACA. Highlights include:

- From June 2013 to June 2014, enrollment in commercial plans, Medicaid, Medicare Advantage and OEBB and PEBB plans increased by 15 percent, with 422,549 more individuals having health care coverage than in June 2013. Enrollment in Medicaid drove this increase, with 363,267 people enrolling in the program.

- In the first half of 2014, the number of emergency department visits per 1,000 member months among Medicaid, Medicare Advantage, and PEBB members decreased from the first half of 2013.
- In the first half of 2014, per member, per month spending on Medicaid and OEBB members decreased in all spending categories.

This leading indicators quarterly report is available at http://www.oregon.gov/oha/OHPR/RSCH/DashboardDocs/Leading%20Indicators%20Report%20September%202015.pdf, and will continue to guide policymakers with data on leading health system indicators. It will help Oregonians understand where we are and where we are heading as health system transformation progresses and the CCM spreads across the health care system.

The Child and Family Well-Being Measures Workgroup completed its charge to develop a shared measurement strategy to inform program planning, policy decisions, and allocation of resources for child and family well-being in Oregon. The final report and recommendations were presented to the joint subcommittee of the OHPB and the Early Learning Council in September. Recommendations include: implementing the 15-item child and family well-being measure dashboard for high-level monitoring; and encouraging the Oregon Metrics & Scoring Committee, OHA, Early Learning Council, and the Early Learning Division of the Department of Education to consider the child and family well-being measures in the accountability measure sets for their management and contracting arrangements with CCOs and EL hubs. The final report and recommendations are available online here: http://www.oregon.gov/oha/elcohpbdocs/Joint%20Subcommittee%20Meeting%20Materials%20-%20Sept.%2014,%202015.pdf

Driver 5: Testing and accelerating the spread of the model

Transformation Center

Oregon's strategies to leverage public purchasing capabilities and influence health care market offerings toward the CCM have been successful in the current SIM demonstration period. Much of our success to date is due to the SIM-funded Transformation Center, which has become a hub of innovation and learning as planned, working with health systems, health plans and providers to spread best practices and engage the delivery system in transformation.

As a result of requests from CCOs and their Community Advisory Councils (CACs), in October 2014 the Transformation Center began offering CCOs and their CACs the opportunity to receive technical assistance (TA) in key areas to help foster health system transformation. In addition to support and technical assistance provided by other parts of OHA, for year one each CCO was designated 35 hours of free consultation from outside consultants on contract with the Transformation Center. The designated 35 hours included 10 hours of consultation to support CACs and other community-based work. The first year of TA hours were accessible through September 2015, and starting October 2015, a new allocation of 35 hours per CCO was made available. Requests to access year-two hours were made by June 2015, and year-two hours must be used by September 2016. The Transformation Center continues to recommend that 10 of those 35 hours be used to support CACs and other community-based work.

As of September 2015, the Transformation Center had received 27 TA Bank requests from CCOs, for a total of 403 anticipated TA hours upon completion of those requests. Fifty-two percent of these requests focused on CAC development, including the community health assessment and community health improvement plan. Other requests focused on health equity, quality improvement and measurement, program evaluation and alternative payment methods.

The Transformation Center graduated a cohort of 13 Council of Clinical Innovators in summer 2015. These 13 providers from across the state serve as champions of change and support the implementation of the coordinated care model through their innovation projects and provider-to-provider conversations. Their local innovation projects address behavioral health integration, care transitions, teledermatology, health literacy, care coordination, oral health care access in rural communities, obesity prevention in Latino communities, trauma informed care and payment reform for behavioral health. In January 2015, the Clinical Innovators submitted six-month progress reports describing the status of their projects and feedback on their experience of the program to date. The second cohort for Year 3 was selected in May 2015. The second cohort's year-long learning experience, beginning in July 2015, will develop and refine their skills in leadership, quality improvement, and implementation and dissemination science. Detailed information on the first cohort of Clinical Innovators and their projects is available at: http://www.oregon.gov/oha/Transformation-Center/Pages/Council-Clinical-Innovators-Fellows-2014-2015-Bios.aspx.

This Transformation Center convened learning collaboratives, which include the following:

- Quality and Health Outcomes Committee Learning Collaborative, which includes CCO medical directors, behavioral health directors, oral health directors and quality improvement coordinators;
- Community Advisory Council Learning Collaborative, which includes consumers and community partners including some local public health agencies, involved a CAC summit;
- Complex Care Collaborative, which includes multiple provider disciplines;
- The Improvement Science in Action Collaborative;
- Health Equity Learning Collaborative, including CCO staff and CAC coordinators; and
- The Quality Improvement Community of Practice.

In addition, the Transformation Center is working with the Foundation for Medical Excellence to support research on clinician vitality in the context of health system transformation, and completed and disseminated the results of a statewide CCO clinical advisory panel environmental scan to help connect the clinical advisory panels with relevant activities and partners.

Spread of the model to other payers and populations

As the purchaser of health care benefits for more than 130,000 Oregonians, the Public Employees' Benefit Board (PEBB) uses its buying power to get the best health care available from health plans that serve its members. In September 2014, PEBB conducted open enrollment for more than 130,000 public employees. PEBB developed communications to educate beneficiaries about their plan options and the CCM. In January 2015, the new plans began

offering elements of the CCM across the state bringing better care, better health and lower costs to public employees. PEBB is currently focusing efforts on:

- Developing year two reporting requirements for APMs and health system transformation efforts
- Reviewing alignment with CCO metrics and finalizing technical issues for all claims-based measures
- Working closely with Oregon's Office of Health Analytics to align more of the non-claims based measures (e.g., EHR adoption measure for the PEBB network)
- Developing baseline year for all carriers (CY 2015) to establish benchmarks and performance targets for carriers for CY 2016. The Board will then engage carriers in discussions regarding incentives and risk pool.

Building upon the successful PEBB Request for Proposals (RFP) process and technical assistance provided through SIM, the Oregon Educators Benefit Board (OEBB), which provides coverage to 147,000 teachers, their dependents and retirees, is preparing their RFP for the 2017 benefit year. The RFP is designed to further strengthen the coordinated care principles and supports transformation efforts. OEBB's major carrier, MODA, is a major partner in one of the Medicaid CCOs in Eastern Oregon, and provided a new plan offering for PEBB and OEBB employees in 2015 in both Eastern Oregon and in the Willamette Valley that included CCM elements. Effective October 1, 2015, OEBB aligned its contracts with CCO metrics and is developing baseline year data for establishing benchmarks and performance targets.

The Coordinated Care Model Alignment Workgroup

The OHPB has charged the Coordinated Care Model Alignment (CCMA) Workgroup with spreading the CCM to the commercial market. The Workgroup is charged with developing a host of tools that will assist in the implementation of CCM principles across multiple market segments, including a toolkit for purchasers. In addition, the CCMA Workgroup sponsored an environmental scan to develop a more comprehensive picture of Oregon's health insurance market and existing programmatic and operational efforts to adopt the CCM. The scan has been used to develop a more robust understanding of the challenges, needs, and the resources available to facilitate the spread of the CCM.

OHA, with support from Bailit Health Purchasing, interviewed carriers and purchasers throughout the state to develop an understanding of the various market segments and their underlying concerns and motivations. This will aid OHA in the creation of a messaging and communications framework that describes the model and the benefits to the consumer, carrier, and purchaser. Additionally, the information will help the CCMA workgroup define other tools that might be helpful to purchasers and carriers thinking about adoption of the CCM components and for consumers seeking to understand the model.

From the interviews, the CCMA workgroup learned the following:

- Continued education about the CCM is critical;
- Collaboration and continued engagement between carriers, purchasers, and the OHA is necessary;
- Multi-payer payment reform is critical to support innovations in the care delivery model; and

- the OHA and the CCMA workgroup should provide resources and support to purchasers and carriers as they determine the degree to which their infrastructure can support adoption of the CCM.

Analytical Tools and Resources
Oregon has committed to a number of financial, quality, access, health status and patient experience of care metrics that can be tracked over delivery settings and populations. It is OHA's intent to use not only CCO quality metrics, but also state-level measures of population health to ensure that we are making progress toward better health, better care and lower cost for both the CCOs and the overall population.

Quality, Access and Population Health Metrics
The quality pool is a key component of health system transformation that will hold CCOs responsible for health care spending and quality of care provided using 17 of the 33 identified metrics. The percent of the global budget assigned to the quality pool will gradually increase over time, continuing to reward CCOs for outcomes rather than utilization of services.

Using an open and public process, the state's Metrics and Scoring Committee identified 17 quality and access metrics by which CCOs will be held accountable for improved outcomes. These metrics evaluate performance in access to care, member satisfaction with care, and quality of care in seven focus areas: (1) improving behavioral health/physical health coordination; (2) improving perinatal and maternity care; (3) reducing preventable re-hospitalizations; (4) ensuring care is delivered in appropriate settings; (5) improving primary care; (6) deploying care teams to reduce unnecessary and costly utilization by super-utilizers; and (7) addressing population health issues. The state is accountable to CMS for an additional 16 metrics related to improved outcomes related to specific chronic conditions, preventive care and population health.

In July 2015, the Metrics & Scoring Committee selected two new incentive measures (childhood immunization status and tobacco use prevalence) and eliminated one measure (electronic health record adoption) for the 2016 CCO incentive measures. These new measures align with OHA's SHIP priority areas and are likely to drive increased coordination between CCOs and local public health. The 2016 Measures Set is available at http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx.

Financial Metrics
One promise of Oregon's health system transformation is our state's commitment to reduce the trend of Medicaid spending. Oregon's new Governor, Kate Brown, has directed continued support for health system transformation as she took office this year. Our Legislature just concluded its recent session that highlighted continued support and refinement of the CCM in Medicaid and furthered spread to PEBB and OEBB with a similar trend cost cap of 3.4 % and directed alignment of performance metrics across the populations.

Data indicates CCOs are continuing to hold down costs and Oregon is staying within the budget that meets its commitment to CMS to reduce the growth in spending by two percentage points per member, per year. As part of our commitment to financial transparency, OHA monitors data on utilization and costs of services.

Transparency and Reporting
OHA is committed to transparency in health system transformation efforts. All selected measures are reported publicly on the OHA website (http://www.oregon.gov/oha/Metrics/). With the exception of data that is collected annually (for example, patient experience of care surveys), metrics are reported quarterly to track utilization patterns and highlight potential performance issues. This data is used to track program goals, address disparities and drive quality improvement through financial incentives, performance reporting and rapid cycle feedback processes. Measures are reported at the CCO level and stratified by race, ethnicity and other subpopulations where possible and appropriate, including people with serious and persistent mental illness, people with disability and people with special health care needs (for example, chronic conditions or homelessness).

Challenges Experienced in SIM Demonstration Period 2

With a few exceptions, Oregon has experience minimal challenges to implementing the SIM project activities. Challenges experienced are described below.

Executive Leadership Transitions
There have been several significant changes in leadership during demonstration Period 2. On February 18th, Governor Kitzhaber resigned and leadership of the executive branch of state government was transferred to Kate Brown. On March 10, Lynn Saxton was legislatively confirmed as the new Director of the OHA.

Under the leadership of Director Lynn Saxton, OHA undertook broad reorganization and change management initiatives to more fully align the functions and resources of the agency to accomplish health transformation.

In addition, the OHA Medicaid Director and Chief Medical Officer left OHA during this period. While challenging, the changes in leadership have occurred smoothly, thanks to a great deal of supportive guidance and collaboration amongst staff, current and previous leadership. Director Saxton said in a weekly message to all OHA staff, "Change is happening at every level of our agency as we align our functions to better achieve the Triple Aim. We are also taking a look at recent agency successes and learning from the work it took to get there."

Sustainability of SIM activities (e.g. Transformation Center, PCPCH, analytical work) and 2017 Waiver Renewal planning are on-going and include executive leadership, the OHPB and legislators – ensuring needed amendments and/or funding is identified and addressed thoughtfully.

Statewide Health Information Exchange (42 CFR Part 2)
Oregon's plans and providers continue to struggle with legal, regulatory, and technical barriers to information sharing in support of care coordination. In particular, 42 CFR Part 2 creates substantial confusion and poses constraints for integrated, whole-person care. As noted earlier, OHA has undertaken efforts to support providers through the Behavioral Health Information Sharing Advisory group (see page 7). To help further clarify remaining issues and questions about the federal privacy laws, the state will contract with the Legal Action Center's Actionline

to provide telephonic consultation (via a hotline) to providers and CCOs for a limited period of time.

In addition, OHA has engaged in discussions with federal partners about recommended changes, and OHA Director Lynn Saxton submitted a letter to Secretary Burwell in support of further review and evaluation.

Self-Evaluation Findings from SIM Demonstration Period 2

During this reporting year, Oregon contributed to evaluation of the SIM grant through the following activities:

- Assisting CMMI's contracted evaluators with their site visits and data collection activities.
- Finalizing self-evaluation measures, and reporting these measure to CMMI on a quarterly basis.
- Partnering with independent evaluators to assess the effectiveness of Oregon's CCM in Medicaid, assess the spread of the CCM to other payers and populations, and assess targeted initiatives to transform Oregon's health system.
- Enhancing data available for assessing spread and effects of the CCM from Oregon's APAC and publishing cross-payer reports from APAC.

The following sections describe accomplishments and findings from these activities in this reporting year.

Assisting CMMI's Contracted Evaluators
In this reporting year, OHA continued to assist CMMI's contracted evaluators with data collection. OHA program staff provided updates on program activities and self-evaluation efforts through monthly calls with national evaluators. In addition, OHA consulted with the national evaluators about the availability of data for the evaluation data from Oregon's APAC, which national evaluators view as a potential data source for evaluating Oregon's PCPCH program. Oregon will continue to support the national evaluation, providing data and assisting in coordination as needed.

Reporting Self-Evaluation Measures
In this reporting year, OHA and CMMI finalized the set of self-evaluation measures for quarterly reporting. OHA transmitted an updated Oregon Metrics Reference Guide reflecting the finalized measure set to CMMI on October 1, 2015. The following table displays measure results from the most recent quarterly report along with the baseline and target for each measure. Please refer to the Metrics Guide for measure specifications and other details.

	Measure	Baseline	Q3 2014	Target
Beneficiaries Impacted	Percentage of state population impacted by CCM	14%	53%	26%
	Percentage of state employees impacted by CCM	0%	97%	100%
	Percentage of Medicaid beneficiaries enrolled in a CCO	74%	87%	90%
	Percentage of CCO members enrolled in a PCPCH	52%	80%	95%
	Percentage of Medicare dual eligibles enrolled in a CCO	55%	55%	65%
Providers Participating	Number of clinics recognized as PCPCHs	280	589	600
	Median number of individuals receiving care through PCPCHs	NA	3,500	NA
	Percentage of physicians with Medicaid patients	87%	89%	TBD
	Percentage of hospitals that received a Medicaid or PEBB payment	100%	100%	100%
Data for Coordination and Health	Percentage of hospitals live on Emergency Department Information Exchange (EDIE)	0%	100%	100%
	Percentage of targeted provider organizations enabled for HIE via CareAccord	0%	33%	100%
	Percentage of targeted provider organizations enabled for HIE via PreManage	0%	10%	28%
	Percentage of targeted provider organizations enabled for HIE via CareAccord or PreManage	0%	25%	72%
	Number of hospitals that received an EHR incentive payment	0	59	NA
	Number of eligible professionals that received an EHR incentive payment	0	6,940	NA
	CCOs' use of Oregon Public Health Assessment Tool (OPHAT)	0%	44%	100%
Health Care Quality and Patient Experience	Emergency department visits per 1,000 member months	TBD	24	TBD
	Percentage with hospital stays who were readmitted for any diagnosis within 30 days	11%	11%	11%
	Commercial plan members with diabetes who received an HbA1c test	88%	88%	91%
	Medicaid/CHIP members with diabetes who received an HbA1c test	72%	71%	87%
	Medicare members with diabetes who received an HbA1c test	82%	86%	84%
	Commercial plan members with diabetes who received an LDL-C screening	80%	78%	87%
	Medicaid/CHIP members with diabetes who received an LDL-C screening	61%	58%	80%

	Measure	Baseline	Q3 2014	Target
	Medicare members with diabetes who received an LDL-C screening	75%	79%	92%
	Percentage of patients who rated their hospital 9 or 10 rating on a 10-point scale	70%	71%	71%
Health Status and Behaviors	Adults age 18 to 64 who are overweight or obese	60%	58%	58%
	Adults age 65 and over who are overweight or obese	25%	26%	26%
	In the past 30 days, average days that poor physical health kept adults from doing usual activities	2.89	2.88	2.80
	Percentage of adults who are current smokers	18%	17%	15%
Payment Models and Sustainability	Spending per member, per month by commercial plans	$324	$375	TBD
	Spending per member, per month by Medicaid/CHIP	$262	$267	$319
	Spending per member, per month by PEBB plans	$434	$455	$501
	Percentage of CCO payments to providers that are not fee-for-service	52%	56%	58%
	Percentage of PEBB plan payments to providers that are not fee-for-service	TBD	Work is in progress on a reporting mechanism to capture non-FFS payments by PEBB plans.	TBD
	Sustainable health care growth methodology	NA	Work is in progress with OHSU to analyze spending by geography, analyze spending drivers, and recommend accountability mechanisms.	NA
Spreading and Supporting the CCM	Number of learning collaboratives established by the Transformation Center	0	9	9
	Number of people who completed state health care interpreter training program	0	51	150
	Percentage of long term supports and services (LTSS) shared accountability tasks completed on time	NA	87%	NA

Assessing CCM Effectiveness, CCM Spread, and Targeted Initiatives
Oregon's Medicaid waiver requires a midpoint evaluation and a summative evaluation assessing trends and impacts of the waiver on key outcomes. In this reporting period, the midpoint evaluation was delivered and the request for proposals for the summative evaluation was drafted. In addition to the wavier evaluation, Oregon has contracted with independent evaluators to assess the spread of the CCM among health care payers, providers, and employer purchasers, and to analyze "spillover" of improved care practices for Medicaid patients to non-Medicaid populations. In this reporting period, evaluators delivered an initial report on CCM spread and an analysis of specific activities CCOs are carrying out to transform the health system. Oregon also contracts with evaluators to assess targeted initiatives related to the CCM, including OHA's PCPCH Program, Transformation Center, and Housing with Services demonstration. Key findings from these activities are described below.

Assessing CCM Effectiveness
During this reporting year, Oregon continued to assess CCM effectiveness by evaluating the model for Oregon's Medicaid population. In April 2015, Mathematica Policy Research (MPR) delivered a midpoint evaluation assessing the first two years of Oregon's Medicaid waiver.[4] The evaluation assessed the extent to which OHA and CCOs supported and implemented activities to transform Medicaid, and analyzed whether changes in specific measures of access to care and quality of care could be attributed to the demonstration. MPR found that OHA and CCOs made significant progress implementing transformation activities:

- OHA facilitated transition of the Medicaid delivery system from managed care entities to CCOs, implemented global budgets and CCO incentive payments, and created the Transformation Center, innovator agents, and learning collaboratives to spread innovations.
- CCOs contracted with appropriate mental health, addiction services, and alcohol treatment providers to integrate physical health, behavioral health, and addiction services, expanded PCPCH enrollment, and collaborated with communities to conduct community health assessments.

MPR also identified areas of transformation where more work remained for OHA and CCOs:

- For OHA, more work remained in the areas of reassessing its administrative structure, implementing a certification process for non-traditional health workers, and defining effective approaches to promote use of flexible services.
- At the time data were collected, CCOs were still in the design and early testing stages for APMs, implementation of HIT, and strategies to address cultural and linguistic diversity and eliminate disparities.

MPR found few statistically significant changes in measures of access and quality associated with the introduction of CCOs, with significant changes concentrated in the area of improving primary care. MPR concluded that a longer observation period following the introduction of CCOs in mid-2012 is needed to make robust conclusions about the effect of CCOs on outcomes.

[4] Irvin, Carol et al. 2015. *Midpoint Evaluation of Oregon's Medicaid Section 1115 Demonstration: Mid-2012 through Mid-2014.* Mathematica Policy Research. Available at http://www.oregon.gov/oha/OHPB/Documents/Final%20Report%20for%20the%20Midpoint%20Evaluation%20%204-30-2015.pdf

Also during this reporting period, OHA drafted an RFP for the summative evaluation of Oregon's Medicaid waiver. The summative evaluation will answer questions regarding trends in Medicaid spending, quality of care, member experience of care, access to care, and health status over the waiver period, and provide estimates of the waiver's impact on observed trends. In addition, the summative evaluation will assess OHA's and CCOs' activities to transform Medicaid and their relationship to trends and impacts. The summative evaluation scope of work invites potential contractors to conduct a rigorous quantitative analysis of trends and impacts using appropriate econometric techniques and comparison groups, and to leverage findings from Oregon's other evaluation activities (including SIM evaluation activities) to assess OHA's and CCOs' transformation activities. The summative evaluation will leverage data from a longer observation period than the midpoint evaluation, making possible more robust conclusions about the effect of the CCM on health care quality and outcomes for Oregon's Medicaid population.

Assessing CCM Spread

OHA has contracted with the OHSU Center for Health Systems Effectiveness (CHSE) and the Providence Center for Outcomes Research and Education (CORE) to assess the spread of the CCM across health care payers, providers, and purchasers, and to evaluate the impact of the CCM on populations outside Medicaid. The evaluation includes three primary components:

- Payer and Provider Spread Assessment: Using two rounds of surveys and interviews, the contractors will assess the spread of the CCM among CCOs, commercial carriers, and health care providers. The surveys and interviews will capture data on the extent of transformation in 11 domains identified by the contractors and OHA.
- Employer CCM Awareness and Spread Assessment: In early 2016, the contractors will carry out surveys and interviews to assess awareness of the CCM among a sample of Oregon employers, and assess the extent to which employer-sponsored coverage incorporates elements of the CCM.
- "Spillover" Analysis: Using APAC data, the contractors will determine whether changes in health care utilization, spending, and quality at clinics with a high percentage of Medicaid patients appear to have spread to non-Medicaid populations as health care providers apply care practices for Medicaid patients to other populations.

The contractors carried out the first round of payer and provider surveys and interviews from February to April 2015 and delivered a baseline study assessing the extent of transformation among payers and providers in June 2015. The study found that Oregon is most transformed in domains related to community engagement and integrated care and least transformed in domains related to population health and alternative payment systems. Transformation among health plans equals or exceeds that among CCOs in some domains, suggesting payer transformation is not limited to CCOs.

To provide additional context for findings from surveys and interviews, and to facilitate detailed analysis of CCOs' activities to transform the health system, CORE completed a detailed analysis of key documents that CCOs report to OHA. For this project, CORE reviewed and entered data on activities described in CCOs' transformation plans, community health improvement plans, Transformation Fund grant reports, and progress reports. CORE then analyzed the data to

describe where CCOs are focusing their effort and what kinds of successes and challenges CCOs are experiencing. Key findings from CORE's analysis of CCO documents include:

- CCOs focused heavily on physical, mental and dental integration and workforce development.
- Relative to other areas, CCOs focused less on HIT transformation and APMs. This may be related to high upfront investments needed to support HIT transformation, since APMs often require performance data.
- Common barriers to transformation included provider and workforce capacity, challenges with outreach to the Medicaid population, obtaining demographic and health disparities data, and startup times for collaborating with other organizations.

In addition to an analytic report, CORE delivered the coded data set used for document analysis. OHA will update the coded data set from the project as new documents are received. The data will be analyzed to evaluate CCOs' transformation activities, assess contract compliance, identify and spread promising practices and better support CCOs.

In September 2016, CHSE and CORE will deliver a final evaluation report that incorporates and synthesizes findings from each component of the evaluation. In this reporting year, CHSE and CORE made progress on activities that will feed in to the final report. The contractors will conduct the second round of surveys and interviews in February – May 2016 using the panel of organizations from the first survey. The second round will include employer-purchasers of health insurance coverage. In this reporting year, the contractors began preparing for the second round of surveys and interviews, including selecting of the employer sample and revision of the surveys and interview guides.

The contractors delivered an analytic plan for spillover analysis and began analysis of claims data. As a first step, they analyzed the extent to which clinics in Oregon specialize in serving Medicaid patients; that is, whether some clinics serve a high percentage of Medicaid patients while others serve a low percentage of Medicaid patients, or whether percentage of Medicaid patients is relatively uniform across clinics. This step will enable the contractors to assess the association between Medicaid and utilization, spending, and quality measures for Medicaid and non-Medicaid patients.

Assessing Targeted Initiatives

Oregon's PCPCH Program has contracted with independent evaluators to assess PCPCH performance and identify best practices among PCPCHs. During this reporting year, CORE delivered an analysis of written reports from PCPCH Program site visits to 57 PCPCHs in 2013 and 2014. In the analysis, CORE found evidence of progress in the areas of care coordination, continuity of care, and comprehensive whole-person care:

- Nearly all sites have a designated care coordinator. External coordination with referral and specialty care clinics appears high.
- Many sites are able to share information in real time with outside providers and nearly half reported successful two-way communication with outside providers.
- Half of all sites used a pre-visit plan where providers and staff would "huddle" to discuss patient needs prior to scheduled appointments.

Going forward, evaluators will assess 15 to 30 recognized clinics considered to be top-performing or exemplary practices. They will interview key staff at each practice to determine which aspects of the PCPCH model are most important to successful practice transformation. In this reporting year, practices were recruited and interview protocols were refined for this assessment.

OHA is partnering with OHSU on an ongoing evaluation of its Transformation Center. In this reporting year, evaluators focused on specific topics of interest for the Transformation Center, analyzed data in real-time, and routinely debriefed with the Transformation Center to share emerging findings and to refine the direction of the evaluation. Evaluators also delivered a final report from the Transformation Center evaluation. In addition to working with an external evaluator, OHA analyzed participant satisfaction and feedback from its learning collaboratives in order to inform future collaboratives. Recommendations made to the Transformation Center as a result of this evaluation include more opportunities for peer-to-peer sharing between CCOs.

OHA is partnering with Portland State University's Institute on Aging to evaluate the Housing with Services demonstration. The demonstration delivers or makes available health care services to low-income residents of select affordable housing buildings in the Portland area. In this reporting year, the evaluators carried out interviews with Housing with Services partners and planned for additional data collection, including coordination with housing providers to track residents for follow-up.

Enhancing and Reporting Data from APAC

APAC is a key resource for assessing the spread of the CCM across Oregon's population and health care payers. With data from more than 3.2 million Oregonians in 2014, this database contains information about enrollment, utilization, and spending for 81% of Oregon's four million residents. This includes data from populations and payers targeted for spreading the coordinated care model under the SIM grant:

- PEBB and OEBB plans;
- Medicare Advantage plans and Medicare fee-for-service (FFS);
- Commercial plans offered on Oregon's health insurance exchange (APAC captures data from all commercial carriers with over 5,000 members in Oregon, including those offering plans on the exchange).

In addition, APAC includes data from CCOs and Medicaid fee-for-service coverage. Inclusion of these data enables Oregon to compare commercial, Medicare, PEBB, and OEBB outcomes with results for Medicaid CCOs, the "test bed" for Oregon's health system transformation.

In this reporting year, Oregon leveraged APAC to assess coordinated care model spread and evaluate health system transformation through a variety of reports and projects:

- SIM self-evaluation measures: Oregon reported multiple self-evaluation measures using APAC data. These include cost of care for commercial members and public employees, and chronic conditions quality measures for commercial, Medicaid, and Medicare populations.
- Leading Indicators for Oregon's Health Care Transformation: In this reporting year, Oregon continued public reporting of enrollment, utilization and spending metrics from

APAC in the Leading Indicators report. Reports are available at http://www.oregon.gov/oha/OHPR/RSCH/Pages/dashboards.aspx.

- Assessing CCM spread: External evaluation partners are using APAC data to assess potential "spillover" of Medicaid transformation to non-Medicaid populations (see above).

In addition, Oregon began enhancing APAC data collection in this reporting year. This effort will improve the usefulness and validity of APAC data for monitoring CCM spread and evaluating health system transformation.

- In 2014, Oregon began working with a stakeholder workgroup composed of carriers, health care providers, and APAC data users to identify data elements needed for evaluation and price transparency efforts. Based on the workgroup's recommendations, Oregon began collecting new data elements pertaining to commercial health plan enrollment, inpatient admissions, and other areas in mid-2015. These data elements will enable Oregon to segment and analyze enrollment, utilization, and spending among the individual, small group, and large group segments of the commercial market. Of particular importance for SIM evaluation, the new data elements will also enable Oregon to identify Oregonians who purchased coverage on Oregon's health insurance exchange and analyze enrollment, utilization, and spending among exchange plans.
- Also in mid-2015, Oregon finalized and published requirements for reporting billed premium amounts for commercial and Medicare Advantage plans to APAC. Collection of billed premium data will begin in January 2016, and will enable Oregon to more accurately analyze the cost of health care across Oregon's payers and population.
- In July 2015, Oregon began discussion with the APAC stakeholder workgroup about collecting data from non-claims-based payment methodologies in APAC. These data will enable Oregon to monitor the spread of payment systems that pay for outcomes and health across health care payers. Oregon plans to begin collecting non-claims-based payment data beginning in 2017.

Sustainability Strategies from SIM Demonstration Period 2

Creating a Sustainable Vision for Multi-Payer Delivery System and Payment Reform
Oregon has made a commitment to the CCM and transformation of the health care delivery system as demonstrated by an intentional multi-year planning and implementation process that included extensive public discussion across the state and active engagement by the Governor, the Legislature and OHA. The SIM grant has been an extremely valuable opportunity for Oregon to strengthen and support the CCM for Medicaid clients and spread the key elements of the model to other payers including PEBB, OEBB, Medicare-Medicaid beneficiaries and initial efforts with other stakeholders to spread further into the commercial marketplace.

Metrics are showing continued improvement in the delivery system performance in Medicaid. During this third test year, we will be doing further analysis of impact to PEBB and other parts of the delivery system. With 94% of the state's providers seeing Medicaid clients, we know that now going into our third demonstration year, many providers are currently participating in the CCOs APMs and incentive pools. Approximately 2,200 primary care providers are practicing in a PCPCH caring for over 2 million Oregonians. All diagnosis related – group (DRG) hospitals

are engaged in the hospital quality pool and efforts to support our smaller urban hospitals through the transition are progressing forward.

Ninety percent of our 1.1 million Oregonians in Medicaid are enrolled in the CCOs. Almost all of the 130,000 PEBB members are served with plans operating under contracts with the state that include key elements of the CCM and we anticipate 147,000 school district employees to be similarly served by 2017. It is expected that this activity will continue and hopefully tip into the commercial marketplace even as the SIM investment concludes.

While the state has faced some challenges and transitions during the course of the SIM grant, there is a solid base of support and interest to carry the state forward in its efforts at the conclusion of the grant. Our new Governor, Kate Brown, has fully supported efforts to proceed and has directed the OHA to continue to implement reforms as developed under the Kitzhaber administration. The most recent legislative session resulted in legislation that further refines efforts in Medicaid; confirms and supports additional spread to PEBB and OEBB; and directs the OHPB to further align performance measurement and metrics.

The OHPB will continue in its role to monitor and guide the strategic vision of health system transformation, advising the Governor, the Legislature and the OHA on any refinements or adjustments. The Board is particularly focused on further integration of behavioral health and population health as the model matures, as well as ongoing assessment of overall performance of the CCM.

Since Oregon's strategy to achieve the Triple Aim through delivery system transformation was built upon existing state and local infrastructure with broad community support in its application, the state did not build a separate SIM governance structure. By using existing governance and leadership, the CCM is firmly ingrained. As the State continues to move further into implementation, propelled by the initial SIM funding, the community partners and the state intend to sustain current efforts and adapt as the model continues to mature, grow and spread.

Oregon applied its SIM funding on top of an existing infrastructure and activities which led to the successful startup of our Transformation Center and increased capacity of our Office of Health Analytics, Office of Health Equity, Office of Health Information Technology and many other areas such as the state's PCPCH program. OHA's sister agency, Oregon's Department of Human Services, augmented its efforts to establish long term innovator agents with SIM funding and remains a partner in efforts with those eligible for both Medicaid and Medicare. The Division of Consumer and Business Services (DCBS) now houses Oregon's Marketplace, as CoverOregon was transitioned, alongside the Oregon Insurance Division. DCBS is working closely with the OHA and SIM efforts to consider next steps to spread to qualified health plans as the Marketplace is maturing. Oregon's state health agencies infrastructure was purposefully structured to implement and sustain the model.

Prior to SIM, Oregon built strong public and private support for the CCM through extensive stakeholder engagement for initial implementation for Oregon's Medicaid population. The model begins at the community level, with SIM activities strengthening community activities and efforts in each region. The CCOs were structured to have community participation in their

governance, including county public health and behavioral health representation. Many of the new CCOs have worked across their communities with some remote frontier areas in Eastern Oregon spanning twelve counties. SIM investments have fueled expansion of efforts in communities statewide, including public health grants, regional equity coalitions, and public-private partnerships to support primary care transition into the new primary care home model, and setting up housing with clinical and social services.

The OHA has increased efforts to monitor performance of our contracted partners, the CCOs and health plans, as well as using our data, especially our APAC Database and performance metrics to monitor via dashboards and other performance measures to ensure transparency, compliance and ongoing quality improvement. The Transformation Center will continue to monitor efforts and strive to share and move best practices rapidly across delivery system networks. Future technical assistance will be targeted based on performance metrics and in the key areas of behavioral health integration and population health.

In addition, the Legislature regularly requests and receives updates and progress assessments of CCM implementation, which will continue after the conclusion of SIM. Legislative engagement is critical for long-term, sustainable transformation and is intrinsic given budget and quality impacts.

OHA has been planning for sustainability post-SIM funding in key areas of transformation. OHA submitted a policy option package (POP) to support continued funding of the Transformation Center as well as the Patient-Centered Primary Care Home Program and support for the Office of Health Analytics through the remainder of the 15-17 biennia, as the SIM grant concludes. That package was included in the recently approved state budget. Further work will help shape what will be needed as the state proceeds through this budget cycle and prepares for the 17-19 biennium in these areas and others. Year 3 of SIM allows time and resources to ensure a detailed and comprehensive analysis.

Oregon's 1115 Medicaid Waiver refinement work is underway for the rest of this five-year demonstration, but the state is also looking forward to the upcoming waiver renewal process. As Oregon first initiated the model in Medicaid in 2012, the state was able to secure some additional funding through the Delivery System Reform Incentive Payment aspect of the demonstration that was invested to support the startup of the CCOs. As Oregon examines possible approaches to sustain key infrastructure elements long-term that have fueled the success of our model in Medicaid, we will need to have further discussions during our waiver renewal with CMS. Infrastructure like the Transformation Center's efforts or further investment in key areas such as behavioral health integration—especially in rural Oregon—are two areas under consideration that can improve the delivery of care to Oregon's vulnerable populations.

SIM funding has been critical to date and developing sustainable funding opportunities for future years, targeted to the needs we are identifying in our current evaluations and metrics, will move transformation of the delivery system even further. Work on sustainability of key infrastructure elements will be our aim as we look to the next demonstration period's focus.

We are continuing to improve efforts to work within existing regulatory parameters such as behavioral health information sharing and the new managed care regulations, and will continue to monitor those key levers controlled at the federal level that create barriers for fully coordinated care and innovation in the delivery system. We will also continue to examine and resolve any of our own state regulatory issues as we engage with our stakeholders and partners in order to ensure our collective ongoing success at implementing the CCM.

In conclusion, Oregon's health transformation activities will continue beyond the SIM, through various strategies aimed at maintaining current achievements in cost reductions and continuing to seek additional opportunities to achieve the Triple Aim. We have started to identify the specific next steps as we look at each of the activities that SIM has funded. Many of the activities using SIM investment were vital for “start-up” or to expand existing capabilities and further funding may not be necessary. For example, the SIM investment in developing health care interpreter capacity has always been intended to be a “jumpstart” activity to create an initial pool of professional interpreters across the state and teach providers and health systems how to use this patient engagement strategy effectively. Other areas have an ongoing need to be sustained beyond the current state budget allocation. Oregon will use Year 3 to further examine in more detail all of the activities in the context of where the state agencies, or our partners in the community, are heading and what steps will be necessary to continue to incentivize and monitor of the spread of the CCM.