Oregon's State Innovation Model Project
Progress Report
January 1, 2014–March 31, 2014

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Introduction

This is an exciting time at the Oregon Health Authority (OHA). We are in a time of rapid change driven by a common goal for our health system and the people of our state: better health, better care and lower costs. Since January 1, 2014, with the implementation of the Affordable Care Act and changes in the eligibility guidelines, OHA is now able to serve over 230,000 additional, new Oregon Health Plan members, bringing overall enrollment in Medicaid close to a one million or 1 in 4 Oregonians. With almost 80% of Oregon providers seeing Medicaid members and coupled with increased enrollment through the exchange of another 60,000, the State Innovation Model support is a critical factor in fueling and accelerating Oregon's health transformation efforts as we take on broad systems change to achieve the triple aim. This quarterly report summarizes the exciting work underway made possible by State Model Innovation investments.

SIM Overview & Highlighted Accomplishments January - March 2014

Oregon transformation efforts supported by SIM resources gained additional momentum during this second quarter of the demonstration period, fueling the spread of the coordinated care model from the Medicaid population to other payers and populations more quickly and effectively. Significant accomplishments from the second quarter include the following:

- **First quarterly multi-payer dashboard.** Thanks to SIM resources, the Oregon Health Authority (OHA) accomplished one of its major goals toward enhanced transparency. The OHA's Office of Health Analytics developed and presented an initial quarterly dashboard providing data on health care cost and utilization, health insurance coverage and quality of and access to care. This is built from Oregon's All-Payer All-Claims Database, among other data sources. OHA's intent is to provide a clear view of Oregon's health system from available data sources, including commercial insurance carriers, Medicare and Medicaid. Trends will be tracked over time and new data sources will be added as they become available. By mapping the shifting terrain of Oregon's health care landscape, OHA seeks to inform transformations impact to policymakers, health care providers, insurers, purchasers and individuals. The Initial Quarterly Dashboard is included as Appendix A.

- **Public Employee Benefit Board (PEBB) contracting.** Consultation provided through CMMI SIM resources assisted the Oregon Health Authority and PEBB in the development of the request for proposals for the health benefits for 2015 covering over 100,000 state employees and their families. Following a very successful RFP posting, PEBB evaluated ten proposals with multiple options, which included several Coordinated Care Organizations (CCOs) and several commercial domestic carriers that are also partners in CCOs for Medicaid lives. Currently, negotiations are underway with successful bidders, including two CCOs and several of the commercial plans. PEBB is on schedule to have contracts that reflect elements of the coordinated care model in place before open enrollment in October of 2014. This accomplishment will be a significant

achievement toward the spread of the coordinated care model to populations outside of Medicaid.

- **Patient-Centered Primary Care Home (PCPCH) milestone**. As of March 2014, over 500 clinics in Oregon have achieved Patient-Centered Primary Care Home certification (based on 2011 and 2014 criteria). Oregon met this milestone ahead of the projected timeline. The PCPCH model can function as a critical starting point for further delivery system and payment reform, so increasing adoption of the PCPCH standards around the state supports spread of the coordinated care model.

- **Health Information Technology (HIT) development**. Significant progress has been made implementing the Emergency Department Information Exchange (EDIE) with all of Oregon's hospitals engaged. As of late March, 53% of Oregon hospitals have begun the IT Integration process, and 24% are expected to have live data feeds with the EDIE vendor by the end of March.

SIM Accomplishments

Oregon Health Policy Board (OHPB)

Oregon's SIM goals and activities take place in the context of the Governor's vision and direction for overall health system transformation. In June 2013, Governor Kitzhaber directed the OHPB to develop recommendations to align Oregon's implementation of the Affordable Care Act (ACA) with Oregon's health system reform efforts and spread the triple aim goals across all markets. The Governor charged the board with developing recommendations which:

- Move the marketplace toward one characterized by coordinated care and growth rates of total health care that are reasonable and predictable;
- Mitigate cost shift, decrease premiums and increase transparency and accountability;
- Enhance the Oregon Insurance Division rate review process; and
- Align care model attributes within the Public Employees' Benefit Board, Oregon Educator's Benefit Board and Cover Oregon's Qualified Health Plans.

The OHPB responded with the following recommended strategies:

1. Create system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard that tracks the effect of ACA implementation and Oregon's health system reforms.
2. Increase transparency and enhance rate review by including metrics in rate filings.
3. Move the health care marketplace toward a predictable and sustainable rate of growth.
4. Improve quality and contain costs by expanding an innovative and outcome-focused primary preventive and chronic care infrastructure and by supporting metrics alignment at the provider level.
5. Move the foundation of Oregon's health system transformation – the coordinated care model – forward by spreading the model to the broader marketplace.
6. Implement communication outreach strategies that work for health plans and consumers and administrative simplification.

The full OHPB report is available online. During this quarter, the board developed a 2014 work plan that identifies next steps, deliverables and timelines, and work is underway to implement the strategies the Governor approved. These next pieces of work will take Oregon forward to spread the coordinated care model beyond Medicaid and align efforts across the health care delivery system. For more details, please see Appendix B, which contains a presentation on the work plan from the February 2014 OHPB meeting. Status updates will be provided on the progress of the work in subsequent quarterly reports.

Additionally, the OHPB oversees the distribution of $27 million in state general funds known as transformation funds to accelerate innovation across sixteen CCOs and has reviewed and evaluated CCO progress reports on transformation. The Transformation Center has reviewed proposals and negotiated agreements. This additional infusion of state resources magnifies and enhances SIM investments in innovation and health systems improvement in Oregon. Additional work conducted by the Transformation Center under the auspices of OHPB is described below.

Transformation Center

The Transformation Center has been a busy place this quarter, planning and delivering activities to improve the health care delivery system. In addition to the work described below, the Transformation Center is working to identify needed internal systems innovation.

Learning Collaboratives

During this reporting period, the Transformation Center hosted learning activities for each of its four collaboratives: 1) Statewide CCO learning collaborative with CCO medical directors, behavioral health directors and quality improvement coordinators; 2) Community Advisory Council (CAC) learning collaborative; 3) Complex Care Collaborative; and 4) the Innovator Agents learning collaborative. Participants report that the learning collaboratives are of high value for their work. Highlights are provided below and detailed evaluation results are in the evaluation section of this report.

The statewide CCO learning collaborative had facilitated sessions in January and March. The January session focused on the CCO developmental screening incentive measure. The session also addressed how CCOs can connect to Oregon's early learning system transformation efforts. Fifty-seven people participated. The March session focused on physical and mental health assessments for children in foster care. The Transformation Center played a key role in convening discussions to ensure that OHA and DHS were coordinated in their approaches to this measure. Sixty-six people participated in this session. The February session was cancelled due to weather and will be rescheduled.

For the CAC learning collaborative, the Transformation Center convened a CAC Steering Committee with representatives across CCO CACs to help guide the future direction of the learning collaborative and advise plans for a statewide CAC summit in May 2014. The steering committee meets monthly and rotates membership on overlapping six-month terms. The CAC learning collaborative included two webinars. The February session focused on community health improvement plans and 51 people participated. The March session addressed health equity

with a presentation on language access for clients with limited English proficiency and 41 people participated.

As a part of the Complex Care learning collaborative, the Transformation Center, in collaboration with the Oregon Comprehensive Primary Care Initiative (CPCI), hosted a webinar on trauma-informed care in primary care settings. With a total of 277 participants, this webinar was one of the Transformation Center's most highly attended events since the center opened in April 2013. A wide range of stakeholders participated, including county public health departments, local clinics, community-based health organizations, CCOs, private payers and OHA staff. Fifty percent of evaluation respondents identified their primary role as clinical. Approximately 95% of respondents indicated that the webinar was valuable for supporting their work. The next meeting of the Complex Care learning collaborative is April 29. Please see Appendix C for a meeting agenda.

The Innovator Agents gathered for monthly in-person meetings. Their learning collaborative activities focused on working with Paul Krissel, a consultant with expertise in governance, management processes, organization, team and leadership development and change management, to identify strategies to support transformation internal to OHA. The Innovator Agents also participated in a webinar presentation on Federally-Qualified Health Center (FQHC) funding structures from Craig Hostetler, Executive Director of the Oregon Primary Care Association (OPCA). OPCA has implemented alternative payment methodologies (APMs) in FQHCs that serve as helpful examples to CCOs that are pursuing APMs. Additionally the Transformation Center Innovator Agents met with the newly hired Long-Term Services and Supports (LTSS) Innovator Agents to discuss roles, responsibilities and lines of communication, as well as to support the LTSS Innovator Agents' entrance into community settings.

Additionally, as part of spreading knowledge and the practice of improvement science, the Transformation Center is sponsoring a three-day training with the Institute of Health Care Improvement. CCOs are sending improvement teams and have selected at least one project supported by the Transformation Funds (described in the OHPB update above) in which to apply the improvement tools and processes learned in the training. Planning has been underway for this Science of Improvement in Action Training, which will be delivered April 30-May 2, 2014. A pre-work webinar was held to share information on improvement project charters and driver diagrams. At least 19 quality improvement teams will participate in this ongoing project, with at least one from every CCO and three from OHA.

Council of Clinical Innovators (CCI)
The CCI will be a statewide, multidisciplinary cadre of innovation leaders, consultants and mentors who are actively working to implement health care transformation projects in their local communities. CCI is guided by a steering committee of Oregon health care leaders and supported by the Transformation Center. This quarter, the Transformation Center launched a call for applications for the Council of Clinical Innovators (CCI). Through developing innovation projects and participating in a year-long learning experience, the Clinical Innovation Fellows will develop and refine skills in leadership, quality improvement, implementation and methods

for dissemination that spread expertise in innovation across the delivery system. This pilot cohort will participate in a year-long program from July 2014 to June 2015.

The Good Ideas Bank
Through the Innovator Agents and learning collaborative activities, the Transformation Center has been identifying, collecting and compiling information on innovative or promising practices. The information will be housed within a searchable database on the Transformation Center website. At the end of this reporting period, 131 projects had been collected. The searchable database is scheduled to go live in June 2014.

Integrating Systems and Developing Partnerships
The Transformation Center is collaborating on dental integration opportunities with Capitol Dental and Access Dental. The Transformation Center brought representatives from these groups to speak with the Innovator Agents and has been developing concepts for learning and integration activities as CCOs begin their dental integration beginning July 1.

The Transformation Center completed planning for an environmental scan of behavioral health integration activities across the state, which will start in the next quarter. This will assist with targeting needed technical assistance to communities and the delivery system.

OHA is working with the Center for Evidence-based Practice, the group that helped to facilitate a 2013 multi-payer agreement on alternative payment strategies for patient-centered primary care homes, to engage delivery system stakeholders on next steps for payment reform in other areas. To date, interviews with key thought leaders have been conducted and planning is underway for follow-up focus groups.

Patient-Centered Primary Care Homes (PCPCH)
The PCPCH program has reached the critical milestone with 502 clinical practice sites recognized as primary care homes based on 2011 and 2014 criteria. The program launched the 2014 PCPCH recognition criteria in January 2014. The new criteria are based on the most recent evidence in the literature, provider experience with the 2011 PCPCH criteria, and broad stakeholder input. The new standards for recognition provide a comprehensive roadmap for primary care transformation, further enhancing the adoption of evidence-based practices as a core element of Oregon's coordinated care model. The program also launched a new online application system based on the 2014 recognition standards.

With SIM support, continued technical assistance to clinics is being provided through the Patient-Centered Primary Care Institute, housed with our partner, the Oregon Health Care Quality Corporation. Planning and contract execution were completed in March 2014 for the next phase of technical assistance through the institute for primary care practices across Oregon.

Technical assistance provided by the institute during this period included:

- Brief Intervention Skills for Primary Care Clinicians and Behavioral Health Consultants in the PCBH Model (webinar)
- Clinician Wellness: Building Resiliency in the Primary Care Home Team (webinar)

- Panel: What Do You Do After Every Patient Has an Assigned Care Team? (webinar)
- Launch of the PCPCH 2014 Recognition Standards Online Learning Modules
- Behavioral Health Integration – As a follow-up to the behavioral health integration trainings held in the fall of 2013, three practices were selected to receive additional training. Each practice received a week-long onsite training conducted in late January/early February.

Certification site visits were largely suspended for this reporting time period to allow the PCPCH program to focus on revising site visit protocols and materials and also to expand the capacity of the site visit part of the program. Site visits will resume in the second quarter of 2014.

Thanks to the SIM support, four positions related to the certification site visits were posted allowing the program to expand capacity to conduct site visits and provide additional technical assistance to clinics. Two program analyst positions were posted to verify the standards and measures attested to by primary care clinics for the PCPCH program as well as provide practice facilitation and coaching to help clinics meet their transformation goals. Two compliance specialist positions were also posted to provide consultation, technical assistance and evaluation services to verify that recognized PCPCHs are meeting program requirements. Hiring is expected to be completed in the next quarter.

Office of Health Analytics
In addition to developing the initial quarterly dashboard described above in the Oregon Health Policy Board update, Health Analytics has executed a contract to share data, analytic and scientific capabilities to build an Accountable Care Data System (ACDS). The ACDS will be an interactive data and dashboard system that tracks cost and quality measures over time, compares CCO performance and allows for dynamic exploration of outcomes by key subgroups. Additionally a request for proposals has been posted for a data layout consultant to help with presentation of dashboards for external audiences including the general public. The RFP closes April 25th.

The Office of Health Analytics, with the assistance of the SIM Project Officer and CMMI staff, is working with the Centers for Medicare & Medicaid Services to acquire Oregon's Medicare data set to be included in the All Payers/All Claims database to develop a full picture of the health care delivery system in Oregon and assist our evaluation of the coordinated care model and its impacts.

The Office of Health Analytics is working to execute a contract to partner with a vendor to begin CCO metric automation to further build a sustainable, efficient system for measuring and monitoring quality.

Office of Health Information Technology (OHIT)
SIM funds support our partnership with the Oregon Health Leadership Council to further the implementation of the Emergency Department Information Exchange (EDIE). EDIE alerts hospitals in real time when a patient is visiting the emergency room and allows emergency department clinicians to identify patients who visit the emergency room frequently or who have

complex care needs and direct them to the right care setting. All of Oregon's hospitals have engaged with this project. As of late March, 53% of Oregon hospitals have begun the IT integration process, and 24% are expected to have live data feeds with the EDIE vendor by the end of March. The EDIE governance group has met four times through this quarter.

Continuing development of Oregon's planned HIT/HIE Phase 1.5 services, three stakeholder meetings of the Health Information Technology Advisory Group (HITAG) have provided guidance in the development and implementation of critical HIT infrastructure to support health care transformation and CCO efforts. OHA also convened a Provider Directory Subject Matter Experts Work Group (PD SME WG) to provide guidance on scope, functions and parameters of a state-level provider directory. The work group held three meetings this quarter. In addition, OHA is piloting a statewide expanded HIE provider directory to allow Oregon organizations participating in DirectTrust access to addresses of other Direct secure messaging users. The expanded provider directory will serve as a foundational element for informing development of the state-level provider directory, while also supporting exchange of clinical health information as an interim solution. To support this work, a group of stakeholders met with OHA staff and contractors twice during this quarter to discuss progress and implementation strategies. In addition, the Health Information Technology Oversight Council (HITOC) held its quarterly public meeting.

In coordination with the Transformation Center, OHIT staff met with Innovator Agents individually to coordinate support to CCOs related to health information technology and increase awareness of health information technology initiatives underway across the state. OHIT staff worked with Transformation Center staff to review the CCOs health information technology plans included in their updated transformation plans.

Translating Evidence to Practice: Health Evidence Review Commission (HERC)
SIM funding continues to support the OHSU Evidence-based Policy Center's work toward making recommendations for improving the Health Evidence Review Commission's clinical evidence synthesis and translation work to aid the spread of the coordinated care model. Work during this period included a survey of over 200 external stakeholders on the usefulness of HERC products to date and what changes or different products they would like to see in the future. Discussion was also held on the initial topics from which translational tools would be developed. In addition, an environmental scan of other state health technology assessment programs and additional trusted sources is being conducted to determine what types of tools would result in the most meaningful outcomes for CCOs and health plans in guiding providers and their patients to evidence-based care. The center is completing planning on several facilitated discussions with stakeholders on the results of the survey as they work to complete this evaluation during the upcoming quarter.

Community Health
This quarter marks the beginning of the SIM-supported community health initiatives. The initiatives require CCOs and local health departments and community stakeholders to work together to develop innovative approaches to improving population health. These SIM supported initiatives include:

- The Center for Human Development is partnering with local public health authorities serving Baker, Grant, Harney, Lake, Malheur, Morrow, Gilliam, Sherman and Umatilla counties and Eastern Oregon Coordinated Care Organization to implement universal developmental screening for children in the first 36 months of life in community, early childhood and health system settings. The Healthy Eastern Oregon Consortium will also establish evidence-based home visiting programs for pregnant women and their families.
- Jackson County Public Health and the Health Care Coalition of Southern Oregon (HCCSO) are partnering with AllCare Coordinated Care Organization, Jackson Care Connect Coordinated Care Organization, Josephine County Public Health and PrimaryHealth of Josephine County Coordinated Care Organization to implement a comprehensive preconception health program. HCCSO and its partners will improve routine screening for pregnancy intent among women of childbearing age and will implement a communitywide preconception health campaign with an emphasis on reaching Latinas.
- Intercommunity Health Network Coordinated Care Organization and Linn, Lincoln and Benton county health departments are partnering to reduce tobacco use by improving tobacco screening, referral and cessation support offered in the health system and by establishing and strengthening licensing requirements for retailers that sell tobacco products.
- Multnomah County Health Department, in partnership with Clackamas and Washington County health departments, the HOPE Coalition and Health Share of Oregon Coordinated Care Organization, is working to address the growing issue of prescription and non-prescription opiate use. The Portland Metro Tri-County Consortium will train social service providers and their clients in how to distribute and/or administer naloxone to reverse opiate overdose, and will work with area health care providers to develop standard opiate prescribing guidelines. The consortium will also develop and implement a plan to engage communities of color and other communities served by HOPE members in overdose prevention strategies (including naloxone distribution) and substance abuse treatment education.

Additionally, preparations for the release of the Oregon Public Health Assessment Tool (OPHAT) version 2.2 are underway. This release will include a redesign of the user interface and updated data. A communication plan has been developed to promote the new release to existing and potential OPHAT users, including CCOs and local health departments.

Regional Health Equity Coalitions (RHECs)
During this reporting period, grant agreement negotiations were completed with each of the newest Regional Health Equity Coalitions (RHECs) and grant agreements were executed. This group forms the second cohort of coalitions. Each of these coalitions developed project plans, and the Office of Equity and Inclusion (OEI) developed work plans and timelines to assist coalitions to manage contract deliverables. Templates for expenditure reports and tools for tracking meeting participant demographics were created and distributed to the coalitions.

A new site visit protocol was developed as a collaborative effort between OEI and the Public Health Division Health Promotion and Chronic Disease Prevention (HPCDP) Section. Much of the development of this new protocol was guided by previous evaluation findings and feedback from the first RHEC cohort. The revised protocol focuses on how each coalition conceptualizes their RHEC model and is a formative evaluation tool that will guide the overall evaluation plan for the RHECs in the future. Scheduling of site visits has begun, and while most will take place in May 2014, one site visit was completed in March 2014.

Planning for the RHEC Spring Gathering is currently taking place with the venue established and the agenda in draft. General topics to be covered during this event include: evaluation, administration of grants, CCO updates, networking and information sharing, and policy and collaboration training. Approximately 30 people will attend the RHEC Spring Gathering.

Representatives from the RHECs have participated in a number of speaking engagements including the CCO Community Advisory Committee (CAC) learning collaborative, the Future of Public Health Task Force, and a panel regarding promoting health equity for a Developing Equity Leadership through Training and Action (DELTA) session.

Developing Equity Leadership through Training and Action (DELTA)
The second cohort of 23 members began the DELTA program in January. Between January and March, three DELTA training sessions were held focused on the following topics: DELTA Orientation and Social Determinants of Health/Disparities in Oregon; Diversity in Recruitment, Hiring and Retention; and Race, Ethnicity and Language Access Data and Health Equity Metrics. These sessions were facilitated by trainers from OEI's Qualified Training Registry for Diversity, Inclusion and Health Equity, as well as outside subject matter experts. After each session, cohort participants are expected to complete individual training evaluations. These evaluations are intended to assess attainment of training objectives, opportunities for learning application and logistics. The DELTA Coordinator compiles and analyzes the qualitative and quantitative results and creates summary reports for each session. In this quarter, three evaluation summaries have been compiled.

During this reporting period the DELTA Coordinator gave two presentations on the DELTA Program. The Office of Equity and Inclusion presented DELTA Program updates during a Health Equity Policy Committee meeting, which is a statewide, stakeholder engagement meeting to discuss equity, diversity and inclusion policies and implementation. The DELTA presentation included a general overview of the program and the structure and makeup of the 2014 cohort. The coordinator also discussed individual participant projects that focused on changing policies and enhancing procedures within their respective organizations. A second presentation was for the Governing for Racial Equity conference, at which OEI co-presented on "Organizational Strategies and Best Practices for Building Sustainable Leadership for Equity, Diversity and Inclusion." The coordinator discussed the role of the DELTA Program in best practices, which included the purpose, overarching goals, cohort recruitment and detailed logistics. The audience was comprised of government (federal, state, local and county) and community-based agency representatives from multiple states.

OHA has resubmitted an alternative proposal for the SIM-supported Health Care Interpreter Project. CMMI review is underway.

Long-Term Services and Supports (LTSS)
Aligning long-term care work with social services and behavioral health is a critical component of coordinating care and achieving the triple aim. A current focus is to develop revised or renewed memoranda of understanding between CCOs and the Aging and People with Disabilities offices, Area Agencies on Aging and other stakeholders. SIM resources supported a pilot project focused on developing innovative housing integrated with health and social services. Throughout the quarter, support focused on bringing Long-Term Services and Supports Innovator Agent work on board and convening stakeholders to make recommendations on metrics.

Long-Term Services and Supports Innovator Agents
SIM resources supplement state general funds to support a cadre of seven Long-Term Services and Supports (LTSS) Innovator Agents; SIM supports three of the seven positions. All of the positions have been hired and received extensive orientation training. These staff work closely with the Transformation Center Innovator Agents to coordinate communications and activities with CCOs, LTSS providers, consumers and other community partners. Additionally the LTSS Innovator Agents are developing relationships with the Division of Medical Assistance Program CCO account representatives and quality improvement coordinators.

Shared Accountability
The Shared Accountability subcommittee reconvened, following submission of their draft recommendations in December 2013, to develop LTSS metric recommendations and financial mechanisms for shared savings, incentives and penalties. The group will present their LTSS metrics work to the Metrics & Scoring Committee in the next quarter and develop a partnership to align LTSS metrics with other metrics. OHA and DHS leadership received a draft plan that articulated the intention to include LTSS metrics in CCO incentive metrics.

Housing with Services
SIM resources support a pilot project focused on developing innovative housing integrated with health and social services. The work of this project has been on infrastructure building including developing policies, procedures, information technology and accounting systems; the limited liability corporation agreement and other contracts; and marketing plans, materials and meetings for resident involvement. Rate plan development has progressed through the work of the health care economist. Meetings continue with the Resident Advisory Council. Cultural ambassadors have been selected to support outreach and community education. A revised evaluation plan was developed to expand evaluation to cover additional buildings joining the project. The goal is to open by July 1, 2014.

Evaluation
Oregon's SIM evaluation activity during January-March 2014 focused on facilitating and coordinating with the national evaluation. Oregon SIM staff assisted the Urban Institute and other CMMI contractors with planning for focus groups and interviews during the early March

site visit by providing: consultation on sample design; data pulls to identify potential participants; input on discussion guides; and outreach to target groups for long-term care focus groups (2 each with consumers and providers) and PEBB beneficiary focus groups (2). Staff also assisted the national evaluation team with identifying relevant personnel at OHA, DHS, and partner agencies for key informant interviews. Finally, Oregon SIM staff collaborated with national contractors on plans for a physician survey to be fielded later this year that will provide data for OHA's monitoring needs as well as baseline data for the national SIM evaluation.

Highlights from Oregon's self-evaluation activities for the period include:

- A key tool for both monitoring and evaluation of Oregon's transformation, he state's first multi-payer dashboard containing information on utilization, costs, quality, enrollment, and access was released in March as outlined in our operational plan. The dashboard will continue to develop with future iterations to include additional lines of business (including Medicare FFS), additional splits (for example, pulling PEBB and OEBB out from the larger commercial line), and trends over time. See Appendix D.
- To meet new quarterly accountability measure reporting requirements for CMMI, and to assist in quality improvement, a process for rapidly evaluating the effectiveness of the Transformation Center's learning collaboratives was piloted during this period. This process will consistently track attendance (including the roles of attendees) and will ask participants to respond to a standard set of questions after each event (e.g. value of the session for supporting their work, actions attendees plan to take as a result of the session, what attendees found most useful, and ideas for improvement). This will allow the Transformation Center to track satisfaction from session to session, and across learning collaboratives. In addition, there are plans to survey collaborative members on a biannual basis in order to assess their opinions of the learning collaborative process overall. This process was piloted from February to March, and preliminary results are anticipated for the next quarterly report.
- Oregon identified accountability milestones for CMMI's consideration. Oregon plans to report on progress toward these milestones quarterly, or as often as feasible given the data source, along with some of the other metrics proposed for quarterly reporting by CMMI and RTI.
- The independent evaluation of how the Coordinated Care Model (CCM) is operating in Medicaid—which will inform Oregon's efforts to spread the model to other payers and populations—is proceeding on schedule. During the first three months of 2014: the evaluation plan was finalized; document review and key informant interviews commenced; and the contractors finalized data collection tools that will be used to assess CCOs' degree of transformation on key CCM elements.
- Contract negotiations for an independent, formative evaluation of Transformation Center also began during this period. It is hoped that the contract will be finalized in the next quarter.

Also in this quarter, Oregon met with researchers to discuss plans for independent analyses of the degree and pace of spread of the CCM across markets in Oregon. We anticipate moving these plans into implementation during the next reporting period.

Planned Activities for the Next Quarter and Likelihood of Achievement

As described previously, Oregon's SIM goals and activities take place in the context of the Governor's vision and direction for health system transformation. The Oregon Health Policy Board (OHPB) has established a draft work plan to begin to implement the strategies presented to Governor Kitzhaber.

The OHPB related activities that stretch from the next quarter through the end of 2014 include:

- Complete negotiations by July 2014 and execute contracts reflecting elements of the coordinated care model in plans for the Public Employee Benefit Board for the 2015 benefit year in time for the November open enrollment period.
- Review of the PEBB RFP process and begin the RFP development process for the Oregon Educators Benefit Board (OEBB) benefit package.
- Continue to develop a health system dashboard and measurement framework to be in place by August 1, 2014
- Develop a focused set of dashboard metrics for informal inclusion in 2015 rate filings
- Establish a work group to formulate and implement a sustainable rate of growth measurement and make accountability recommendations. This work group is expected to begin meeting in the April-June 2014 period.
- Develop recommendations to hold health care entities and plans above methodology accountable and forward to the Governor's office and 2015 legislature
- Development measurement and reporting on primary/preventive/chronic care infrastructure including patient centered primary care homes at purchaser level. Forward recommendations to the Governor's Office and legislature to increase resources directed toward primary, preventive and chronic care infrastructure.
- The alternative payment work initiated in this Jan-March 2014 quarter, will continue with the Center for Evidence-based practice wrapping up interviews with key thought leaders and beginning to engage stakeholder groups to identify the next area of payment reform focus.
- HB 2118 requires OHA and Cover Oregon to establish a health plan quality metrics work group, with representation from the Oregon Health Authority and PEBB, among other organizations, to make recommendations on appropriate health outcomes and quality measures for Qualified Health Plans (QHPs) by May 2014. The Oregon Insurance Division will ask carriers who are filing 2015 rates to also report a few of the metrics shortlisted by the HB 2118 workgroup. Metrics will have no impact on rate review this year however, the information will be made public.

The Transformation Center

The Transformation Center is on track to meet the next quarter's SIM supported goals and objectives. The Statewide CCO Learning Collaborative plans to co-host a metrics retreat in April with the OHA Office of Health Analytics. This retreat will help determine the sequence of measures to address during ongoing, monthly learning collaborative sessions. Colorectal cancer screening is scheduled for the May session as a makeup from December 2013 (cancelled due to inclement weather).

The statewide CAC Summit is planned for May 29-30, 2014 in Eugene. The CAC learning collaborative is the focus of a quality improvement project. The summit will provide a platform to collect baseline information on the effectiveness of Transformation Center technical assistance to CACs and staff will conduct plan/do/study/act improvement cycles over the summer, with follow up data collection at the CCO summit in the fall of 2014. The CAC learning collaborative will continue to host monthly webinar meetings with the Steering Committee and larger learning collaborative.

The Complex Care Collaborative will host its second meeting April 29, 2014 in Eugene. The agenda includes a keynote session on sustaining the work and supporting staff compassion satisfaction, and three presentation topics: opioids/pain management, maternal health and behavioral health.

The Innovator Agents will continue to meet monthly in person and work with consultant Paul Krissel. Upcoming presentations include the Choosing Wisely campaign and Oregon data on trauma, Adverse Childhood Experiences (ACEs) and resiliency. The Transformation Center and the Long Term Care Innovator Agents will continue to coordinate activities and communications to ensure smooth collaboration in the field.

The Council of Clinical Innovators steering committee will select eight to ten fellows based on written applications, phone interviews and professional reference checks. The fellows will be announced in June 2014 and will begin the program in July 2014.

Patient-centered Primary Care Homes (PCPCH)
Due to a number of factors, including loss of key PCPCH program staff and a focus on certification site visit and on-line application activities, two milestones were not completed in the current reporting time period. These milestones will be completed in the next reporting period instead.

- Implement revised PCPCH payment strategy for FFS Medicaid clients
- Develop annual PCPCH program report

Office of Health Analytics
SIM supported health analytic activities in the next period include preparation of request for proposals to support engagement in 1) development of online interactive data tools to allow broader access to the data OHA collects and 2) development of an internal analytic training program to improve analyst capacity as well as sustainability of the analytic model. Additional work to incorporate additional data into the quarterly dashboard will continue, including Medicare and Medicaid populations, dependent on data availability (Medicare).

As the baseline metrics reporting for 2013 winds down in the next quarter the performance picture will be more complete. Incentive pool payments will be initiated in June of 2014 for those CCOs that met or exceeded the seventeen benchmarks.

Office of Health Information Technology (OHIT)
OHA is changing its approach to the telehealth pilots. Instead of hiring a consultant, OHA expects to partner with the Office of Rural Health at Oregon Health & Science University and leverage their experience in this area to administer the pilots.

Health Evidence Review Commission (HERC)
HERC will continue the work of reflecting on the evidence review process and identifying opportunities to improve effectiveness and efficiencies. Activities in the next period include:

- Complete the environmental scan of translational tools from trusted sources to inform selection of topics and defining requirements of patient decision aids or other derivative products from HERC evidence-based reports.
- Conduct facilitated discussions involving HERC and other key stakeholder groups to discuss initial findings of process improvement assessment and begin forming recommendations on how to increase the efficiency of HERC's process, deliverables and translation to evidence-based clinical decision tools.

As the topics and form of the translational tools will benefit from both the results of the stakeholder survey being conducted as part of the process improvement assessment and an environmental scan of such products already developed by trusted sources, the selection of the initial topics and development of these tools is being postponed until the 4th quarter of the demonstration year 1. Discussions are underway to include the Transformation Center in the development and to explore best avenues for future dissemination and ongoing sustainability. It is projected that ten such transitional tools will still be able to be produced by the end of the grant period.

Community Health
Over the next quarter, the Public Health Division will continue to provide technical assistance to Community Prevention grantees. A version of the state Behavioral Risk Factor Surveillance System Survey (BRFSS) will be fielded to Medicaid recipients.

The Oregon Public Health Analytical Tool (OPHAT) version 2.2 will be launched, and the OPHAT communication plan will be implemented to increase the number of CCOs and local health departments accessing population health data. The Public Health Division anticipates meeting all SIM goals and objectives; however, the OPHAT Steering Committee will need to adjust the priorities and timeline for the version 3.0 release in light of the fact that planned costs for development of version 2.2 have been higher than anticipated.

Regional Health Equity Coalitions
The quarters in which statewide meetings and site visits are taking place have shifted due to delays in executing grant agreements. No further delays are anticipated at this time. Coalition site visits will continue in May 2014. The Office of Equity and Inclusion will convene a statewide meeting, the RHEC Spring Gathering, for coalition training in June 2014. At this time there are no perceived barriers to achieving next quarter's objectives.

Developing Equity Leadership through Training and Action (DELTA)
The following DELTA sessions and activities are on track for delivery in the next quarter:

- Training Session #4- Effective Community Engagement
- Presentation of DELTA Program at Grantmakers of Oregon and Southwest Washington & Philanthropy Northwest Conference
- Training Session #5- Exploring Racism and Privilege
- Advisory Committee Meeting
- Training Session #6- Health Literacy and Language Access
- Ongoing: DELTA Training/Facilitator meetings; planning for recruitment of future participants

Currently, there are no anticipated barriers to implementing the scheduled activities above.

Health Care Interpreters
Continued progress on increasing health care interpreters as described in our application and operations plan depends on CMMI approval of our revised proposal. It is hoped this will be accomplished and activities can resume in the next quarterly period.

Long Term Services and Supports
Significant LTSS activities in the next quarter include a focus on presenting draft LTSS metrics proposal to the Metrics and Scoring Committee, and continued work with the Shared Accountability workgroup as well as finalizing the LTSS innovator agent measures. The project plan for implementing recommendations made by the LTC/CCO study group will be submitted for leadership review and approval. Tools for the LTSS innovator agent tools will be developed including an issues tracker, monthly reporting templates, and other tools. Staff and partners will complete preparations for launch of the Housing with Services project on July 1, 2014. Baseline data for the housing with services project will be reported.

Medicare/Medicaid Dually Eligible
The Medicaid/Medicare Analyst position has been posted. Hiring and orientation will be completed in the next period. With now 56% of those dually eligible for Medicaid and Medicare already enrolled in a CCO, discussions with the Office of the Duals in May will further explore needed technical assistance and steps needed to further engage this population in the coordinated care model.

Evaluation
Oregon is on track to meet its overall evaluation objectives for April – June 2014. Activities planned for the next quarter include:

- Finalization of accountability milestones and quarterly reporting metrics for SIM. Oregon's identified accountability milestones are with CMMI for review, and Oregon discussed some minor alterations to the quarterly progress metrics with our Project Officer on March 21.
- Continued collaboration with SIM national evaluators to develop and implement a physician survey.
- Development and finalization of a scope of work for an independent analysis of the degree and pace of spread of the CCM across markets in Oregon.

- Finalization of a contract for an independent, formative evaluation of Transformation Center
- Production of the next iteration of the multi-payer health system performance dashboard.

Please see Appendix E for a compiled, revised timeline and milestones project plan.

Projected Quarterly Accountability Targets

The Accountability Targets and Process Measure Results table on the next pages lists Oregon's accountability milestones and related measures from the RTI/CMMI list of "process measures and milestone metrics by state," (edited per Oregon's conversation with the Project Office on March 21 and subsequent communications). The column at the right will show results for this reporting quarter or will note progress toward future milestones. While only some of the measures are populated for the January-March 2014 time frame, we have included the table in this report to showcase the intended reporting format. Future quarterly reports will contain additional data points.

Accountability Targets and Process Measure Results		
CMMI Domain	**Measure (accountability milestones and process measures)**	**Jan. – Mar. 2014**
Legislative/ policy activities to support transformation	**Accountability milestones**	
	Each CCO testing at least one primary care and one non-primary care alternative payment methodology (APM) by mid-2015	Will report after July 2014, when Transformation Plan progress reports with milestones are due
	Each PEBB plan testing at least one primary care and one non-primary care APM by 2016	Will report progress beginning in 2015 when new PEBB plans are in place
	Oregon adopts methodology and benchmark for sustainable rate of health care cost growth by 2016.	Workgroup charter and membership list drafted; first meeting anticipated in May 2014
	Process measures	
	Any legislative policies, plans, or levers put in place to support transformation	Health policy bills in Oregon's short 2014 legislative session focused on ACA implementation; no significant legislative action to report.
	Number of alternative payment arrangements put in place by working with major payers or providers	None new this quarter; stakeholder engagement work continues
	Proportion of CCO plan payments and CCO payments to providers that are non-FFS	Data collection began in January 2014; to be reported in future quarters
	Proportion of PEBB service payments that are not FFS	Data collection mechanism in development for 2015 plan year; will report progress beginning in that year.
Provider participation	**Accountability milestones**	
	500 PCPCHs recognized by 2015; 600 by July 2016	As of the end of March, 2014, there are 502 recognized PCPCHs in Oregon.
	Process measures	
	Number of learning collaboratives established	Three external LCs: (1) Statewide CCO LC focused on incentive metrics; (2) LC for CCO Community Advisory Council members; and (3) Complex care collaborative. A fourth internal LC for CCO Innovator Agents also exists.
	Number of learning collaborative or quality improvement sessions held	5 learning collaborative sessions

Accountability Targets and Process Measure Results		
CMMI Domain	**Measure (accountability milestones and process measures)**	**Jan. – Mar. 2014**
	Number of participants in learning collaboratives or QI events (by role where possible)	Average of 98 participants per LC session in this quarter. (This figure includes LC sessions only, not other QI efforts).*
	Evaluation results from learning collaboratives or QI events	To be reported in future quarters; please see Section 2 for what will be reported in the future.
Population reached/ consumer engagement	**Accountability milestones**	
	65% of dual eligibles receive care through CCOs - ongoing	56% of duals are in CCOs as of Feb. 15, 2014
	75% of PEBB lives in plans with CCM elements by 2015 plan year (report as %)	PEBB plan selection for 2015 in progress; will assess plan elements when negotiations have concluded.
	75% of OEBB lives in plan with CCM elements by 2016 plan year (report as %)	OEBB RFP for 2016 plan year in development; will assess plan elements when plans have been selected and negotiations concluded.
	50% of QHP lives in plan with CCM elements by 2016 plan year	QHP certification criteria for 2016 not yet in development.
	Process measures	
	Approx. number of Oregonians and % of population covered by model	CCM model currently implemented for Medicaid beneficiaries and (optionally) dual eligibles. 716,000 individuals are enrolled in CCOs as of Feb. 15, 2014, or approx. 18% of Oregon's population.
	Number of individuals receiving care through recognized PCPCHs	Data collection began in January with implementation of new system and approx. 200 PCPCHs have provided data so far, so it is not yet possible to provide a total number. Among the 200 clinics reporting, the average number of patients is 7,159 but the variation is large (min. 50 to max. 100,078).
Health workforce development	**Accountability milestones**	
	150 new health care interpreters trained by July 2016	Awaiting CMMI approval of new approach
	Process measures	
	Number of learning collaborative or quality improvement sessions held	5 learning collaborative sessions

Accountability Targets and Process Measure Results		
CMMI Domain	**Measure (accountability milestones and process measures)**	**Jan. – Mar. 2014**
	Number of participants in learning collaboratives or QI events (by role)	Average of 98 participants per LC session in this quarter. (This figure includes LC sessions only, not other QI efforts).*
Collaboration with public health	**Accountability milestones**	
	75% of CCOs and local public health authorities (LPHAs) have OHA-supported collaborative projects focused on population health by July 2015	6 CCOs (38%) currently collaborating with 20 (59%) LPHAs
	Process measures	
	Any community health or prevention initiatives implemented	Four SIM Community Health projects were funded bringing together CCOs, local health departments and community partners in new collaborative partnerships. Six initiatives are underway; see pages 9-10 for details.
	Number of CCOs registered to access local population health data via the Oregon Public Health Assessment Tool (OPHAT)	N/A at this time – OHPAT registration will be opened to CCOs in spring 2014.
Disparities and SDOH	**Accountability milestones**	
	150 new health care interpreters trained by July 2016	Awaiting CMMI approval of new approach
	Process measures	
	Number of Regional Health Equity Coalitions implemented	3 new coalitions supported by SIM resources join 3 existing coalitions. Coalition development training scheduled for June 2014.
	Evaluation results as available from specific initiatives (e.g. congregate housing pilot project, Regional Health Equity Coalitions, etc.)	To be reported in future quarters.
Coordination with other initiatives	**Accountability milestones**	
	65% of dual eligibles receive care through CCOs - ongoing	56% of duals are in CCOs as of Feb. 15, 2014
	Process measures	

Accountability Targets and Process Measure Results		
CMMI Domain	**Measure (accountability milestones and process measures)**	**Jan. – Mar. 2014**
	Approx. number of Oregonians and % of population covered by model	CCM model currently implemented for Medicaid beneficiaries and (optionally) dual eligibles. 716,000 individuals are enrolled in CCOs as of Feb. 15, 2014, or approx. 18% of Oregon's population.
	Number of individuals receiving care through recognized PCPCHs	Data collection began in January with implementation of new system and approx. 200 PCPCHs have provided data so far, so it is not yet possible to provide a total number. Among the 200 clinics reporting, the average number of patients is 7,159 but the variation is large (min. 50 to max. 100,078).
Health Information Technology	**Accountability milestones**	
	75% of hospitals live on EDIE (emergency department information exchange) by end of 2014	All OR hospitals have signed agreement; contracting is underway. As of late March, 53% of Oregon hospitals have begun the IT Integration process, and 24% are expected to have live data feeds with the EDIE vendor by the end of March.
	Cross payer, multi-data source dashboard with interactive functionality available at the end of the project period (fall 2016)	First version of dashboard released March 2014; development ongoing
	Process measures	
	Number of Oregon providers who have ever received an incentive payment through Medicare or Medicaid EHR incentive program, by provider type	59 hospitals and 5,123 Eligible Professionals (EPs) have received payments
	Percentage of PCPCHs that have achieved meaningful use	Data in development; will be reported in future quarters
	Number of users of CareAccord® Direct secure messaging	1,000 as of February 2014
	Percentage of Oregon community HIEs connected to CareAccord® for interoperable Direct secure messaging	0%

* In addition to the learning collaboratives, the Transformation Center hosts online learning communities via its Groupsite webpage. There are currently four subgroups: 1) The CCO community (for the Statewide CCO learning collaborative focused on incentive metrics); 2) the Community Advisory Council (CAC) community; 3) the CAC Steering Committee; and 4) one for Transformation Center staff. Total membership for the first two of these online learning communities—the CCO and CAC groups—is tracked on a monthly basis, as are the number of posts. From January - March 2014, membership in the CAC learning community increased from 125 to 148 members, with the number of posts ranging from 9 to 21 in the first quarter of 2014. Over this same time period the CCO learning community increased from 88 to 93 members, with three to four posts to the Groupsite per month. As of March 2014, the roles of members of the CCO online learning community were as follows: 19% medical directors, 21% behavioral health directors, 24% QI coordinators, while 36% had other roles. Plans for the next quarter include launching a complex care community, and setting up a community for the Council of Clinical Innovators (which will not launch until July).

Substantive Findings

Related to Oregon's overall Health Transformation, the latest Health System Transformation Quarterly Report (Appendix D) includes some early promising indicators. The report includes data from the first nine months of 2013, an update on the November 2013 report that had 6 months of data reported. In summary:

- Data from the first nine months of coordinated care point to trends of improved care and a shifting of resources toward primary care.
- Data continue to show reduced emergency department visits and spending. This shows Oregon is reducing unnecessary hospitalizations and improvements in hospital readmissions. The percentage of adults who were readmitted for any reason dropped 8 percent from baseline in the first nine months.
- Decreased hospitalizations for chronic conditions-CCOs reduced hospital admission for congestive heart failure by 32 percent; chronic obstructive pulmonary disease by 36 percent, and adult asthma by 18 percent.
- Increased adoption of electronic health records (HER) doubled among measured providers with 58 percent of eligible providers adopting EHRs.
- Patient-centered primary care enrollment is improving.
- Developmental screening during the first 36 months of life has increased 11 percent in the first nine months of 2013.

The early indicators are promising, though we are continuing to monitor for expected occasional setbacks. Oregon is encouraged by the first nine months of progress data and favorably impressed with the innovative work the CCOs are doing to improve health and lower costs. Next quarter we will be able to have our first full year of CCO metrics collected and analyzed, with initial set of incentive payments to be distributed in June.

In addition to the accountability milestones as outlined above in the "Accountability Targets and Process Measure Results" table, some additional findings this quarter include:

The Transformation Center

The Transformation Center learned from the November 2013 Complex Care Collaborative meeting and from the high level of participation at the Trauma-Informed Care in Primary Care Settings webinar in February that understanding patient trauma histories and providing trauma-informed care is critical to meeting the physical and behavioral health needs of the Medicaid population, especially those who require the most complex care.

Understanding vicarious trauma and compassion fatigue is critical to building and sustaining a workforce that is equipped to respond effectively to the Medicaid population. This is why the Transformation Center selected a keynote speaker for the April 29, 2014 Complex Care Collaborative meeting who focuses on trauma-informed care, workforce resiliency and compassion satisfaction.

Ongoing learning activities within this collaborative will continue to provide communities needed technical assistance in partnership with OHA's Addictions and Mental Health Division as Oregon continues to focus on behavioral health integration efforts.

Lessons Learned

The impact of Transformation efforts in Medicaid through the Coordinated Care Organizations has been greater than just touching the Medicaid population's care to date, based on what the PEBB Board of Directors saw in applications for their recent RFP. The delivery system is responding to the key elements of the coordinated care model already, and the proposers built on those existing efforts and provider networks already focused on the Triple Aim in their applications. Coordinating across multiple lines of healthcare purchasing appears to be furthering initial spread of the model, though there is much work still to be done.

Suggestions/Recommendations for Current/Future SIM States

The implementation of the ACA with over 230000 new Medicaid members has been a major focus of OHA and our CCO partners in this quarter. The enrollment work has been more complex than originally anticipated due to some limitations of our Cover Oregon Health Insurance Exchange website intended to streamline the eligibility and enrollment process on the Medicaid side, in addition to enrolling the private insurance applicants. This has had an impact on furthering innovation both at a state agency level and with the CCOS, where ensuring access to care has been a prime focus this past quarter and into the next. This focus on enrollment and access to care has limited staffs' availability to focus on other efforts such as duals integration and practice model change as much as originally expected but we remain close to our intended milestones of our Operational Plan. Work continues on transformation efforts as well as cleaning up enrollment and eligibility issues. Other test states may want to consider major transformation initiatives in terms of the timing and alignment with other federal or state expansion efforts and overall capacity.

Suggestions/Recommendations for CMMI SIM Team

Oregon has made progress on obtaining Medicare FFS data but additional assistance through the SIM Project Officer is requested to continue to press forward on obtaining the data.

With the new, expanded risk mitigation plan deliverable along with expanded quarterly reporting, Oregon is concerned about continued growing administrative requirements as we are now halfway through our first test year and need to focus on implementation of our activities. Oregon is also concerned about developing whatever application documentation might be required for the next demonstration period. As we move into the next quarter, we would like to understand and plan for the application process, budget requirements, carryover policy etc., particularly in light of summer and staff vacation scheduling.

Oregon suggests that CMMI consider the quarterly report due July 30th with testing states showing appropriate progress as the necessary narrative documentation along with a detailed budget and 424 forms as the application materials for the next demonstration period.

Findings from Self-Evaluation

Please see the Accomplishments Section for information and preliminary data from Oregon's self-evaluation. We have not included any discussion of the data included on the multi-payer dashboard that debuted in February 2014 because it is baseline data only and in some cases incomplete or still undergoing validation.

Problems Encountered/Anticipated and Implemented or Planned Solutions

Challenges Oregon continues to monitor and respond to:

- Due to the challenges associated with the launch of Oregon's Health Insurance Exchange Cover Oregon in October and planning for Medicaid expansion in January 2014, OHA has deferred establishing a Transformation Center Multi-Payer Steering Committee until later in 2014 to ensure our partners are able to fully engage with the Transformation Center.
- With now over 230,000 new Oregonians signing up for coverage either through our Medicaid program or for a Qualified Health Plan on the exchange, OHA and its sister agencies, the Department of Human Services, the Oregon Insurance Division and CoverOregon are working to ensure those enrolled are getting access to coverage. This is a major focus of this next upcoming quarter as it has been this last quarter. While implementation and spread of the coordinated care model remain the state's focus, leadership and staff are stretched as we enter into the third quarter of the Demonstration Period.
- The execution of a contract for an OHA master website plan, development of the website and data portal is delayed. The important website, which will support communication about the coordinated care model to external audiences and multiple payers, was delayed due to the priorities and staffing levels in the Office of Information Services, largely due to staffing needed to prioritize system activation for the Health Insurance Exchange and planning for Medicaid expansion. The Transformation Center plans to move forward in the next quarter with this project.

Community Health

Development of Oregon Public Health Analytic Tool (OPHAT) version 2.2 took longer and cost more than originally budgeted. As a result, not all OPHAT work plan items were completed in this phase. The interval between the release of OPHAT version 2.2 and beginning of development of version 3.0 will be used to refactor the underlying application code in such a way as to make future updates and development more efficient.

Long Term Services and Supports

The full complement of LTSS Innovator Agents have been hired will continue to work in the field and coordinate their activities with the Transformation Center Innovator Agents.

Medicare/Medicaid Dually Eligible

An extended period of vacancy in the Medicaid/Medicare analyst position has slowed down the administrative alignment work. The position is currently posted and is expected to be filled in the

next quarter, allowing this work to regain traction. Discussions with the Office of the Duals are scheduled for mid-May to identify any technical assistance needs to further Oregon's efforts with those dually eligible for Medicare and Medicaid. As noted in the "Accountability Targets and Process Measure Results" table, 56% of the population is already enrolled in the Coordinated Care Organizations as of this quarter.

Work Breakdown Structure

Please see Appendix F for the Work Break Down Structure.

Contact Information

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Appendix A

Oregon Health Policy Board

Initial Quarterly Dashboard

Oregon Health Authority

Presented March 4, 2014

Table of Contents

Data Tables can be found at here

Background

Oregon's health system is in the midst of significant changes as it implements both state and federal reforms. Policies to expand insurance coverage, improve health, provide better care and reduce costs affect the lives of all Oregonians.

The Oregon Health Authority (OHA) presents this initial dashboard to the Oregon Health Policy Board for review and feedback. OHA's intent is to provide a clear view of Oregon's health system from available data sources, including commercial insurance carriers, Medicare, Medicaid, health care providers, and surveys. Trends will be tracked over time and new data sources will be added as they become available. By mapping the shifting terrain of Oregon's health care landscape, OHA seeks to inform the direction of policymakers, health care providers, insurers, purchasers and individuals.

The dashboard includes information on the following aspects of health and health care in Oregon:

- Health Care Cost and Utilization
- Health Insurance Coverage
- Access to Care
- Quality of Care

Much of the data in this initial dashboard does not yet capture changes that are anticipated following Affordable Care Act insurance coverage expansions that went in to effect at the beginning of 2014, but subsequent editions of this dashboard will reflect these changes. This will allow the Oregon Health Policy Board and other stakeholders to understand how the state's health systems are changing as reforms are implemented, develop programs and policies that correspond to the changing system, and communicate effectively what changes are taking place in Oregon.

The data for the dashboard are derived from a number of sources which are described at the end of this document. OHA seeks to provide the most recent data available, which varies by source. In some instances, data included in the dashboard is incomplete due to ongoing submission or has not been checked to confirm accuracy. OHA will update future editions of the dashboard to reflect any more recent and validated data. In particular, OHA and the Oregon Insurance Division are forming a technical advisory group to enhance its All-Payer All-Claims database, which is the source of much of the cost and utilization data provided here. The group's work will improve the information OHA is able to provide in future dashboards.

Please direct questions and comments on the OHPB Dashboard to:

Gretchen Morley, Director, Office of Health Analytics - Gretchen.Morley@state.or.us
Russell Voth, Manager, Health System Research and Data, Office of Health Analytics - Russell.Voth@state.or.us

Cost and Utilization

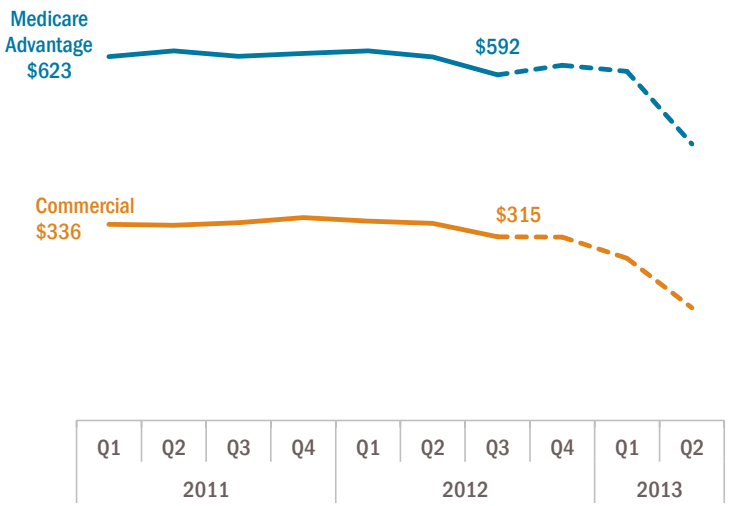
Overview

This section presents the rates of health care utilization and total allowed amounts per member per month by commercial and Medicare Advantage. Medicare Fee-For-Service and Medicaid data will be included in future dashboards.

All data in cost and utilization section of this dashboard are from the All Payer All Claims Database, with the exception of OHA Medicaid inpatient data, which comes from Oregon's Health System Transformation Quarterly Progress Report.

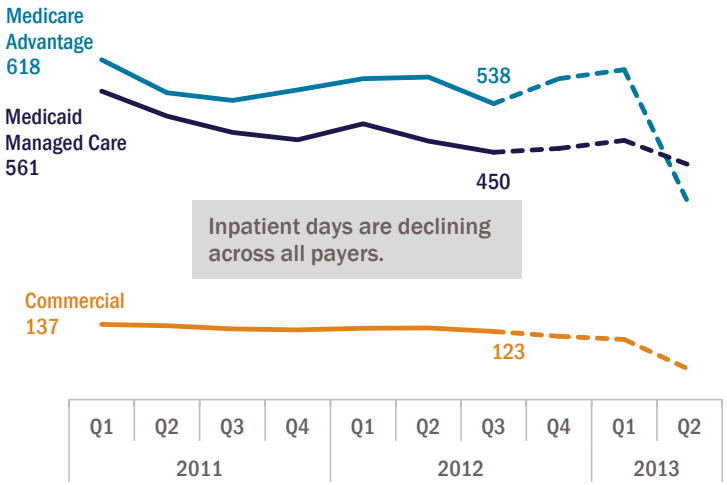
Cost and utilization data are compiled according to Milliman's Health Cost Guidelines grouper. For more details on groupings, see data notes page at end of dashboard. Dashed lines indicate where data are partially incomplete (usually the most recent three quarters).

Total Expenditures Per Member Per Month

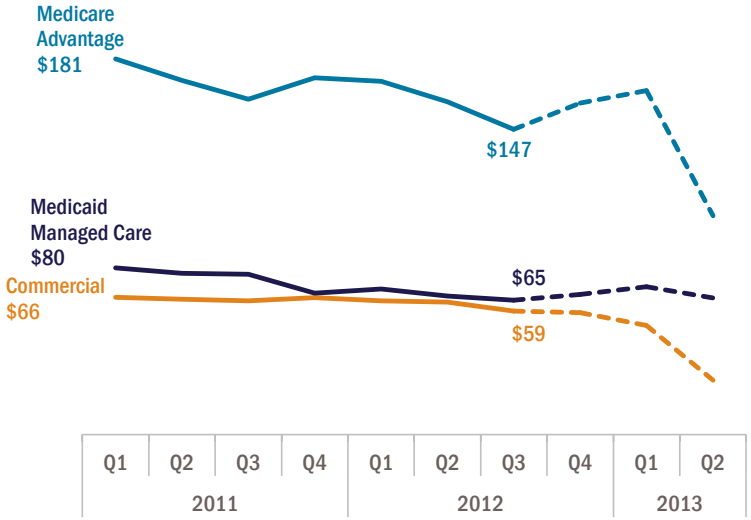


Hospital Inpatient

Hospital Inpatient Days
Annualized / 1,000 members



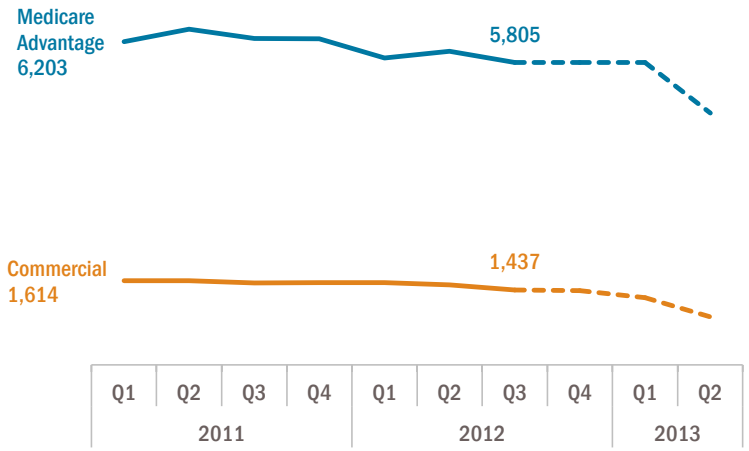
Hospital Inpatient Expenditures Per Member Per Month



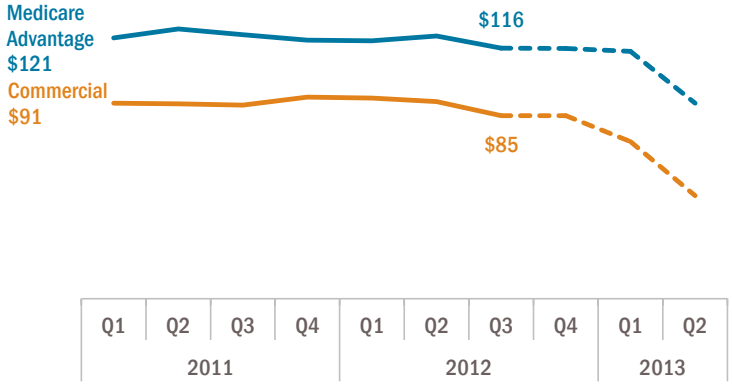
Cost and Utilization, cont.

Outpatient

Visits
Annualized / 1,000 members

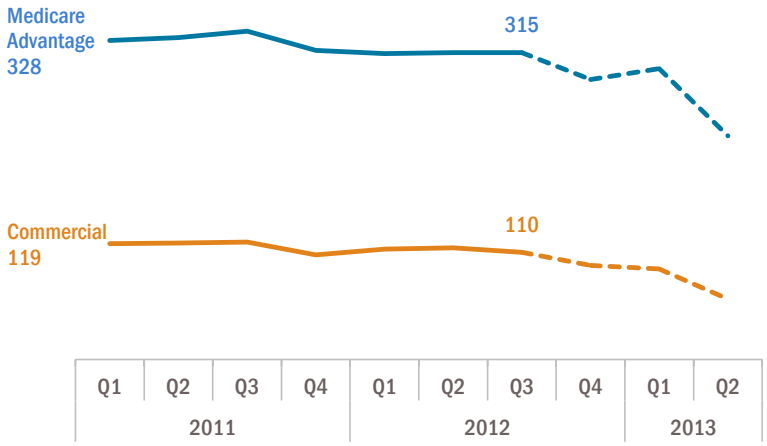


Expenditures Per Member Per Month

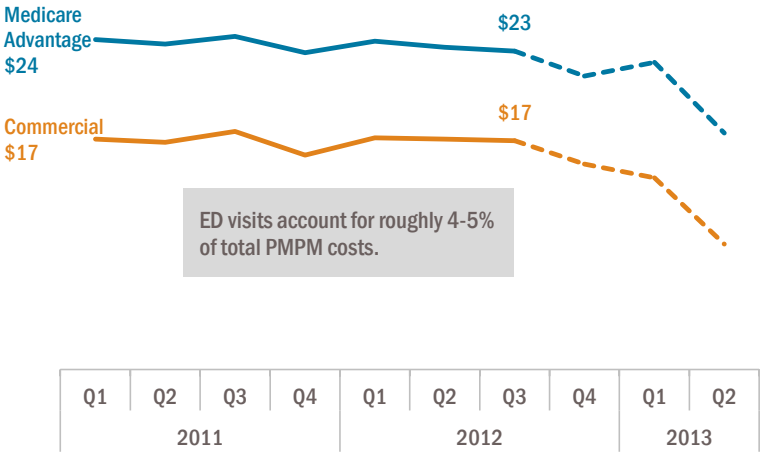


Emergency Department

Visits
Annualized / 1,000 members



Expenditures Per Member Per Month

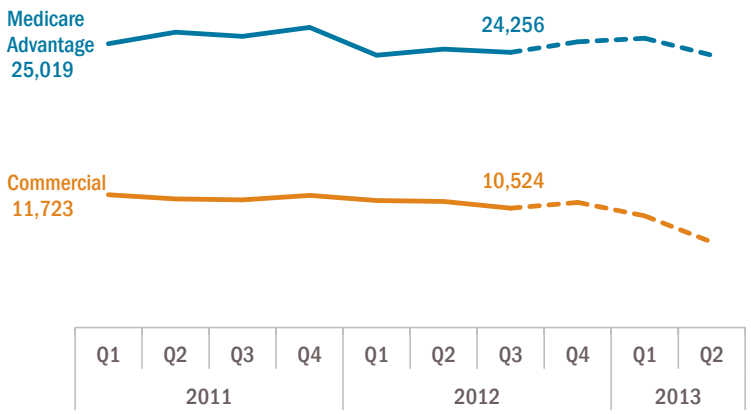


ED visits account for roughly 4-5% of total PMPM costs.

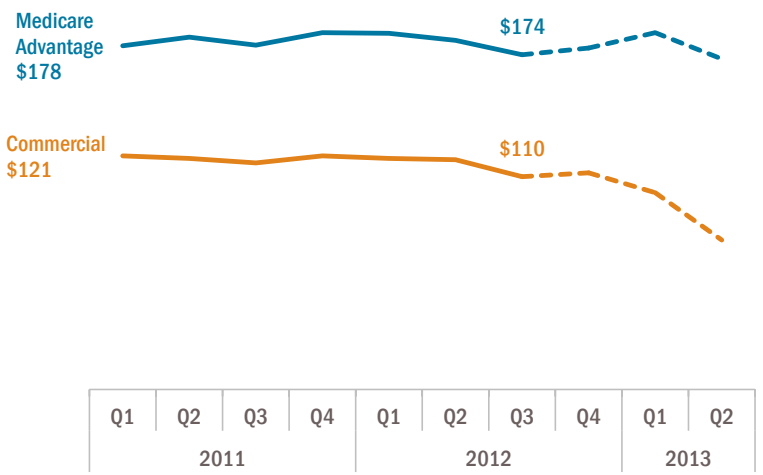
Cost and Utilization, cont.

Professional

Procedures & Visits
Annualized / 1,000 members

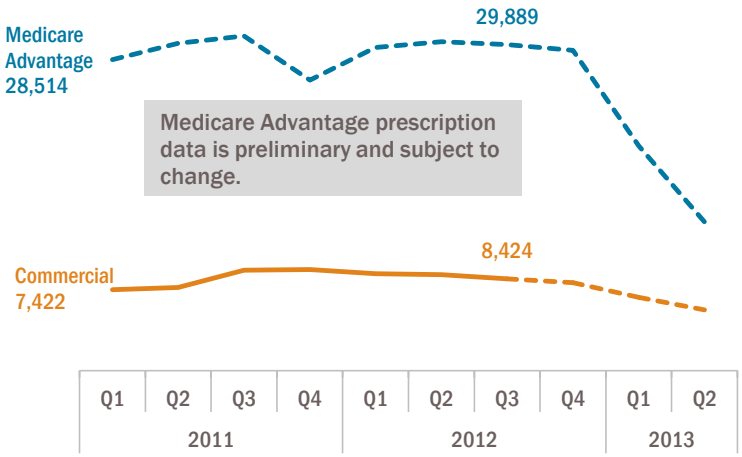


Expenditures Per Member Per Month

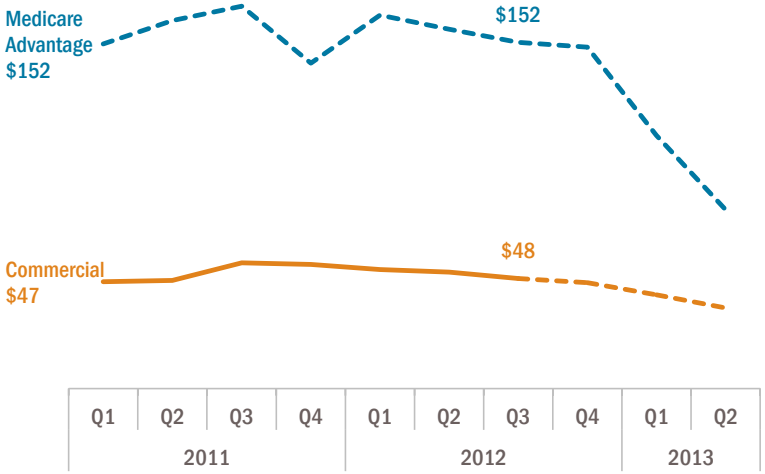


Pharmacy

Prescriptions
Annualized / 1,000 members



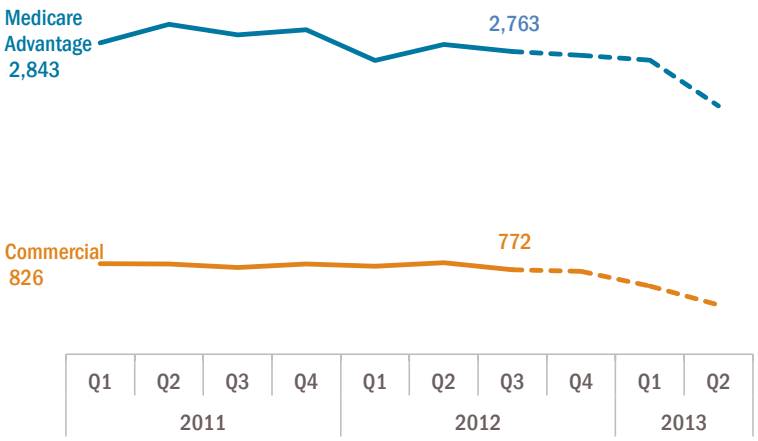
Expenditures Per Member Per Month



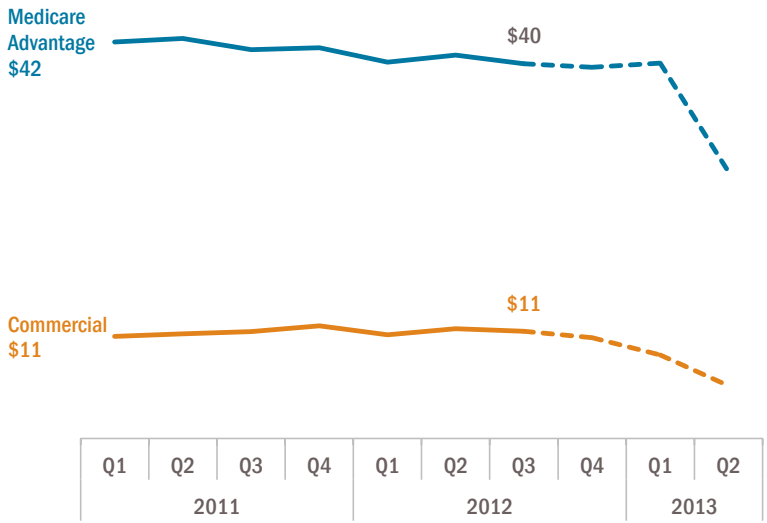
Cost and Utilization, cont.

Ancillary Services*

Procedures & Visits
Annualized / 1,000 members



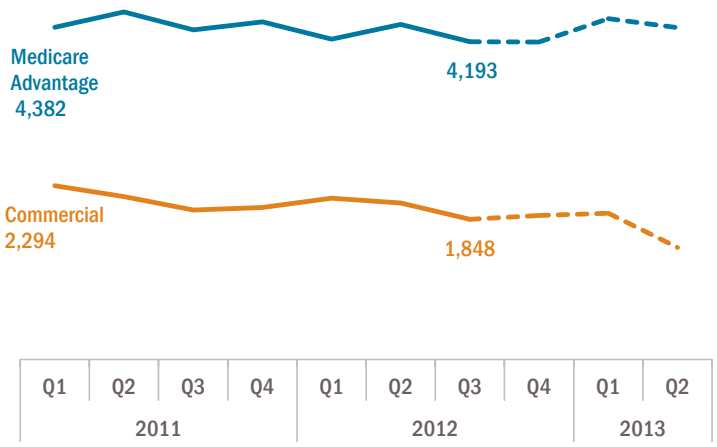
Expenditures Per Member Per Month



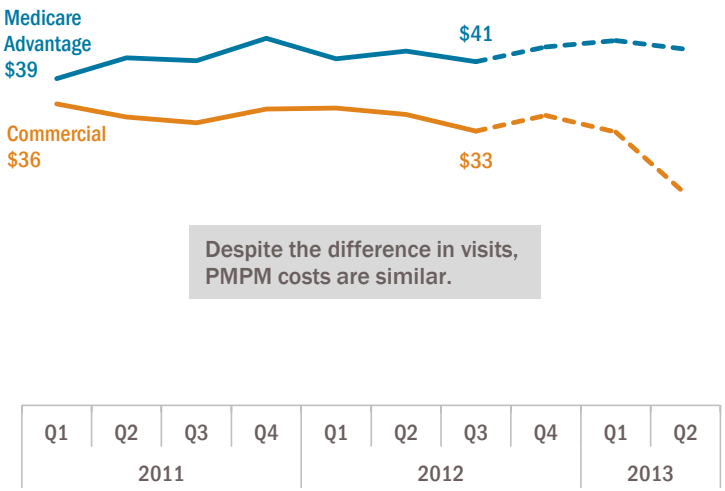
* Ancillary Services include durable medical equipment, therapeutics, and certain forms of custodial care

Primary Care*

Visits
Annualized / 1,000 members



Expenditures Per Member Per Month



Despite the difference in visits, PMPM costs are similar.

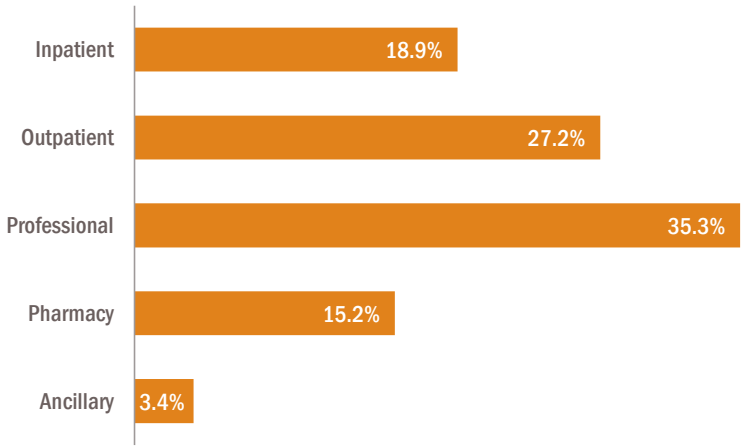
* see data notes page for Primary Care definition

Cost and Utilization: Expenditures Across Types of Care

The type of care Oregonians receive varies by population. Commercially insured Oregonians tend to be younger and healthier th an Oregonians with Medicare Advantage coverage. Medicare Advantage members receive more of their care in an inpatient setting and rely more heavily on ph armaceuticals while the commercially insured receive more of their care in an outpatient setting and rely more heavily on professional services. In addition, Medi care Advantage members receive a greater share of their care in the form of ancillary services, which includes durable medical equipment, therapeutics and certain for ms of custodial care.

Commercial

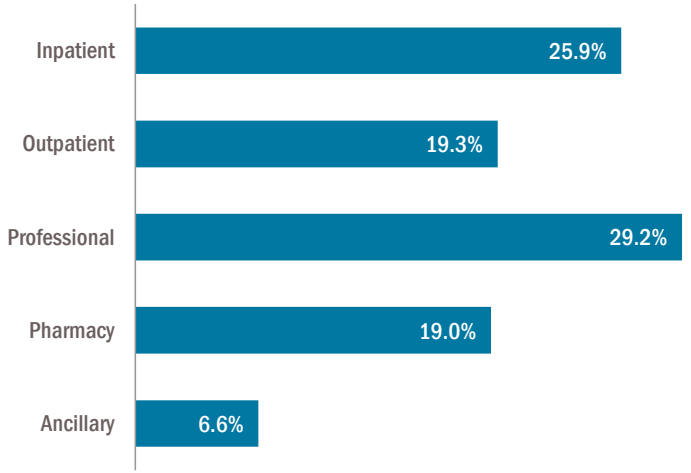
Total Expenditures by Health Cost Group in 2012



ED and Primary Care are included in Outpatient and Professional. ED accounts for 5.0% of total expenditures, Primary Care for 10.6%.

Medicare Advantage

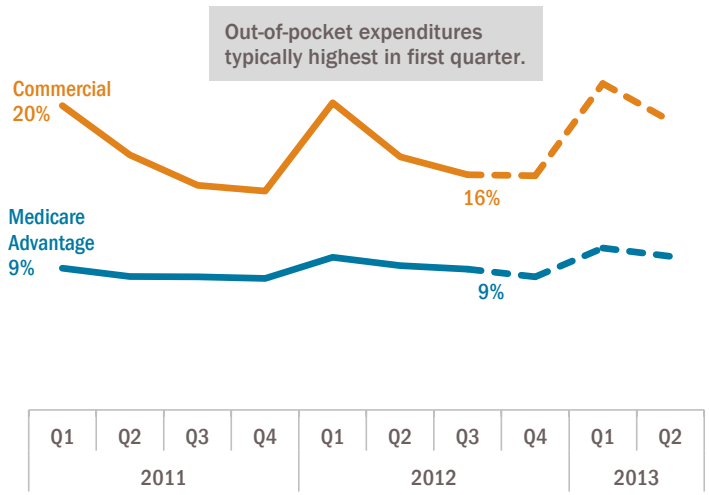
Total Expenditures by Health Cost Group in 2012



ED and Primary Care are included in Outpatient and Professional. ED accounts for 3.7% of total expenditures, Primary Care for 6.9%.

Cost and Utilization: Consumer Out-of-Pocket Expenditures

Consumer's Out-of-Pocket Share of Total Expenditures



Consumer's out-of-pocket expenditures include copayments, coinsurance, and deductibles. These expenditures are larger early in the calendar year due to annual deductible requirements.

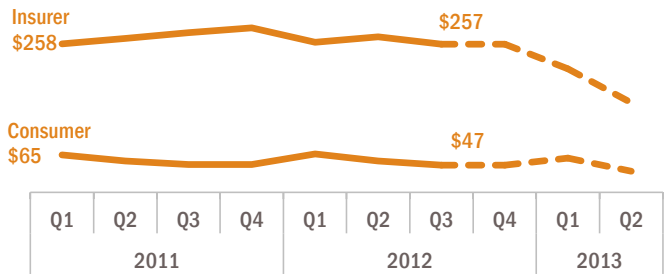
In general, consumers pay the lowest share for inpatient services (4-7% of total inpatient expenditures).

For commercial consumers, the highest share of expenditures is for ancillary services (20-30% of total ancillary expenditures) and ED visits (20-26% of total ED expenditures).

Dashed lines indicate where data are partially incomplete. All data in this section are sourced from the All Payer All Claims Database.

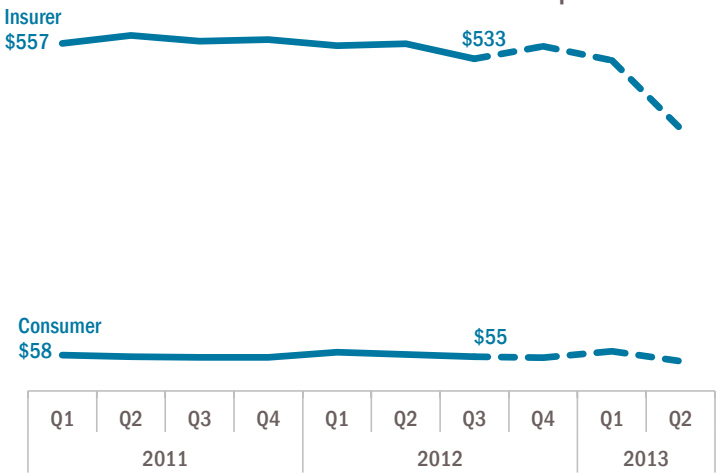
Commercial

Total PMPM
Insurer Covered and Consumer Out-of-Pocket Expenditures



Medicare Advantage

Total PMPM
Insurer Covered and Consumer Out-of-Pocket Expenditures



Cost: Top Health Care Treatment Episodes

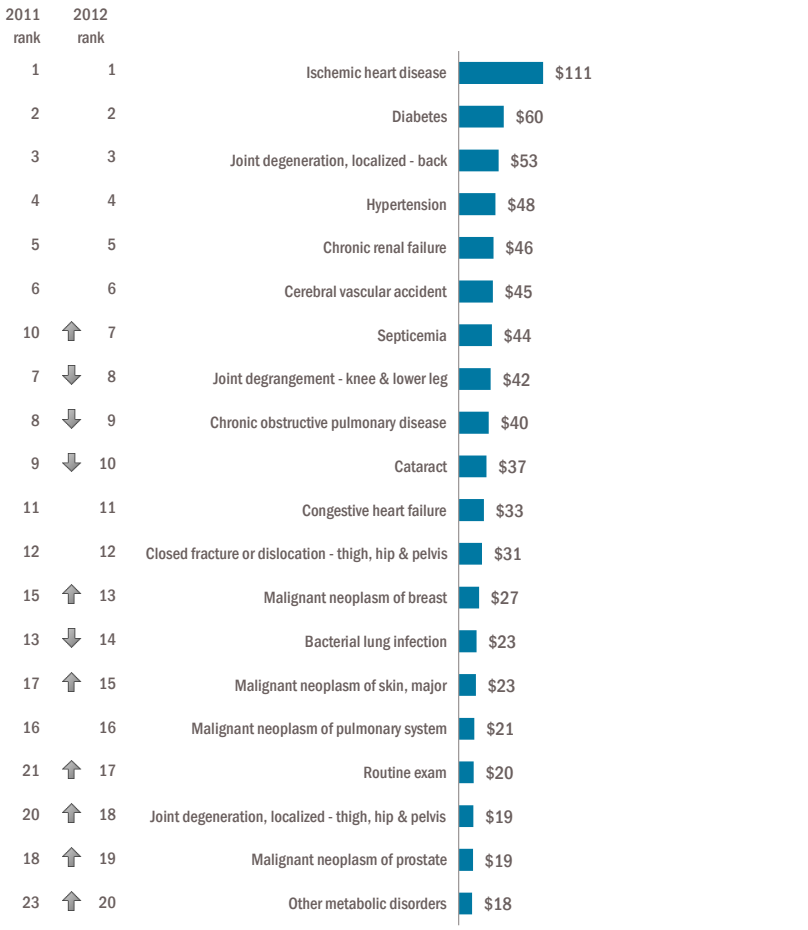
- Episode Treatment Groups identify unique episodes of care. An episode of care combines all clinically related services for one patient and a discrete diagnostic condition. Together the top 20 episodes from 2012 account for about 35% of total claim costs.
- Arrows indicate movement in rank from 2011 to 2012.

Commercial

Top 20 Episodes by Total Expenditures, 2012
Dollars in millions

Medicare Advantage

Top 20 Episodes by Total Expenditures, 2012
Dollars in millions

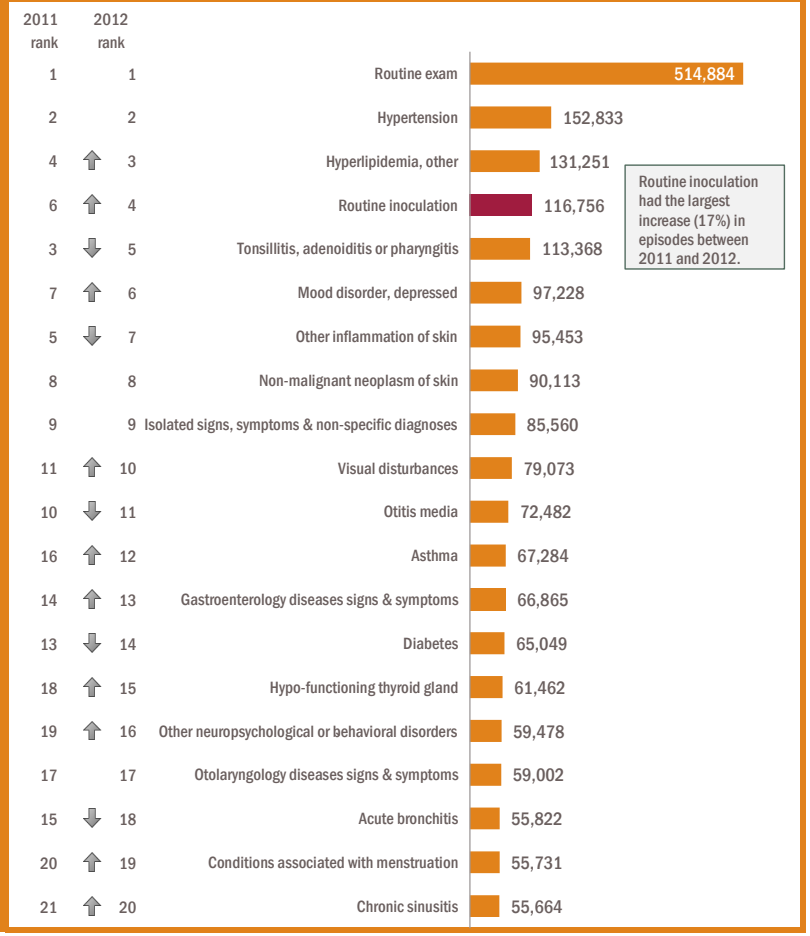


Utilization: Top Health Care Treatment Episodes

- Episode Treatment Groupers identify unique episodes of care. An episode of care consists of all clinically related services for one patient and a discrete diagnostic condition.
- Arrows indicate movement in rank from 2011 to 2012.
- All data in this section are sourced from the All Payer All Claims Database.

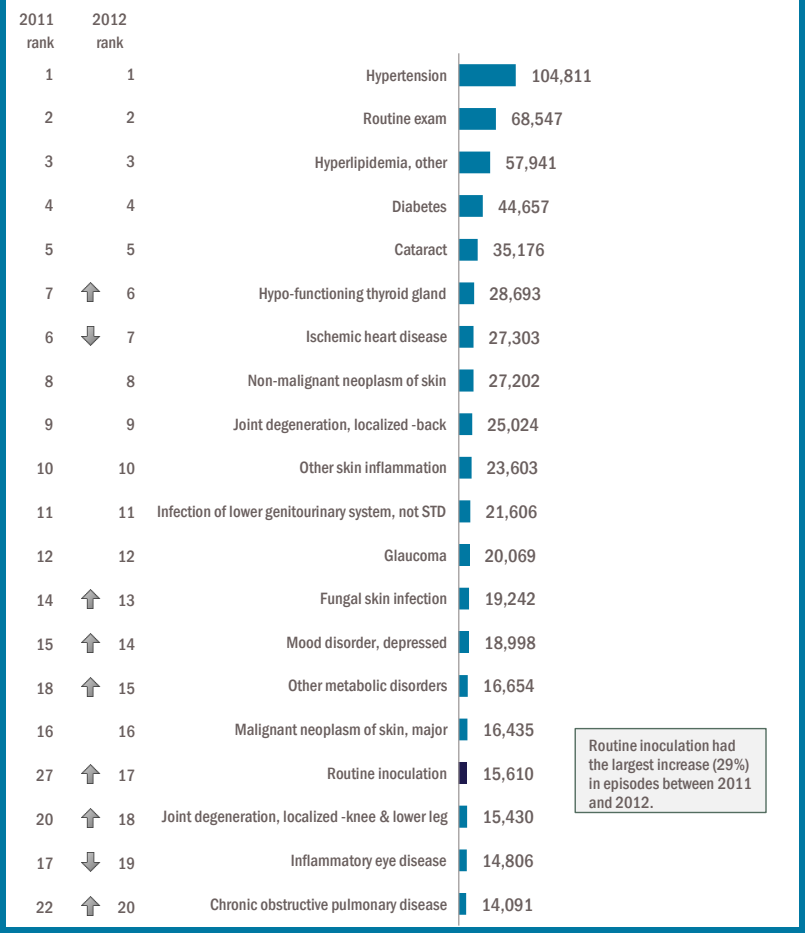
Commercial

Top 20 Episodes by Number of Episodes, 2012



Medicare Advantage

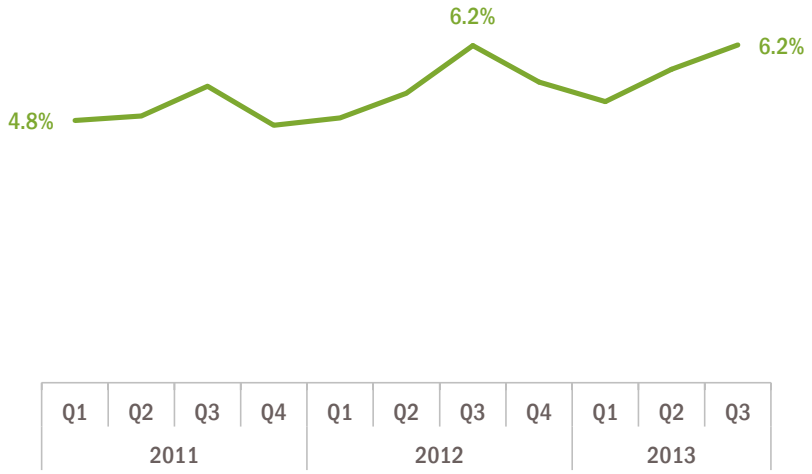
Top 20 Episodes by Number of Episodes, 2012



Cost & Utilization: Uninsured and Uncompensated Hospital Utilization

While hospital care for the uninsured has remained relatively stable over the last several years, that trend may change as more Oregonians are covered through the Affordable Care Act insurance coverage expansions. Uninsured hospital discharges are sourced from Oregon's hospital discharge database. Hospital uncompensated care is sourced from Databank.

Uninsured Hospital Discharges
as a percentage of total hospital discharges



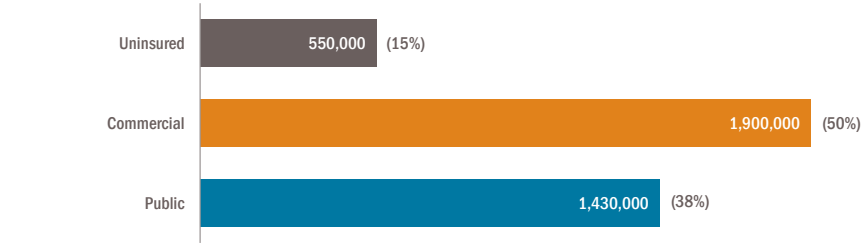
Hospital Uncompensated Care
as a percentage of hospital gross charges

Enrollment: Health Insurance Coverage

Overview

Insurance Coverage and Percent of Oregon Population, 2013

Some Oregonians have more than one form of coverage. Percentages do not add to 100.



Roughly half of Oregonians receive commercial health insurance, and a growing portion receive public health insurance such as Medicaid or Medicare.

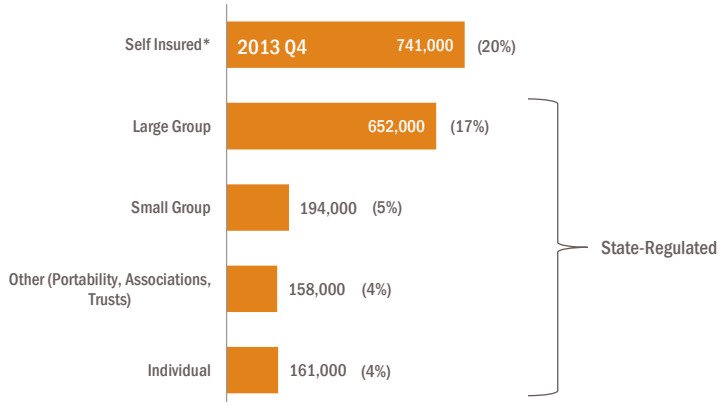
Roughly 30% of Oregonians receive large group, small group, individual or other forms of coverage that are regulated by the Department of Consumer and Business Services (DCBS) and approximately 13% of Oregonians receive coverage that is subject to DCBS's rate review process.

Between December 2013 and January 2014 Medicaid enrollment increased by over 30% percent, largely the result of Fast Track enrollment efforts.

Commercial health insurance enrollment is sourced from quarterly enrollment reports submitted to DCBS.

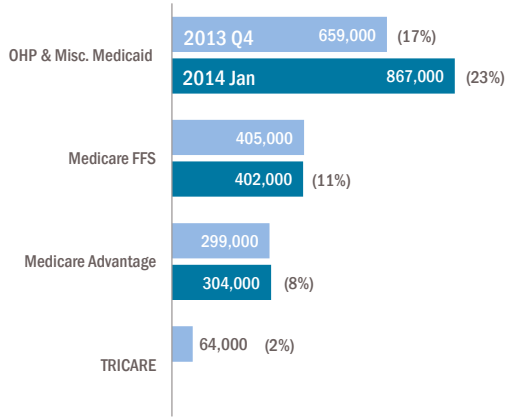
Medicaid enrollment comes from OHA, Medicare from Center for Medicare and Medicaid Services and TRICARE from DCBS.

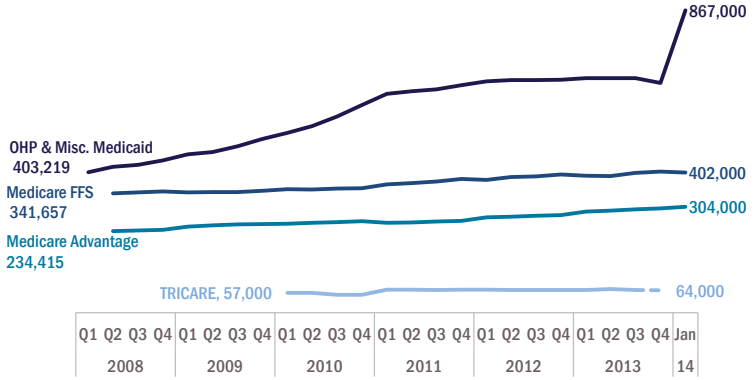
Commercial Insurance



**Only a portion of Self-Insured plans report enrollment data*

Public Insurance

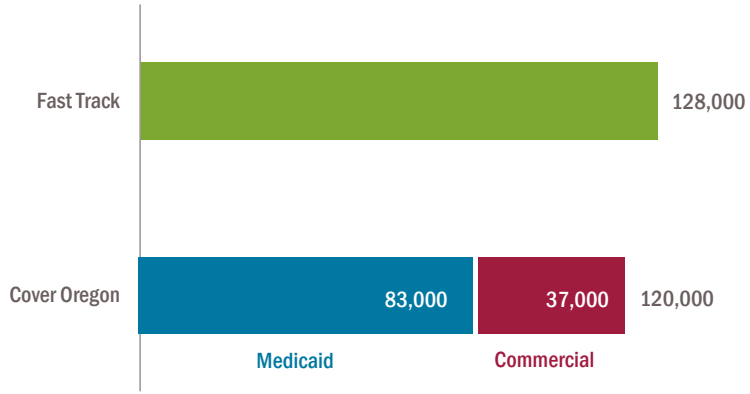




Enrollment: ACA Expansion

Overview

Medicaid Fast Track and Cover Oregon Enrollment
week of 2/24/2014



The ACA expanded access to health insurance by creating the Cover Oregon insurance marketplace, providing subsidies for commercial coverage in Qualified Health Plans and expanding non-elderly adults' eligibility for Medicaid.

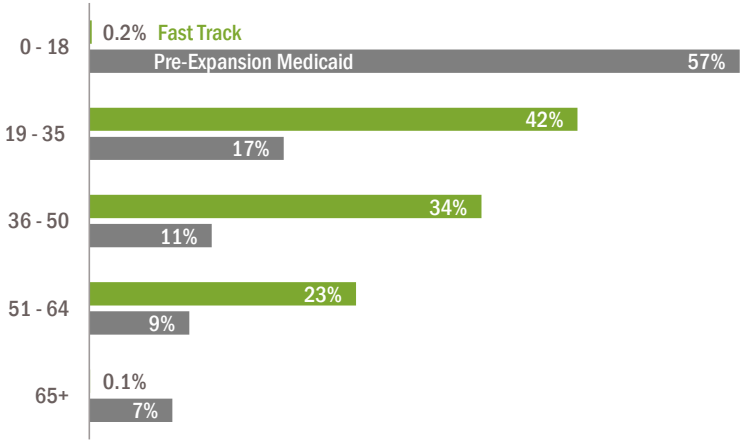
The Medicaid expansion was facilitated by Fast Track enrollment efforts, which were authorized through a CMS waiver to reduce administrative barriers and streamline the enrollment process by using existing program application data primarily through the Supplemental Nutrition Assistance Program (SNAP) to confirm Medicaid eligibility.

The bottom two charts compare the characteristics of Medicaid members who were enrolled prior to Fast Track enrollment with the new Medicaid members who enrolled through the Fast Track outreach program. The new enrollees consist almost entirely of non-elderly adults, while traditionally Medicaid enrollees were mostly children. The new enrollees are also evenly split between women and men whereas traditionally Medicaid enrolled more women than men.

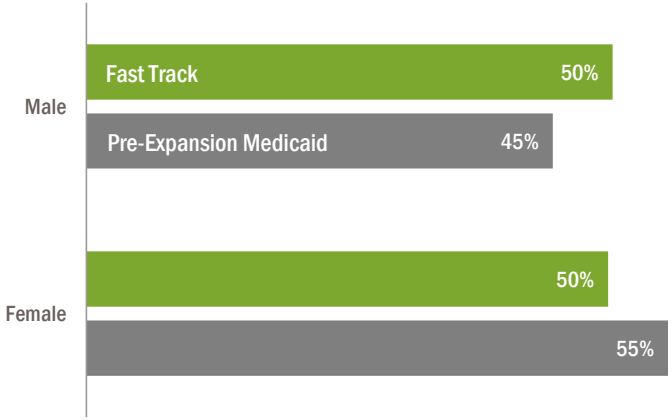
Fast track enrollment data is from OHA. Cover Oregon provided their enrollment statistics.

OHP Fast Track

Fast Track Compared to Medicaid before ACA Expansion by Age, week of 2/24/2014



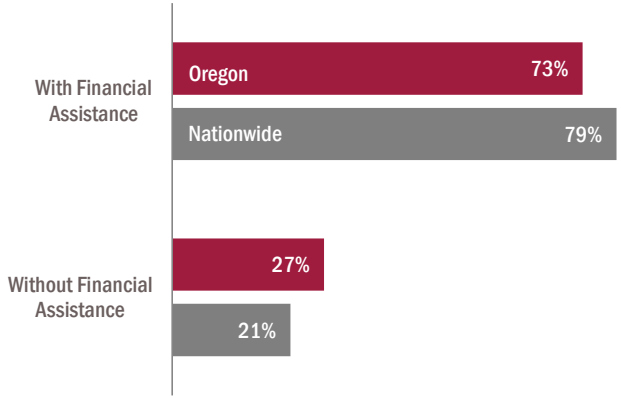
Fast Track Compared to Medicaid before ACA Expansion by Gender, week of 2/24/2014



Enrollment: Qualified Health Plans through Cover Oregon

Cover Oregon Marketplace Enrollment & National Average

By Financial Assistance Status
as of 2/1/2014

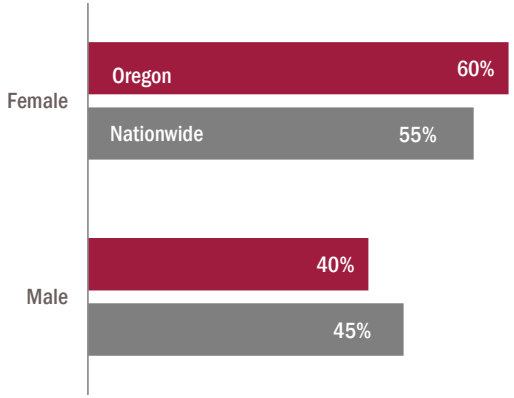


Oregonians who have purchased individual insurance through Cover Oregon have similar characteristics to the national average.

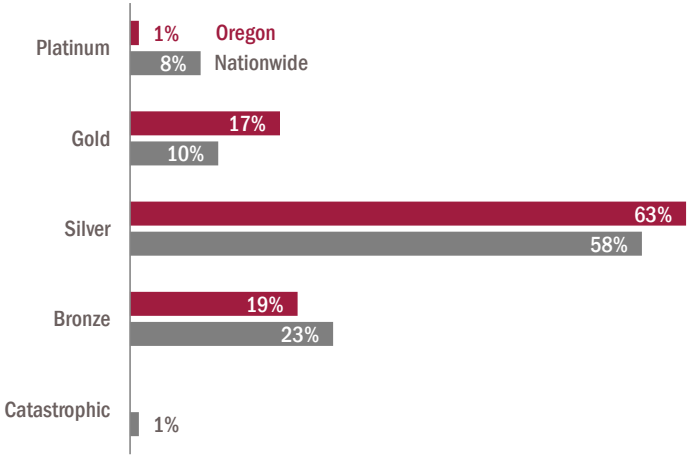
In Oregon, a slightly smaller share of enrollees receive financial assistance than they do nationwide; a slightly larger share are female; and a somewhat greater share of enrollees select the gold and silver tiers of coverage.

This data is sourced from the February 12, 2014 Issue Brief distributed by the federal Department of Health and Human Services, which reports total health insurance marketplace enrollment from October 1, 2013 to February 1, 2014.

By Gender
as of 2/1/2014



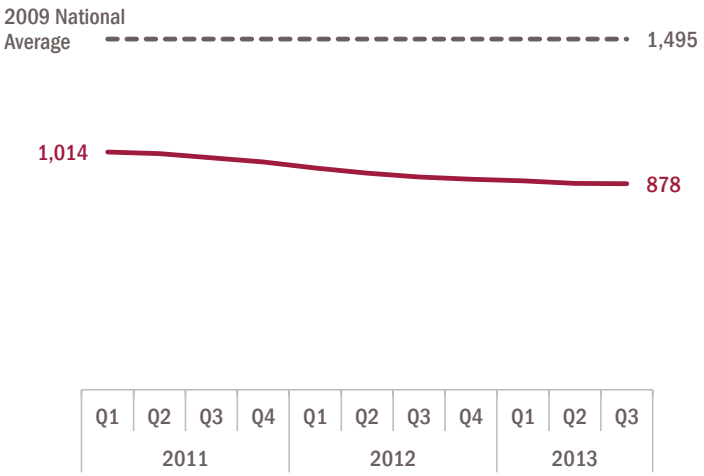
By Metal Tier (Actuarial Value of Coverage)
as of 2/1/2014



Composite Measures

Total Prevention Quality Indicator (PQI) Admissions

Four-quarter moving average per 100,000 person years

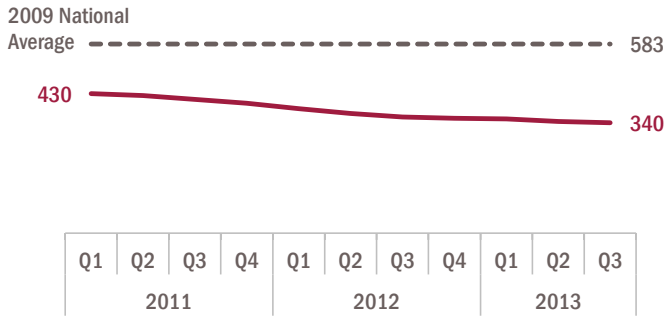


The Prevention Quality Indicators (PQIs) presented in this section are federally-specified measures used to identify hospitalizations that could likely have been avoided through early intervention and outpatient care. The four condition-specific measures on the following page align with the four PQIs also reported for the Medicaid Coordinated Care Organizations (CCOs). These PQIs include hospitalizations of all Oregon residents in Oregon hospitals. As uninsured individuals gain coverage and easier access to outpatient care, these hospitalizations may decline. In interpreting the graphs, a lower rate is better.

The dashboard's quality metrics will be educated by work underway to identify a core set of quality metircs across Cover Oregon, Oregon Educators Benefit Board, Public Employees Benefit Board, and the CCOs.

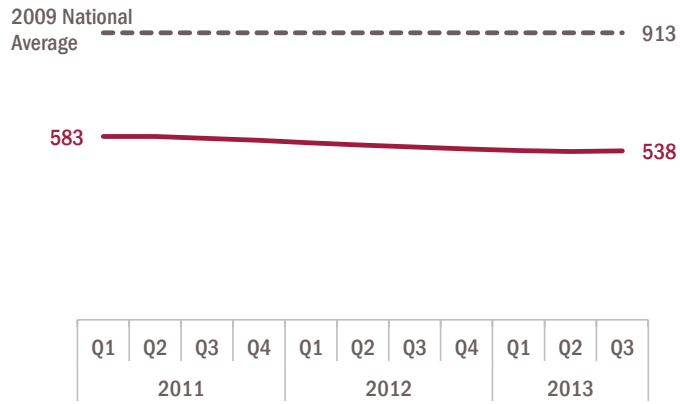
Acute PQI Admissions

Four-quarter moving average per 100,000 person years



Chronic PQI Admissions

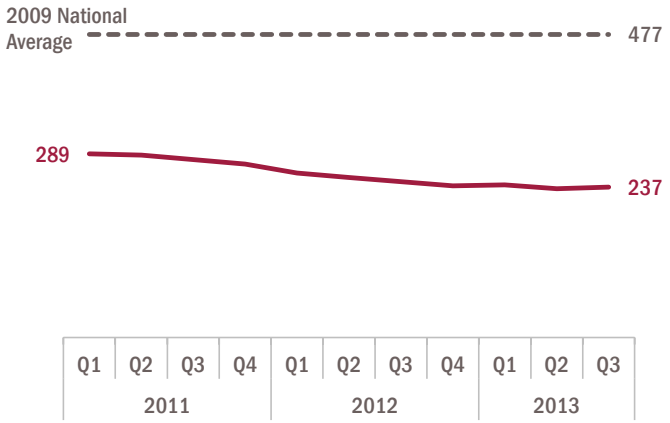
Four-quarter moving average per 100,000 person years



Individual PQIs

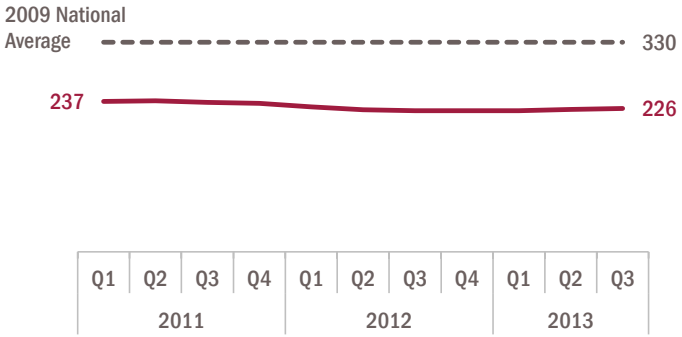
Chronic Obstructive Pulmonary Disease Admissions

Four-quarter moving average per 100,000 person years



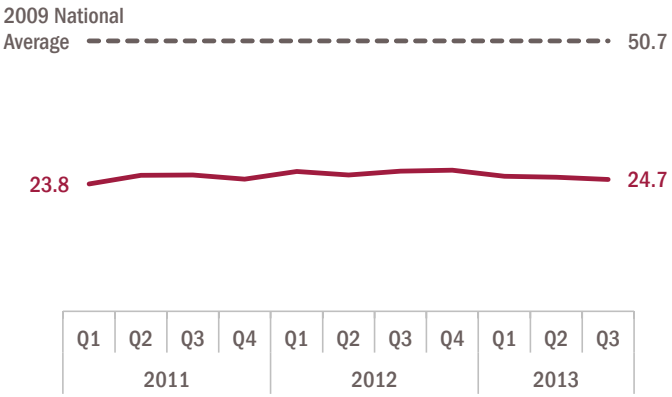
Congestive Heart Failure Admission

Four-quarter moving average per 100,000 person years



Adult Asthma Admissions

Four-quarter moving average per 100,000 person years



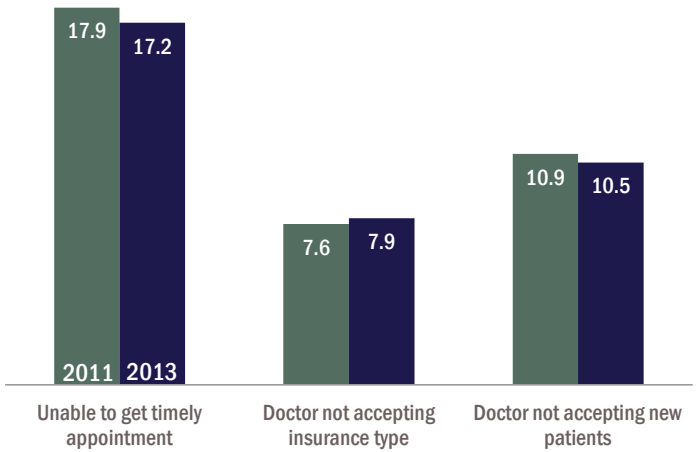
Diabetes Short Term Complications Admissions

Four-quarter moving average per 100,000 person years

Access

Overview

OHIS Health Care Access Measures

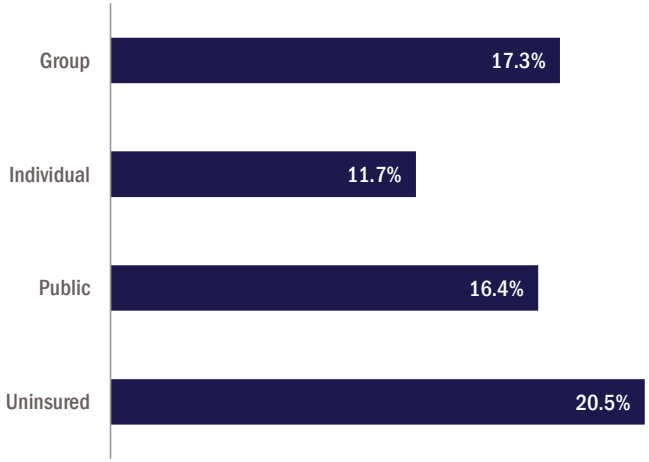


The data in the Access section are from the Oregon Health Insurance Survey (OHIS). OHIS did not show statistically significant changes in the 2011 and 2013 responses to questions about health care access.

However, differences do exist among the responses of Oregonians with different types of coverage or no coverage at all. These differences are described in the following boxes. In all instances, a smaller response rate or smaller bar demonstrates better access to care.

Making an appointment

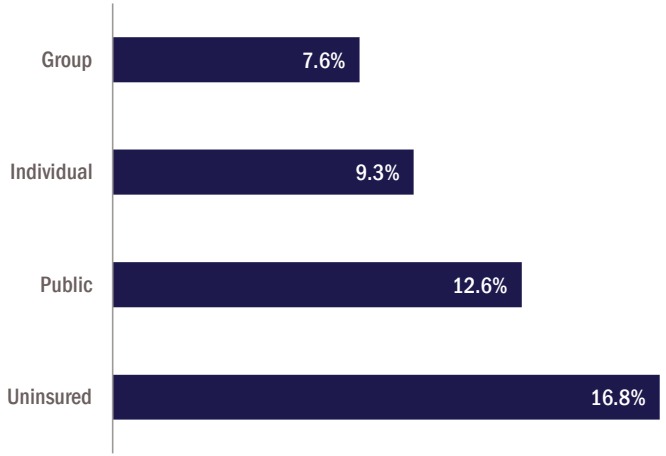
Unable to get timely appointment



Oregonians with individual coverage reported fewer problems with being able to see a doctor as soon as thought necessary, in comparison to other insurance types. This may be a sign of better access for this group or that they have different expectations. OHIS did not find significant differences among uninsured, public, and group-insured Oregonians.

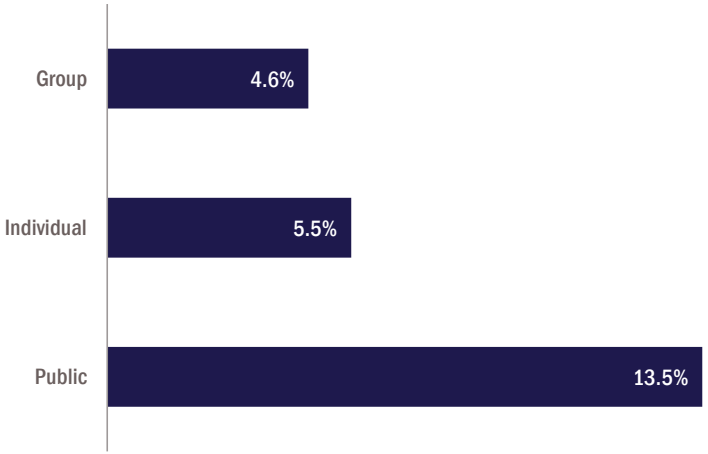
Finding a Doctor

Doctor not accepting new patients



Uninsured Oregonians were more likely to be told by a doctor's office or clinic that they are not accepting new patients. OHIS did not find significant differences among public, group or individually-insured Oregonians.

Doctor not accepting patients with insurance type



Oregonians with public insurance (primarily consisting of Medicaid and Medicare) were more likely to have been told that doctor's office or clinic is not accepting their insurance type. OHIS did not find significant differences between group and individually-insured Oregonians. Uninsured respondents are not asked this question.

Data Notes

Cost & Utilization by types of care (pages 2-6)

Data for the most recent quarters (typically the most recent three quarters) is partially incomplete due to claims data lag. Claims data lag occurs due to a delay between the time that a health care claims occurs and when it is reported and processed by the insurance carrier.

Skilled nursing facility claims and alcohol and drug abuse treatment claims are not included in the data for the dashboard.

Utilization rates per thousand members is annualized by multiplying monthly rates by 12.

Per member per month (PMPM) expenditures are calculated using allowed amount to capture total claim expenditures—insurer amount and consumer out-of-pocket spending.

For reporting cost and utilization, claims are classified into 5 categories using Milliman's Health Cost Guidelines (HCG) grouper: inpatient, outpatient, professional, pharmacy, and ancillary. Additional breakouts of emergency department and primary care also are provided.

Hospital inpatient PMPM and outpatient PMPM expenditures represent facility claims only. Separately billed inpatient and outpatient physician fees are included in the professional category.

Outpatient data include emergency department and primary care claims.

Professional utilization includes visits (office visits and exams) and procedures (surgeries, deliveries, anesthesia, imaging, and others).

Professional data include emergency department and primary care claims.

Medicare Advantage pharmacy data are preliminary pending ongoing work on the integration of Medicare Prescription Drug Plans (Part D) into APAC.

Ancillary services include durable medical equipment, therapeutics, certain forms of custodial care, and other categories (such as dental, non-emergency transportation, and ambulance). Ancillary utilization includes visits and procedures.

Emergency department PMPM expenditures include hospital facility claims and professional claims.

Primary care visits include home and office visits, well-baby exams, and physical exams. Primary care PMPM expenditures include claims for primary care visits as well as preventive procedures. The Office of Health Analytics is using this as a preliminary measurement of primary care utilization and cost while continuing to work with

stakeholders on identifying the appropriate claims to include when measuring primary care. Primary care PMPM expenditures include outpatient facility claims and professional claims.

Total PMPM expenditures are the sum of hospital inpatient, outpatient, professional, pharmacy, and ancillary services claims. (Emergency department and primary care claims are included in outpatient and professional.)

Cost & Utilization: Consumer Out-of-Pocket Expenditures (page 7)

Data for the most recent quarters (typically the most recent three quarters) is partially incomplete due to data lag. Claims data lag occurs due to a delay between the time that a health care claims occurs and when it is reported and processed by the insurance carrier.

Insurer covered expenditures represent insurer paid amounts. Out-of-pocket share includes copayments, coinsurance, and deductibles. For some claims, insurer share and out-of-pocket share may not account for all expenditures as coordination of benefits and other risk-sharing arrangements are not fully captured in APAC.

Cost & Utilization: Top Health Care Treatment Episodes (pages 8-9)

Episode Treatment Groups (ETGs) are a basic illness classification methodology that identify unique episodes of care. A patient's episode of care consists of all clinically related services for a discrete diagnostic condition. The ETGs can track an episode of care across medical treatment settings (inpatient, outpatient, professional, ancillary, or pharmacy). ETGs in APAC are grouped according to OptumInsight's methodology. For more information, see http://www.optuminsight.com/transparency/etg-links/learn-about-etgs/.

Episodes by Number of Episodes is calculated annually using episodes prorated allowed—a measurement that allows episodes spanning more than one year to be allocated between those years. For example, if 75% of an episode's allowed expenditures occurred in 2011 and 25% occurred in 2012, then 2011 is credited with 0.75 episodes and 2012 with 0.25 episodes. An episode for a chronic condition such as diabetes is considered to be one year's worth of care related to the condition.

Episodes by Total Expenditures are ranked according to the total annual allowed amount of expenditures on each ETG.

Cost & Utilization: Uninsured and Uncompensated Hospital Utilization (page 10)

Dashboard data represent uninsured and total discharges at Oregon acute care hospitals by Oregon residents. Uninsured discharges are defined as self pay and charity care discharges. Total discharges include all Oregon residents regardless of their form or lack of health insurance.

Charity care is the total amount of health care services, based on full, established charges, provided to patients who are determined by the hospital to be unable to pay for the cost of health care services.

Bad debt is the unpaid obligation for care, based on full, established charges, for which the hospital expected payment but is unable to collect.

Charity care and bad debt are expressed as a percentage of hospitals' total charges.

Enrollment: Health Insurance Coverage (page 11)

Not all self-insured entities are required to report to DCBS, which may result in the self-insured coverage being under-represented. In addition, some Oregonians have more than one form of coverage. In such cases, these individuals will be reported separately by each form of coverage. For example, an individual with both Medicare and Medicaid coverage would be counted twice in the Public category. Consequently, these numbers are not directly comparable to the number of unique individuals who receive coverage in each category, and the numbers cannot be summed to the total population in Oregon.

Percentages are based on estimated total non-group quarters population from the 2011 American Community Survey.

Enrollment: ACA Expansion (page 12)

Fast Track enrollment distributions by age and gender are based on actual enrollments and Fast Track consent letters awaiting enrollment.

Enrollment: Cover Oregon (page 13)

Cover Oregon enrollment data distributions are estimates based on analysis of enrollment files sent to issuers through December 31, 2013, for those individuals for whom this data was available. For more information see the "Health Insurance Marketplace: February Enrollment Report for the period October 1, 2013–February 1, 2014," available from the Department of Health and Human Services here:
http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

Quality (page 14-15)

Prevention Quality Indicators (PQIs) have been determined by the Agency for Healthcare Research and Quality (AHRQ) as measures of potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). For more information see: http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

Chronic PQIs include diabetes short-term complications, diabetes long-term complications, chronic obstructive pulmonary disease (COPD) or asthma in older adults, hypertension, congestive heart failure, angina without procedure, uncontrolled diabetes, asthma in younger adults and rate of lower-extremity amputation among patients with diabetes.

Acute PQIs include dehydration, bacterial pneumonia, and urinary tract infections.

Sources

All Payer All Claims Database

The 2009 Oregon State Legislature passed HB 2009, which created the All Payer All Claims Reporting Program (APAC) to measure the quality, quantity, and value of health care in Oregon. The Oregon Health Authority contracts with Milliman, Inc. to collect data on all paid claims from commercial health plans, licensed third party administrators, pharmacy benefit managers, and the Oregon Health Plan.

At this time, APAC excludes certain lines of business that are not required to report, such as carriers with less than 5,000 covered lives; Medicare Fee-For-Service; TRICARE; uninsured and self-pay; and stand-alone vision and dental coverage. Additionally, data from Kaiser Health Plan of the Northwest also is missing from APAC at this time.

This quarter's version of the dashboard includes APAC data for commercial and Medicare Advantage claims. OHA is working to convert state Medicaid data into Milliman groupers for inclusion in future dashboards. OHA also is working with the Centers for Medicare and Medicaid Services to collect Medicare Fee-For-Service data for APAC.

Inpatient Hospital Discharge Database

The inpatient hospital discharge database is updated quarterly with information on discharges from Oregon acute care hospitals. Data elements include length of stay, discharge date, discharge status, payer, and procedure and diagnosis codes.

Databank

OHA receives utilization and financial data from each of Oregon's hospitals at the end of each quarter from the Oregon Databank program, a state-mandated hospital reporting program administered by Apprise Health Insights.

Department of Business and Consumer Services Quarterly Enrollment Reports

All licensed carriers, third party administrators and special districts report total enrollment on a quarterly basis to the Department of Consumer and Business Services (DCBS). Data are available via the DCBS Report Catalogue: http://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?ProgID=UM8902

Medicare Data

Medicare Advantage and Fee For Service enrollment comes from the Medicare Advantage State/County Penetration File from the federal Center for Medicare and Medicaid Services: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html

Oregon Health Insurance Survey

The Oregon Health Authority and OHPR conducted this large-scale health and health insurance survey of Oregonians in the first quarter of 2011 and again in early 2013. Information gathered from the survey is helping the state understand the health care needs and concerns as we move through state and federal health reform. For more information see: http://www.oregon.gov/oha/OHPR/RSCH/pages/insurance_data.aspx#Survey_Reports_and_Data

Appendix B

Oregon Health Policy Board 2014 Workplan Update

Prepared by Jeff Scroggin for the Oregon Health Policy Board
March 4, 2013

Introduction

In a June 2013 letter, Governor Kitzhaber asked the Board (OHPB) for recommendations to better align Oregon's implementation of the Affordable Care Act (ACA) with Oregon's current health system reform efforts and to spread the triple aim goals across all markets. The letter charged OHPB with providing recommendations which:

- Move the marketplace toward one characterized by coordinated care and growth rates of total health care that are reasonable and predictable;
- Mitigate cost shift, decrease premiums, and increase transparency and accountability;
- Enhance the Oregon Insurance Division (OID) rate review process;
- Align care model attributes within the Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB) and Cover Oregon Qualified Health Plans (QHPs).

Principles for the Board's 2013 Recommendations

- Leveraging the coordinated care model
- Enhancing transparency
- Promoting and ensuring shared accountability
- Focusing on outcomes
- Improving quality and access
- Containing costs

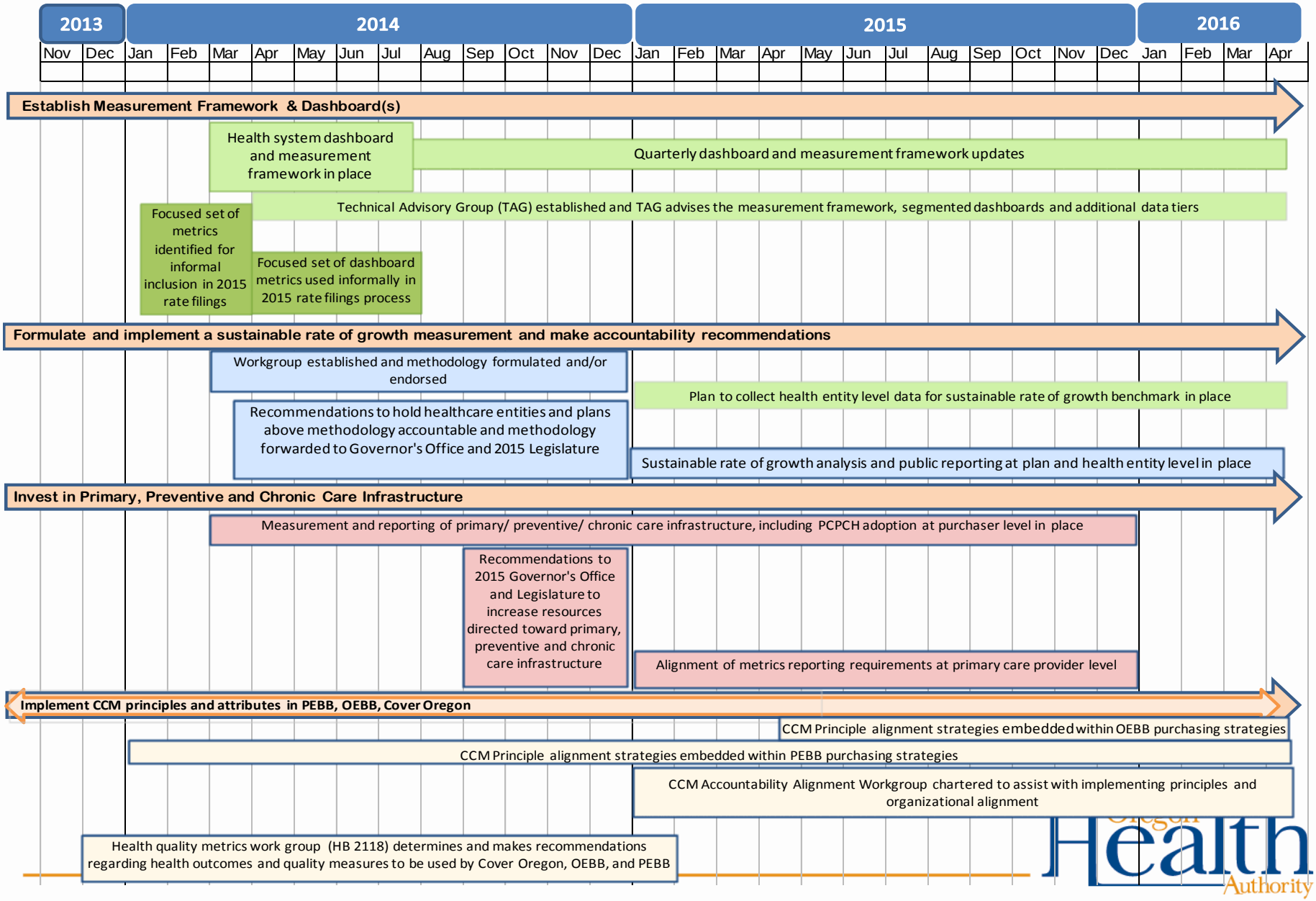
Process for the Board's 2013 Recommendations

- Manatt Health Solutions in collaboration with Oregon Health Authority (OHA) and Oregon Insurance Division (OID) staff, provided OHPB with an overview of potential policy options and related levers, including policy options used by other states.

- OHPB discussed options through a facilitator, and reviewed and refined potential strategies through a public and transparent iterative process.

- The board examined potential policy recommendations through the lens of feasibility and effectiveness, and discussed specific actions, accountabilities, and timelines for each strategy.

Draft Implementation Timeline



OHPB Recommended Strategies

1. Create system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard, which tracks the effect of ACA implementation and Oregon's health system reforms.

2. Increase transparency and enhance rate review by including metrics in rate filings.

3. Move the health care marketplace toward a predictable and sustainable rate of growth.

4. Improve quality and contain costs by expanding an innovative and outcome-focused primary, preventive and chronic care infrastructure and support metrics alignment at the provider level.

5. Move the foundation of Oregon's health system transformation – the coordinated care model – forward by spreading the model to the broader marketplace.

6. Implement communication outreach strategies that work for health plans and consumers and administrative simplification.

Where are we now?

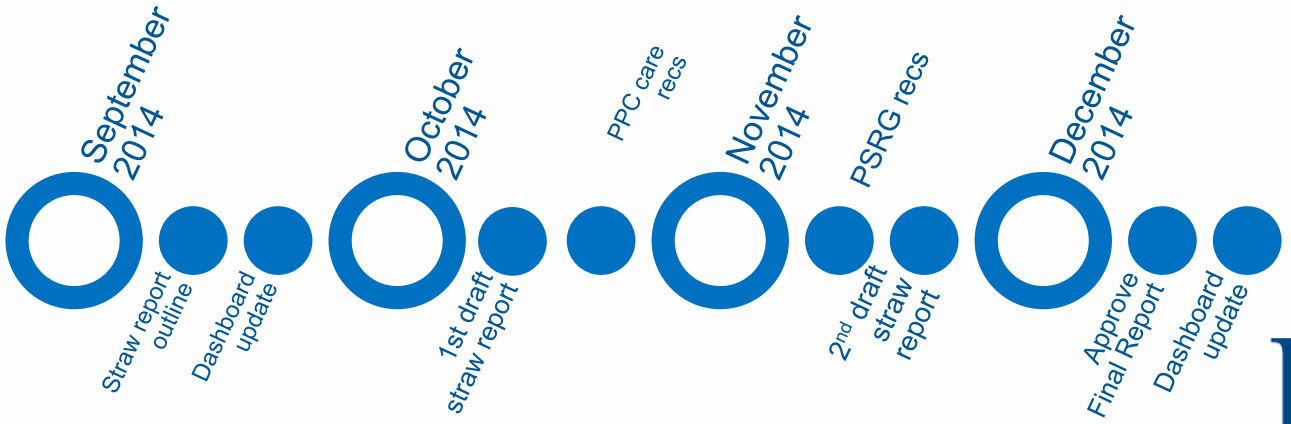
In a January 2014 letter, Governor Kitzhaber wrote the Board regarding their recommendations in response to his 2013 letter and noted that the Board's final report represents fundamental next steps for health system transformation.

The Governor asked the Board to continue to build on Oregon's triple aim goals and progress in advancing the Board's recommendations and that the Board work with the OID and OHA to provide recommendations before 1 December 2014 which:

- Consider implementation strategies, including legislative or regulatory actions necessary to ensure the Board's recommendations can contribute to a more effective and efficient health system.

Proposed next steps

- Use 2013 principles and similar process to guide Board's work and recommendations?
- Use an iterative, facilitated, transparent and public process to review, discuss and advise staff, stakeholder workgroups and consultants regarding specific implementation details of the Board's recommendations and related potential legislative and regulatory actions.
- Review and advise staff regarding the Board's workplan and/or review staff general update regarding the Boards recommended actions.
- Respond to Governor's request by reviewing, editing, advising and approving OHA & OID staff-written straw model reports containing recommended actions regarding implementing the Board's recommendations and related legislative and/or regulatory concepts and actions and ***vote to approve a final report to the Governor.***



Oregon Complex Care Collaborative Meeting

Holiday Inn Eugene/Springfield, 919 Kruse Way, Springfield, OR 97477
Tuesday, April 29, 2014, 7:30 a.m. – 4:30 p.m.

Meeting Objectives:

- Improve health outcomes for Oregon Health Plan members who require complex care.
- Support the spread of innovative complex care models throughout Oregon.
- Promote information sharing and networking.

Registration with continental breakfast 7:30 a.m. – 8:30 a.m.

Agenda

1. **Welcome and introductions** *(30 minutes)* 8:30 a.m. – 9:00 a.m.
   Ron Stock and Emilee Coulter-Thompson

2. **Opening address: Sustaining the work** *(45 minutes)* 9:00 a.m. – 9:45 a.m.
   Fabiana Wallis, PhD, Clinical Psychologist, Trauma Specialist and Consultant

   Fabiana Wallis, PhD, received her doctoral degree in clinical psychology from University of Massachusetts Boston and completed her clinical training at Harvard Medical School and MIT. She has been working with men and women affected by psychological trauma since 1997. She is a Trauma Recovery and Empowerment Model (TREM) Facilitator and Trainer, Eye Movement Desensitization and Reprocessing (EMDR) therapist, co-author of a cultural adaptation of a trauma intervention, and Co-Founder of the Center for Trauma Recovery in Portland, Oregon. She provides clinical services, consultation, supervision, mentorship and training in the areas of trauma, diversity and Latino mental health.

3. **Opioids/pain management presentations & discussions** *(105 minutes)* 9:45 a.m. – 11:30 a.m.

   Each session will include the following format:

   - **Presentations** *(30-40 minutes total for two to three topic panelists)*
   - **Question and answer** with panelists *(10-15 minutes)*
   - **Roundtable discussions** *(30 minutes)*
   - **Reflections** *(10 minutes)* 1-2 pre-assigned spokespeople share key reflections/synthesis.

Session 1:
Jim Shames, Jackson County Health and Human Services
Bob Isler, Providence Persistent Pain Project
Rachel Solotaroff, Central City Concern

Lunch networking session *(75 minutes)* 11:30 a.m. – 12:45 p.m.

Optional round table discussions will meet from 11:45 a.m. – 12:15 p.m. at tables indicated below:

- **Alternative Payment Methodologies,** Tracy Muday, Table 1
- **Behavioral Health Integration,** Jeff Emrick, Table 3
- **Care Coordinators Affinity Group,** Jennifer Johnstun, Table 7
- **Community Based Models for Complex Care,** Anne Alftine, Table 10
- **Community Health Workers Affinity Group,** Kristen Powers, Table 8
- **Early Learning,** Joell Archibald, Table 12
- **Financial Sustainability/The Business Case for Complex Care,** Kate Wells, Table 4
- **Health information technology,** Susan Otter, Table 18
- **Trauma-informed care/Adverse Childhood Experiences,** Fabiana Wallis, Table 14
- **Workforce development, recruitment and provider well-being,** Laurie Lockert, Table 16

4. **Behavioral health presentations and discussions** 12:45 p.m. – 2:15 p.m.
(90 minutes)

Session 2:
Jill Archer, Clackamas County
Daren Ford, OHSU Richmond Clinic
Chris Siegner, Symmetry Care Inc.

Break *(15 minutes)* 2:15 p.m. – 2:30 p.m.

5. **Maternal health presentations and discussions** *(90 minutes)* 2:30 p.m. – 4:00 p.m.

Session 3:
Jennifer Johnstun, Josephine County Maternal Medical Home
Kathryn Lueken, Willamette Valley Community Health
Maggi Machala, Deschutes County Health Services

6. **Next steps** *(20 minutes)* 4:00 p.m. – 4:20 p.m.
Ron Stock and Emilee Coulter-Thompson

7. **Closing comments** *(10 minutes)* 4:20 p.m. – 4:30 p.m.
Ron Stock and Emilee Coulter-Thompson

Appendix D

Oregon's Health System Transformation

Quarterly Progress Report

Oregon Health Authority

MEASUREMENT PERIOD
Baseline Year 2011 and January-September 2013

PUBLISHING DATE
February 2014

CONTENTS

EXECUTIVE SUMMARY

February 2014 Health System Transformation Quarterly Report

The fourth Health System Transformation Quarterly Report highlights statewide performance on key measurements, rates of health care utilization, and costs through the coordinated care organizations (CCOs) that serve Oregon's Medicaid population. These measurements are designed to show how the state is doing in meeting the triple aim of better health, better care and lower costs. Public reporting of this sort is a key element in Oregon's transformation of the state Medicaid system to be more transparent to members, stakeholders and the public.

This report includes data from the first nine months of 2013, an update from the November 2013 report, which included six months of data. The report shows where we started, where we are, and where we want to go in improving our health delivery system. It shows early progress as CCOs work toward targeted improvements. It also shows which are falling short. It will also help us in determining the readiness of the coordinated care model to serve thousands of new Medicaid enrollees over the next few years. In 2013, more than 600,000 Oregonians were enrolled in Medicaid; more than 180,000 have joined since January 1, 2014.

The report includes baseline race and ethnicity data from 2011 for most performance measures. Future reports will show 2013 progress data by race and ethnicity.

Summary

Data from the first nine months of coordinated care point to trends of improved care and a shifting of resources toward primary care. While this is not yet a full year of data, this is the first report showing 2013 CCO-level progress data for most measures. Benchmarks are goals for our state. CCOs also have performance targets they can meet to show improvement.

In this report, we are reporting 14 of the 17 incentive measures. The remaining three come from electronic medical record data and will be included in a future report. We are reporting 30 of the statewide performance measures.

Data continue to show reduced emergency department visits and spending. This shows we are reducing unnecessary hospitalizations for conditions that can better be treated elsewhere, such as in a primary care office. It also indicates improvements in hospital readmissions, largely due to community efforts to achieve the highest quality care.

At the same time there is an increase in primary care enrollment and use, suggesting that as hospitalizations are decreasing in key areas, OHP members are receiving better and more appropriate care. Patient-centered primary care enrollment, key to coordinated care, is also continuing to improve. These are all good trends.

EXECUTIVE SUMMARY

This report also shows an increase in the percentage of young children who were screened for the risk of developmental, behavioral and social delays. This measure increased to 32 percent in the first nine months of 2013, up from a 2011 baseline of 21 percent. Connecting health and early learning provides timely opportunities for improving children's outcomes. By identifying and addressing needs early, this transformational work leads to better health outcomes and reduced costs, and improves learning in these critical early years.

More than 150,000 Oregonians became Oregon Health Plan members on January 1, 2014. And over the next several years, more Oregonians will continue to join the Oregon Health Plan. By using the coordinated care model, focused on improved quality and lower costs, we can ensure a more sustainable system.

Highlighted findings

- **Decreased emergency department visits –** Nine months of reporting shows that emergency department visits by people served by CCOs have decreased 13 percent since 2011 baseline data.
- **Decreased hospitalization for chronic conditions** – CCOs reduced hospital admissions for congestive heart failure by 32 percent, chronic obstructive pulmonary disease by 36 percent and adult asthma by 18 percent.
- **Increased primary care** – Spending for primary care is up by more than 18 percent. Enrollment in patient-centered primary care homes also increased by 51 percent since 2012, the baseline year for that program.
- **Increased adoption of electronic health records** – Adoption of electronic health records has doubled among measured providers. In 2011, 28 percent of eligible providers had adopted certified EHRs. By September of 2013, 58 percent of eligible providers had adopted EHRs.
- **Developmental screening during the first 36 months of life** – The percentage of children who were screened for the risk of developmental, behavioral and social delays increased from a 2011 baseline of 21 percent to 32 percent in the first nine months of 2013.
- **All-cause readmission** – The percentage of adults who had a hospital stay and were readmitted for any reason within 30 days of discharge dropped from a 2011 baseline of 12.3 percent to 11.3 percent in the first nine months of 2013, a reduction of 8 percent.

We expect continued movement in the right direction as well as occasional possible setbacks. We are encouraged by the first nine months of progress data and favorably impressed with the innovative work the CCOs are doing to improve health and lower costs.

Over time, our understanding of what's happening in the health system will grow richer. Each quarterly report tells us more than we knew before. Each report shows us more than has ever before been gathered and reported publicly. The metrics are a tool for not only understanding where we are, but for improvement, and we can use them as standards to guide improvement in other types of health plans.

PERFORMANCE METRICS
CCO Incentive Measures

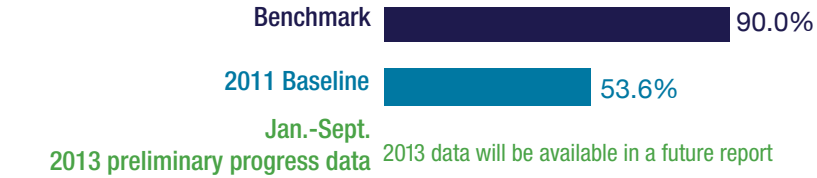
Mental and physical health assessment within 60 days for children in DHS custody

Definition: Percentage of children age 4+ who receive a mental health assessment and physical health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Children under 4 are only required to have a physical health assessment.

Focus areas: Improving access to effective and timely care and improving behavioral and physical health coordination.

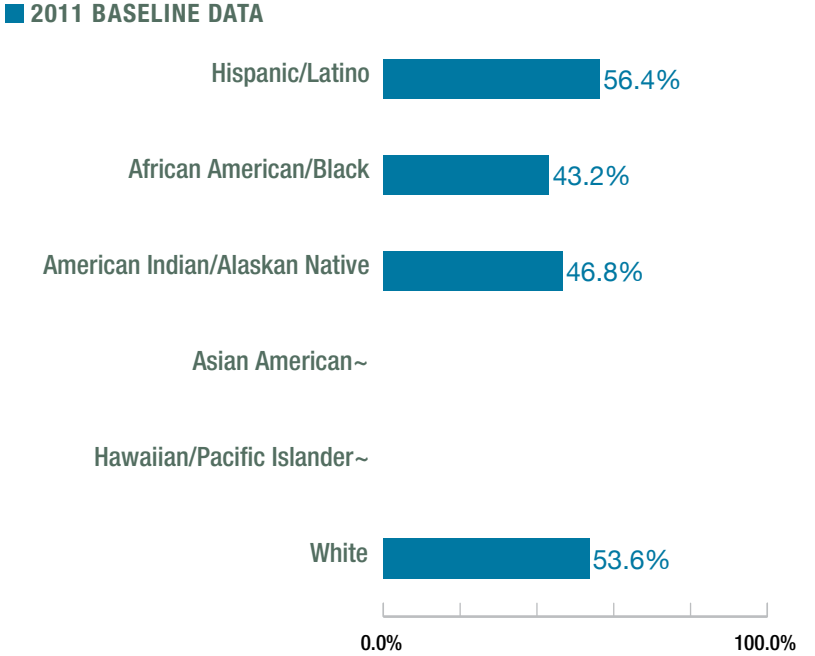
Purpose: Children who have been placed in foster care should have their mental and physical health checked so that an appropriate care plan can be developed. Mental and physical health assessments are a requirement for the foster program because of their importance to improving the health and well-being of a child in a trying situation.

STATEWIDE



Data source: Administrative (billing) claims + ORKids
Benchmark source: Metrics and Scoring Committee consensus

RACE AND ETHNICITY DATA*

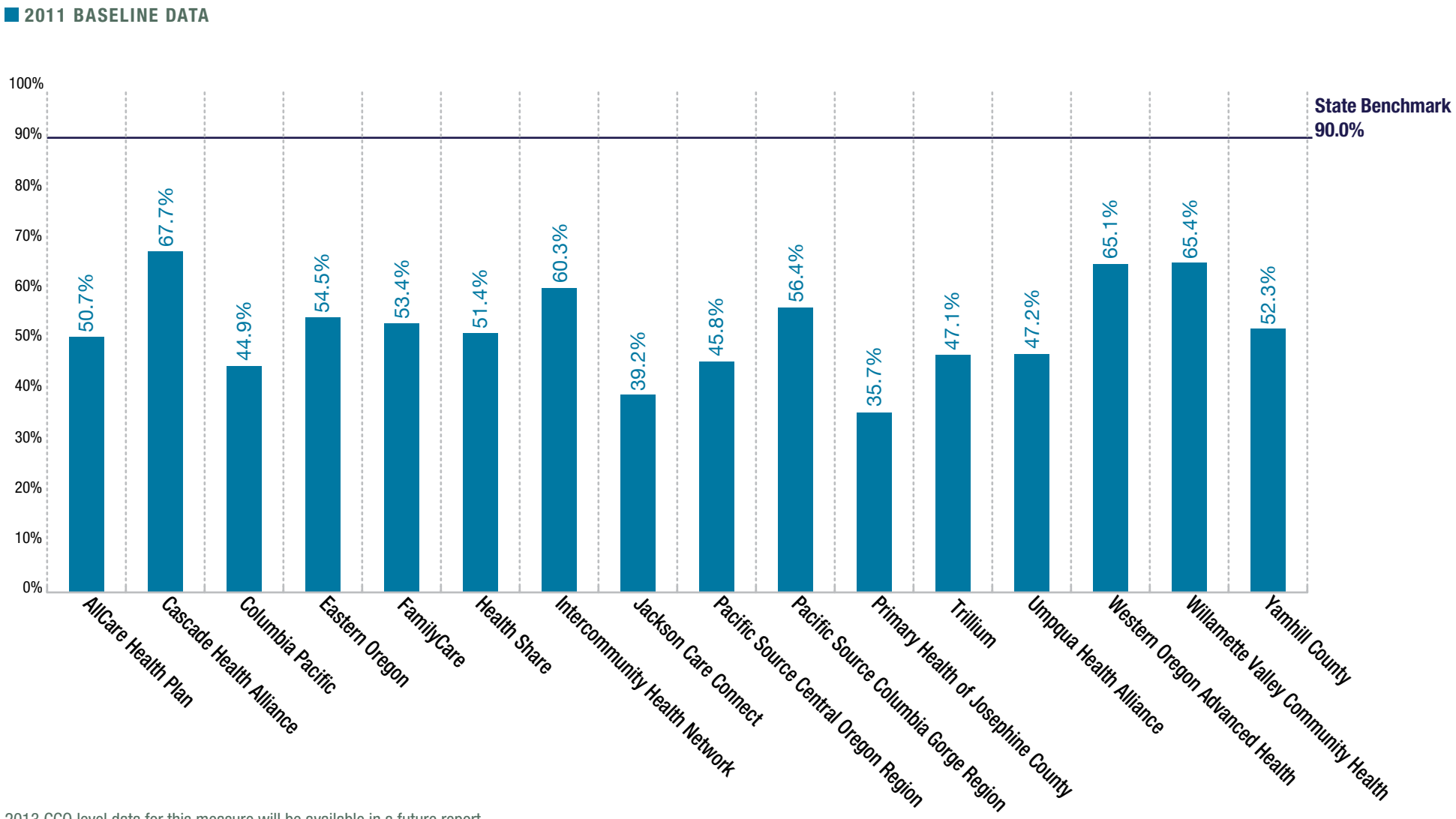


Note: Racial and ethnic information missing for 10.8% of respondents
*Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

CCO Incentive Measures

Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days



2013 CCO level data for this measure will be available in a future report.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

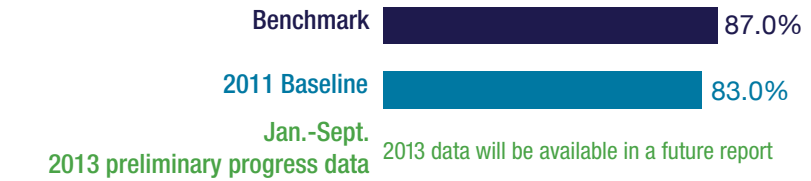
Access to care (CAHPS)

Definition: Percentage of patients (adults and children) who thought they received appointments and care when they needed them.

Focus areas: Improving access to effective and timely care.

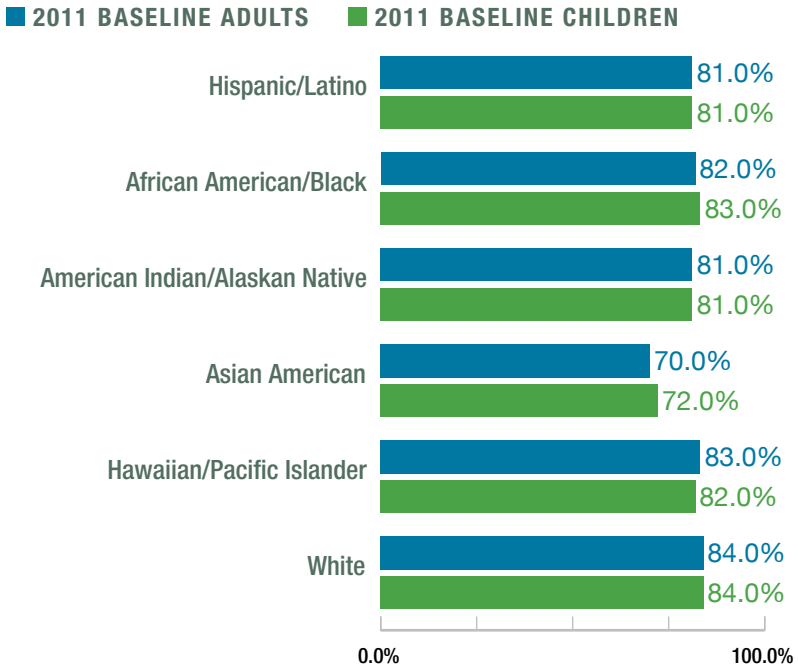
Purpose: Improving access to timely care and information helps increase the quality of care and reduce costs. Measuring access to care is also an important part of identifying disparities in health care and barriers to quality care, including a shortage of providers, lack of transportation, or long waits to get an appointment.

STATEWIDE



Data Source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark Source: 2012 National Medicaid 75th percentile

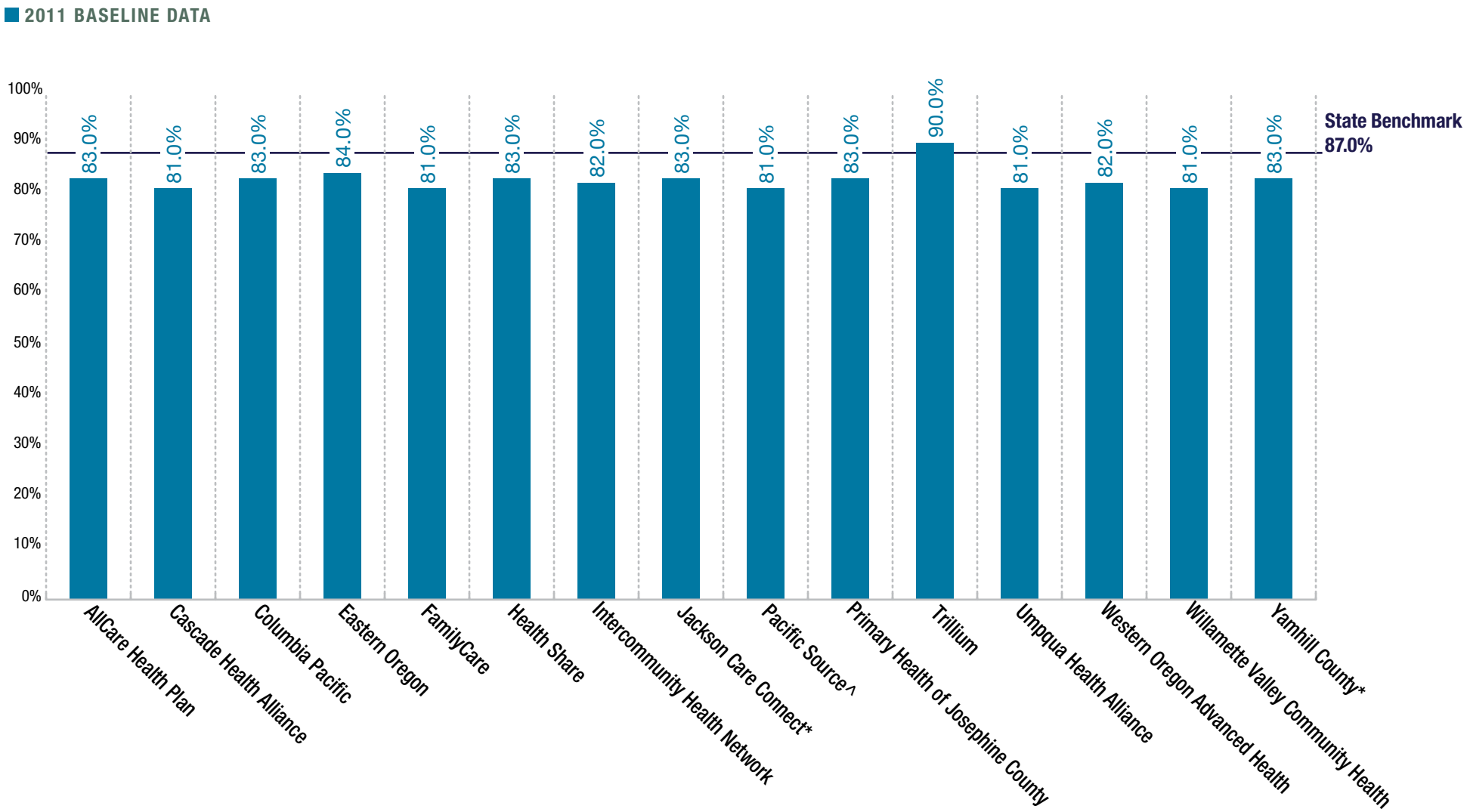
RACE AND ETHNICITY DATA



PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of patients who thought they received appointments and care when needed



2013 CCO level data for this measure will be available in a future report.
*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Adolescent well-care visits

Definition: Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit.

Focus area: Improving primary care for all populations.

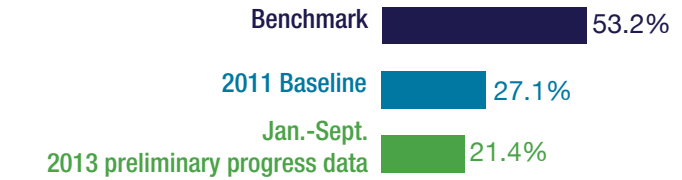
Purpose: Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education or military service.

Jan. – Sept. 2013 data

The percentage of adolescents receiving a well-care visit between January and September 2013 represents the visits that have occurred among all eligible adolescents aged 12–21. The percentage will continue to grow across the year as more eligible adolescents receive their well-care visits. It's also important to look at this metric after we have a full year of data.

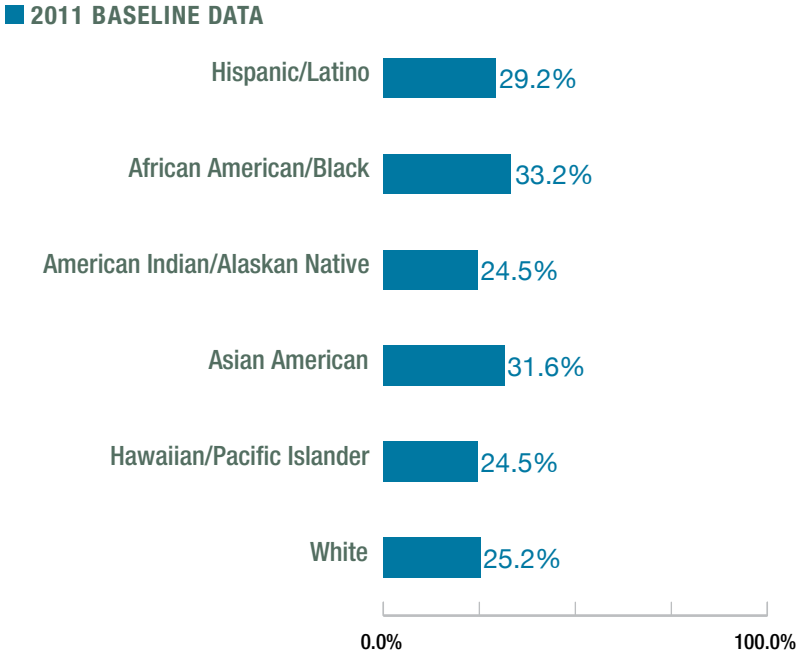
The percentage through September 2013 shows the progress toward the goal on this metric and should not be compared to the 2011 baseline or benchmark until all visits are counted at the end of 2013 when we have a full year of data.

STATEWIDE



2013 n = 105,796
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only)

RACE AND ETHNICITY DATA*

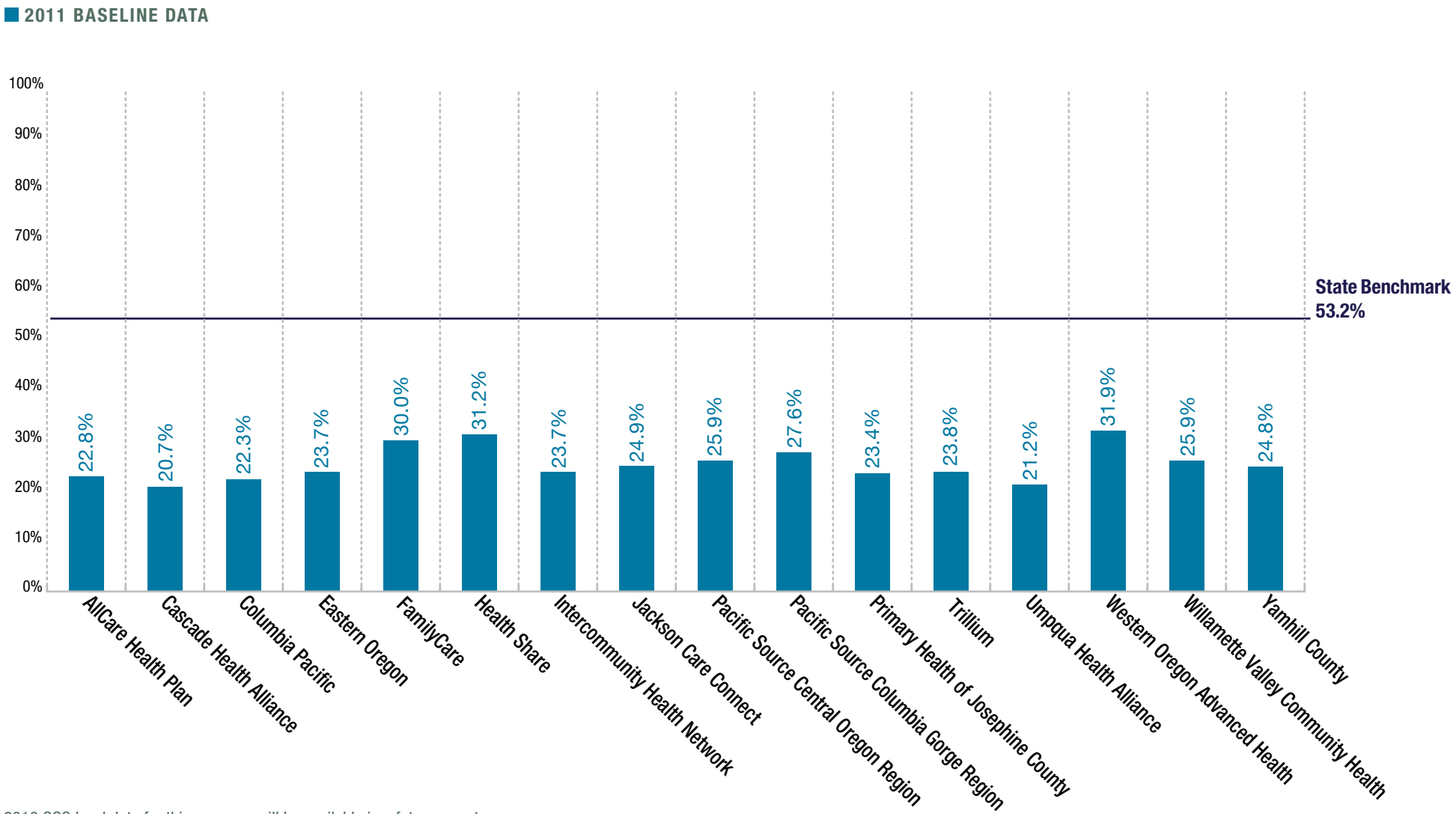


Note: Racial and ethnic information missing for 7.0% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit during the last year



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Alcohol or other substance misuse (SBIRT)

Definition: The SBIRT measure, or Screening, Brief Intervention, and Referal to Treatment, measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

Focus area: Improving behavioral and physical health coordination.

Purpose: By offering a simple but effective screening for alcohol or drug abuse during an office visit, providers can help patients get the care and information they need to stay healthy. If risky drinking or drug use is detected, a brief intervention, and in some cases referral, helps the patient recover more quickly and avoid serious health problems

Jan. – Sept. 2013 data

SBIRT guidance documents were finalized in June 2013. Since that time, there has been a gradual increase in the number of screenings conducted in many CCOs. We expect the rates for this measure to continue to grow as more providers become accustomed to the screening process.

STATEWIDE

2013 n = 192,119
Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus

RACE AND ETHNICITY DATA*

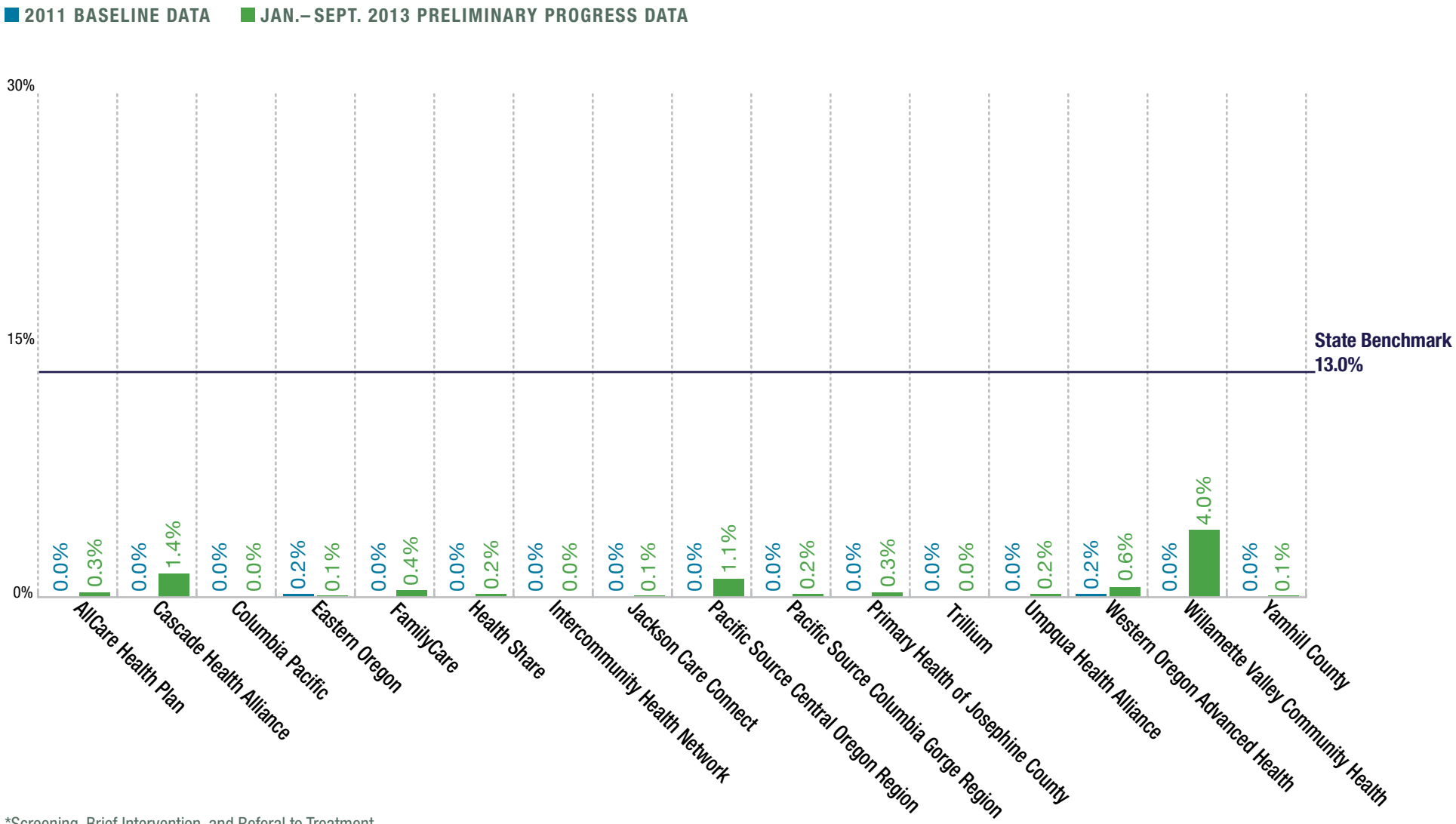
All categories are below one percent.

Note: Racial and ethnic information missing for 5.0% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of adult patients who had appropriate screening and intervention for alcohol or substance abuse (SBIRT*)



*Screening, Brief Intervention, and Referal to Treatment

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Ambulatory care: emergency department utilization

Definition: Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

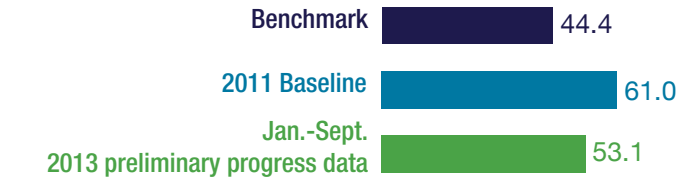
Focus areas: Reducing preventable re-hospitalizations; ensuring appropriate care is delivered in appropriate settings; and reducing preventable and unnecessarily costly utilization by super-users.

Purpose: Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients.

Jan. – Sept. 2013 data

This metric represents emergency department visits between January and September 2013. It shows a preliminary trend toward fewer emergency department visits from January to September 2013. Financial data (pages 84-94) are consistent in showing reduced emergency department visits. These preliminary data show a snapshot in time from the claims information we have today. Additional data will be coming in and numbers are expected to shift slightly.

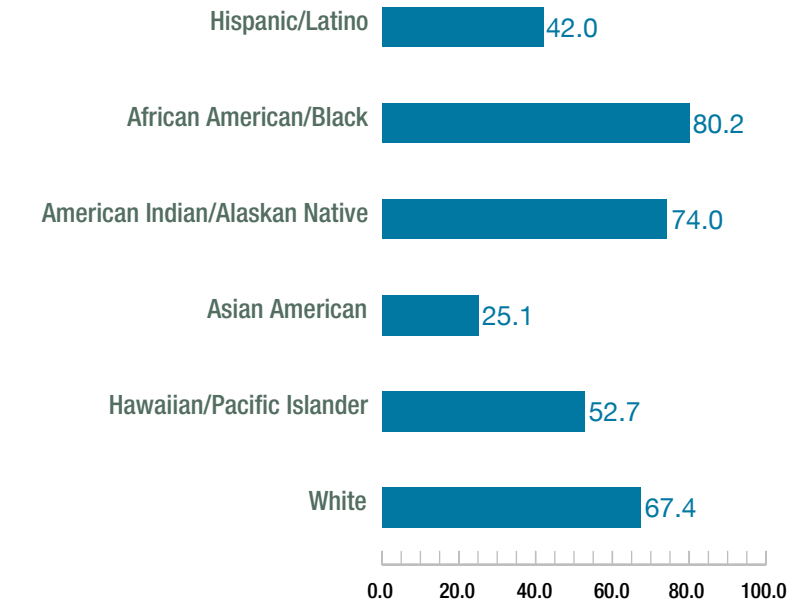
STATEWIDE



2013 n = 4,863,988 (member months)
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

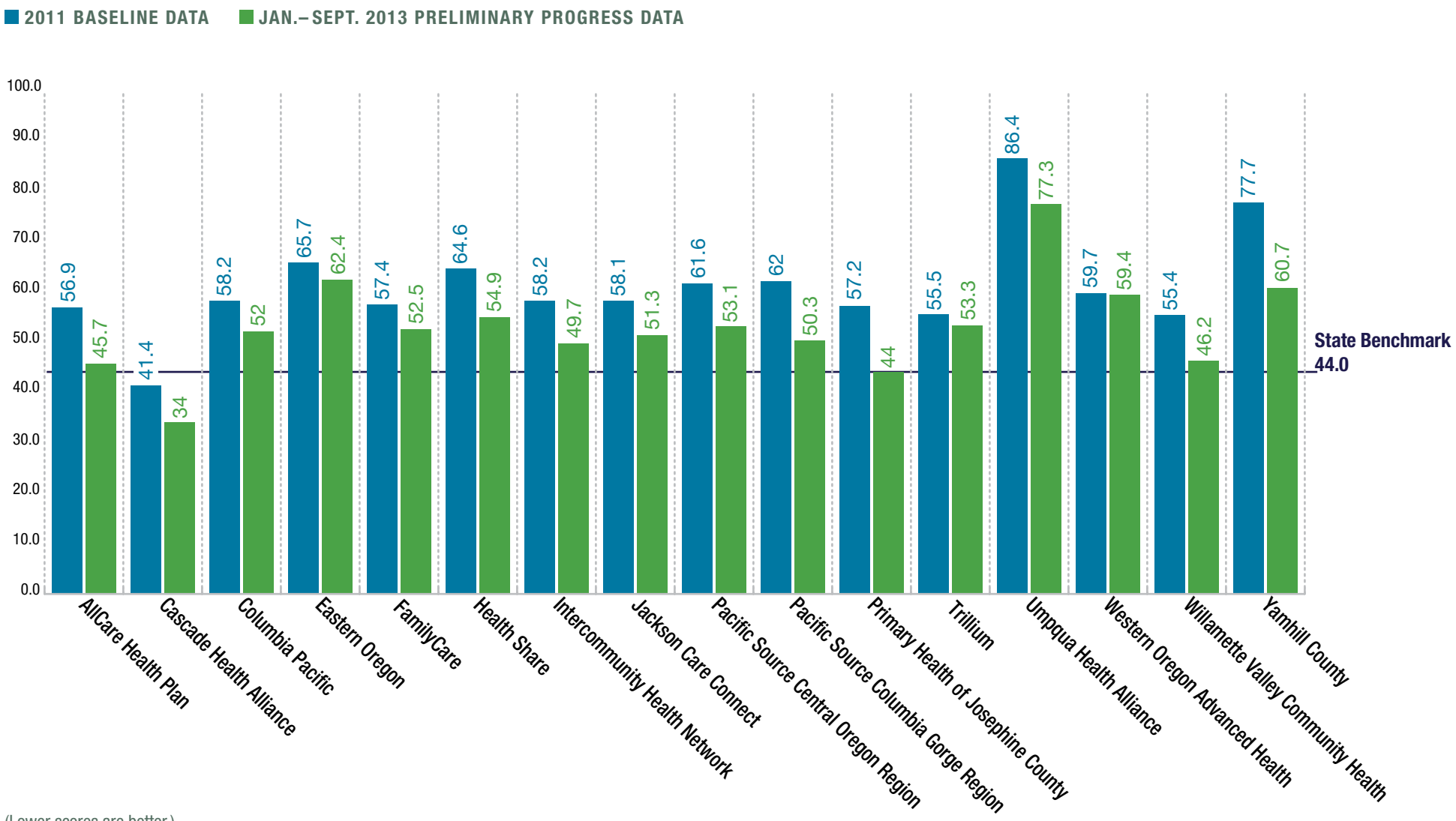


Note: Racial and ethnic information missing for 7.2% of respondents
*Each race category excludes Hispanic/Latino
(Lower scores are better.)

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Rate of patient visits to an emergency department*



(Lower scores are better.)
*Rates are per 1,000 member months

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Ambulatory care: outpatient utilization

Definition: Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

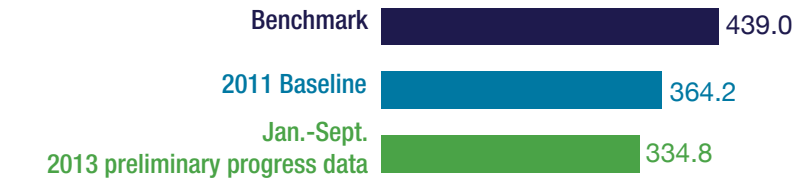
Focus areas: Reducing preventable re-hospitalizations; ensuring appropriate care is delivered in appropriate settings; and reducing preventable and unnecessarily costly utilization by super-users.

Purpose: Promoting the use of outpatient settings like a doctor's office or urgent care clinic is part of Oregon's goal of making sure patients are getting the right care in the right places and at the right times. Increasing the use of outpatient care helps improve health and lower costs by promoting prevention and keeping down rates of unnecessary emergency department use.

Jan. – Sept. 2013 data

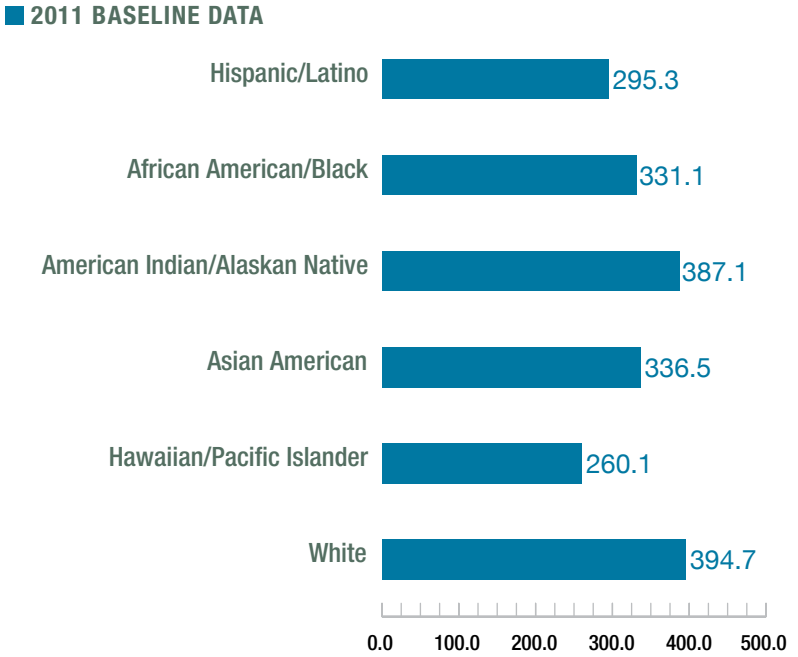
This metric represents outpatient visits that include office visits or routine visits to hospital outpatient departments between January and September 2013. This metric shows a preliminary trend toward fewer outpatient visits from January to September 2013 and may be affected by seasonality and a lag in data submission. Outpatient visits include all visits to primary care and specialists as well as home and nursing home visits.

STATEWIDE



2013 n = 4,863,988 (member months)
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

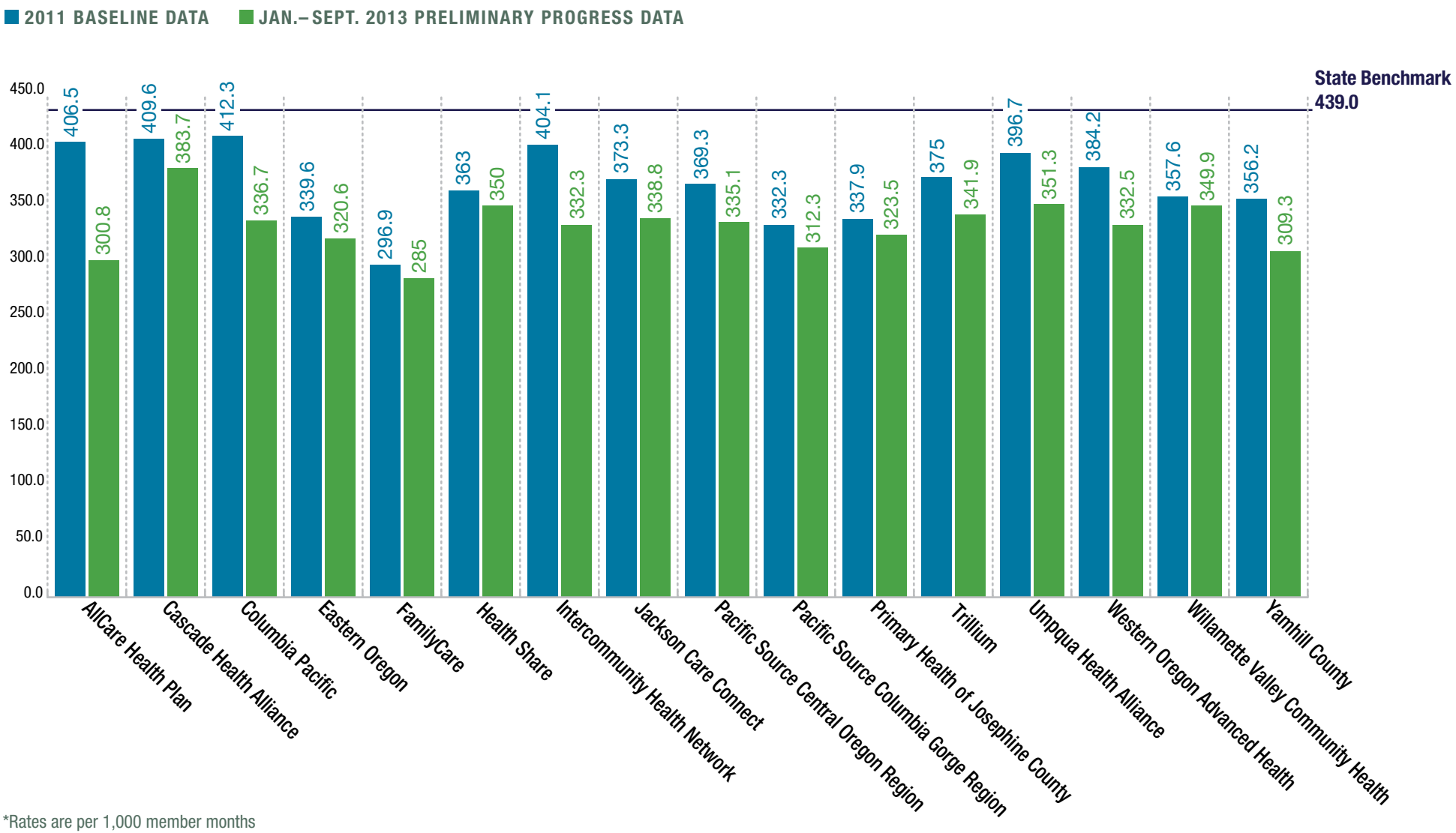


Note: Racial and ethnic information missing for 7.2% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Rate of patient visits to a doctor's office or urgent care*



*Rates are per 1,000 member months

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Colorectal cancer screening

Definition: Rate of adult patients (ages 50-75) who had appropriate screenings for colorectal cancer during the measurement year. Rates are reported per 1,000 member months.

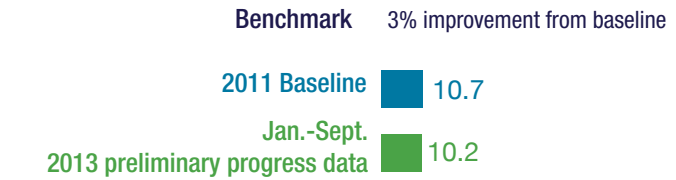
Focus areas: Improving primary care for all populations; ensuring appropriate care is delivered in appropriate settings; and improving access to effective and timely care.

Purpose: Colorectal cancer is Oregon's second leading cause of cancer deaths. With appropriate screening, abnormal growths in the colon can be found and removed before they turn into cancer. Colorectal cancer screening saves lives, while also keeping overall health care costs down.

Jan. – Sept. 2013 data

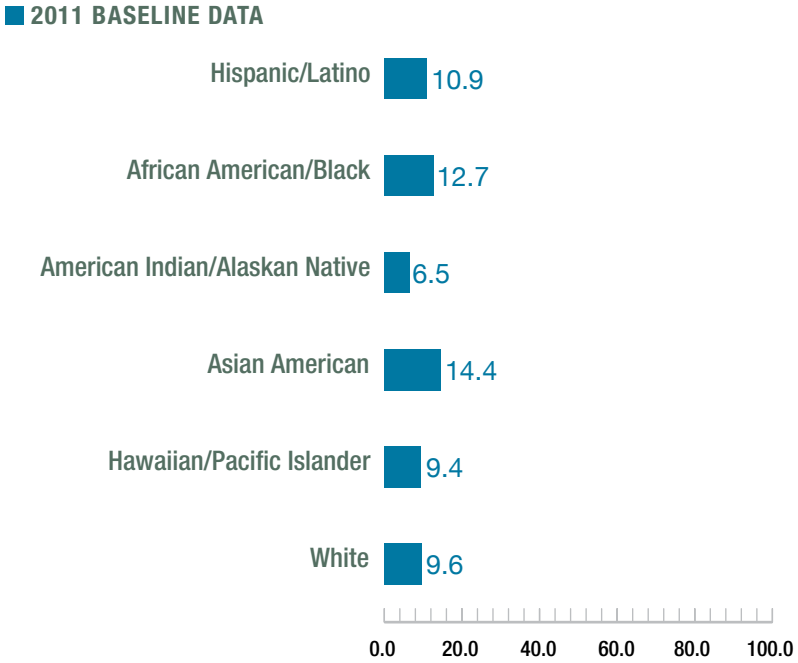
The colorectal cancer screening metric represents screenings that have occurred between January and September 2013 for eligible members (those between 50 and 75 years of age). The rate will continue to change as additional data come in and there is a full year of data.

STATEWIDE



2013 n = 487,894 (member months)
Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus

RACE AND ETHNICITY DATA*

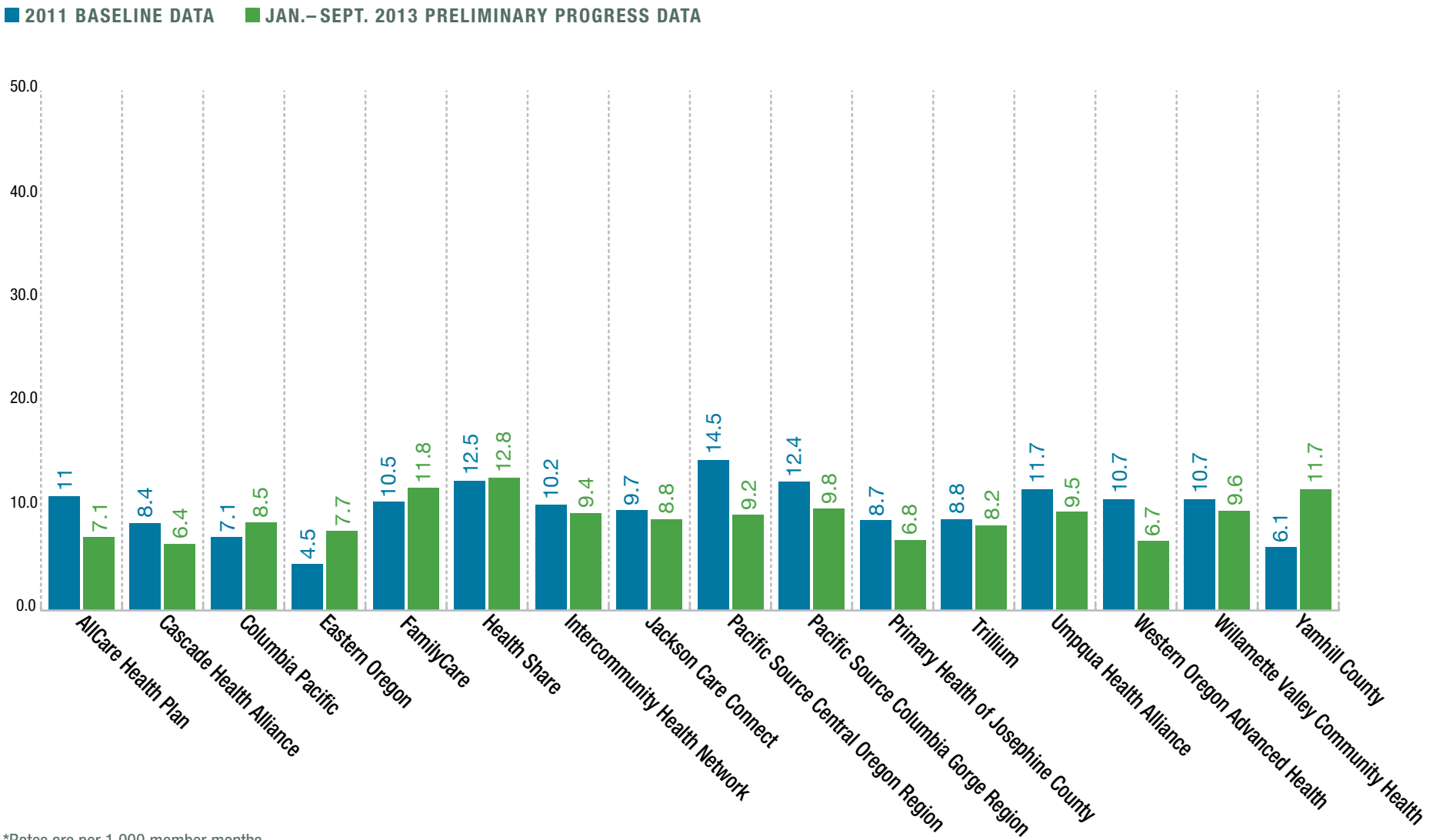


Note: Racial and ethnic information missing for 1.8% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Rate of adult patients who had appropriate screenings for colorectal cancer during the measurement year*



*Rates are per 1,000 member months.
Benchmark is 3% improvement from baseline

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Developmental screening

Definition: Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

Focus areas: Improving primary care for all populations; ensuring appropriate care is delivered in appropriate settings; and improving access to effective and timely care.

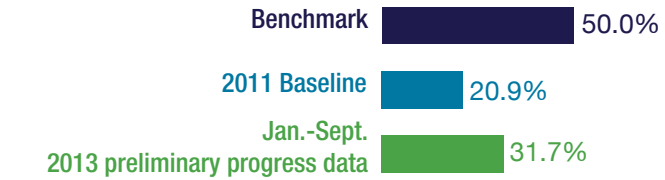
Purpose: Early childhood screening help find delays in development as early as possible, which leads to better health outcomes and reduced costs. Early developmental screening provides an opportunity to refer children to the appropriate specialty care before problems worsen. Often, developmental delays are not found until kindergarten or later – well beyond the time when treatments are most helpful.

Jan. – Sept. 2013 data

The percentage of children receiving a developmental screening between January and September 2013 represents the visits that have occurred among all the eligible children for the full measurement year. Therefore, the percentage will continue to grow across the year as more screenings occur.

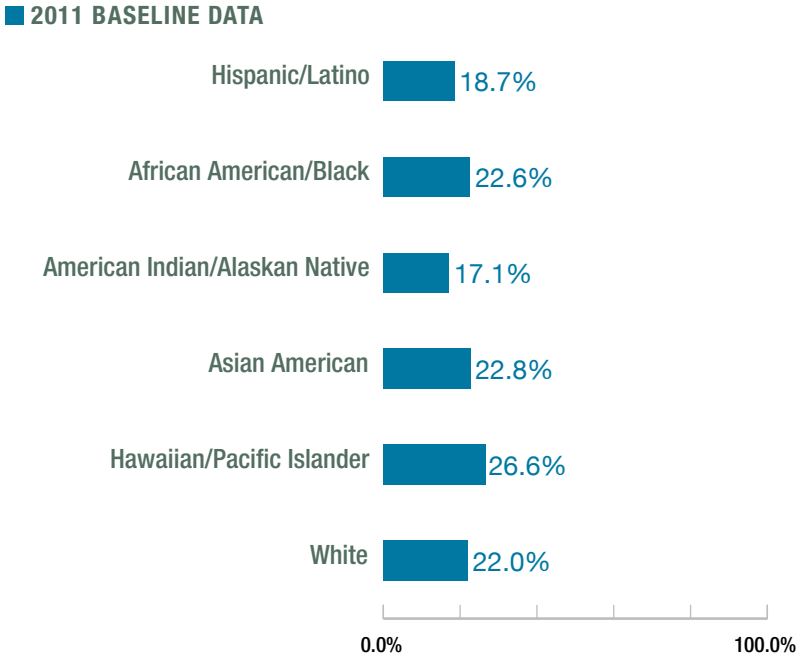
The percentage through September 2013 already shows improvement over the 2011 baseline. However, this metric should not be compared to the benchmark until all screenings are counted at the end of 2013 when we have a full year of data.

STATEWIDE



2013 n = 20,377
Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus

RACE AND ETHNICITY DATA*

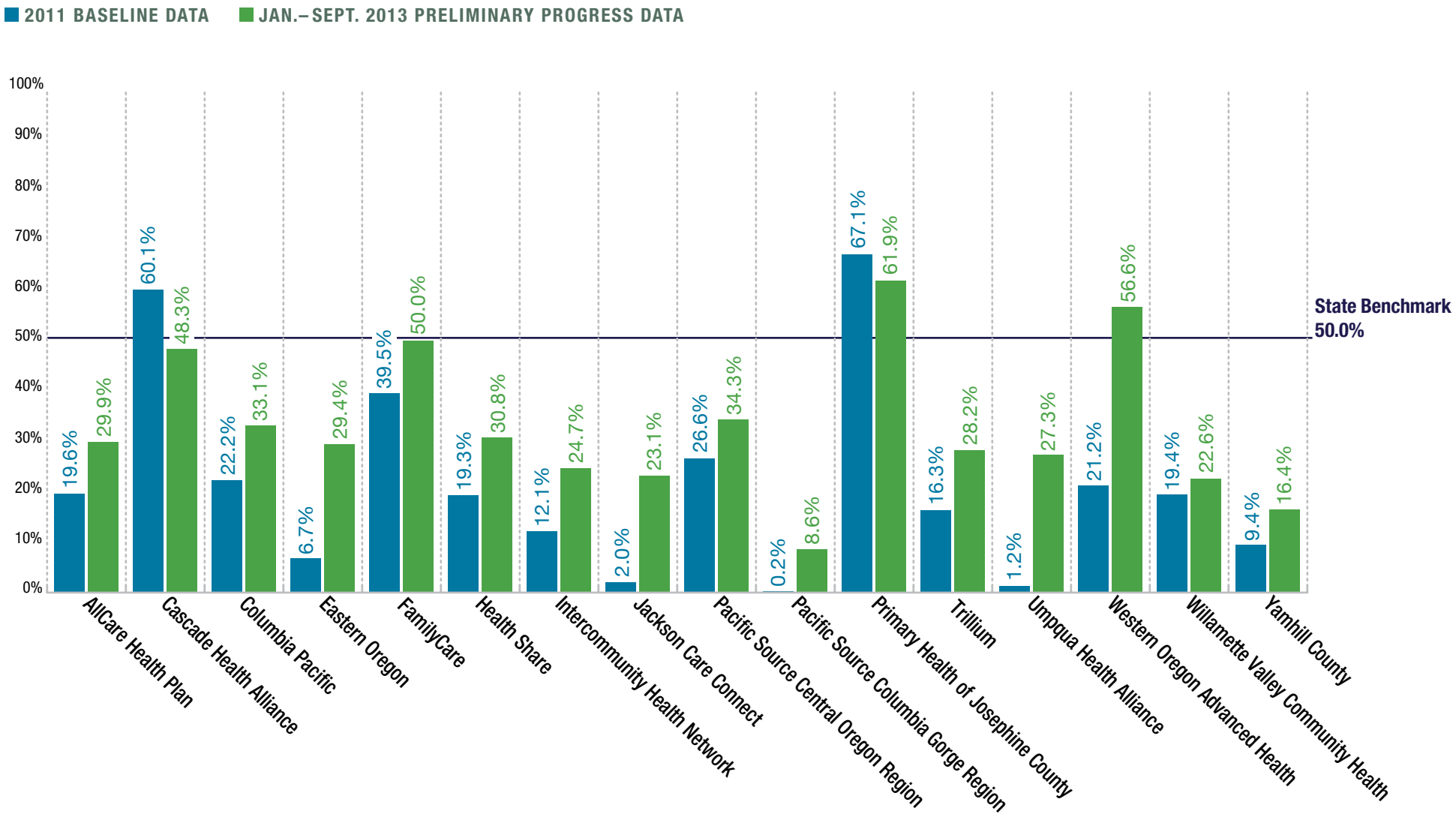


Note: Racial and ethnic information missing for 10.6% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of children up to three-years-old screened for developmental delays



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

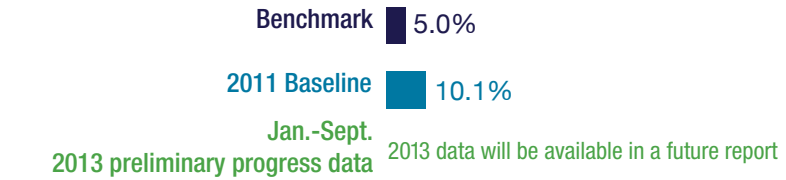
Elective delivery

Definition: Percentage of women who had an elective delivery between 37 and 39 weeks of gestation. (A lower score is better.)

Focus areas: Improving perinatal and maternity care.

Purpose: There is a substantial body of evidence showing that an infant born at 37 weeks has worse health outcomes than one born at 40 weeks. Specifically, stays at the neonatal intensive care unit are higher in children at 37-38 weeks than children who completed at least 39 weeks. Because of this, it has become a national and state priority to limit elective deliveries to pregnancies that have completed at least 39 weeks gestation.

STATEWIDE



Data Source: Administrative (billing) claims, Vital Records, and hospitals.
Benchmark Source: Metrics and Scoring Committee consensus

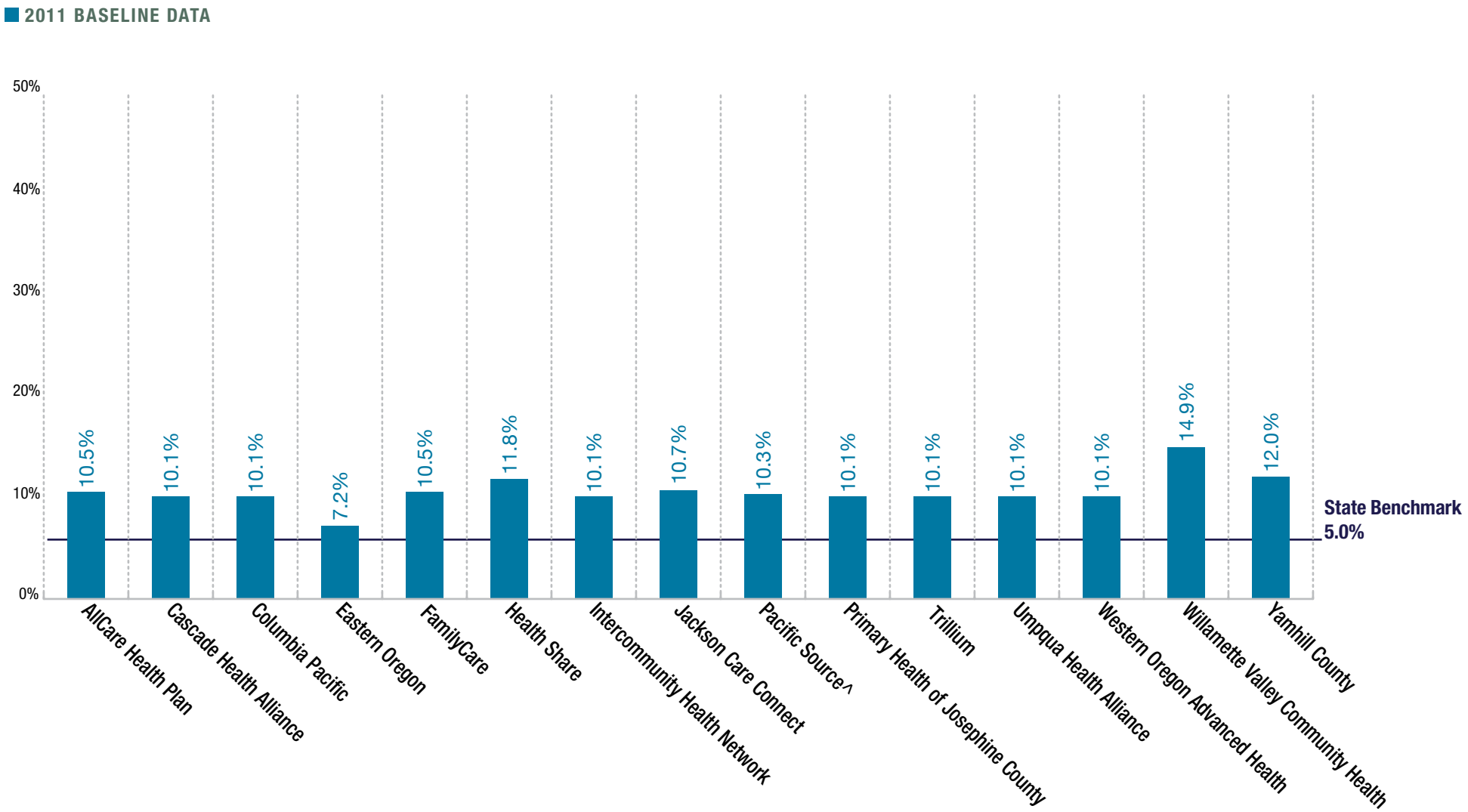
RACE AND ETHNICITY DATA

Race and ethnicity data for this measure is not available.

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of women who had an elective delivery between 37 and 39 weeks of gestation



(Lower scores are better)
2013 CCO level data for this measure will be available in a future report.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Electronic Health Record adoption

Definition: Percentage of eligible providers within a CCO's network and service area who qualified for a "meaningful use" incentive payment during the measurement year through Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.

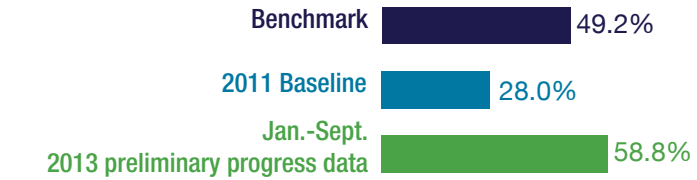
Focus areas: Electronic Health Record adoption

Purpose: Electronic health records have the potential to improve coordination of care, increase patient safety, reduce medical error, and contain health care costs by reducing costly, duplicative tests. Physicians who use electronic health records have more accurate information on each patient, so they can make the most appropriate clinical decisions.

Jan. – Sept. 2013 data

Electronic Health Record adoption measures the percentage of eligible providers who received a "meaningful use" payment for electronic health record adoption. This metric demonstrates an increase in 2013 compared to the 2011 baseline.

STATEWIDE



2013 n = 10,986 (eligible providers)
Data source: state and federal EHR Incentive Program
Benchmark source: federal assumed rate for non-hospital based EHR adoption and Meaningful Use by 2014.

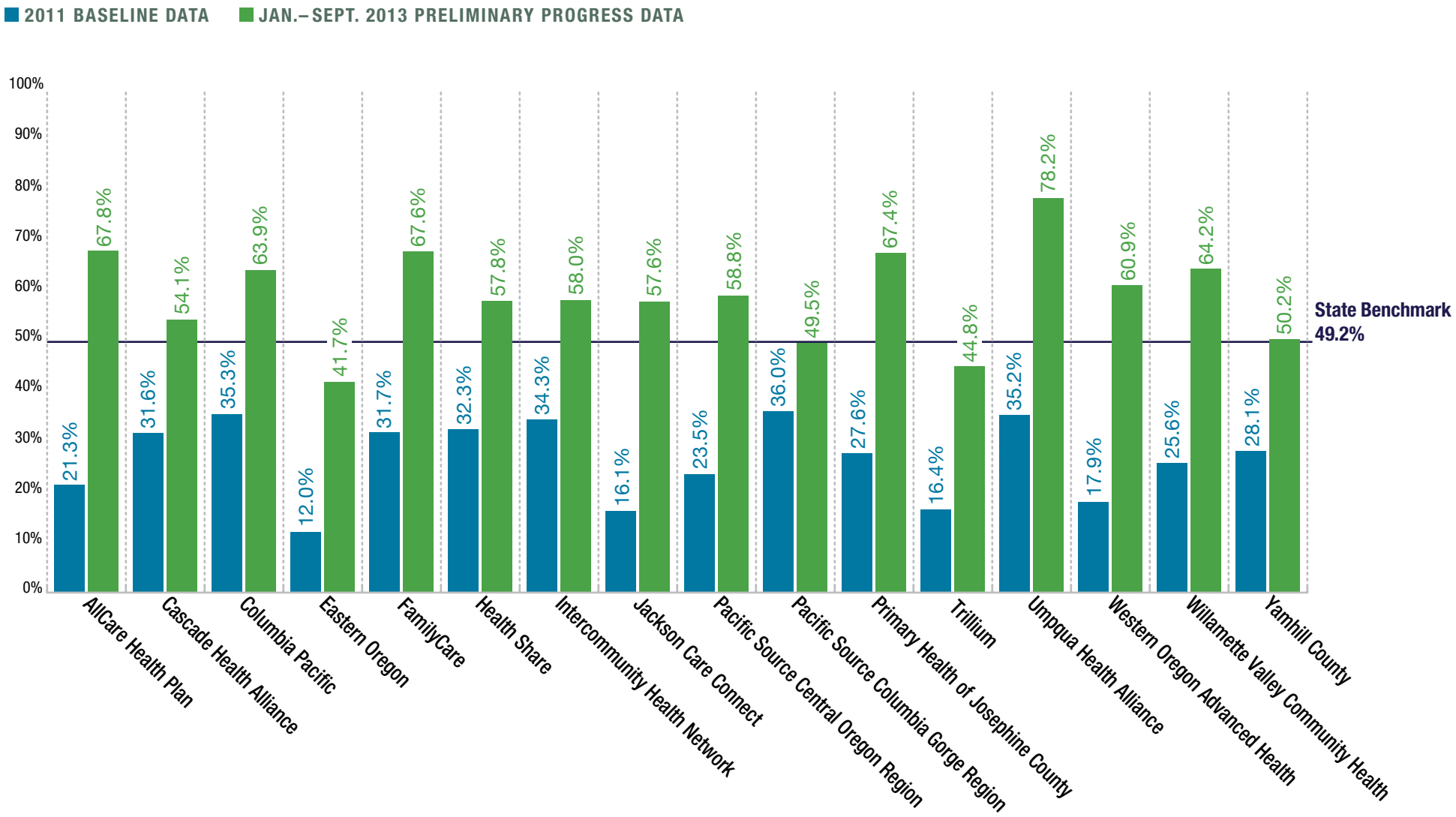
RACE AND ETHNICITY DATA

Electronic Health Record adoption will not be stratified by race and ethnicity.

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of providers who qualified for an EHR incentive payment during the measurement year



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Follow-up after hospitalization for mental illness

Definition: Percentage of patients (ages 6 and older) who received a follow-up with a health care provider within 7 days of being discharged from the hospital for mental illness.

Focus areas: Improving behavioral and physical health coordination and reducing preventable re-hospitalizations.

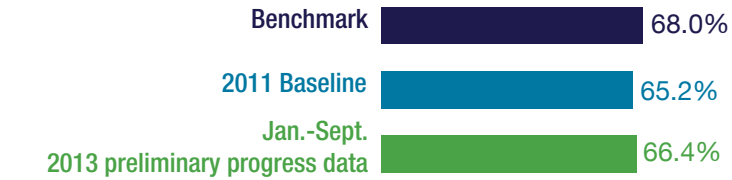
Purpose: Follow-up care is important to help patients make progress and feel better after being in the hospital for mental illness. This measure addresses an emerging issue for children by suggesting follow up for patients ages 6 and up. Additionally, research shows that follow-up care helps keep patients from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.

Jan. – Sept. 2013 data

This metric represents follow-up visits within seven days after members were discharged from a hospital with a mental health diagnosis between January and September 2013.

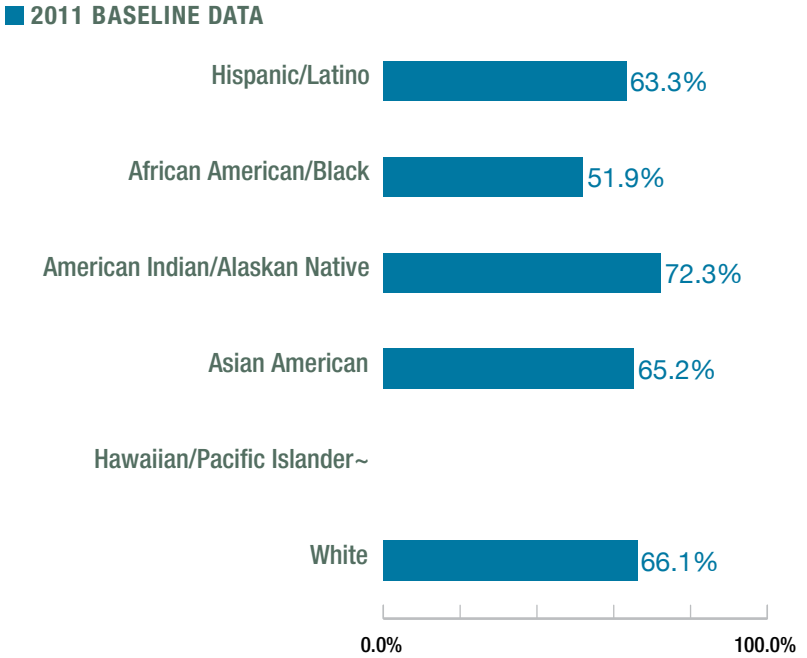
Due to a small number of cases for this metric, it is too early to interpret whether there are improvements on this measure. However, the 2013 preliminary data are encouraging and show a slight increase over the baseline.

STATEWIDE



2013 n = 1,359
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

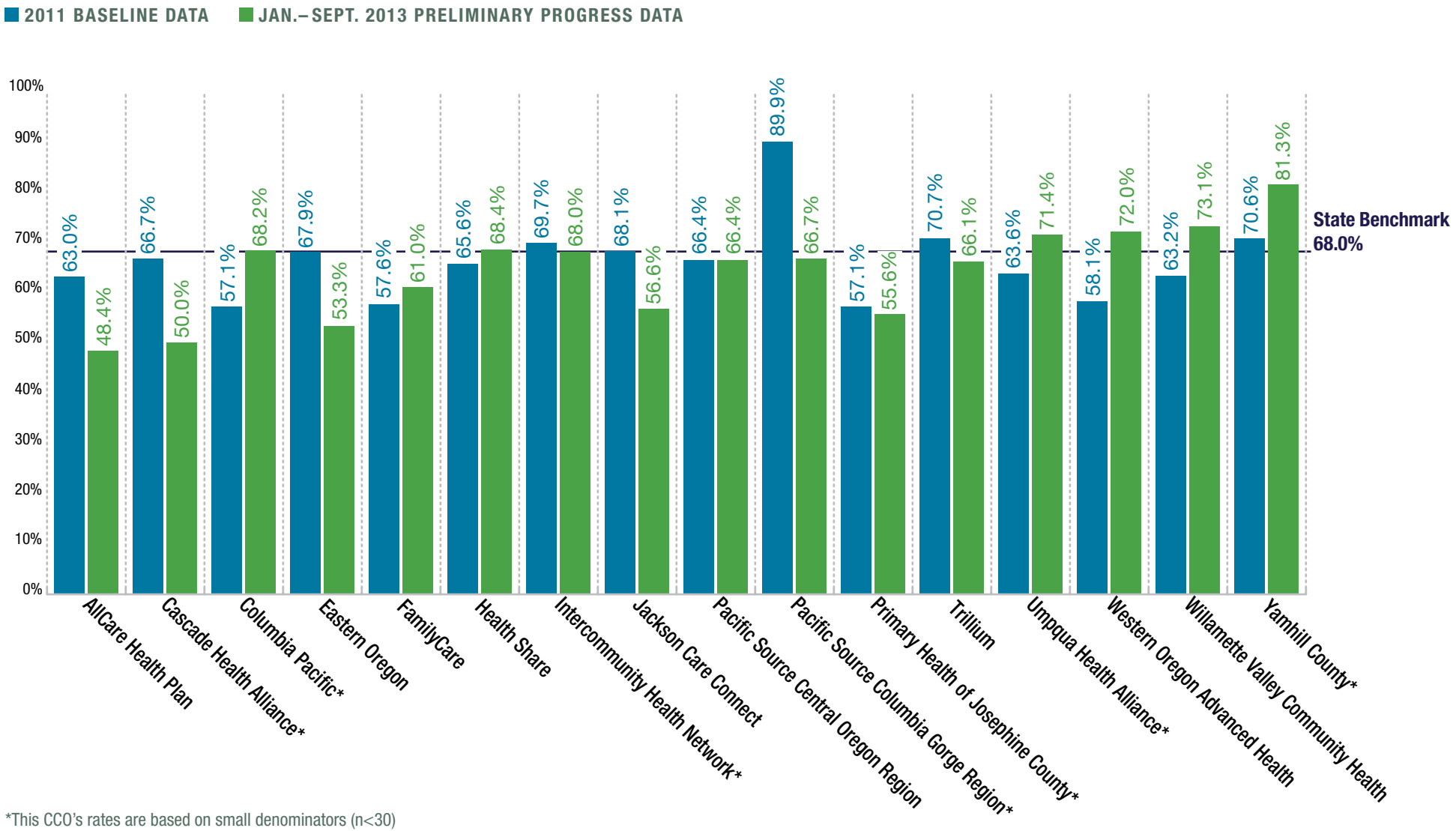


Note: Racial and ethnic information missing for 4.9% of respondents
*Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of patients who received follow-up care within 7 days of being discharged from the hospital for mental illness



*This CCO's rates are based on small denominators (n<30)

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Follow-up care for children prescribed ADHD medication (initiation phase)

Definition: Percentage of children (ages 6-12) who had at least one follow-up visit with a provider during the 30 days after receiving a new prescription for attention deficit hyperactivity disorder (ADHD) medication.

Focus areas: Improving behavioral and physical health coordination and improving access to effective and timely care.

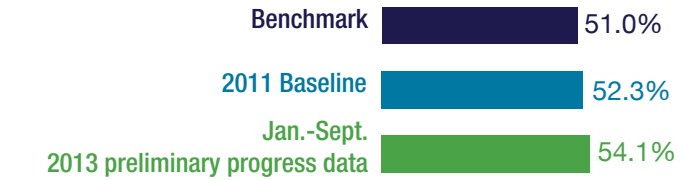
Purpose: Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition. ADHD treatment is an important emerging issue for children.

Jan. – Sept. 2013 data

This metric tracks the percentage of children prescribed ADHD medication who had a follow-up visit within 30 days after receiving a new prescription. Statewide, there was a 5% increase over the January–June data.

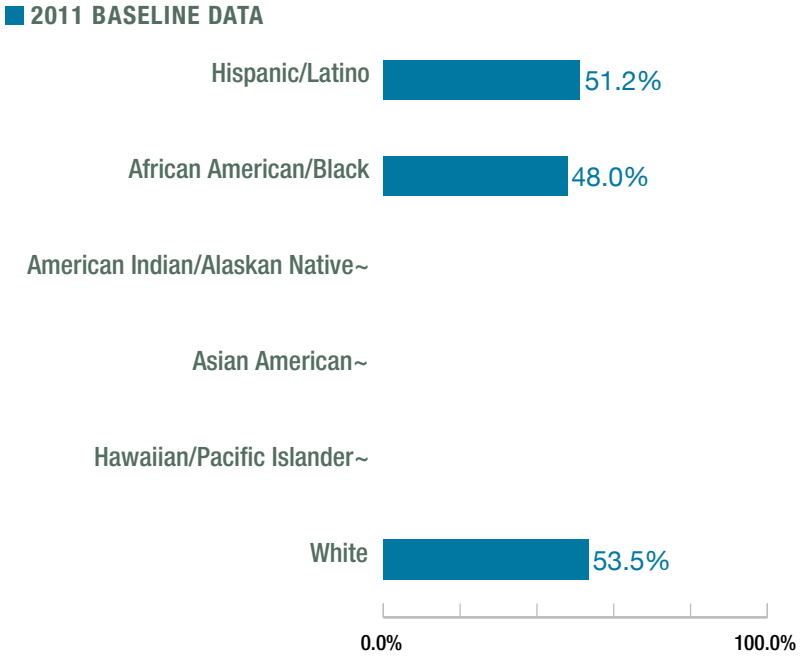
Due to a small number of cases for this metric, it is too early to interpret whether or not there are improvements on this measure. However, the 2013 preliminary data are encouraging and show a slight increase over the baseline.

STATEWIDE



2013 n = 1,590
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

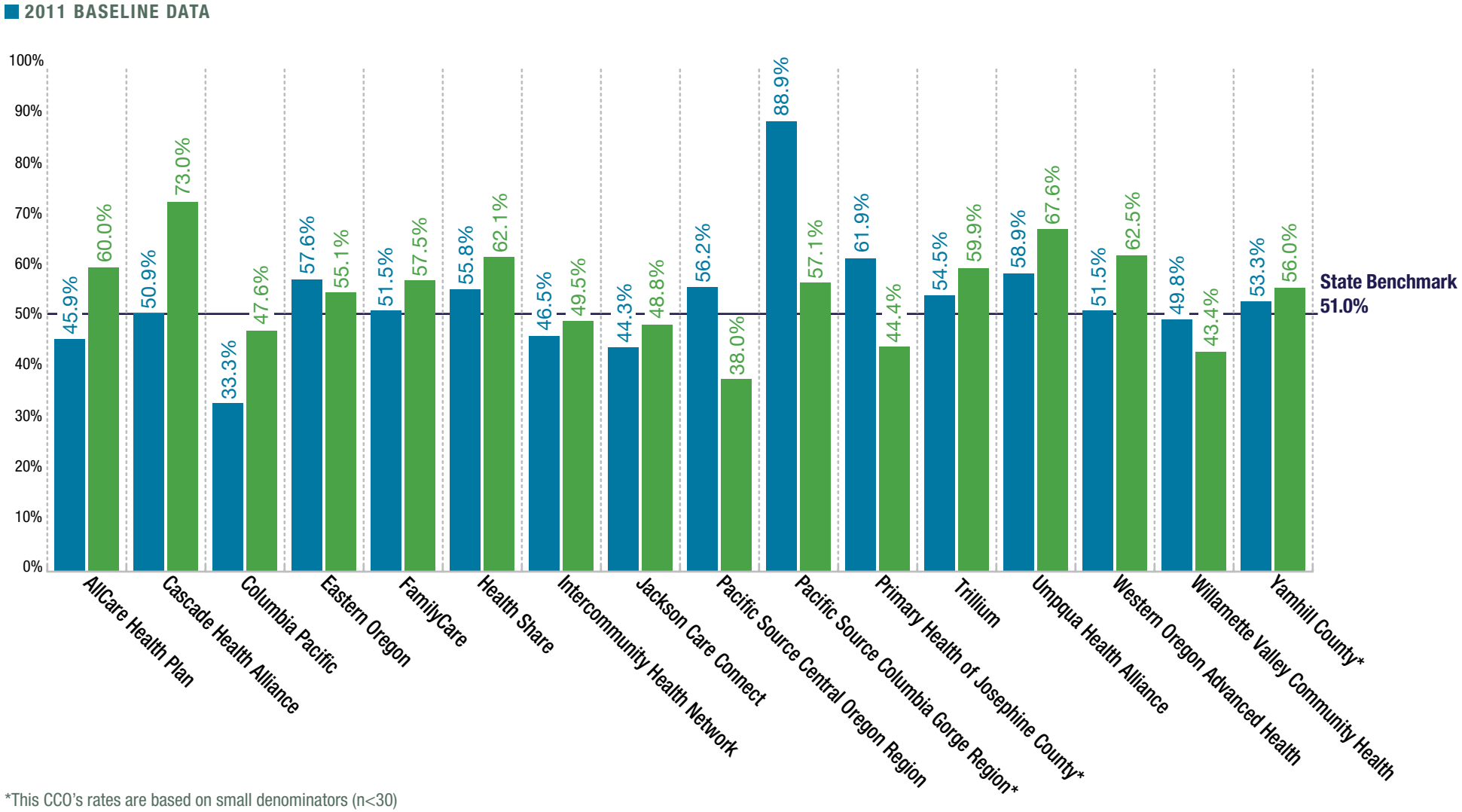


Note: Racial and ethnic information missing for 10.4% of respondents
*Each race category excludes Hispanic/Latino
~ Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for ADHD medication



*This CCO's rates are based on small denominators (n<30)

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)

Definition: Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase (see page 28).

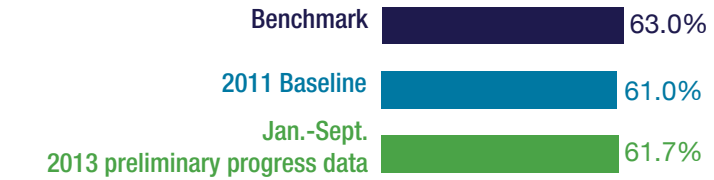
Focus areas: Improving behavioral and physical health coordination and improving access to effective and timely care.

Purpose: Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition. ADHD treatment is an important emerging issue for children.

Jan. – Sept. 2013 data

This metric tracks the percentage of children prescribed ADHD medication who remained on the medication for 210 days and had at least two follow-ups with a provider within 270 days of the prescription. To date, data are similar to baseline numbers.

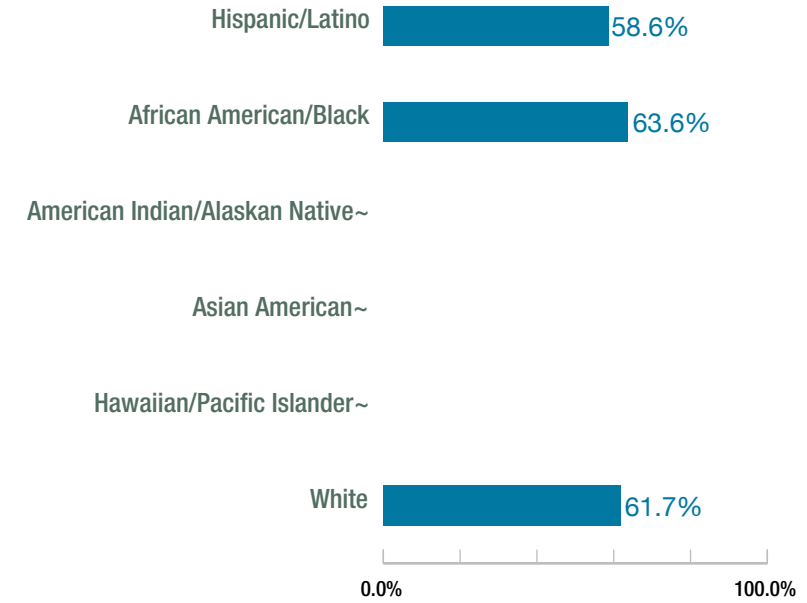
STATEWIDE



2013 n = 1,063
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

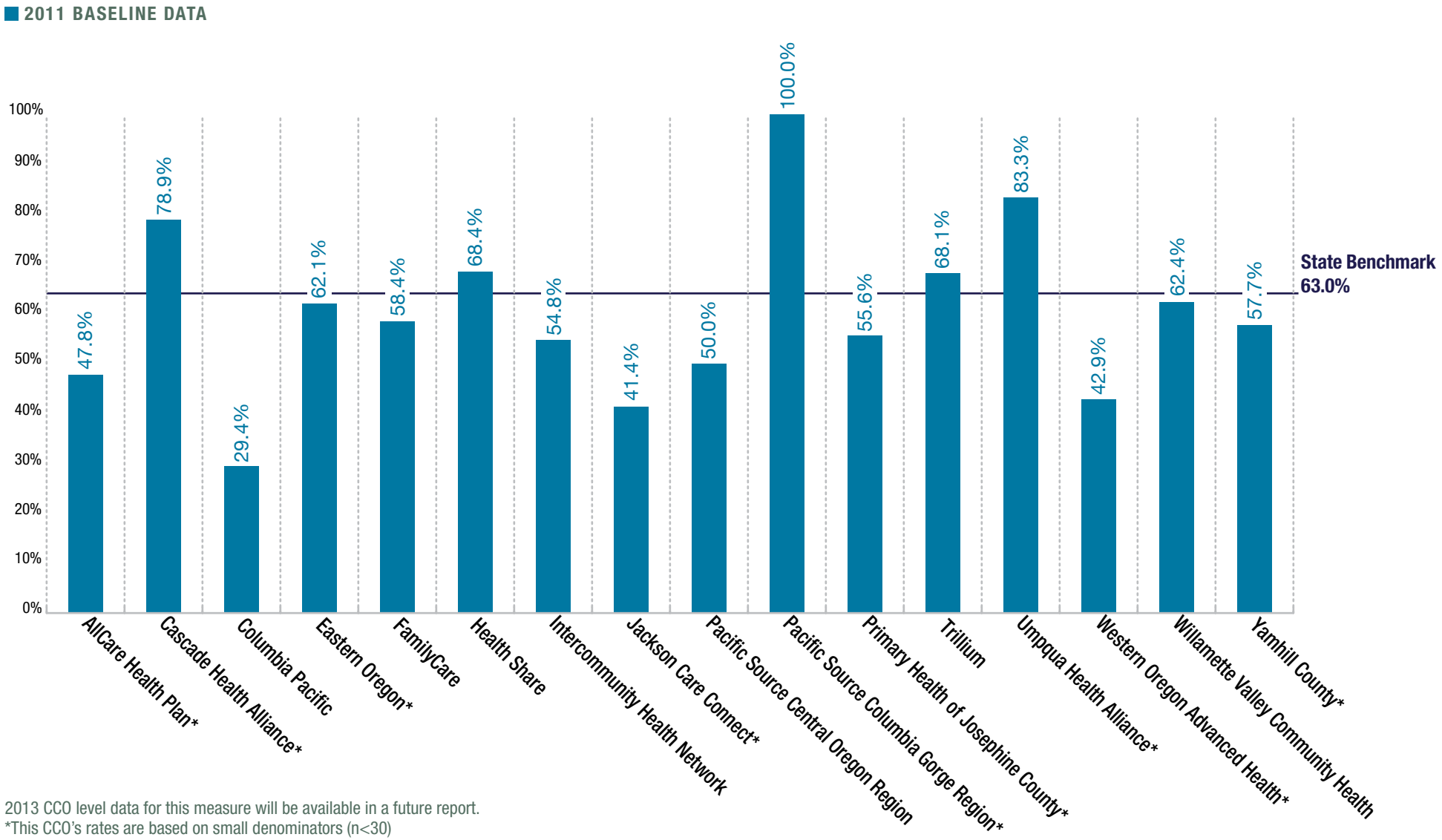


Note: Racial and ethnic information missing for 8.2% of respondents
*Each race category excludes Hispanic/Latino
~ Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of children (ages 6-12) who remained on ADHD medication for 210 days after receiving a new prescription and who had at least two follow-ups



2013 CCO level data for this measure will be available in a future report.
*This CCO's rates are based on small denominators (n<30)

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Patient-centered primary care home enrollment

Definition: Percentage of patients who were enrolled in a recognized patient-centered primary care home (PCPCH).

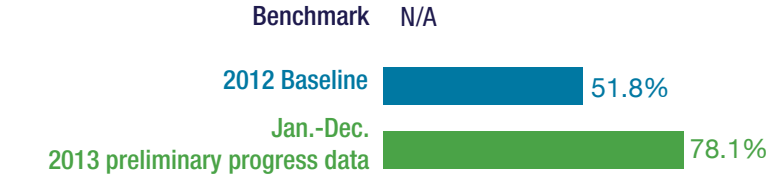
Focus areas: Improving primary care for all populations; ensuring appropriate care is delivered in appropriate settings; and improving access to effective and timely care.

Purpose: Patient-centered primary care homes are clinics that have been recognized for their commitment to quality, patient-centered, coordinated care. Patient-centered primary care homes help improve a patient's health care experience and overall health.

Jan. – Sept. 2013 data

This metric tracks the percentage of CCO members who are enrolled in a recognized patient-centered primary care home. The January through September 2013 data show a trend toward higher enrollment compared to the 2011 baseline and an increase since the November quarterly report.

STATEWIDE



2013 n = 541,538
Data source: CCO quarterly report

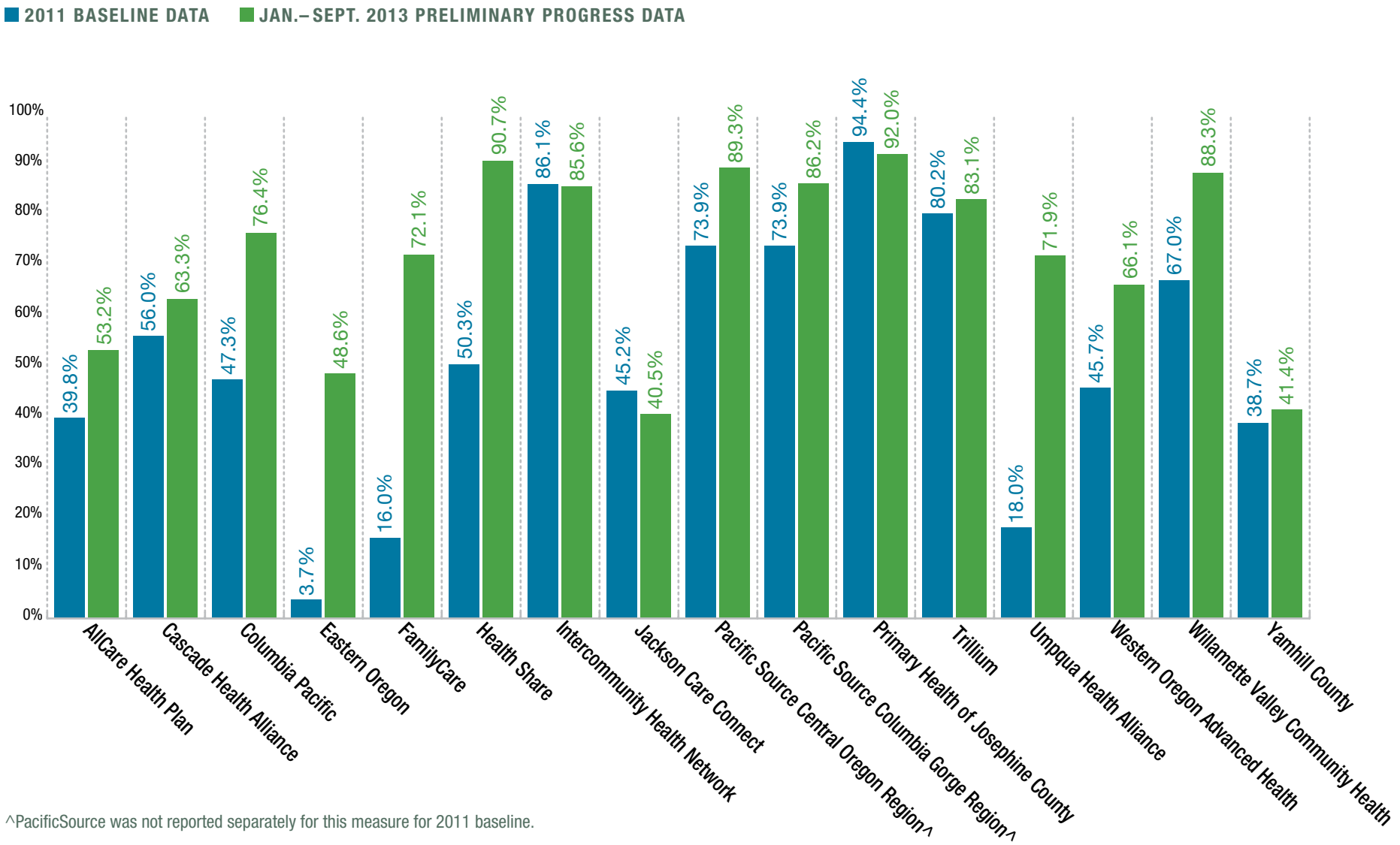
RACE AND ETHNICITY DATA

Patient-centered primary care home enrollment will not be stratified by race and ethnicity.

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of patients who were enrolled in a recognized patient-centered primary care home



^PacificSource was not reported separately for this measure for 2011 baseline.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

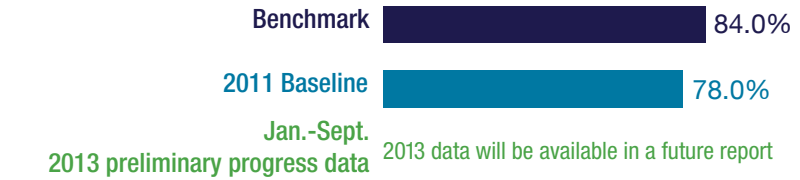
Satisfaction with care (CAHPS)

Definition: Percentage of patients (adults and children) who received needed information or help and thought they were treated with courtesy and respect by customer service staff.

Focus area: Addressing patient satisfaction with health care.

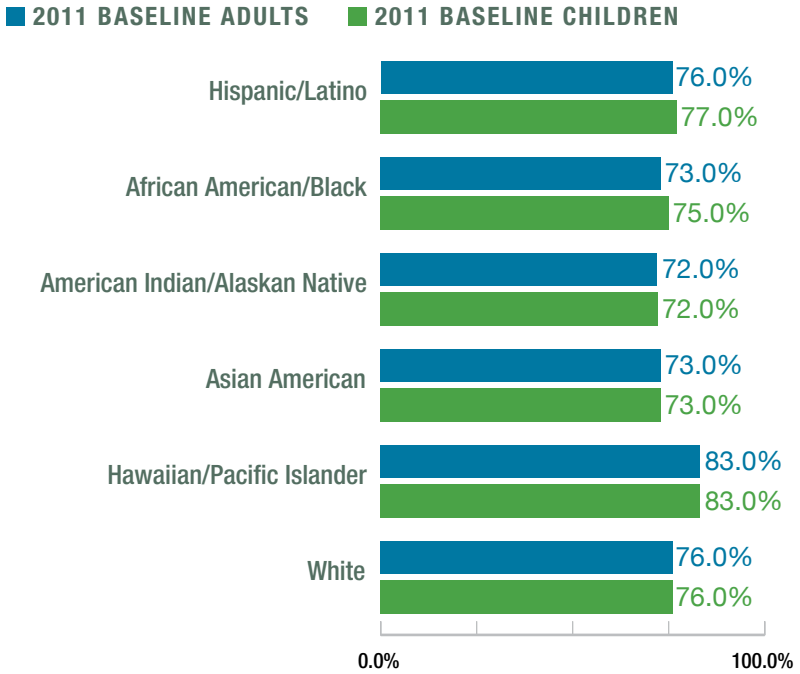
Purpose: A patient's satisfaction and overall experience with their care is a critical component of quality health care. Data shows that healthier patients tend to report being more satisfied with the care they receive. Patients who are not satisfied with their care may miss appointments.

STATEWIDE



Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

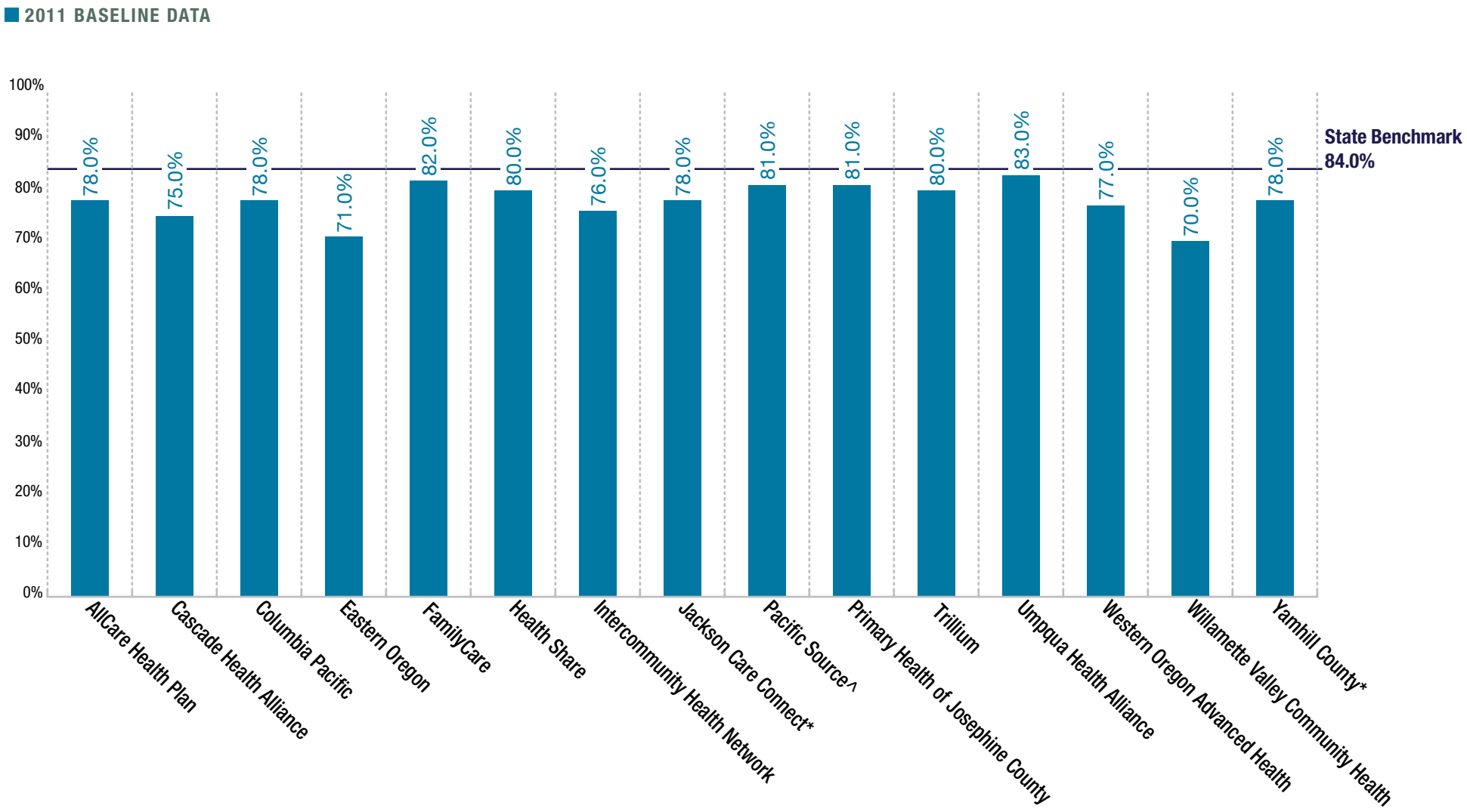


*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of patients who received needed information and thought they were treated with courtesy and respect



2013 CCO level data for this measure will be available in a future report.
*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Timeliness of prenatal care

Definition: Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid.

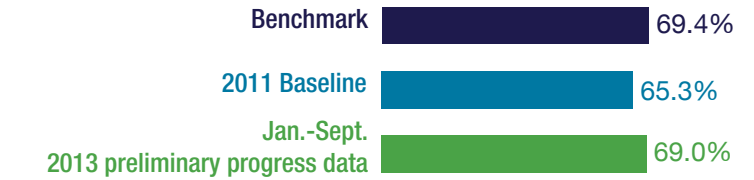
Focus areas: Improving overall perinatal and maternity care and improving access to effective and timely care.

Purpose: Care during a pregnancy, prenatal care, is widely considered the most productive and cost-effective way to support the delivery of a healthy baby. The timeliness of that care is a critical and sometimes overlooked component. This measure helps ensure timeliness by tracking the percentage of women who receive an early prenatal care visit (in the first trimester). Improving the timeliness of prenatal care can lead to significantly better health outcomes and cost savings – as more than 40% of all babies born in Oregon are covered by Medicaid.

Jan. – Sept. 2013 data

This metric tracks the percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid. The preliminary 2013 data show an improvement over baseline and are approaching the statewide benchmark.

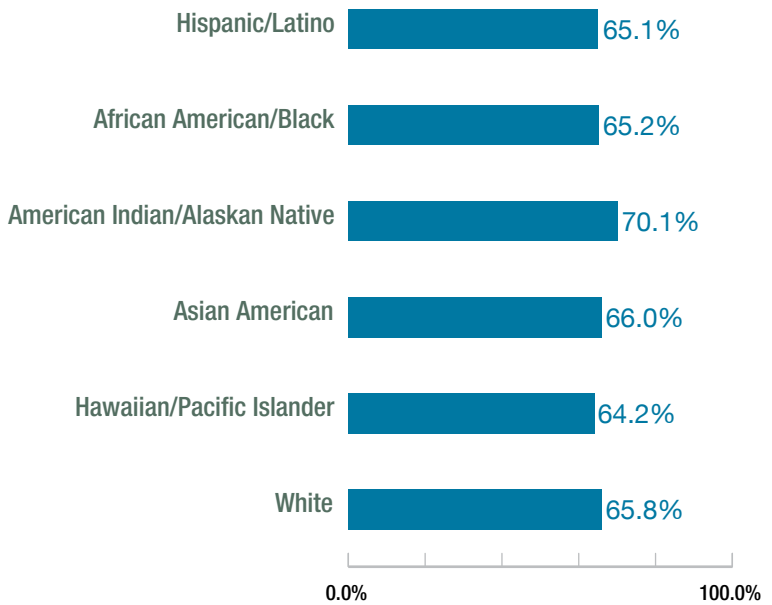
STATEWIDE



2013 n = 3,701
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only)

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

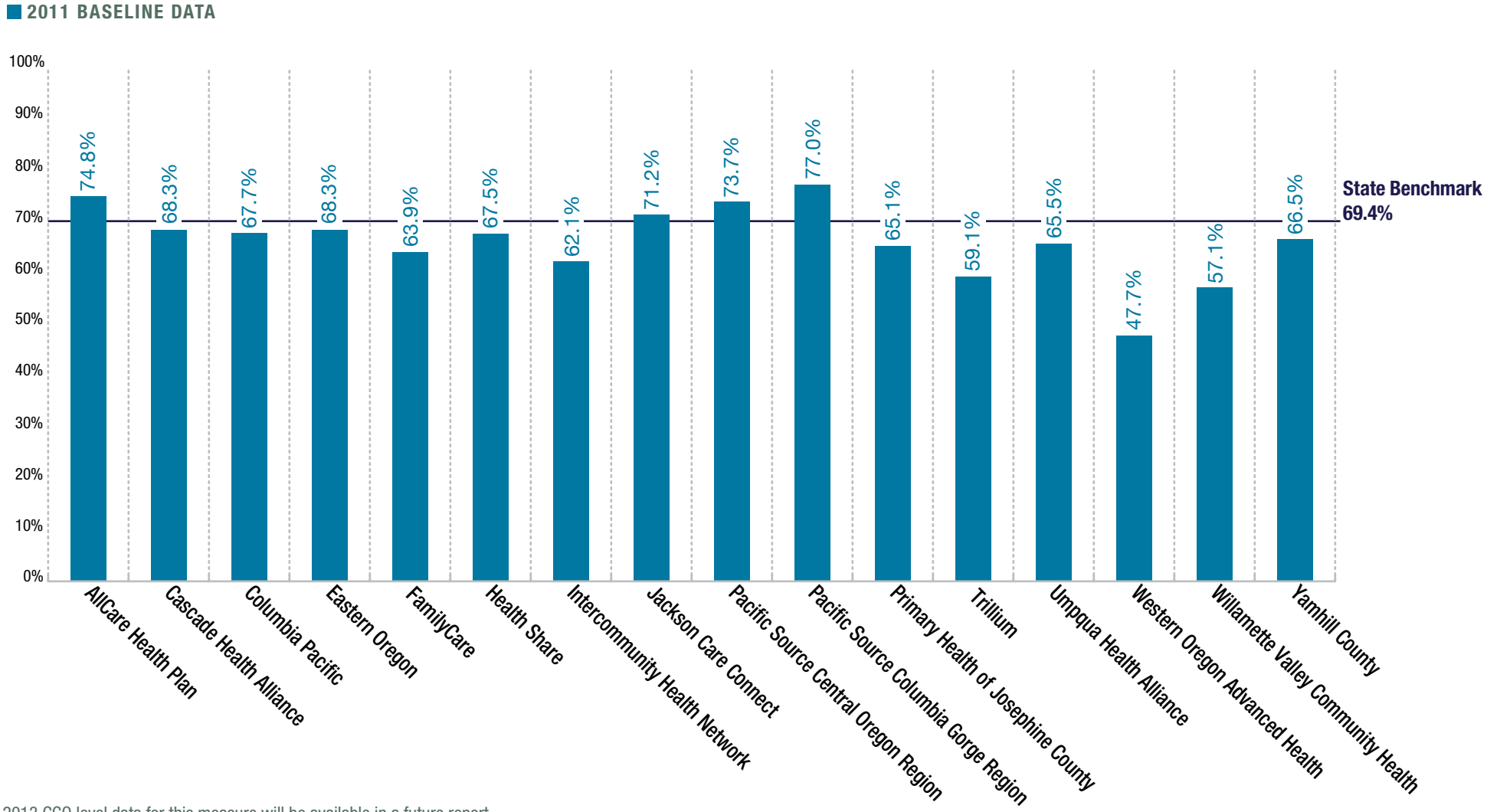


Note: Racial and ethnic information missing for 9.0% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

All-cause readmission

Definition: Percentage of adult patients (ages 18 and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score for this measure is better.

Focus area: Reducing preventable re-hospitalizations.

Purpose: Some patients who leave the hospital end up being admitted again shortly thereafter. Often times, these costly and burdensome "readmissions" are avoidable. Reducing the preventable problems that send patients back to the hospital is the best way to keep patients at home and healthy.

Jan. – Sept. 2013 data

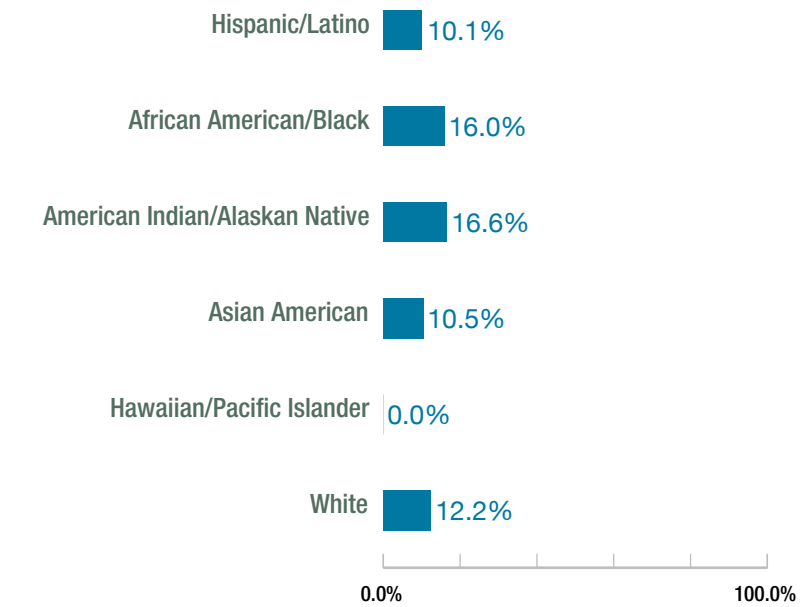
This metric tracks the percentage of adult patients who had a hospital stay and were readmitted for any reason within 30 days of discharge. The January through September 2013 data show a preliminary trend toward lower (better) readmission rates.

STATEWIDE

2013 n = 15,407
Data source: Administrative (billing) claims
Benchmark source: Average of 2012 Commercial and Medicare 75th percentiles

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

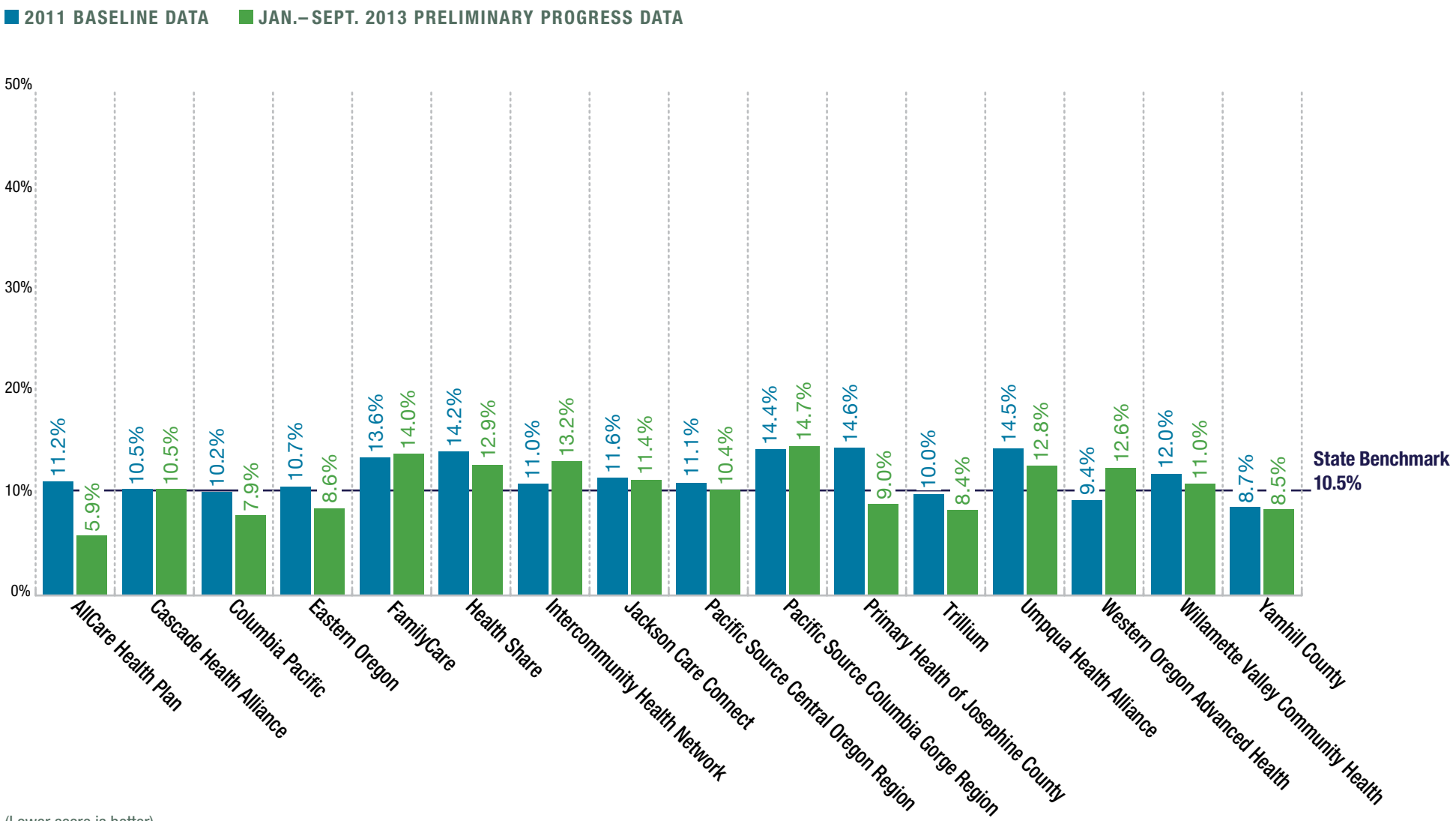


Note: Racial and ethnic information missing for 3.3% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of adult patients who had a hospital stay and were readmitted for any reason within 30 days of discharge



(Lower score is better)

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

Appropriate testing for children with pharyngitis

Definition: Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.

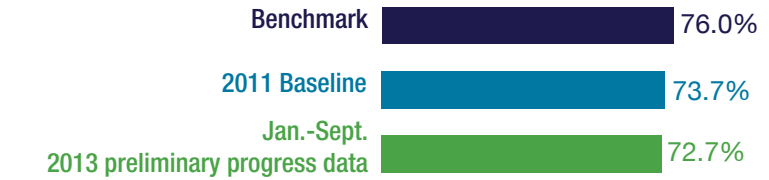
Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

Purpose: A strep test helps determine whether or not a child will benefit from antibiotics for a sore throat (pharyngitis). This test can help reduce the overuse of antibiotics, which can improve care quality and ensure that antibiotics continue to work when they are needed.

Jan. – Sept. 2013 data

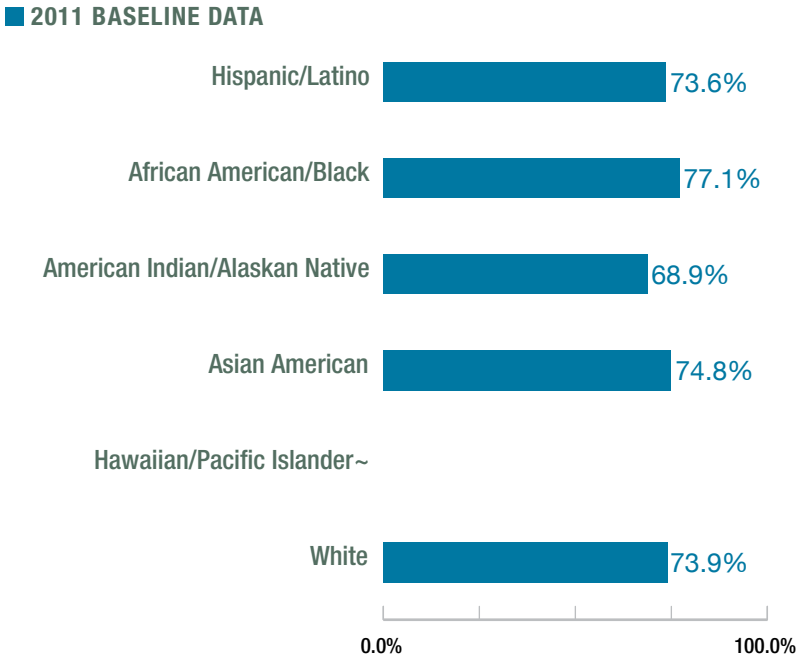
This metric tracks the percentage of children with a sore throat from January through September 2013 who had a strep test before being prescribed antibiotics. The 2013 preliminary data are comparable to the baseline.

STATEWIDE



2013 n = 6,598
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

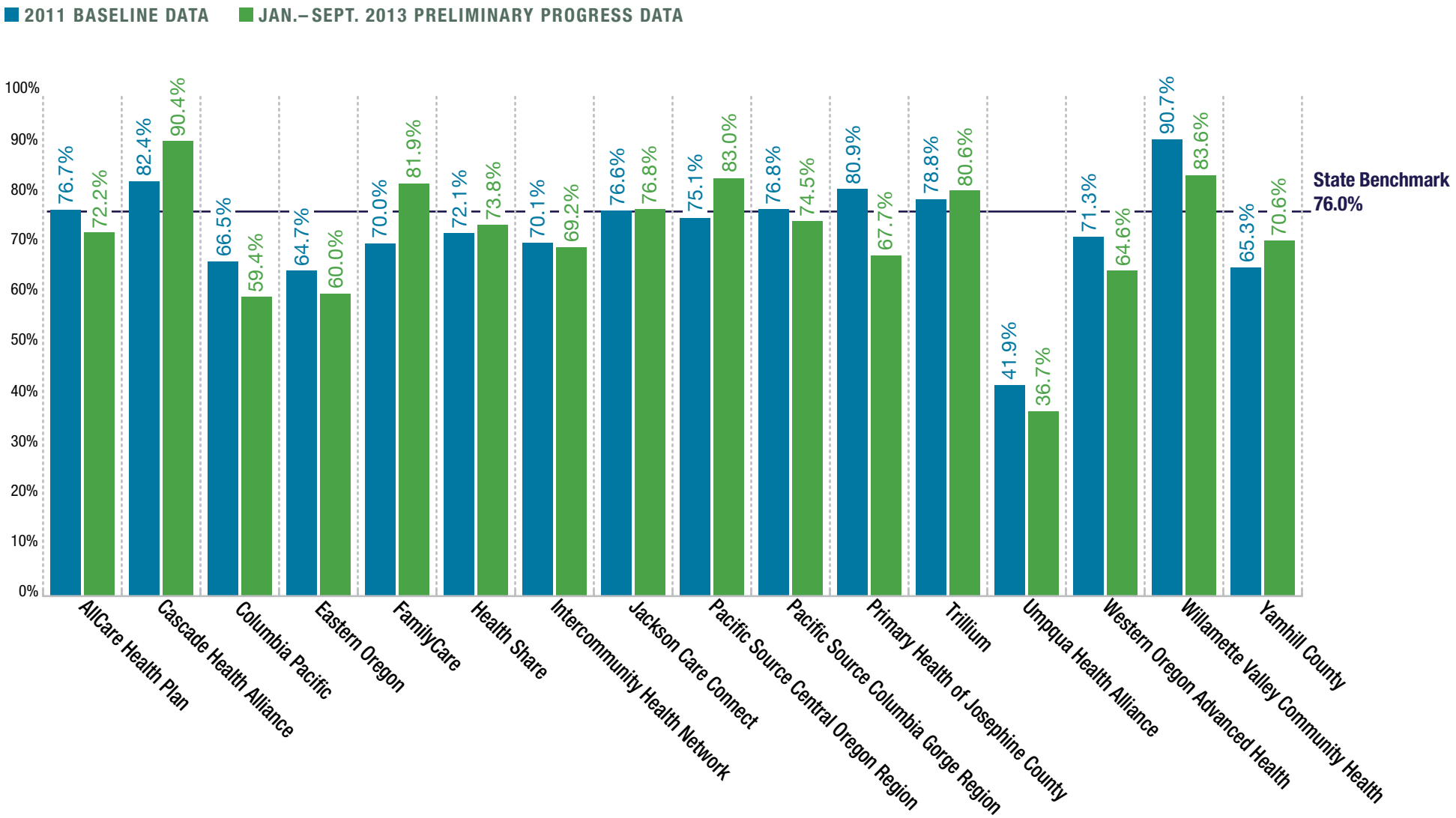


Note: Racial and ethnic information missing for 8.6% of respondents
*Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Percentage of children with a sore throat who were given a strep test before getting an antibiotic



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Cervical cancer screening

Definition: Percentage of women patients (ages 21 to 64) who got one or more Pap tests for cervical cancer in the past three years.

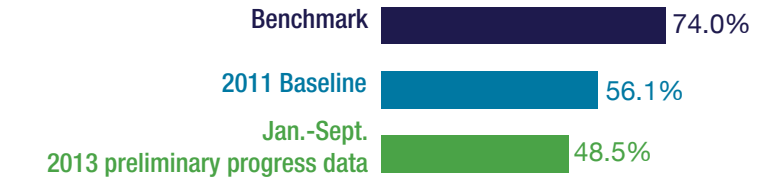
Focus area: Improving access to effective and timely care.

Purpose: A Pap test helps find early signs of cancer in the cervix when the disease is easier and less costly to treat. Treating cervical cancer in its earliest stages also increases the five-year survival rate to 92 percent, according to the American Cancer Society.

Jan. – Sept. 2013 data

This metric tracks the percentage of women (ages 21 to 64) who had one or more Pap tests for cervical cancer in the past three years. The 2013 preliminary data show there is room for further development and attention for cervical cancer screening. The percentage through September 2013 shows the progress toward the goal on this metric and should not be compared to the 2011 baseline or the benchmark until all screenings are counted at the end of 2013 when we have a full year of data.

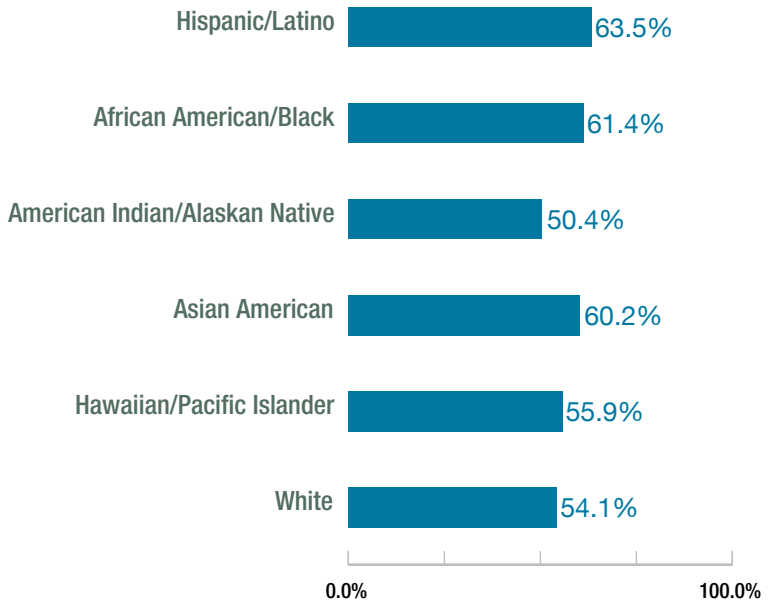
STATEWIDE



2013 n = 83,178
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

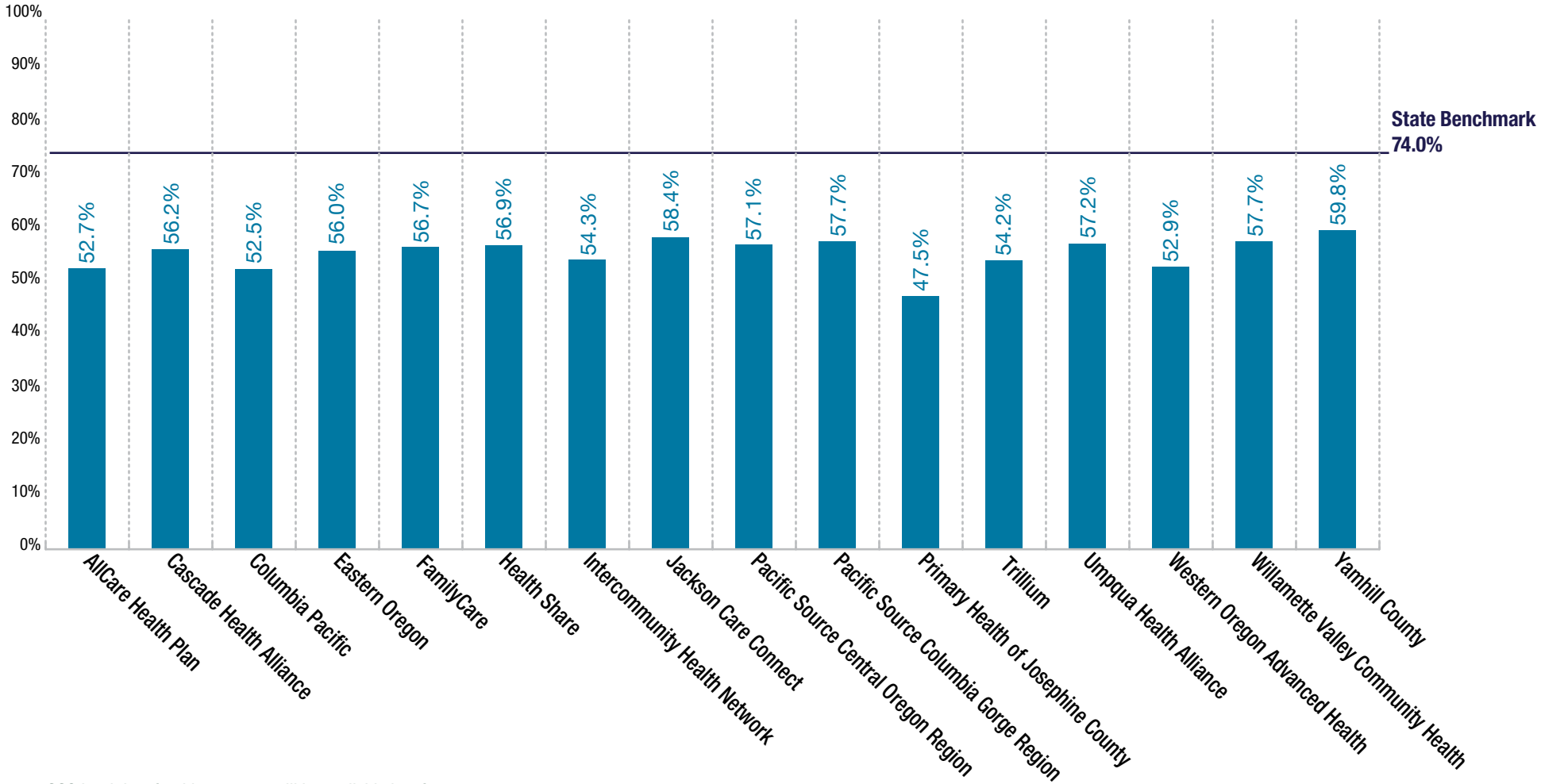


Note: Racial and ethnic information missing for 6.6% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of women patients (ages 21 to 64) who got one or more Pap tests for cervical cancer in the past three years



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Child and adolescent access to primary care providers, all ages

Definition: Percentage of children (ages 12 months – 19 years) who had a visit with a primary care provider.

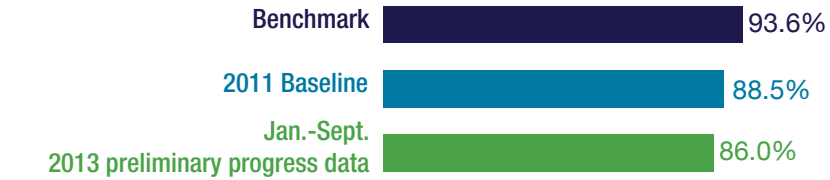
Focus areas: Improving access to effective and timely care and improving primary care for all populations.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

Jan. – Sept. 2013 data

This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. The measure is split into 5 categories: all ages, 12–24 months, 25 months–6 years, 7–11 years and 12–19 years. Each category should not be compared to the benchmark until all visits are counted at the end of 2013 when we have a full year of data.

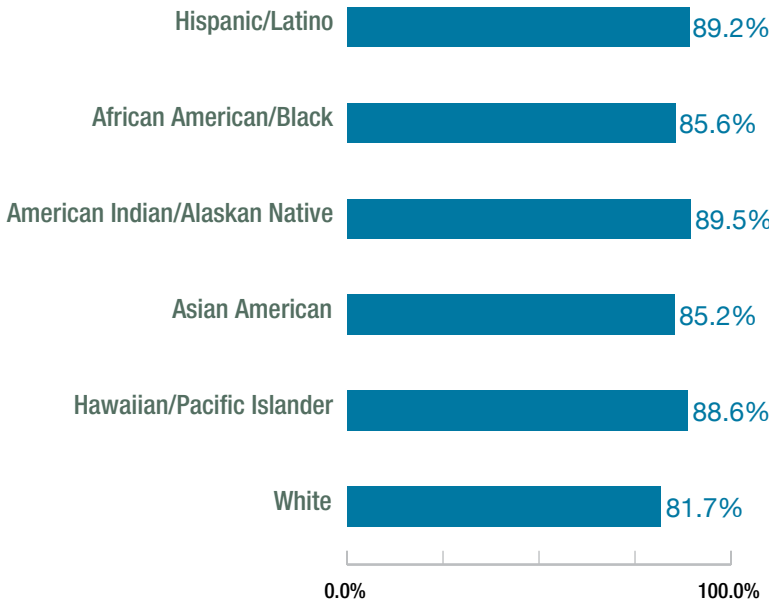
STATEWIDE



2013 n = 281,490
Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile (average of the four age breakouts for this measure)

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

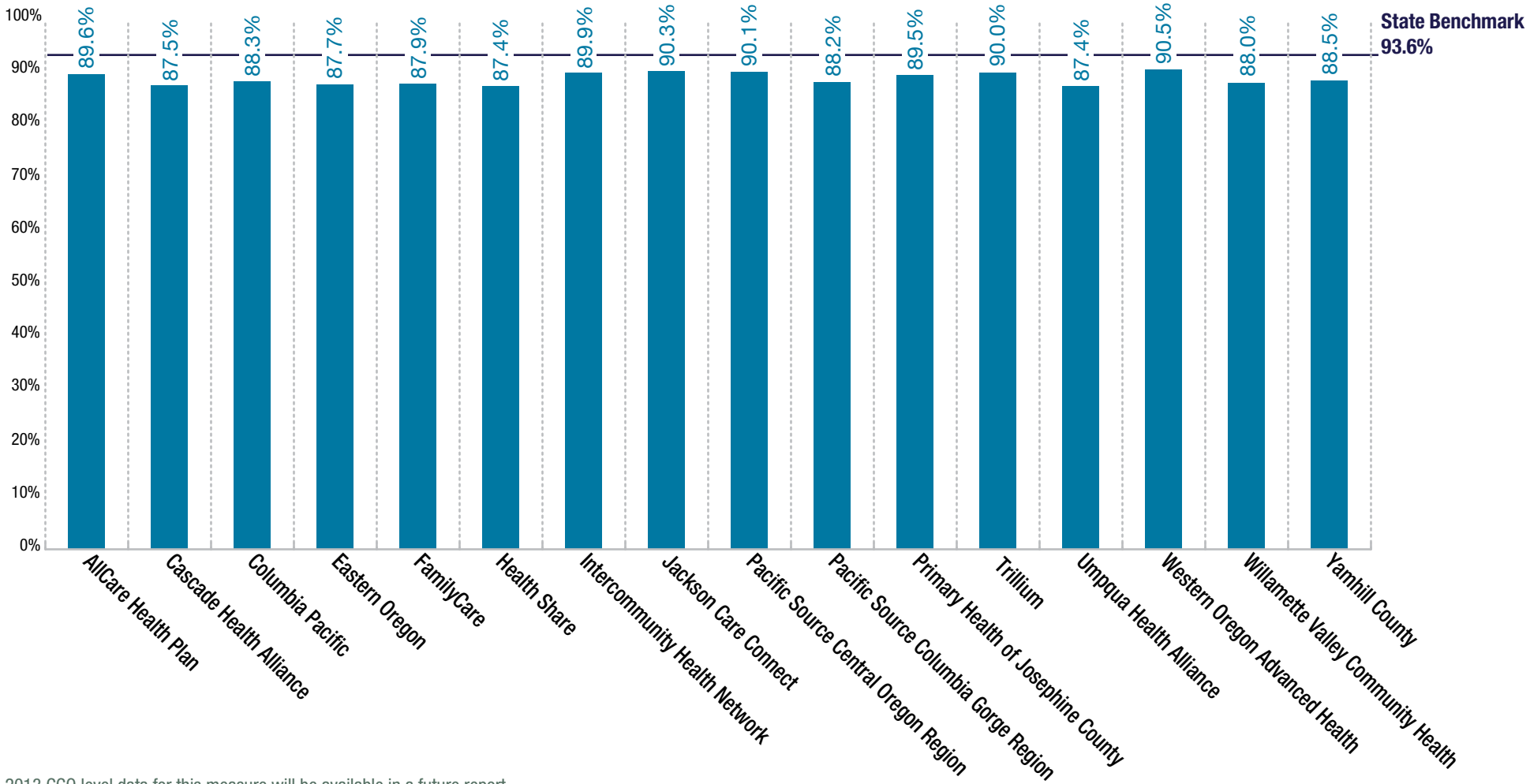


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of children who had a visit with a primary care provider



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

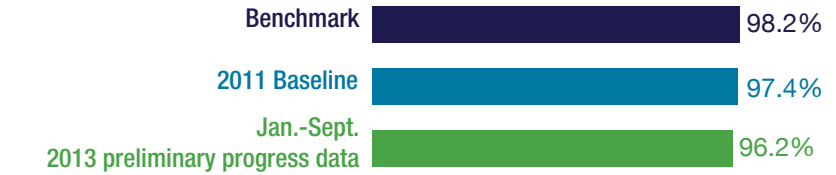
Child and adolescent access to primary care providers, 12-24 months

Definition: Percentage of toddlers (ages 12–24 months) who had a visit with a primary care provider.

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

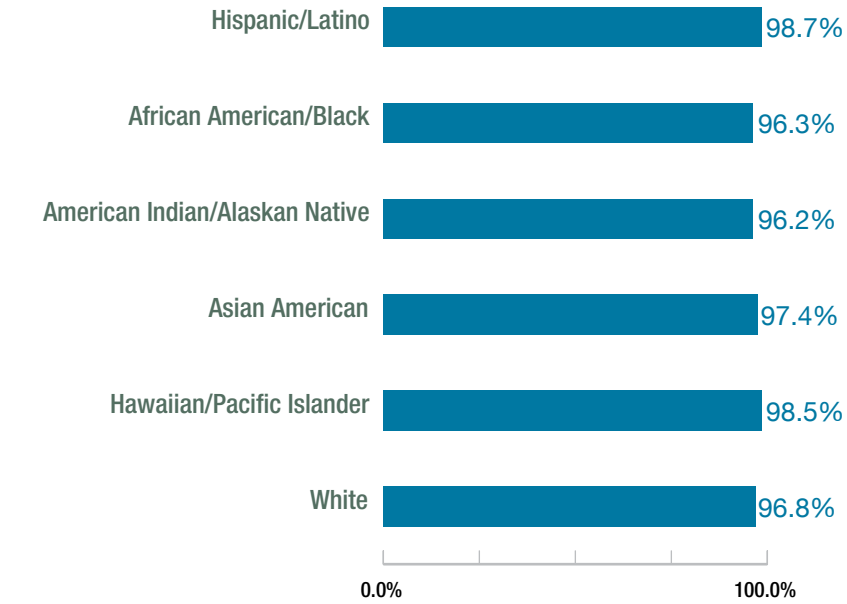
STATEWIDE



2013 n = 20,641
Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

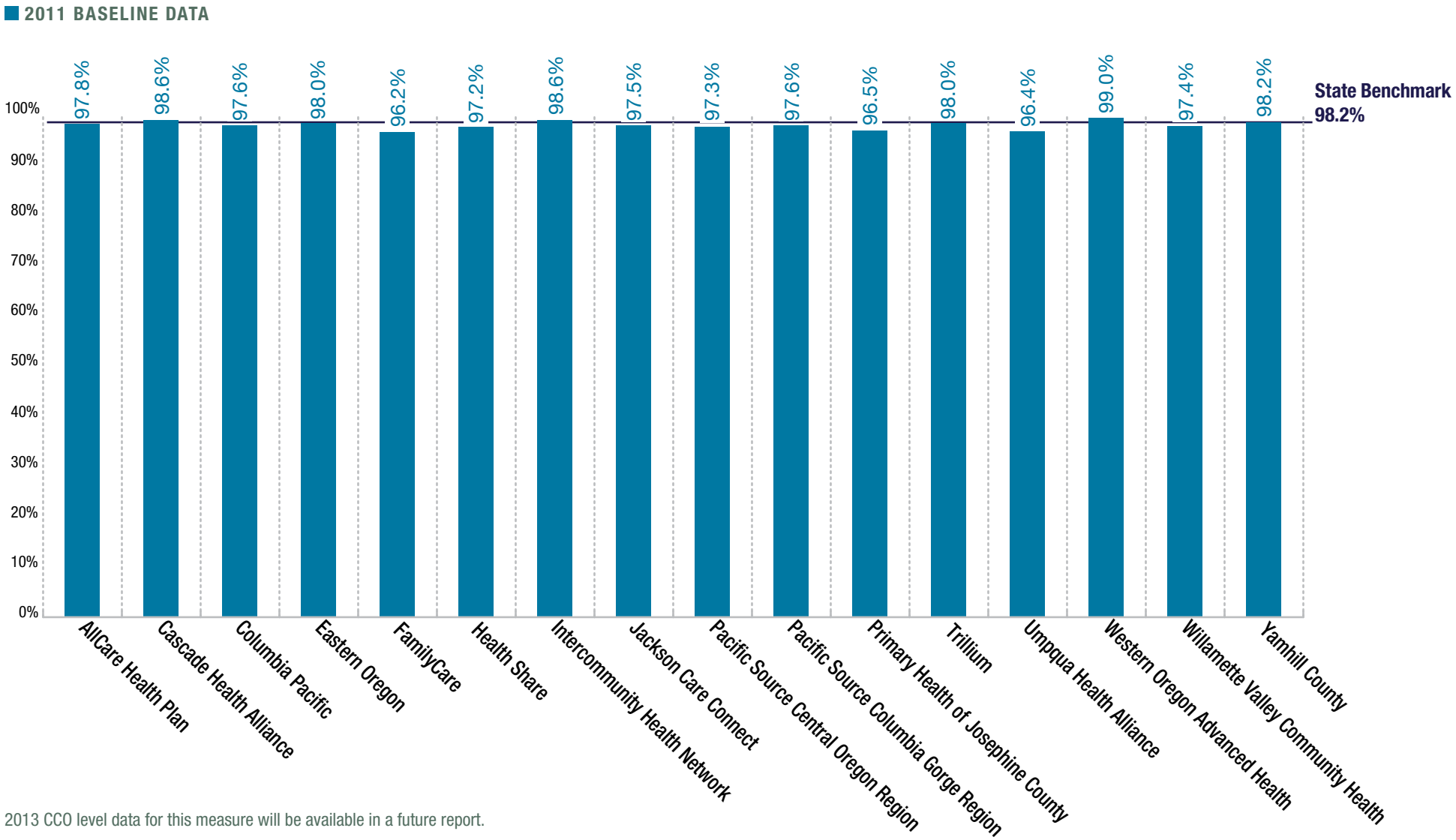


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of toddlers (ages 12–24 months) who had a visit with a primary care provider



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

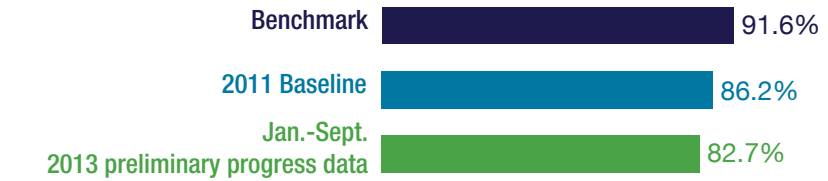
Child and adolescent access to primary care providers, 25 months – 6 years

Definition: Percentage of children (ages 25 months – 6 years years) who had a visit with a primary care provider.

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

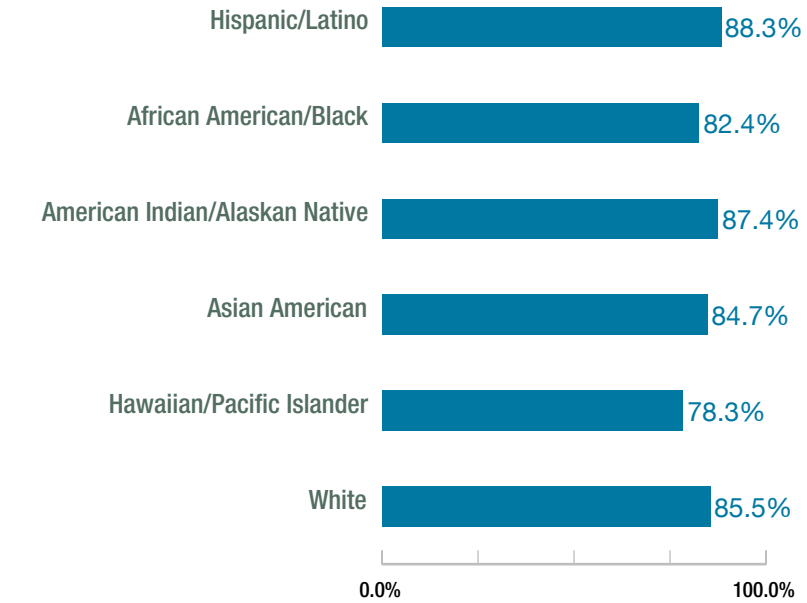
STATEWIDE



2013 n = 95,804
Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

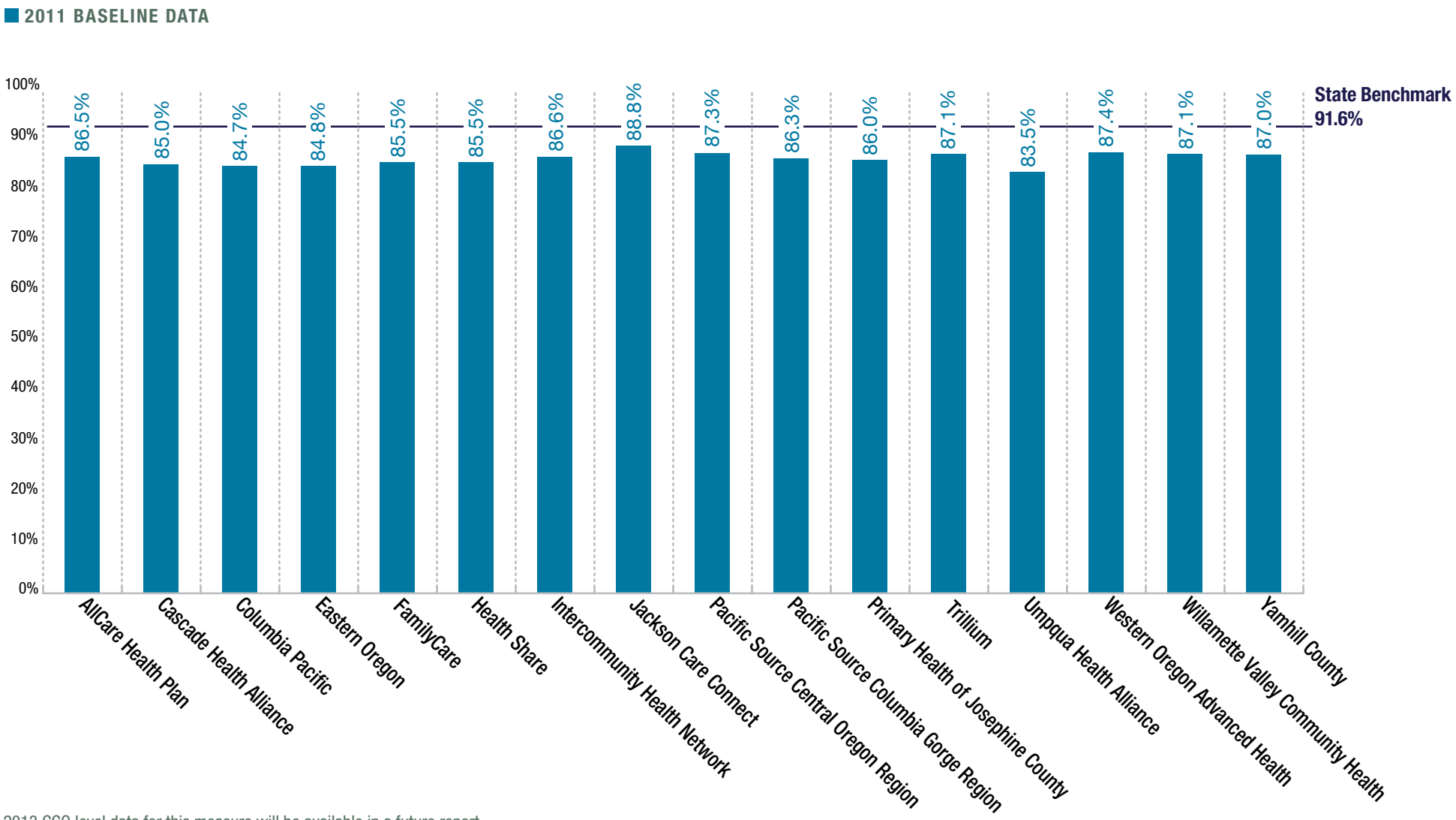


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of children (ages 25 months – 6 years years) who had a visit with a primary care provider



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

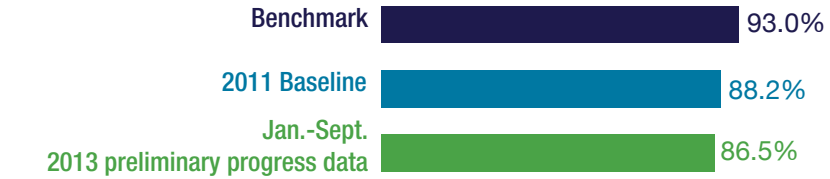
Child and adolescent access to primary care providers, 7-11 years

Definition: Percentage of children and adolescents (ages 7–11 years) who had a visit with a primary care provider.

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

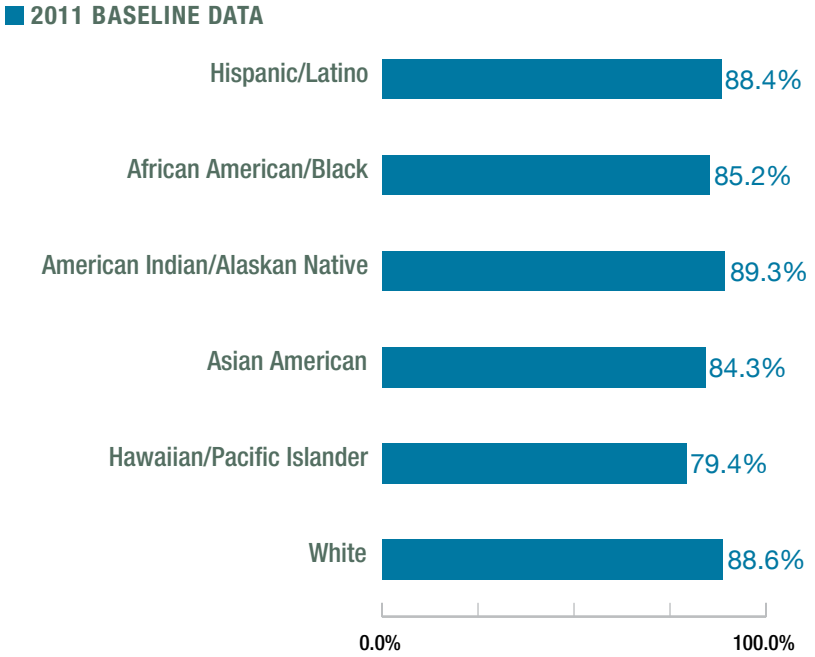
Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

STATEWIDE



2013 n = 74,921
Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

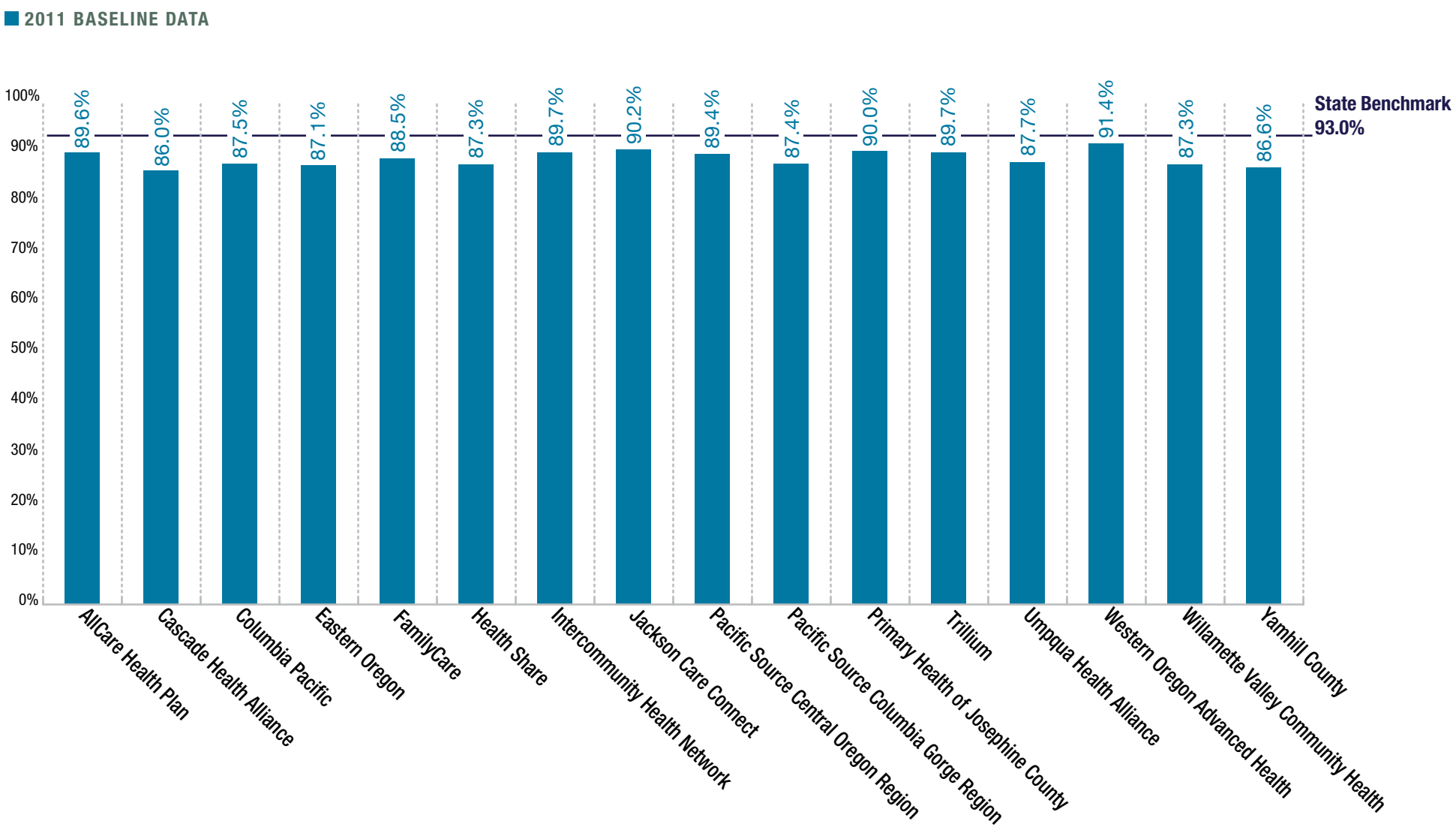


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of children and adolescents (ages 7–11 years) who had a visit with a primary care provider



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

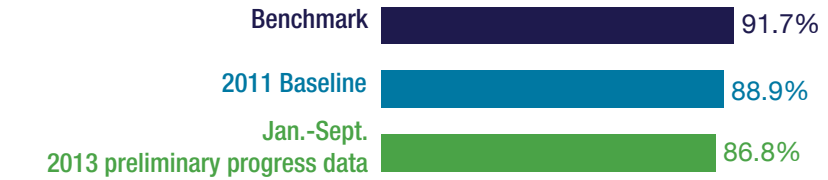
Child and adolescent access to primary care providers, 12-19 years

Definition: Percentage of adolescents (ages 12–19 years) who had a visit with a primary care provider.

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

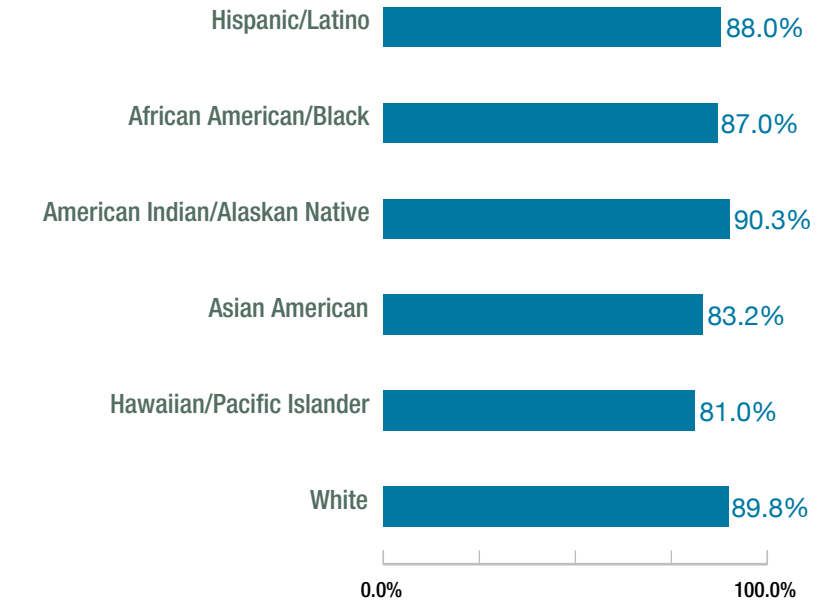
STATEWIDE



2013 n = 90,124
Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

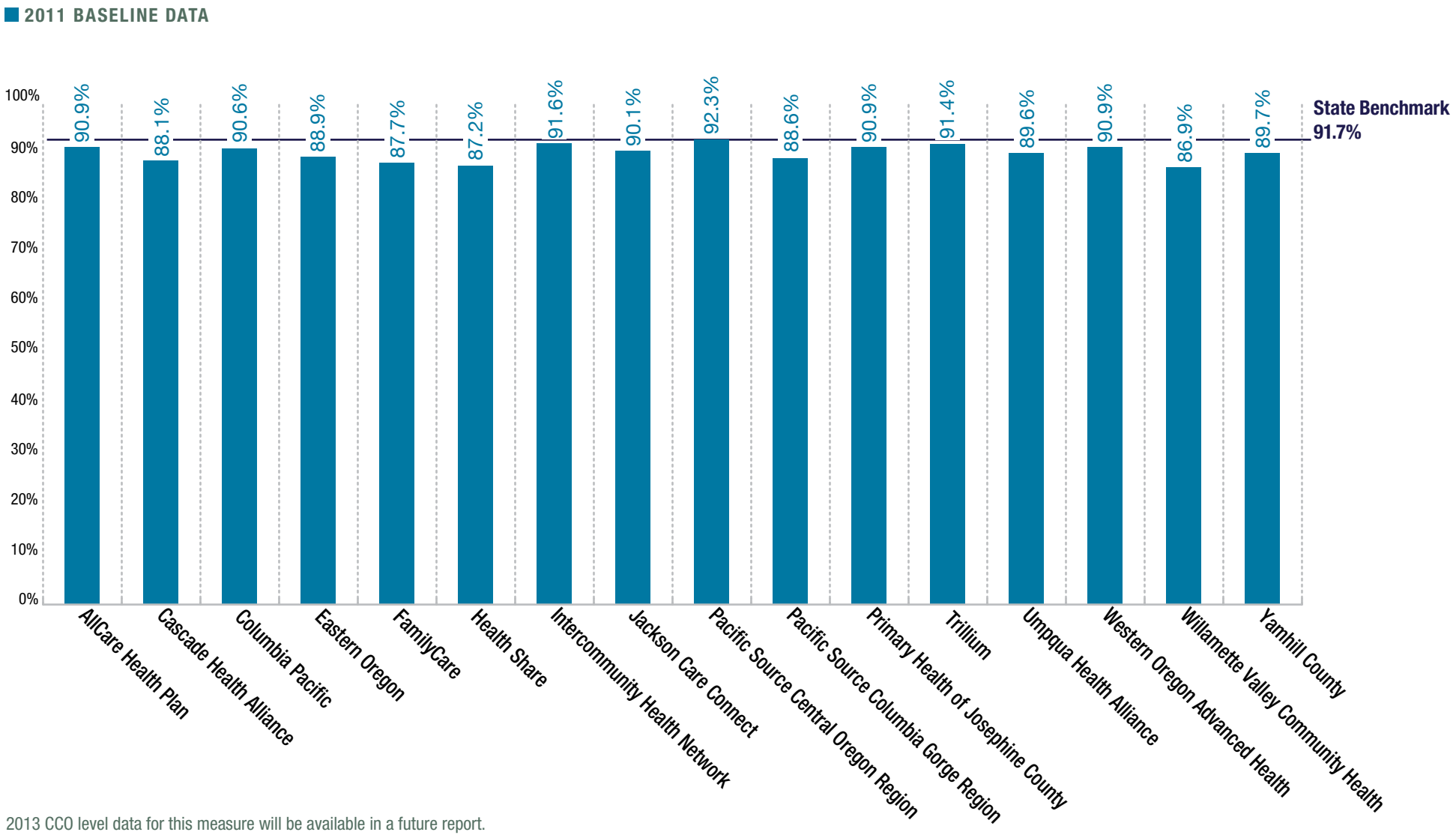


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of adolescents (ages 12–19 years) who had a visit with a primary care provider



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

Childhood immunization status

Definition: Percentage of children who received recommended vaccines before their 2nd birthday.

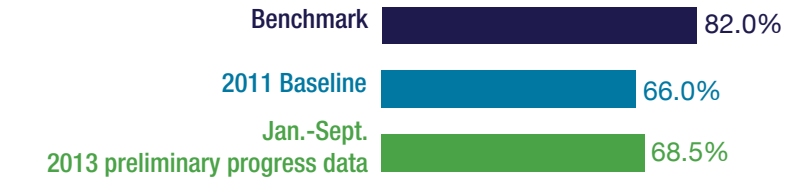
Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

Purpose: Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools that help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats.

Jan. – Sept. 2013 data

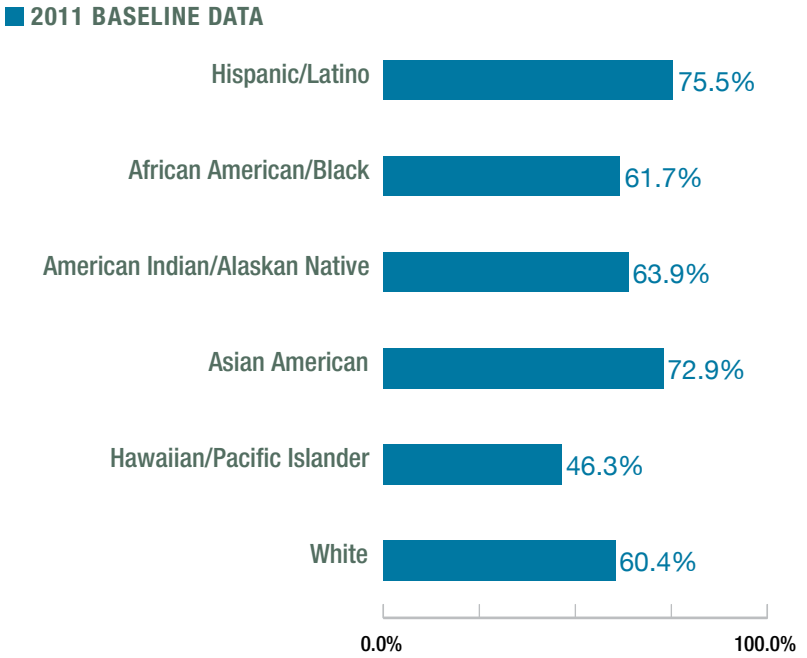
This metric tracks the percentage of children who received their recommended vaccines before their 2nd birthday. The preliminary 2013 data show encouraging results. However, this metric should not be compared to the benchmark until all immunizations are counted at the end of 2013 when we have a full year of data.

STATEWIDE



2013 n = 18,296
Data source: Administrative (billing) claims and ALERT Immunization Information System
Benchmark source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

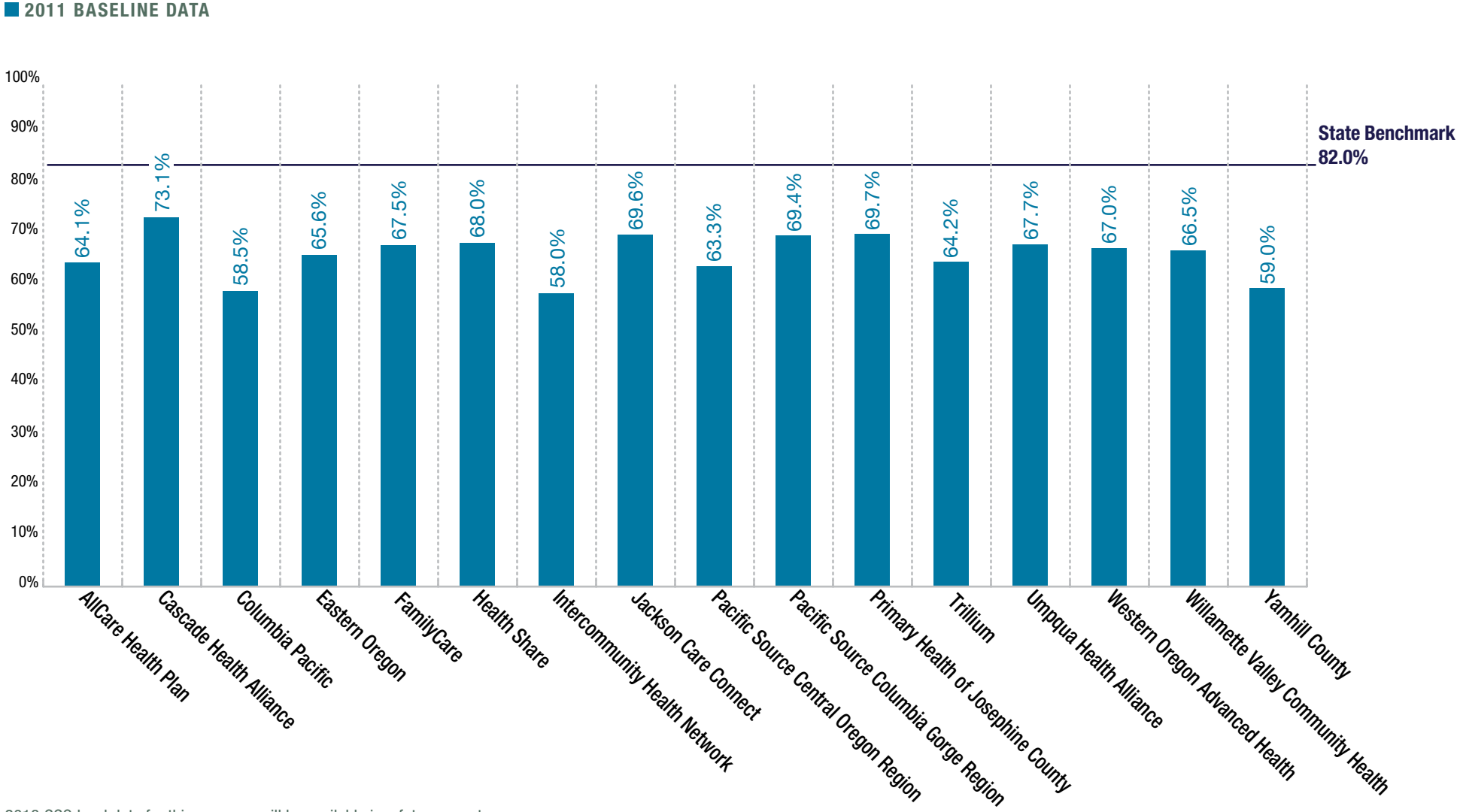


Note: Racial and ethnic information missing for 10.3% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of children who received recommended vaccines before their 2nd birthday



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

Chlamydia screening

Definition: Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection.

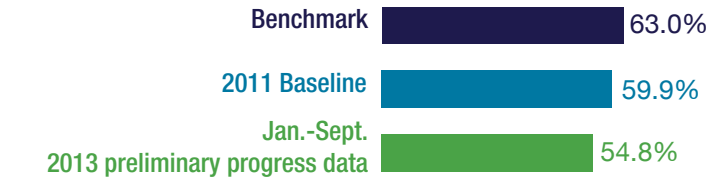
Focus area: Improving access to effective and timely care.

Purpose: Chlamydia is the most common reportable illness in Oregon. Since there are usually no symptoms, routine screening is important to find the disease early so that it can be treated and cured with antibiotics. If Chlamydia is not found and treated, it can lead to pelvic inflammatory disease, which can cause infertility.

Jan. – Sept. 2013 data

This metric tracks the percentage of sexually active women ages 16–24 who were tested for chlamydia infection. The percentage through September 2013 shows the progress toward the goal on this metric and should not be compared to the 2011 baseline or benchmark until all screenings are counted at the end of 2013 when we have a full year of data.

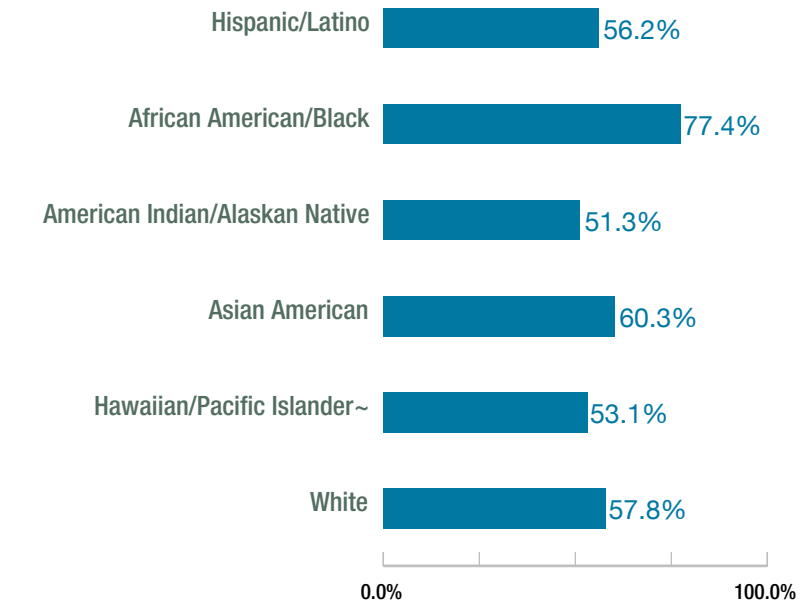
STATEWIDE



2013 n = 6,127
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

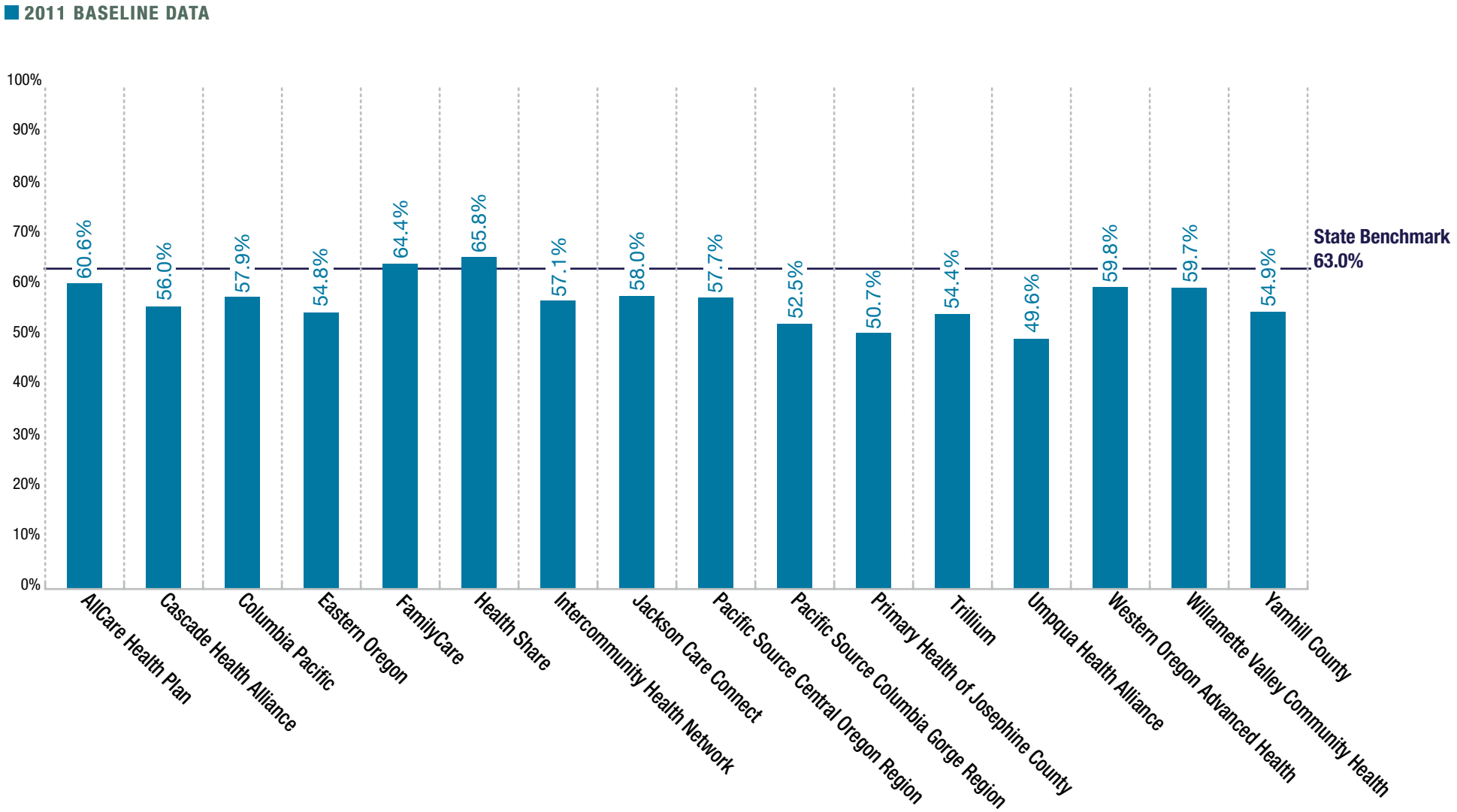


Note: Racial and ethnic information missing for 10.6% of respondents
*Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Comprehensive diabetes care: Hemoglobin A1c testing

Definition: Percentage of adult patients (ages 18-75) with diabetes who received at least one A1c blood sugar test.

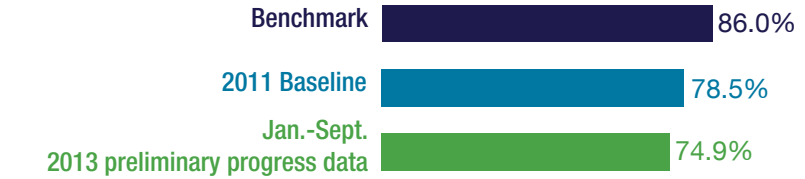
Focus area: Addressing discrete health issues.

Purpose: Controlling blood sugar levels is important to help people with diabetes manage their disease. It is also a key way to assess the overall effectiveness of diabetes care in Oregon. By improving the quality of care for diabetes, Oregon can help patients avoid complications and hospitalizations that lead to poor health and high costs.

Jan. – Sept. 2013 data

This metric tracks the percentage of adult patients with diabetes who received at least one A1c blood sugar test. The 2013 preliminary data are down from 2011 baseline. However, this metric should not be compared to the baseline or benchmark until all tests are counted at the end of 2013 when we have a full year of data.

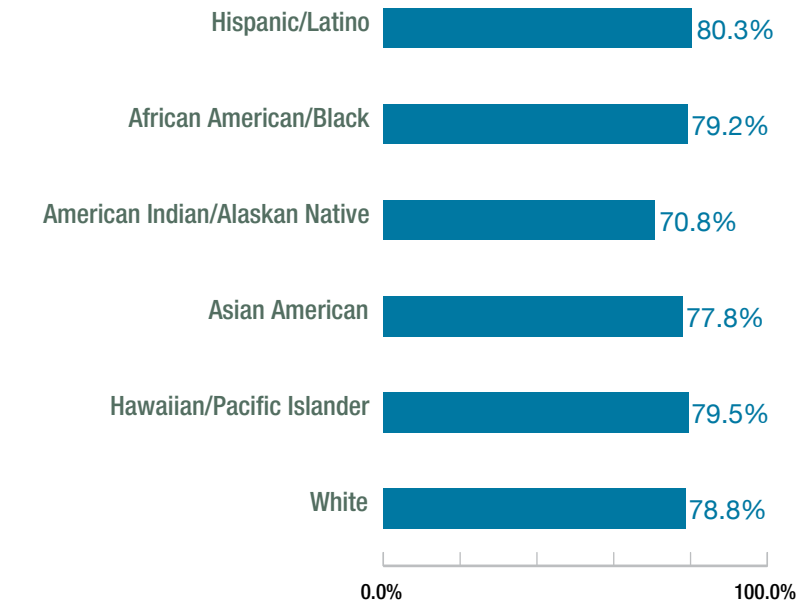
STATEWIDE



2013 n = 20,429
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

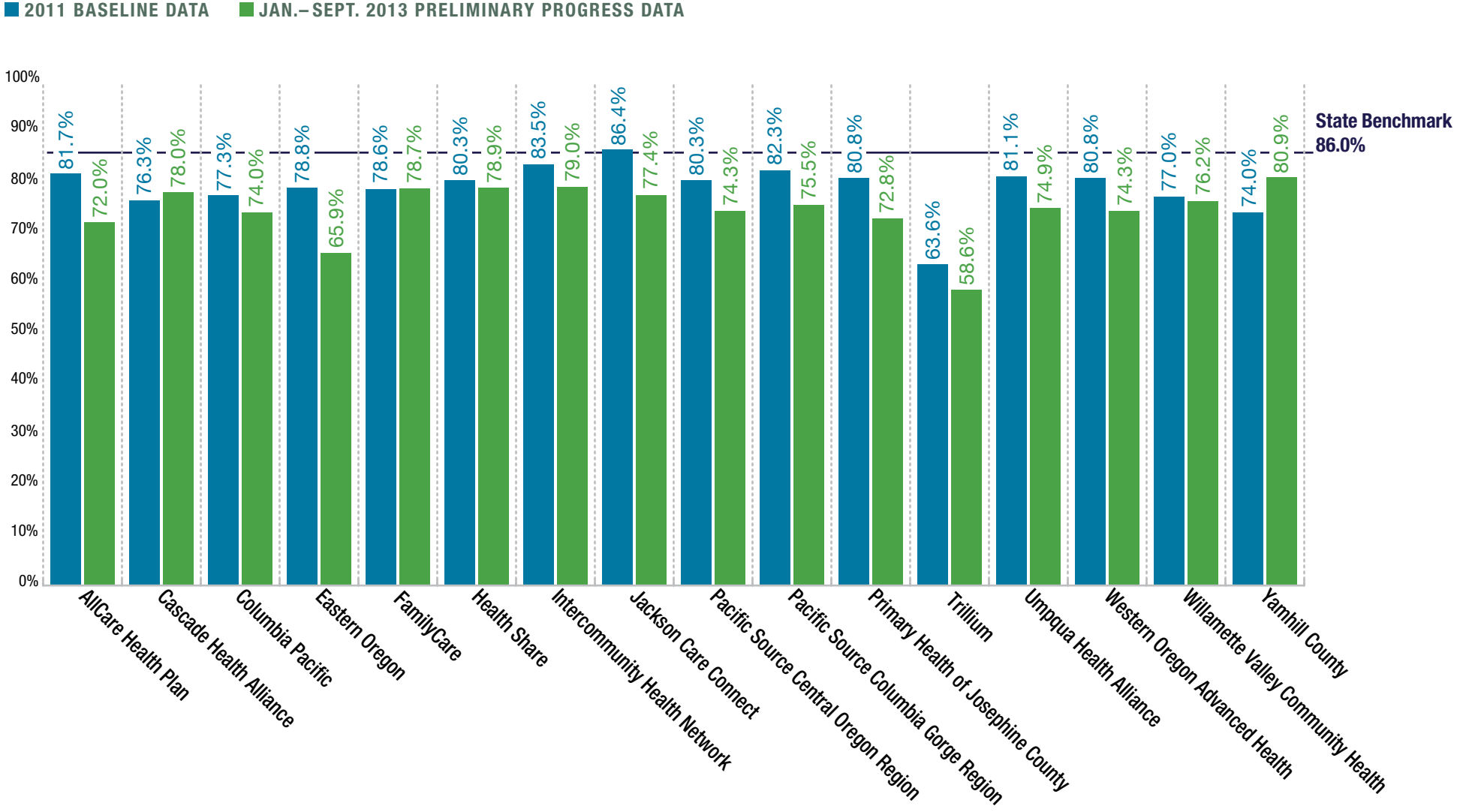


Note: Racial and ethnic information missing for 3.0% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of adult patients with diabetes who received at least one A1c blood sugar test



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

Comprehensive diabetes care: LDL-C screening

Definition: Percentage of adult patients (ages 18-75) with diabetes who received a LDL-C (cholesterol) test.

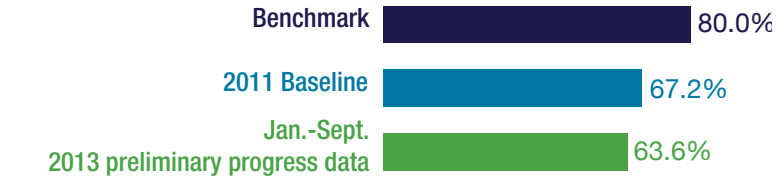
Focus area: Addressing discrete health issues.

Purpose: This test helps people with diabetes manage their condition by measuring the level of 'bad cholesterol' (LDL-C) in the blood. Managing cholesterol levels can help people with diabetes avoid problems such as heart disease and stroke.

Jan. – Sept. 2013 data

This metric tracks the percentage of adult patients with diabetes who received an LCL-C test. The 2013 preliminary data are down from the 2011 baseline. However, this metric should not be compared to the baseline or benchmark until all tests are counted at the end of 2013 when we have a full year of data.

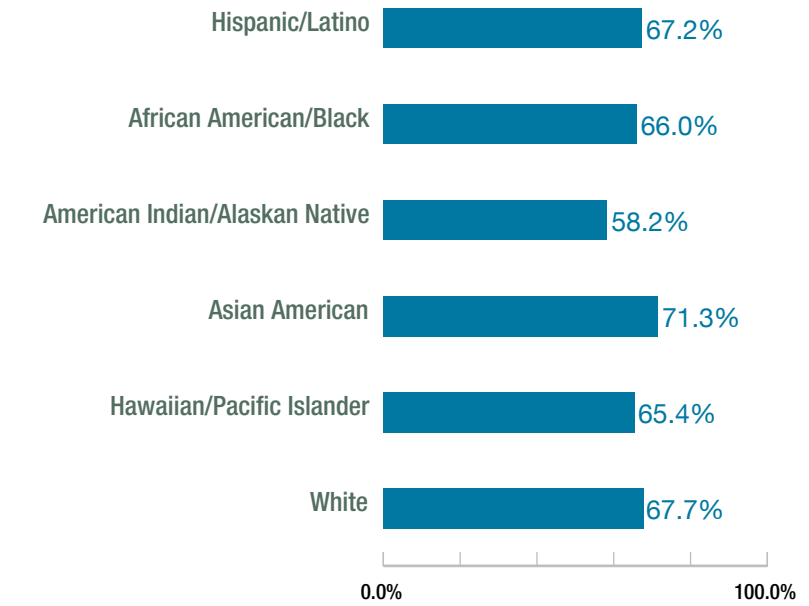
STATEWIDE



2013 n = 20,429
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

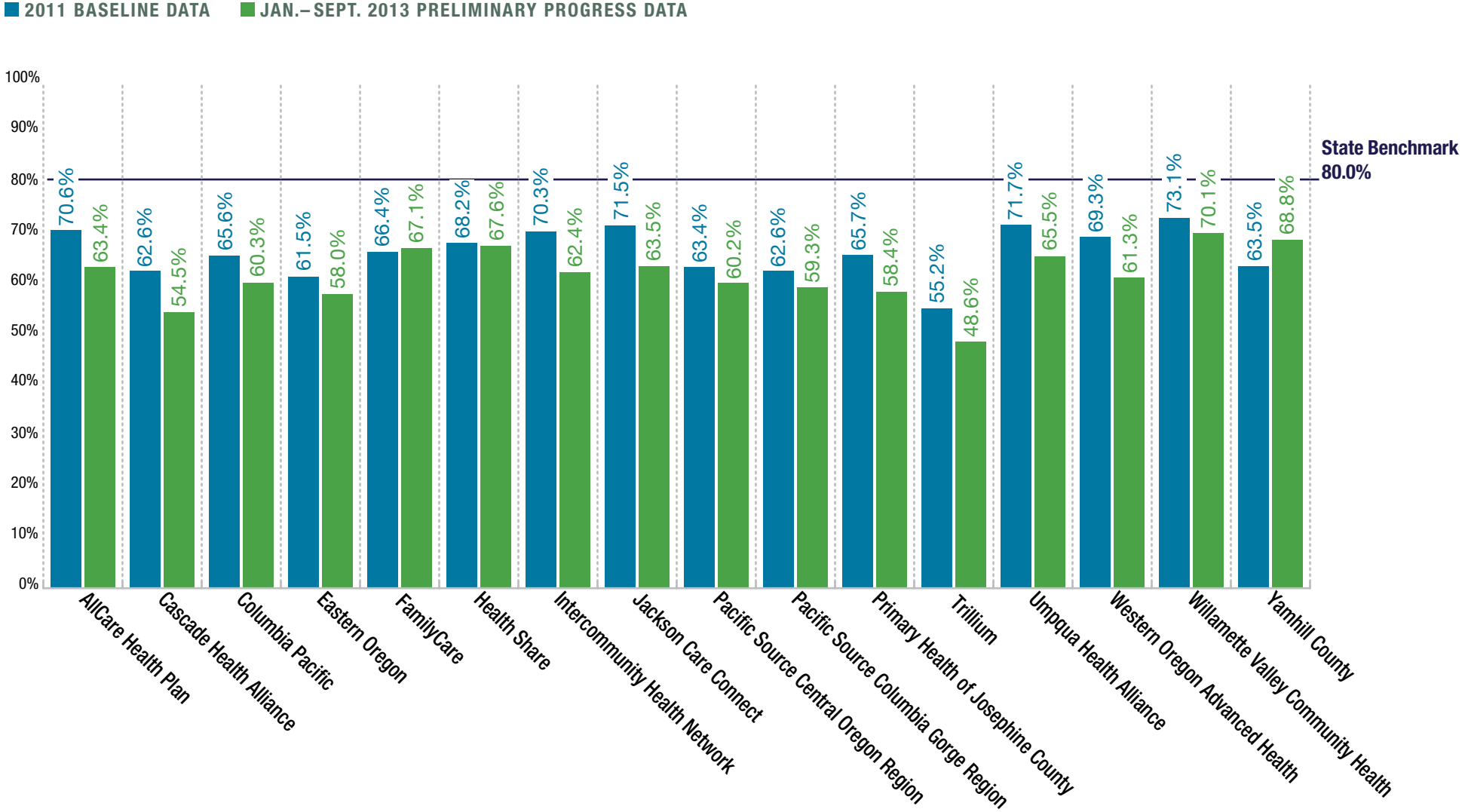


Note: Racial and ethnic information missing for 3.0% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of adult patients with diabetes who received an LDL-C (cholesterol) test



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Immunizations for adolescents

Definition: Percentage of adolescents who received recommended vaccines before their 13th birthday.

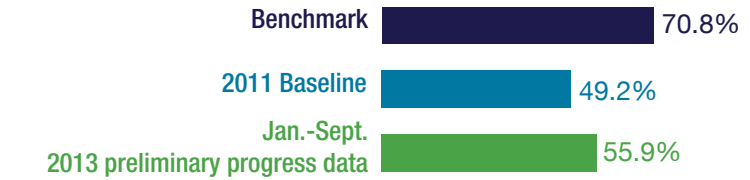
Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

Purpose: Like young children, adolescents also benefit from immunizations. Vaccines are a safe, easy and cost-effective way to prevent serious disease. Vaccines are also cost-effective tools that help to prevent the spread of serious and sometimes fatal diseases.

Jan. – Sept. 2013 data

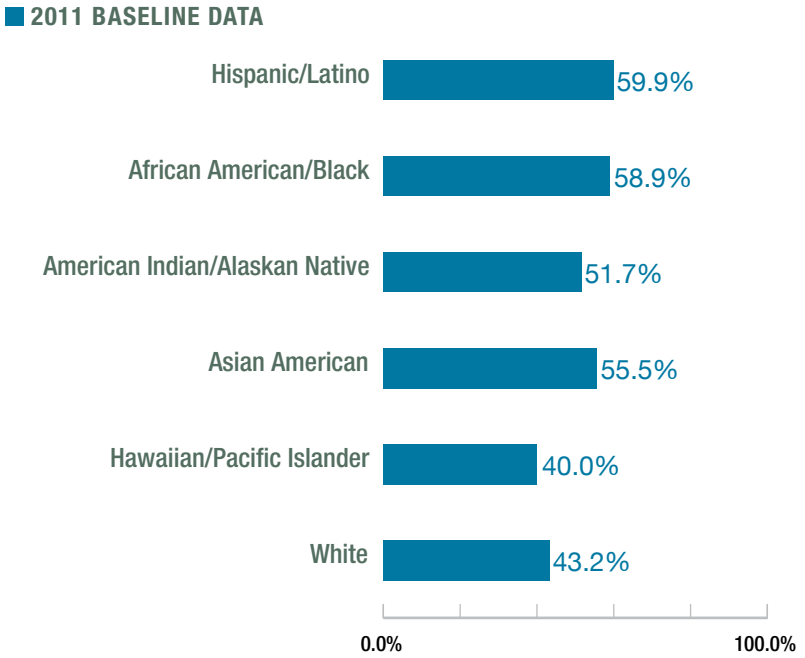
This metric tracks the percentage of adolescents who received their recommended vaccines before their 13th birthday. The preliminary 2013 data show CCOs are doing better at administering vaccines compared to the 2011 baseline. However, this metric should not be compared to the benchmark until all immunizations are counted at the end of 2013 when we have a full year of data.

STATEWIDE



2013 n = 14,877
Data source: Administrative (billing) claims and ALERT Immunization Information System
Benchmark source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA*

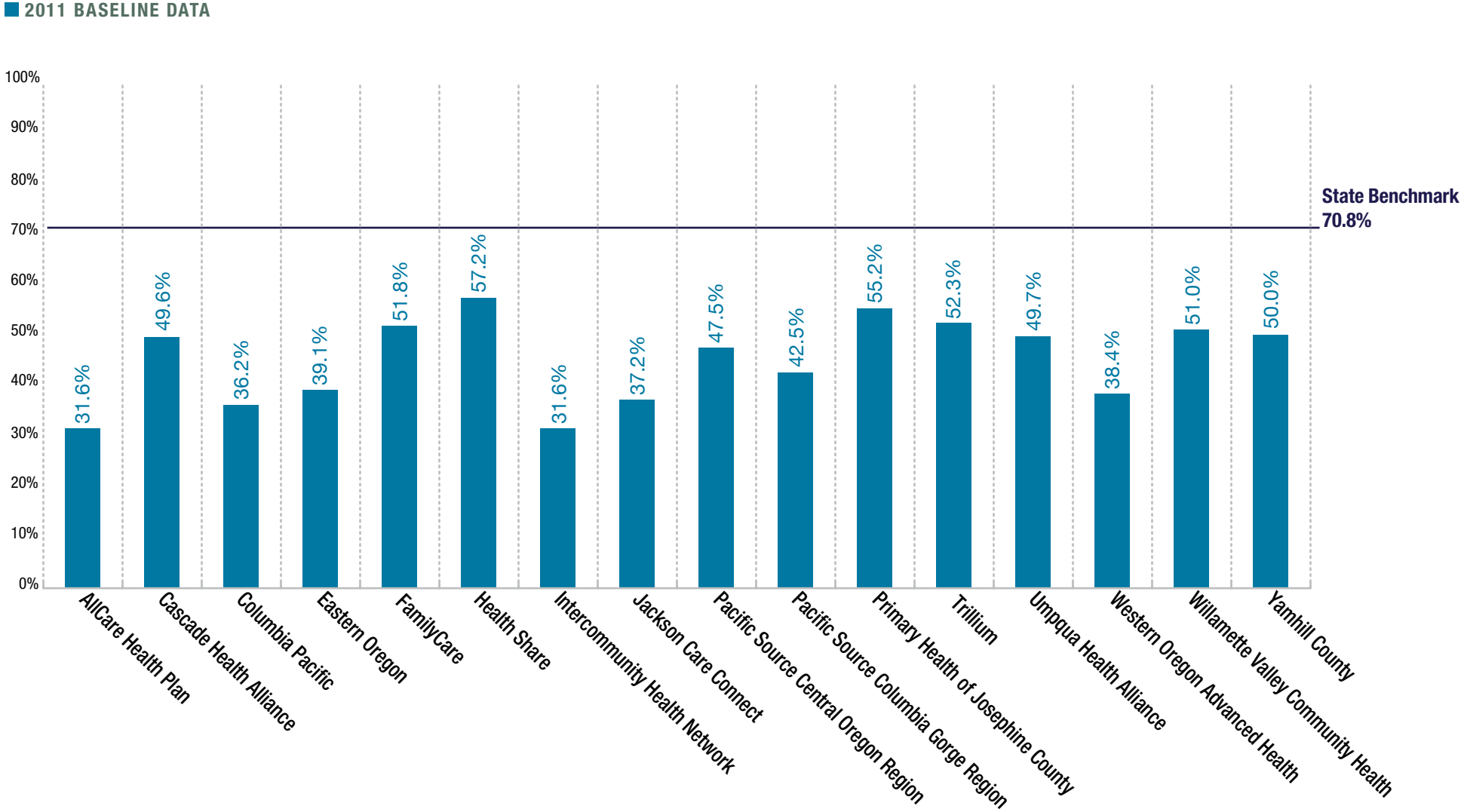


Note: Racial and ethnic information missing for 7.4% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of adolescents who got recommended vaccines before their 13th birthday



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

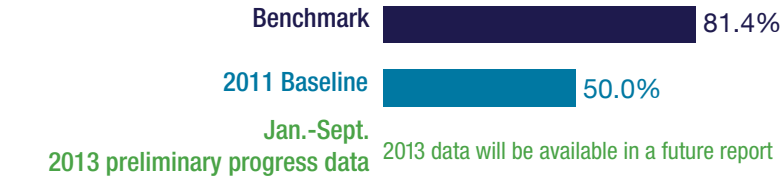
Medical assistance with smoking and tobacco use cessation

Component 1: Percentage of adult tobacco users advised to quit by their doctor.

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

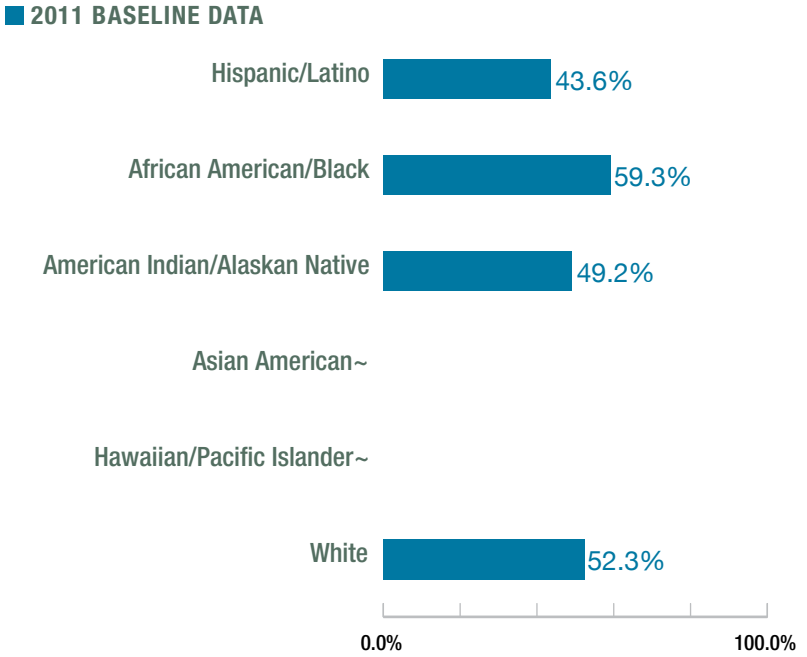
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

STATEWIDE



Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

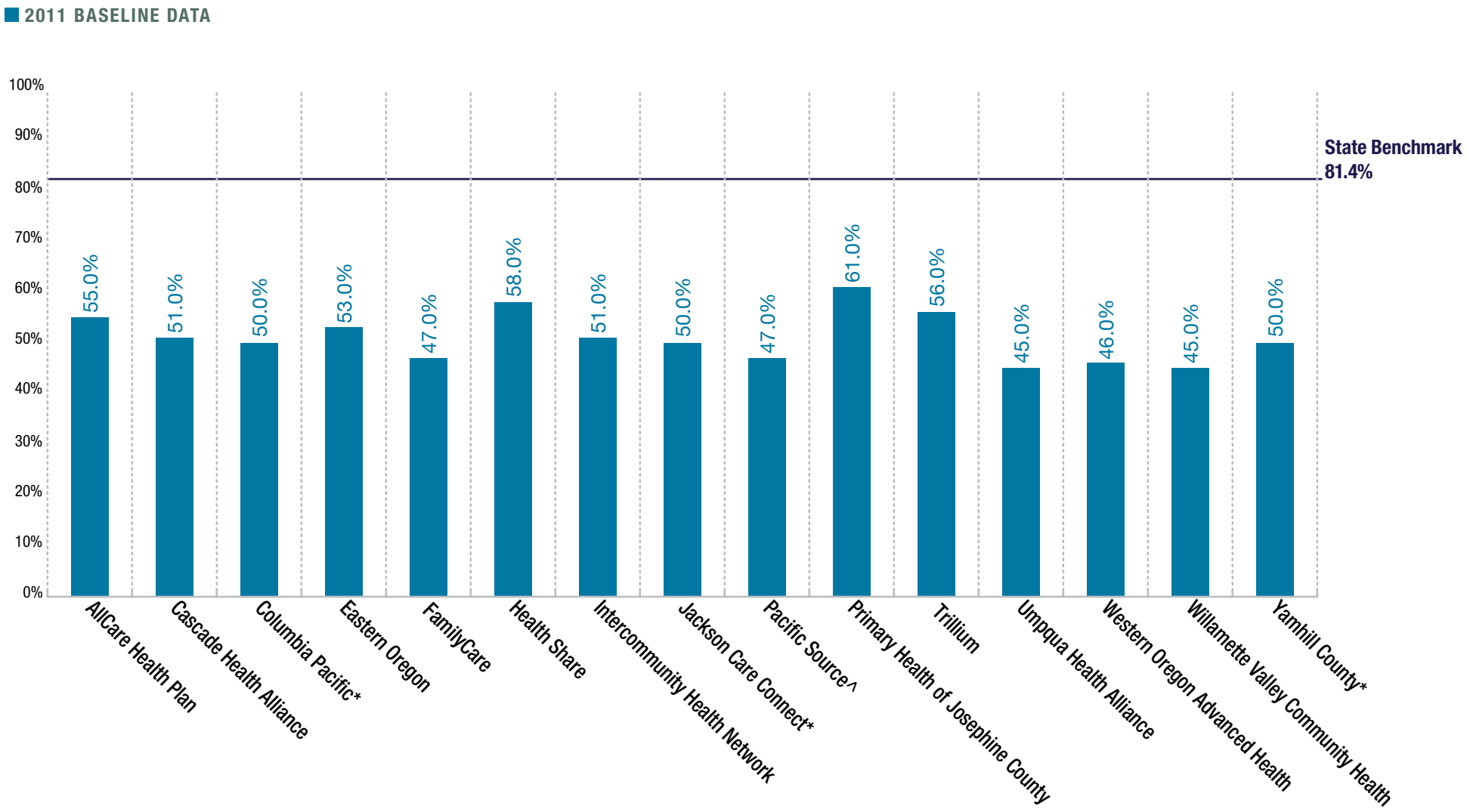


*Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Smoking and tobacco use cessation: Percentage of adult tobacco users advised to quit by their doctor



2013 CCO level data for this measure will be available in a future report.
*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

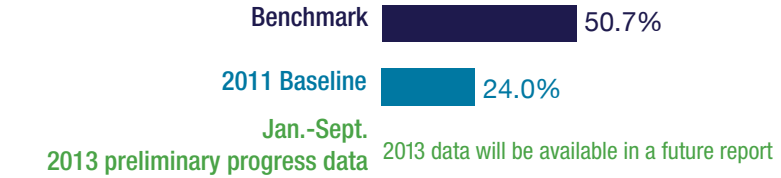
Medical assistance with smoking and tobacco use cessation

Component 2: Percentage of adult tobacco users whose doctor discussed or recommended medications to quit smoking.

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

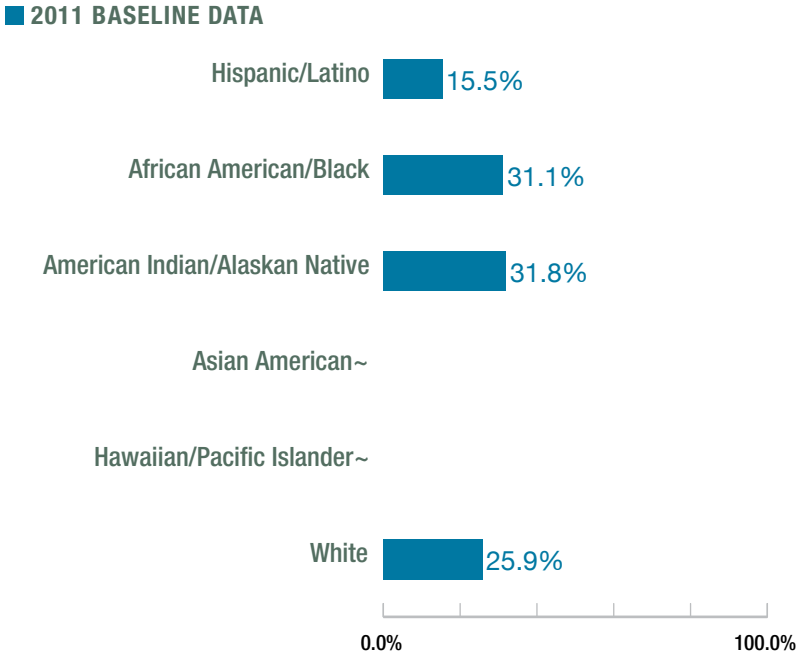
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

STATEWIDE



Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

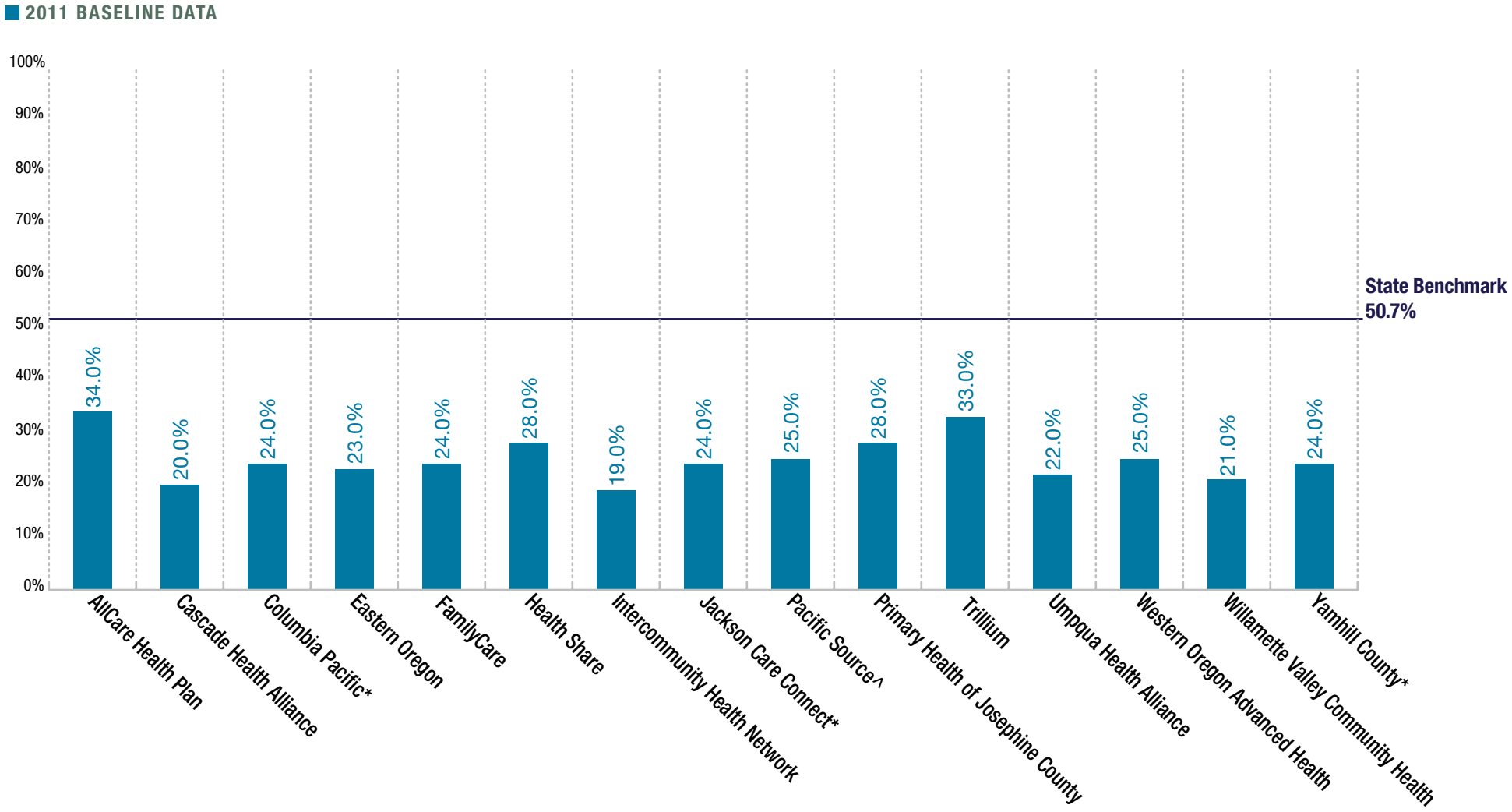


*Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Smoking and tobacco use cessation: Percentage of adult tobacco users whose doctor discussed or recommended medications to quit smoking



2013 CCO level data for this measure will be available in a future report.
*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

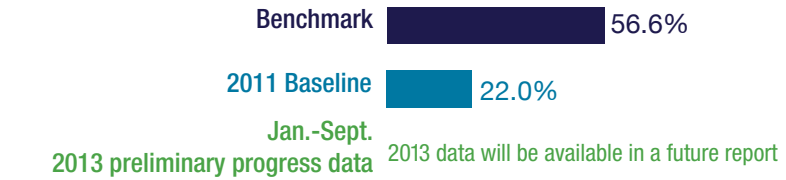
Medical assistance with smoking and tobacco use cessation

Component 3: Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking.

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

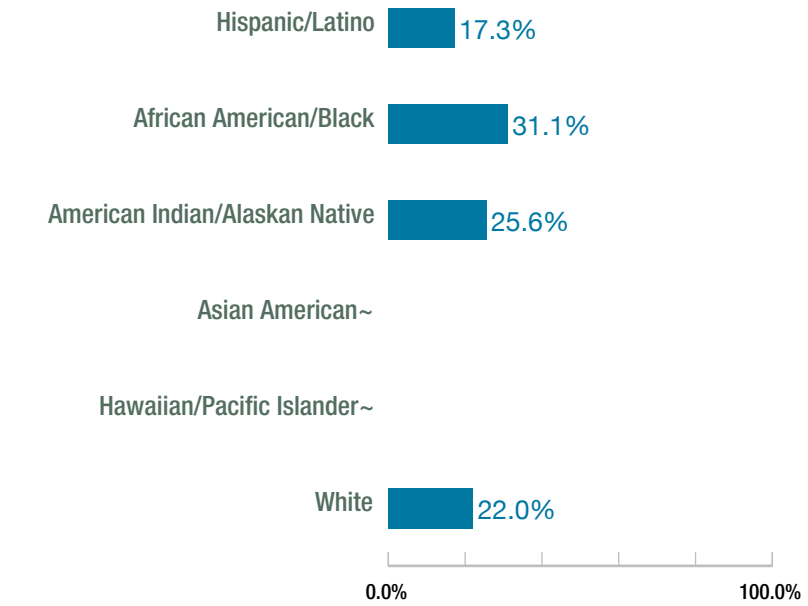
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

STATEWIDE



Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

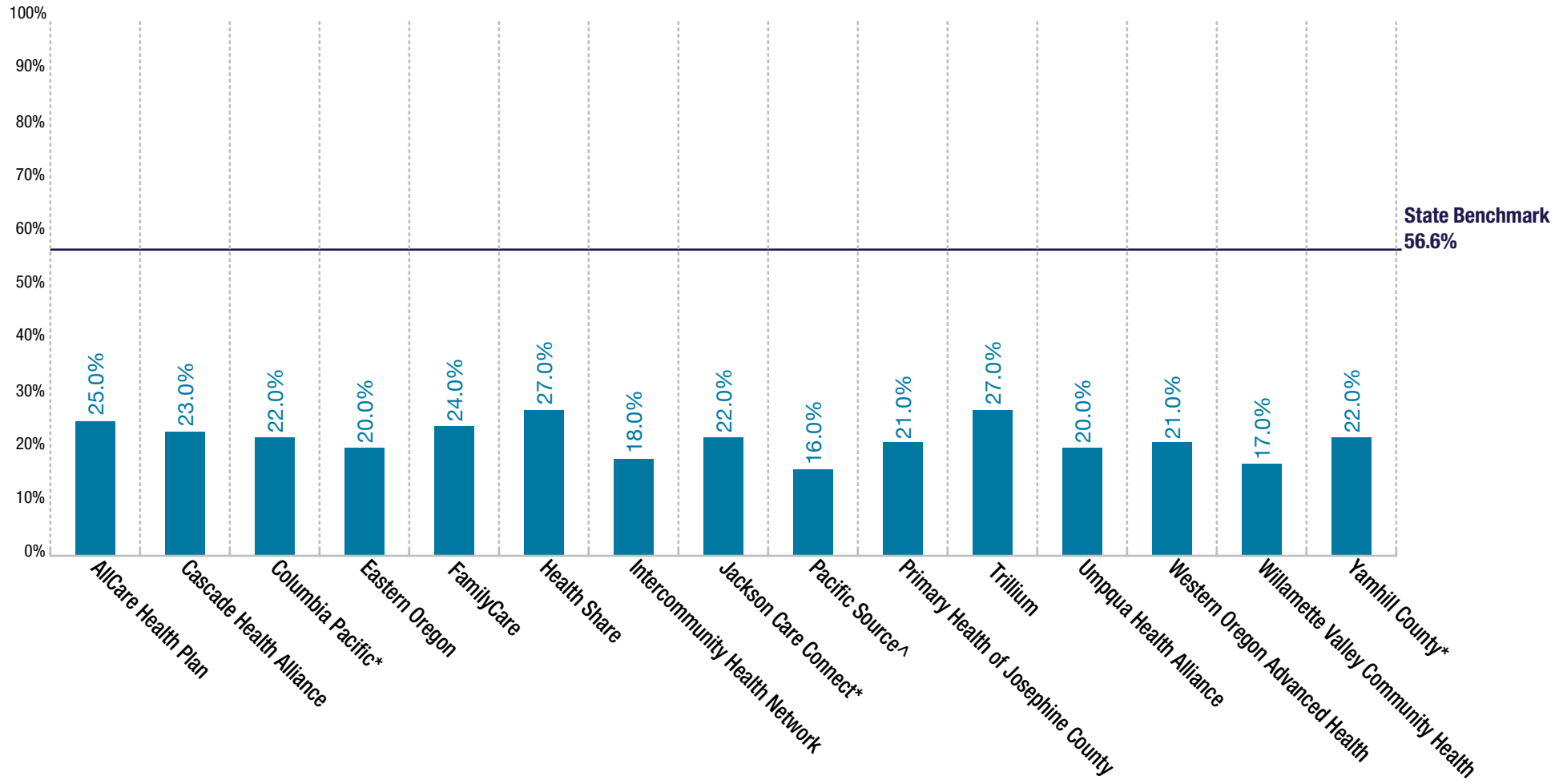


*Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Smoking and tobacco use cessation: Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking



2013 CCO level data for this measure will be available in a future report.
*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

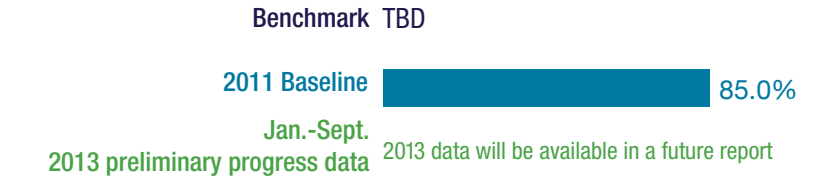
Extent to which primary care providers are accepting new Medicaid patients

Definition: Percentage of primary care providers that are accepting new Medicaid/Oregon Health Plan patients (with both no limitations and some restrictions). This information comes from the Oregon Physician Workforce Survey.

Focus area: Improving access to effective and timely care.

Purpose: Access to primary care leads to better health outcomes and more affordable health care. Improving primary care access for low-income Oregonians can also help reduce health disparities and overall health care costs.

STATEWIDE



Data source: Physician Workforce Survey

RACE AND ETHNICITY DATA

Physician Workforce Survey results cannot be stratified by race and ethnicity

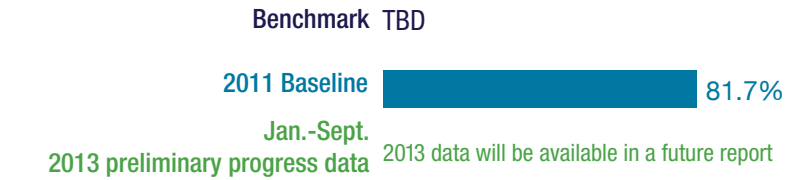
Extent to which primary care providers currently see Medicaid patients

Definition: Percentage of primary care providers that currently care for Medicaid/Oregon Health Plan patients. This information comes from the Oregon Physician Workforce Survey. It does not include "don't know" or missing.

Focus area: Improving access to effective and timely care.

Purpose: Access to primary care leads to better health outcomes and more affordable health care. Improving primary care access for low-income Oregonians can also help reduce health disparities and overall health care costs.

STATEWIDE



Data source: Physician Workforce Survey

RACE AND ETHNICITY DATA

Physician Workforce Survey results cannot be stratified by race and ethnicity

Postpartum care

Definition: Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery.

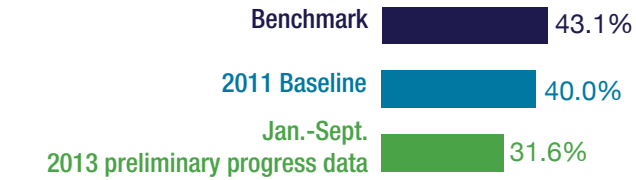
Focus areas: Improving perinatal and maternity care.

Purpose: Having a timely postpartum care visit helps increase the quality of maternal care and reduces the risks for potential health complications associated with pregnancy. Women who have a visit between 21 and 56 days after delivery can have their physical health assessed and can consult with their provider about infant care, family planning and breastfeeding.

Jan. – Sept. 2013 data

This metric tracks the percentage of women who had a timely postpartum care visit after delivery. However, this metric should not be compared to the benchmark until all postpartum care visits are counted at the end of 2013 when we have a full year of data.

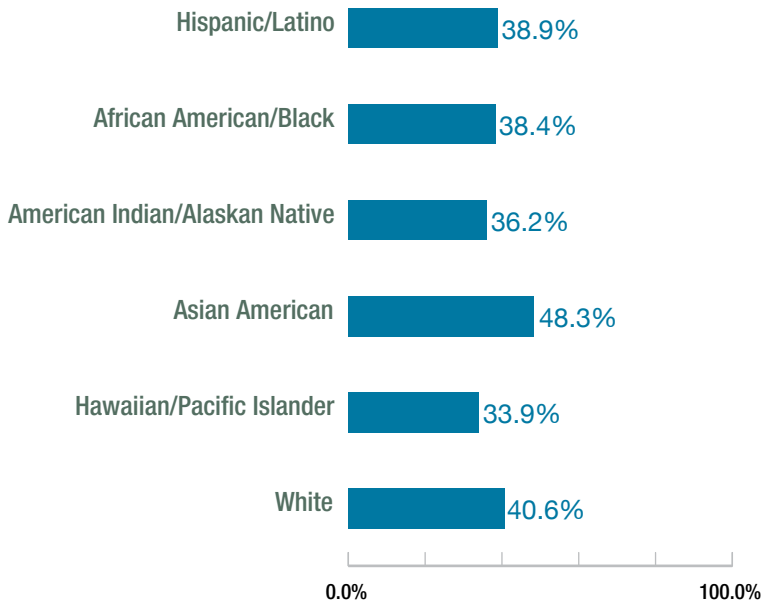
STATEWIDE



2013 n = 13,014
Data Source: Administrative (billing) claims
Benchmark Source: 2012 national Medicaid 75th percentile (administrative data only, adjusted)

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

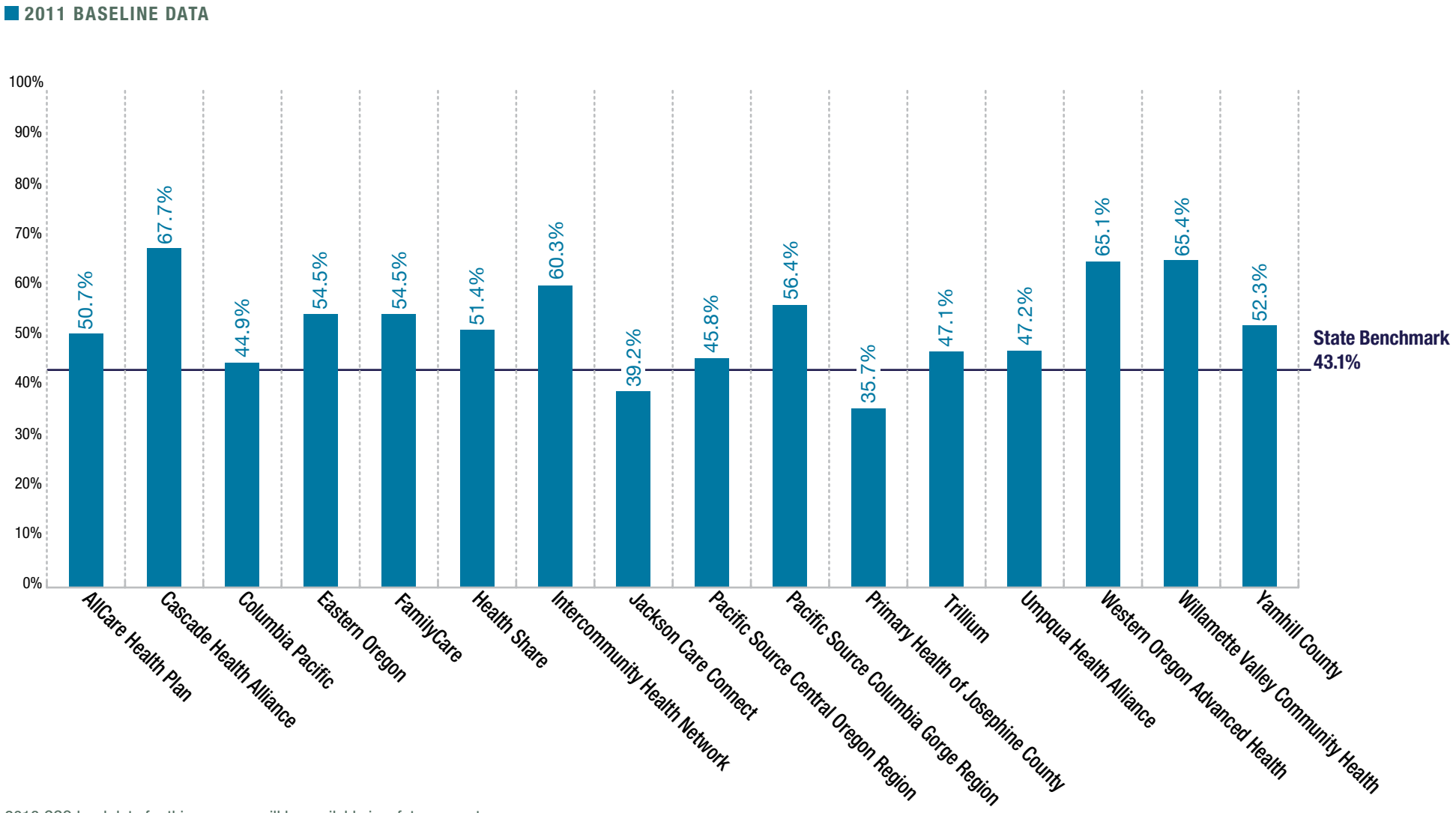


Note: Racial and ethnic information missing for 9.0% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Diabetes short term complications admission rate (PQI 1)*

Definition: Rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease. Rates are reported per 100,000 member years. A lower score is better. PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

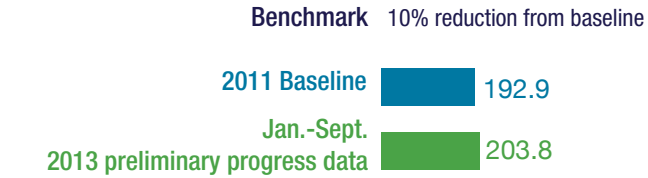
Focus area: Addressing discrete health issues.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce the costs of health care.

Jan. – Sept. 2013 data

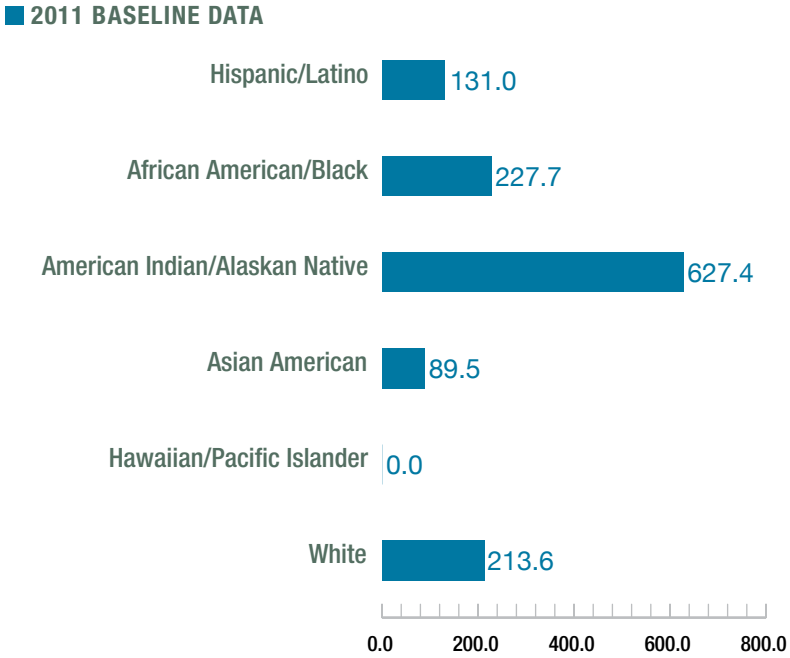
This metric tracks hospital use for adult patients with diabetes that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years, which means the January through September 2013 data is directly comparable to annual data, including the 2011 baseline.

STATEWIDE



2013 n = 2,025,495 (member months)
Data source: Administrative (billing) claims

RACE AND ETHNICITY DATA*

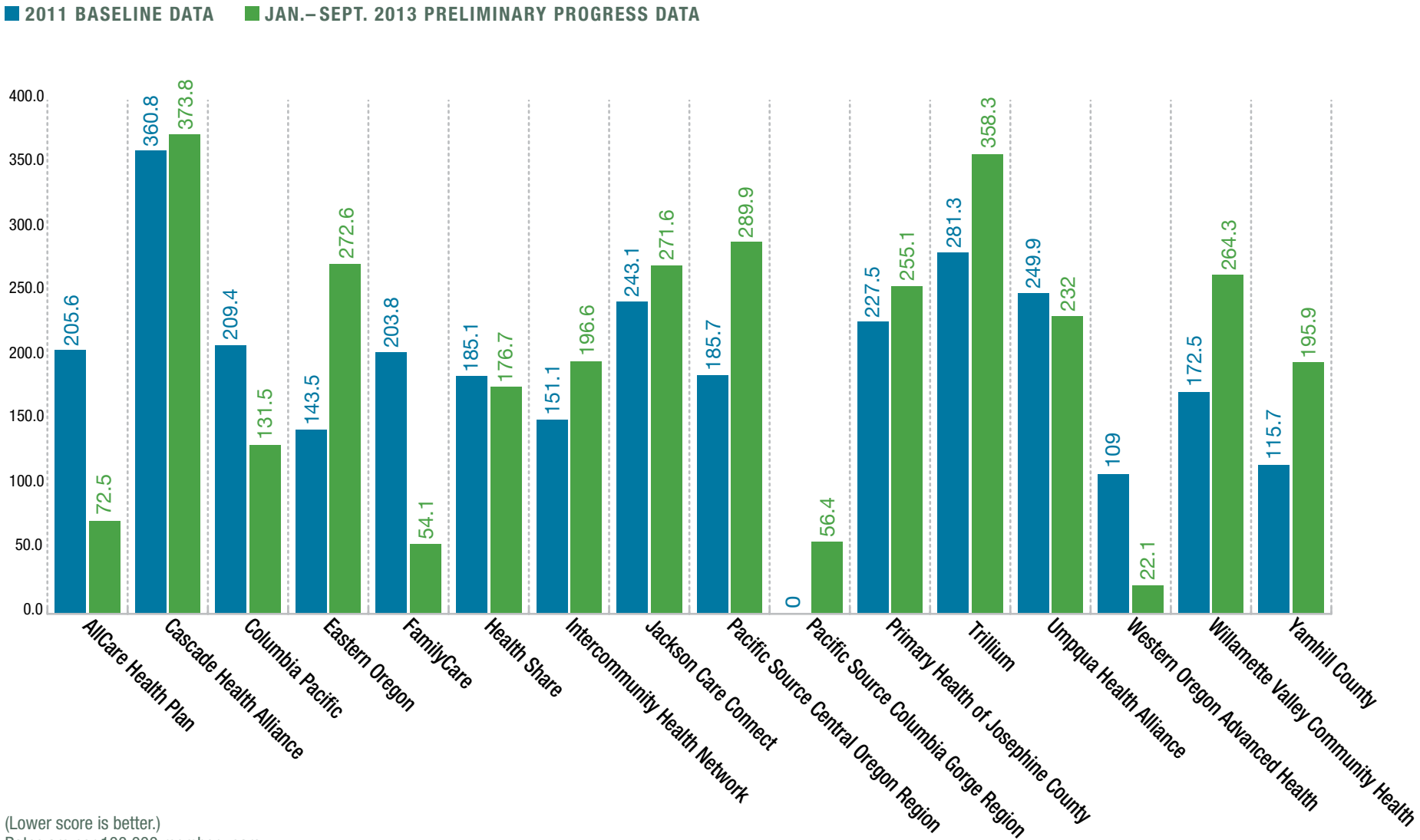


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino
(Lower score is better.)

PERFORMANCE METRICS

State Performance Measures

PQI 1*: Rate of adult patients with diabetes who had a hospital stay because of a short-term problem from their disease



(Lower score is better.)
Rates are per 100,000 member years
Benchmark is 10% reduction from baseline
*PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate (PQI 5)*

Definition: Rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma. Rates are reported per 100,000 member years. A lower score is better. PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

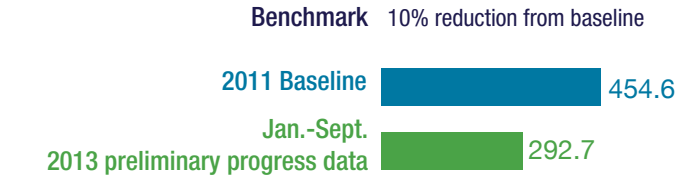
Focus area: Addressing discrete health issues.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce the costs of health care.

Jan. – Sept. 2013 data

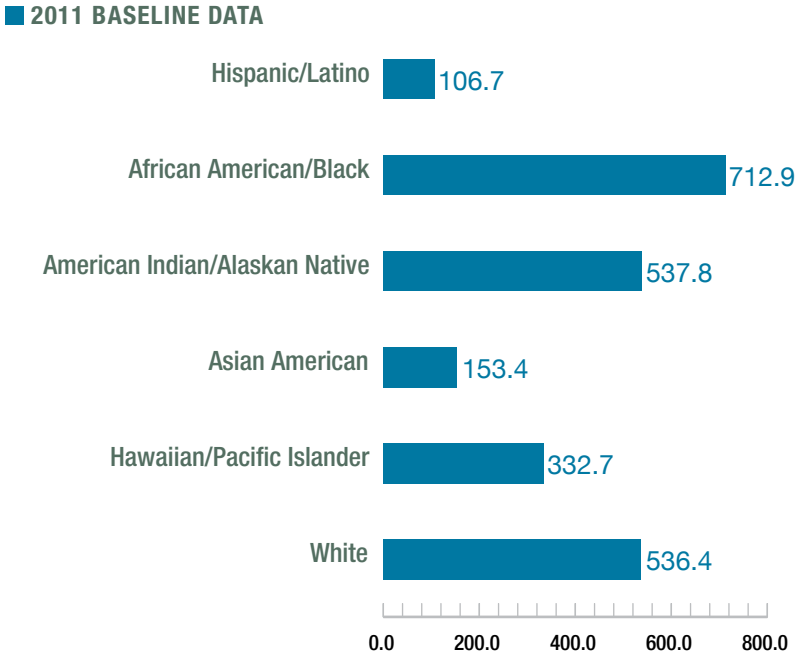
This metric tracks hospital use for older adults with chronic obstructive pulmonary disease or asthma, diseases that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years, which means the January through September 2013 data are directly comparable to annual data, including the 2011 baseline. This metric shows a preliminary trend toward lower hospital utilization for this chronic condition.

STATEWIDE



2013 n = 2,025,495 (member months)
Data source: Administrative (billing) claims

RACE AND ETHNICITY DATA*

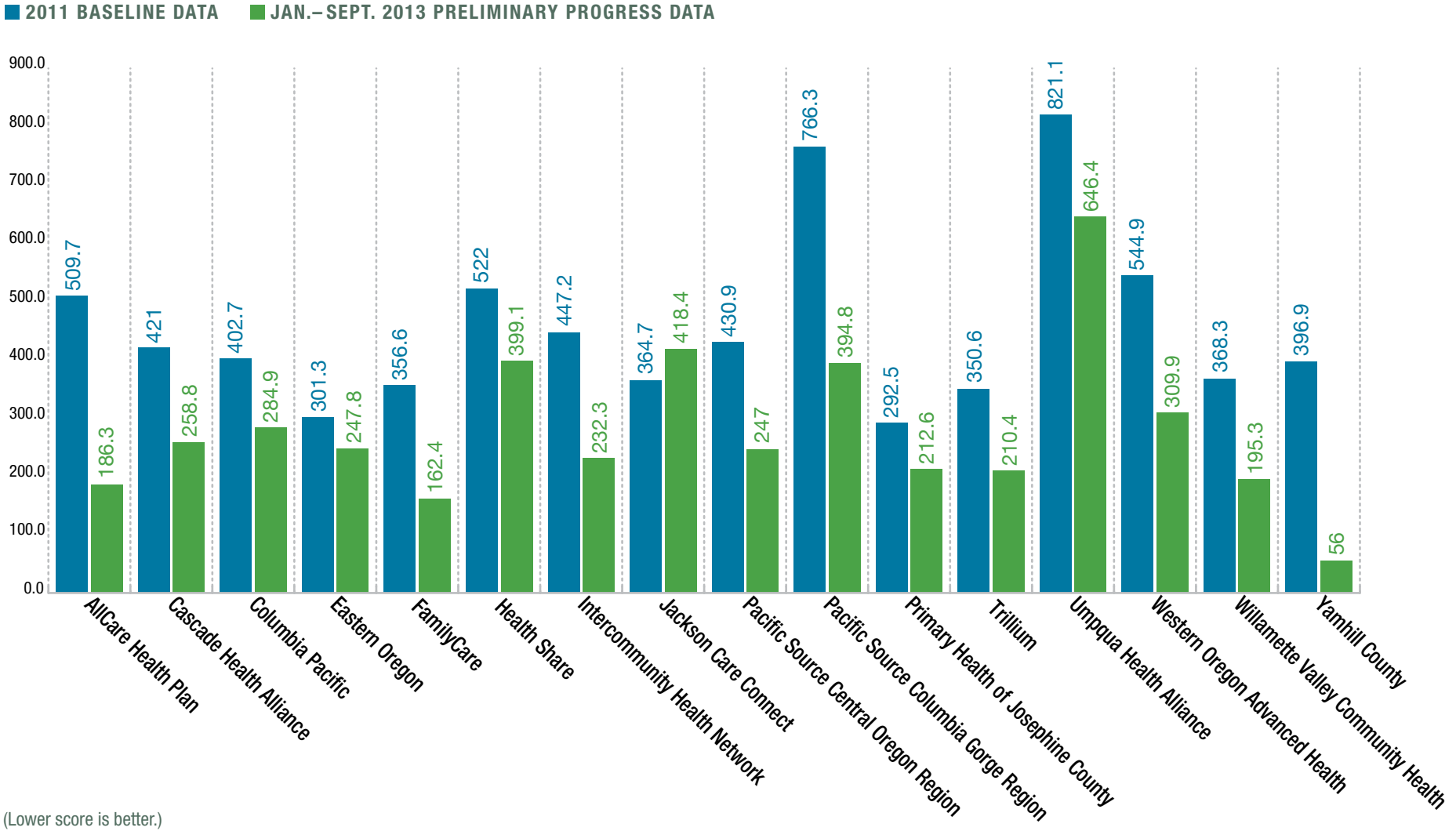


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino
(Lower score is better.)

PERFORMANCE METRICS

State Performance Measures

PQI 5*: Rate of adult patients (ages 40 and older) who had a hospital stay because of asthma or chronic obstructive pulmonary disease



(Lower score is better.)
Rates are per 100,000 member years
Benchmark is 10% reduction from baseline
*PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Congestive heart failure admission rate (PQI 8)*

Definition: Rate of adult patients (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better. PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

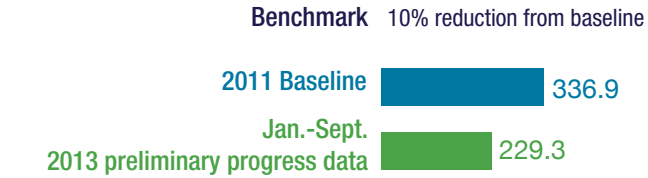
Focus area: Addressing discrete health issues.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce the costs of health care.

Jan. – Sept. 2013 data

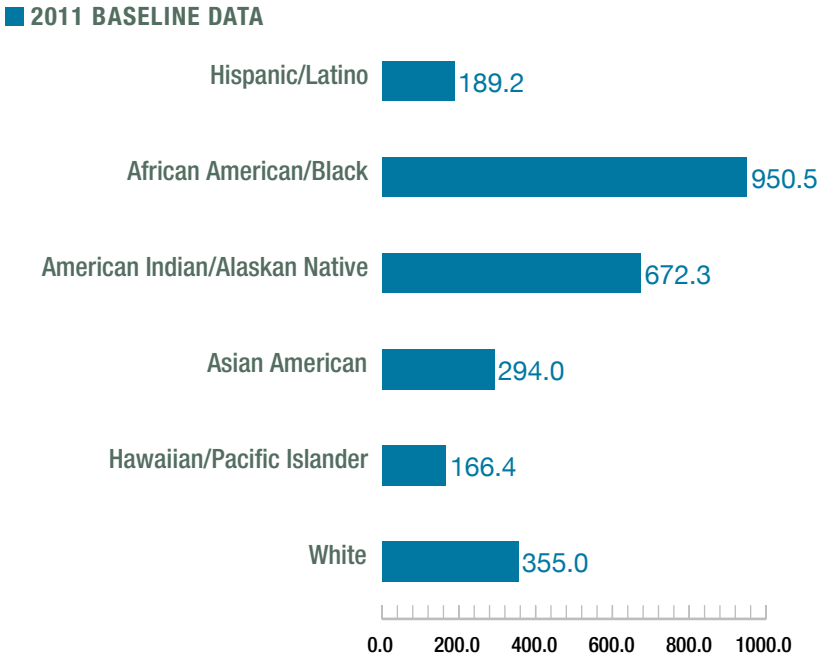
This metric tracks hospital use for adults with congestive health failure that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years, which means the January through September 2013 data is directly comparable to annual data, including the 2011 baseline. This metric shows a preliminary trend toward lower hospital utilization for this chronic condition.

STATEWIDE



2013 n = 2,025,495 (member months)
Data source: Administrative (billing) claims

RACE AND ETHNICITY DATA*

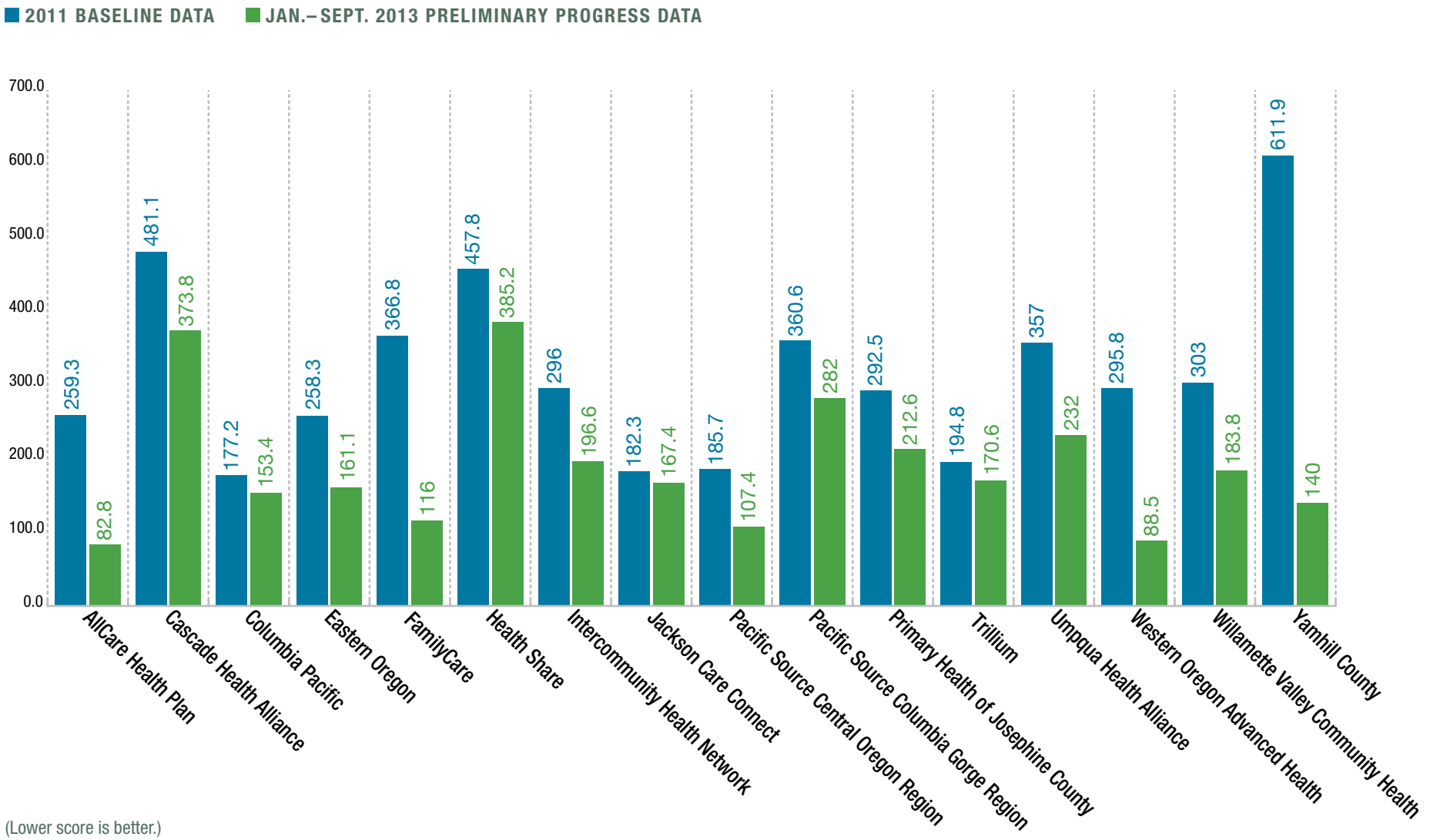


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino
(Lower score is better.)

PERFORMANCE METRICS

State Performance Measures

PQI 8*: Rate of adult patients who had a hospital stay because of congestive heart failure



(Lower score is better.)
Rates are per 100,000 member years
Benchmark is 10% reduction from baseline
*PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Adult (ages 18-39) asthma admission rate (PQI 15)*

Definition: Rate of adult patients (ages 18-39) who had a hospital stay because of asthma. Rates are reported per 100,000 member years. A lower score is better. PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

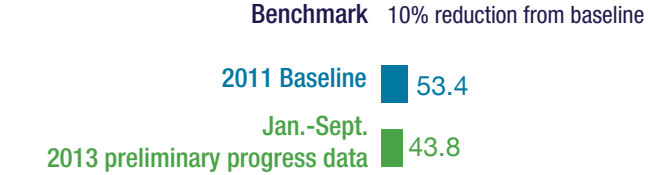
Focus area: Addressing discrete health issues.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce the costs of health care.

Jan. – Sept. 2013 data

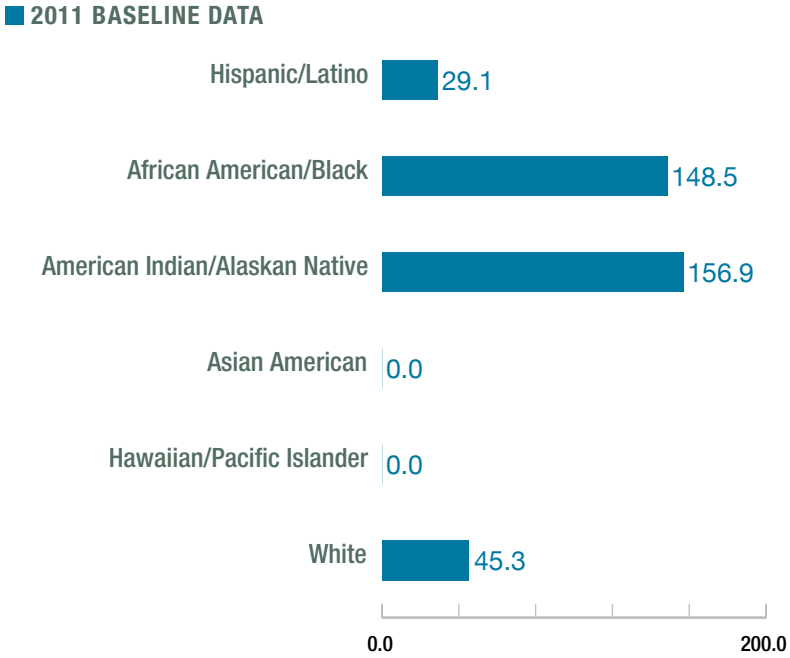
This metric tracks hospital use for adults with asthma that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years, which means the January through September 2013 data is directly comparable to annual data, including the 2011 baseline. This metric shows a preliminary trend toward lower hospital utilization for this chronic condition.

STATEWIDE



2013 n = 2,025,495 (member months)
Data source: Administrative (billing) claims

RACE AND ETHNICITY DATA*

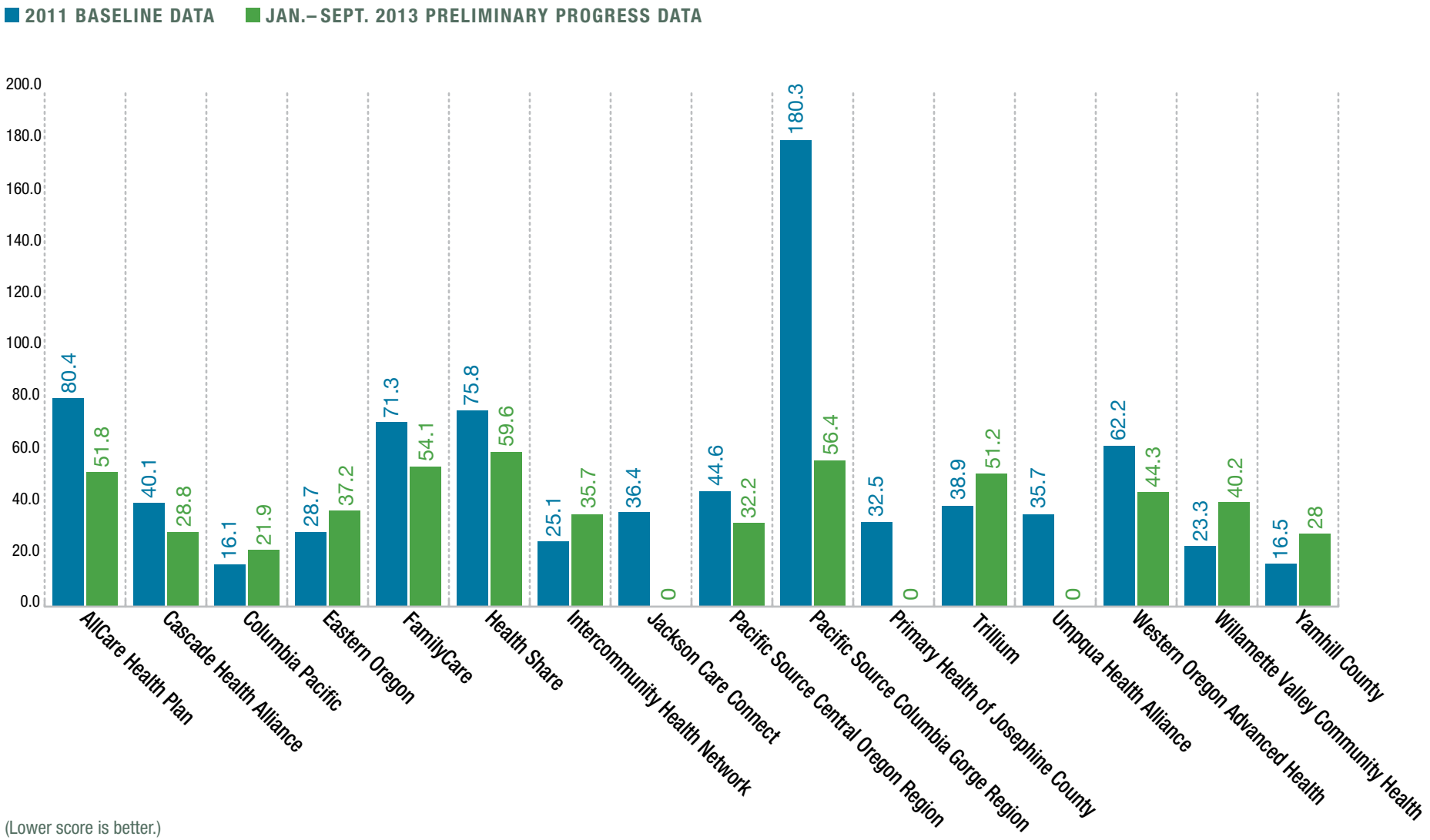


Note: Racial and ethnic information missing for 8.5% of respondents
*Each race category excludes Hispanic/Latino
(Lower score is better.)

PERFORMANCE METRICS

State Performance Measures

PQI 15*: Rate of adult patients (ages 18-39) who had a hospital stay because of asthma



(Lower score is better.)
Rates are per 100,000 member years
Benchmark is 10% reduction from baseline
*PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Well-child visits in the first 15 months of life

Definition: Percentage of children up to 15-months-old who had at least six well-child visits with a health care provider.

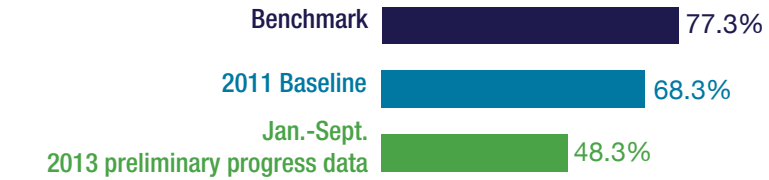
Focus areas: Improving access to effective and timely care; improving primary care for all populations; and ensuring appropriate care is delivered in appropriate settings.

Purpose: Regular well-child visits are one of the best ways to detect physical, developmental, behavioral and emotional problems in infants. They are also an opportunity for providers to offer guidance and counseling to parents.

Jan. – Sept. 2013 data

This metric tracks the percentage of children up to 15-months-old who had at least six well-child visits with a health care provider. The percentage through September 2013 shows the progress toward the goal on this metric and should not be compared to the 2011 baseline or benchmark until all visits are counted at the end of 2013 when we have a full year of data.

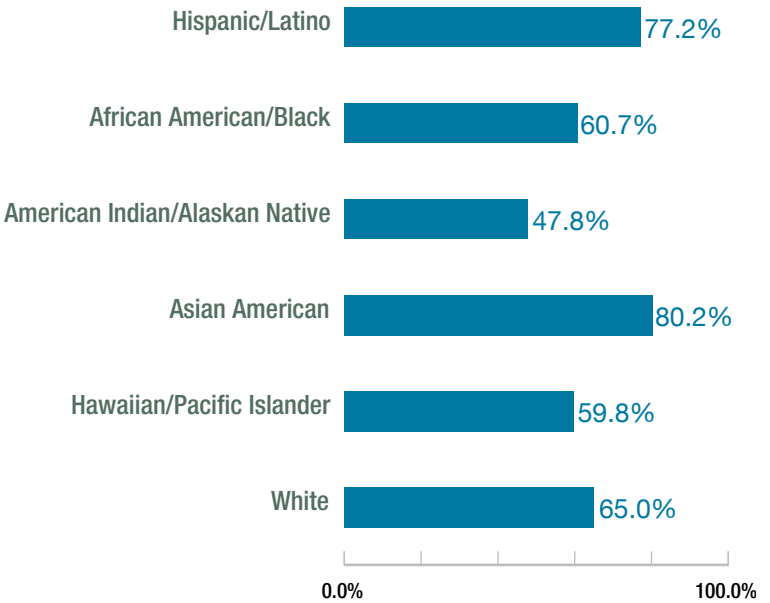
STATEWIDE



2013 n = 5,303
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

RACE AND ETHNICITY DATA*

2011 BASELINE DATA

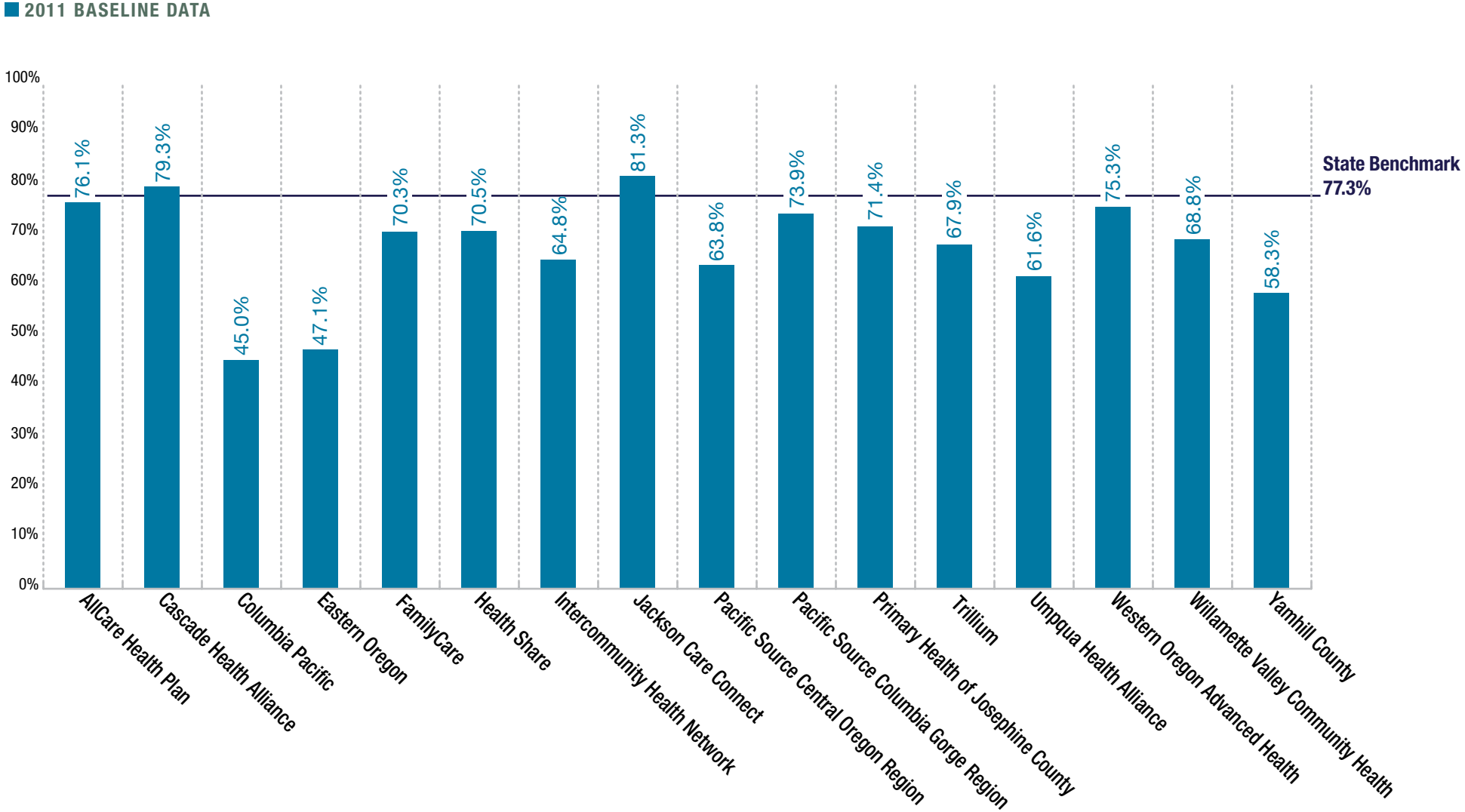


Note: Racial and ethnic information missing for 11.9% of respondents
*Each race category excludes Hispanic/Latino

PERFORMANCE METRICS

State Performance Measures

Percentage of children up to 15 months old who had at least six well-child visits with a health care provider



2013 CCO level data for this measure will be available in a future report.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

COST AND UTILIZATION DATA
Quarterly Data

UTILIZATION DATA STATEWIDE

CATEGORY	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 *	JAN-MAR 2013 *	APR-JUN 2013 *	JUL-SEP 2013 *	OCT 2012 - SEP 2013 AVERAGE
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)							
Inpatient – Medical / General – Patient Days	161.1	****	166.4	187.1	152.0	127.8	158.3
Inpatient – Medical / Rehabilitation – Patient Days	3.0	****	3.3	3.0	2.4	2.3	2.8
Inpatient – Surgical – Patient Days	81.5	****	80.8	78.9	71.1	62.2	73.2
Inpatient – Maternity / Normal Delivery – Patient Days	45.8	****	39.3	42.5	40.7	39.4	40.5
Inpatient – Maternity / C-Section Delivery – Patient Days	27.5	****	21.0	22.7	22.2	23.0	22.2
Inpatient – Maternity / Non-Delivery – Patient Days	9.0	****	6.6	7.2	7.7	6.6	7.0
Inpatient – Newborn / Well – Patient Days	40.0	****	35.0	37.7	36.1	27.4	34.0
Inpatient – Newborn / With Complications – Patient Days	51.7	****	46.0	39.4	45.0	30.4	40.2
Inpatient – Mental Health / Psychiatric – Patient Days	53.1	****	51.8	47.6	43.1	31.1	43.4
Inpatient – Mental Health / Alcohol and Drug Abuse – Patient Days	5.7	****	6.6	4.9	6.2	5.1	5.7
Outpatient – Primary Care Medical Visits (Includes Immun/Inject)	2,655.2	****	3,111.0	3,390.3	3,016.0	2,794.2	3,077.9
Outpatient – Specialty Care Visits	4,163.5	****	3,990.7	3,932.9	3,657.0	3,509.7	3,772.6
Outpatient – Mental Health Visits	885.4	****	983.1	771.0	724.5	603.9	770.6
Outpatient – Dental Visits (preventative)	475.5	****	471.2	518.0	521.4	416.2	481.7
Outpatient – Emergency Dept Visits	SEE AMBULATORY CARE ED UTILIZATION METRIC ON PAGE 14						
Outpatient – Pharmacy Prescriptions Filled	9,490.9	****	8,902.3	9,419.7	8,710.0	8,831.6	8,965.9
Outpatient – Labs and Radiology (Service Units)	4,858.9	****	4,617.1	4,967.2	4,898.2	4,655.2	4,784.4
Outpatient – Freestanding ASC Procedures	25.4	****	22.0	24.7	25.3	23.1	23.8

For footnote explanations, see page 94.

COST AND UTILIZATION DATA
Quarterly Data

UTILIZATION DATA BY CCO, OCT.-DEC. 2012, TABLE 1 OF 4

CATEGORY	STATEWIDE	ALLCARE HEALTH PLAN, INC.	CASCADE COMPREHENSIVE CARE	COLUMBIA PACIFIC CCO, LLC
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)				
Inpatient – Medical / General – Patient Days	166.4	126.0	175.4	107.5
Inpatient – Medical / Rehabilitation – Patient Days	3.3	10.6	0.0	6.0
Inpatient – Surgical – Patient Days	80.8	55.4	144.0	98.0
Inpatient – Maternity / Normal Delivery – Patient Days	39.3	36.8	38.3	40.7
Inpatient – Maternity / C-Section Delivery – Patient Days	21.0	23.0	49.4	21.3
Inpatient – Maternity / Non-Delivery – Patient Days	6.6	3.5	10.6	2.2
Inpatient – Newborn / Well – Patient Days	35.0	37.3	33.9	37.2
Inpatient – Newborn / With Complications – Patient Days	46.0	37.9	57.9	34.4
Inpatient – Mental Health / Psychiatric – Patient Days	51.8	9.7	N/A	73.2
Inpatient – Mental Health / Alcohol and Drug Abuse – Patient Days	6.6	5.6	N/A	11.5
Outpatient – Primary Care Medical Visits (Includes Immun/Inject)	3,111.0	3,151.1	2,646.6	2,944.9
Outpatient – Specialty Care Visits	3,990.7	3,607.4	3,102.6	2,290.3
Outpatient – Mental Health Visits	983.1	566.8	N/A	948.1
Outpatient – Emergency Dept Visits	SEE AMBULATORY CARE ED UTILIZATION METRIC ON PAGE 14			
Outpatient – Pharmacy Prescriptions Filled	8,902.3	8,722.8	8,319.1	10,244.9
Outpatient – Labs and Radiology (Service Units)	4,617.1	4,497.4	3,664.6	4,105.0
Outpatient – Freestanding ASC Procedures	22.0	30.5	7.3	13.1

For footnote explanations, see page 94.

COST AND UTILIZATION DATA

Quarterly Data

UTILIZATION DATA BY CCO, OCT.-DEC. 2012, TABLE 2 OF 4

CATEGORY	EASTERN OREGON CCO	FAMILY CARE CCO	HEALTH SHARE OF OREGON	INTERCOMMUNITY HEALTH NETWORK CCO
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)				
Inpatient – Medical / General – Patient Days	114.0	Data Pending	200.3	213.6
Inpatient – Medical / Rehabilitation – Patient Days	5.8	Data Pending	2.9	2.0
Inpatient – Surgical – Patient Days	55.0	Data Pending	94.1	127.0
Inpatient – Maternity / Normal Delivery – Patient Days	48.1	Data Pending	31.8	40.7
Inpatient – Maternity / C-Section Delivery – Patient Days	25.0	Data Pending	20.4	25.8
Inpatient – Maternity / Non-Delivery – Patient Days	8.1	Data Pending	8.2	3.9
Inpatient – Newborn / Well – Patient Days	39.1	Data Pending	29.5	28.6
Inpatient – Newborn / With Complications – Patient Days	58.8	Data Pending	43.0	66.7
Inpatient – Mental Health / Psychiatric – Patient Days	20.8	Data Pending	84.9	30.1
Inpatient – Mental Health / Alcohol and Drug Abuse – Patient Days	5.3	Data Pending	13.4	0.9
Outpatient – Primary Care Medical Visits (Includes Immun/Inject)	1,495.3	2,814.2	3,178.9	3,572.8
Outpatient – Specialty Care Visits	3,634.1	3,685.2	4,422.0	3,242.1
Outpatient – Mental Health Visits	742.0	864.0	1,383.3	629.3
Outpatient – Emergency Dept Visits	SEE AMBULATORY CARE ED UTILIZATION METRIC ON PAGE 14			
Outpatient – Pharmacy Prescriptions Filled	8,414.3	6,452.0	9,258.1	11,405.0
Outpatient – Labs and Radiology (Service Units)	3,865.5	4,020.3	4,633.4	4,653.0
Outpatient – Freestanding ASC Procedures	6.3	9.7	14.2	18.9

For footnote explanations, see page 94.

COST AND UTILIZATION DATA

Quarterly Data

UTILIZATION DATA BY CCO, OCT.-DEC. 2012, TABLE 3 OF 4

CATEGORY	JACKSON CARE CONNECT	PACIFICSOURCE COMM. SOLUTIONS	PRIMARY HEALTH JOSEPHINE CO CCO	TRILLIUM COMM. HEALTH PLAN
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)				
Inpatient – Medical / General – Patient Days	129.4	132.1	124.4	172.8
Inpatient – Medical / Rehabilitation – Patient Days	5.9	1.7	0.0	3.3
Inpatient – Surgical – Patient Days	77.8	67.5	39.0	81.0
Inpatient – Maternity / Normal Delivery – Patient Days	32.3	43.6	8.2	34.7
Inpatient – Maternity / C-Section Delivery – Patient Days	20.4	21.6	14.4	27.7
Inpatient – Maternity / Non-Delivery – Patient Days	5.9	8.6	8.2	5.1
Inpatient – Newborn / Well – Patient Days	20.2	33.8	13.0	34.0
Inpatient – Newborn / With Complications – Patient Days	79.3	47.7	10.9	57.6
Inpatient – Mental Health / Psychiatric – Patient Days	25.5	39.5	0.0	51.1
Inpatient – Mental Health / Alcohol and Drug Abuse – Patient Days	0.4	4.6	15.7	2.8
Outpatient – Primary Care Medical Visits (Includes Immun/Inject)	3,830.8	2,805.6	1,711.6	3,376.4
Outpatient – Specialty Care Visits	3,498.0	3,823.9	1,956.9	4,839.2
Outpatient – Mental Health Visits	460.4	291.2	647.1	1,318.5
Outpatient – Emergency Dept Visits	SEE AMBULATORY CARE ED UTILIZATION METRIC ON PAGE 14			
Outpatient – Pharmacy Prescriptions Filled	9,414.8	8,925.4	10,246.9	9,832.6
Outpatient – Labs and Radiology (Service Units)	4,503.9	3,755.3	2,681.8	5,384.0
Outpatient – Freestanding ASC Procedures	32.5	29.6	17.8	42.5

For footnote explanations, see page 94.

COST AND UTILIZATION DATA
Quarterly Data

UTILIZATION DATA BY CCO, OCT.-DEC. 2012, TABLE 4 OF 4

CATEGORY	UMPQUA HEALTH ALLIANCE	WESTERN OREGON ADVANCED HEALTH	WILLAMETTE VALLEY COMMUNITY HEALTH	YAMHILL COUNTY CARE ORGANIZATION
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)				
Inpatient – Medical / General – Patient Days	205.9	200.5	160.3	53.7
Inpatient – Medical / Rehabilitation – Patient Days	0.0	4.8	4.2	0.0
Inpatient – Surgical – Patient Days	125.7	79.3	77.0	56.3
Inpatient – Maternity / Normal Delivery – Patient Days	35.7	54.1	40.1	33.1
Inpatient – Maternity / C-Section Delivery – Patient Days	25.8	33.7	15.1	21.9
Inpatient – Maternity / Non-Delivery – Patient Days	4.9	0.7	5.8	1.3
Inpatient – Newborn / Well – Patient Days	36.0	49.7	38.6	30.1
Inpatient – Newborn / With Complications – Patient Days	59.1	60.9	34.2	40.8
Inpatient – Mental Health / Psychiatric – Patient Days	69.8	40.5	23.9	16.9
Inpatient – Mental Health / Alcohol and Drug Abuse – Patient Days	1.5	8.9	7.2	4.3
Outpatient – Primary Care Medical Visits (Includes Immun/Inject)	3,365.7	2,684.8	3,484.6	2,649.3
Outpatient – Specialty Care Visits	4,395.1	4,035.6	4,096.1	2,991.9
Outpatient – Mental Health Visits	794.4	216.0	809.7	530.3
Outpatient – Emergency Dept Visits	SEE AMBULATORY CARE ED UTILIZATION METRIC ON PAGE 14			
Outpatient – Pharmacy Prescriptions Filled	10,225.6	10,701.3	4,305.9	6,495.2
Outpatient – Labs and Radiology (Service Units)	6,232.9	5,606.6	5,306.8	3,463.3
Outpatient – Freestanding ASC Procedures	8.8	38.8	36.7	13.3

For footnote explanations, see page 94.

COST AND UTILIZATION DATA

Quarterly Data

COST DATA STATEWIDE

CATEGORY	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 *	JAN-MAR 2013 *	APR-JUN 2013 *	JUL-SEP 2013 *	OCT 2012 - SEP 2013 AVERAGE
COST PER MEMBER PER MONTH (PMPM)							
Inpatient – Medical / General	$25.51	****	$25.55	$28.37	$23.87	$18.77	$24.14
Inpatient – Medical / Rehabilitation	$0.27	****	$0.27	$0.23	$0.21	$0.15	$0.22
Inpatient – Surgical	$20.99	****	$19.98	$20.46	$19.76	$15.60	$18.95
Inpatient – Maternity / Normal Delivery	$6.47	****	$5.81	$6.03	$5.96	$5.52	$5.83
Inpatient – Maternity / C-Section Delivery	$4.36	****	$3.31	$3.62	$3.54	$3.39	$3.47
Inpatient – Maternity / Non-Delivery	$1.21	****	$0.83	$0.95	$0.91	$0.74	$0.86
Inpatient – Newborn / Well	$2.12	****	$2.07	$2.27	$2.14	$1.48	$1.99
Inpatient – Newborn / With Complications	$7.21	****	$5.73	$5.54	$5.87	$4.57	$5.43
Inpatient – Mental Health / Psychiatric	$3.97	****	$3.38	$3.27	$3.05	$2.22	$2.98
Inpatient – Mental Health / Alcohol and Drug Abuse	$0.52	****	$0.54	$0.42	$0.52	$0.45	$0.48
Outpatient – Primary Care	$20.94	****	$23.51	$26.48	$24.82	$24.22	$24.76
Outpatient – Primary Care / Supplemental Wrap-Around Payments	$13.47	****	$15.12	$17.03	$15.97	$15.58	$15.93
Outpatient – Specialty Care	$25.46	****	$24.36	$25.20	$24.46	$22.59	$24.15
Outpatient – Mental Health	$23.19	****	$21.74	$21.32	$20.78	$18.88	$20.68
Outpatient – Dental	$12.20	****	$8.04	$8.79	$9.03	$7.37	$8.31
Outpatient – Emergency Department	$9.71	****	$7.89	$8.41	$8.00	$7.27	$7.89
Outpatient – Pharmacy Prescriptions	$32.40	****	$32.35	$33.58	$31.91	$33.66	$32.88
Outpatient – Labs and Radiology	$21.72	****	$19.00	$20.17	$19.53	$18.10	$19.20
Outpatient – Freestanding ASC Procedures	$1.60	****	$1.57	$1.83	$1.75	$1.56	$1.68
Outpatient – Health Related Services	$0.00	****	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient – Other Hospital Services	$29.00	****	$24.51	$27.54	$26.80	$23.75	$25.65
Outpatient – All Other	$21.00	****	$21.31	$22.57	$22.51	$22.80	$22.30

For footnote explanations, see page 94.

COST AND UTILIZATION DATA
Quarterly Data

COST DATA BY CCO, OCT.-DEC. 2012, TABLE 1 OF 4

CATEGORY	STATEWIDE	ALLCARE HEALTH PLAN, INC.	CASCADE COMPREHENSIVE CARE	COLUMBIA PACIFIC CCO, LLC
COST PER MEMBER PER MONTH (PMPM)				
Inpatient – Medical / General	$25.55	$17.42	$20.56	$20.74
Inpatient – Medical / Rehabilitation	$0.27	$0.75	$0.00	$0.48
Inpatient – Surgical	$19.98	$13.80	$25.43	$23.80
Inpatient – Maternity / Normal Delivery	$5.81	$5.05	$4.72	$9.44
Inpatient – Maternity / C-Section Delivery	$3.31	$3.34	$5.38	$6.64
Inpatient – Maternity / Non-Delivery	$0.83	$0.87	$0.85	$0.31
Inpatient – Newborn / Well	$2.07	$1.41	$1.19	$3.06
Inpatient – Newborn / With Complications	$5.73	$4.83	$5.33	$4.12
Inpatient – Mental Health / Psychiatric	$3.38	$0.93	N/A	$4.31
Inpatient – Mental Health / Alcohol and Drug Abuse	$0.54	$0.48	N/A	$1.00
Outpatient – Primary Care	$23.51	$23.25	$16.31	$22.33
Outpatient – Primary Care / Supplemental Wrap-Around Payments	$15.12	Data Pending	Data Pending	Data Pending
Outpatient – Specialty Care	$24.36	$18.06	$19.84	$15.31
Outpatient – Mental Health	$21.74	$12.13	N/A	$13.01
Outpatient – Emergency Department	$7.89	$3.77	$2.20	$11.66
Outpatient – Pharmacy Prescriptions	$32.35	$32.69	$29.32	$33.82
Outpatient – Labs and Radiology	$19.00	$14.62	$11.82	$28.35
Outpatient – Freestanding ASC Procedures	$1.57	$1.52	$0.31	$0.51
Outpatient – Health Related Services	$0.00	$0.00	$0.00	$0.00
Outpatient – Other Hospital Services	$24.51	$19.28	$17.60	$41.41
Outpatient – All Other	$21.31	$16.02	$16.98	$16.68

For footnote explanations, see page 94.

COST AND UTILIZATION DATA
Quarterly Data

COST DATA BY CCO, OCT.-DEC. 2012, TABLE 2 OF 4

CATEGORY	EASTERN OREGON CCO	FAMILY CARE CCO	HEALTH SHARE OF OREGON	INTERCOMMUNITY HEALTH NETWORK CCO
COST PER MEMBER PER MONTH (PMPM)				
Inpatient – Medical / General	$25.94	Data Pending	$27.84	$39.97
Inpatient – Medical / Rehabilitation	$0.23	Data Pending	$0.27	$0.16
Inpatient – Surgical	$18.83	Data Pending	$21.02	$30.97
Inpatient – Maternity / Normal Delivery	$9.52	Data Pending	$3.79	$6.98
Inpatient – Maternity / C-Section Delivery	$7.43	Data Pending	$2.55	$6.00
Inpatient – Maternity / Non-Delivery	$1.31	Data Pending	$0.75	$0.78
Inpatient – Newborn / Well	$2.52	Data Pending	$1.07	$2.02
Inpatient – Newborn / With Complications	$5.90	Data Pending	$5.61	$9.77
Inpatient – Mental Health / Psychiatric	$1.35	Data Pending	$5.09	$2.26
Inpatient – Mental Health / Alcohol and Drug Abuse	$0.75	Data Pending	$1.12	$0.17
Outpatient – Primary Care	$12.96	$22.54	$24.46	$28.88
Outpatient – Primary Care / Supplemental Wrap-Around Payments	Data Pending	Data Pending	Data Pending	Data Pending
Outpatient – Specialty Care	$20.55	$19.58	$27.38	$25.31
Outpatient – Mental Health	$14.39	$22.26	$28.83	$16.36
Outpatient – Emergency Department	$10.92	$5.44	$8.27	$6.16
Outpatient – Pharmacy Prescriptions	$29.13	$21.02	$35.01	$49.21
Outpatient – Labs and Radiology	$24.64	$12.51	$18.00	$26.51
Outpatient – Freestanding ASC Procedures	$0.23	$0.61	$0.87	$1.46
Outpatient – Health Related Services	$0.00	$0.00	$0.00	$0.00
Outpatient – Other Hospital Services	$33.19	$12.49	$27.45	$25.86
Outpatient – All Other	$15.62	$12.22	$25.96	$22.36

For footnote explanations, see page 94.

COST AND UTILIZATION DATA
Quarterly Data

COST DATA BY CCO, OCT.-DEC. 2012, TABLE 3 OF 4

CATEGORY	JACKSON CARE CONNECT	PACIFICSOURCE COMM. SOLUTIONS	PRIMARY HEALTH JOSEPHINE CO CCO	TRILLIUM COMM. HEALTH PLAN
COST PER MEMBER PER MONTH (PMPM)				
Inpatient – Medical / General	$17.68	$23.27	$14.96	$25.75
Inpatient – Medical / Rehabilitation	$0.72	$0.11	$0.00	$0.40
Inpatient – Surgical	$18.70	$18.29	$12.33	$25.29
Inpatient – Maternity / Normal Delivery	$4.10	$8.47	$1.08	$5.08
Inpatient – Maternity / C-Section Delivery	$2.53	$3.53	$1.49	$3.64
Inpatient – Maternity / Non-Delivery	$0.75	$1.15	$2.23	$0.63
Inpatient – Newborn / Well	$0.86	$1.78	$0.39	$4.21
Inpatient – Newborn / With Complications	$9.64	$4.23	$2.00	$6.92
Inpatient – Mental Health / Psychiatric	$1.20	$2.82	$0.00	$4.12
Inpatient – Mental Health / Alcohol and Drug Abuse	$0.14	$0.30	$1.64	$0.38
Outpatient – Primary Care	$28.26	$18.03	$20.09	$22.61
Outpatient – Primary Care / Supplemental Wrap-Around Payments	Data Pending	Data Pending	Data Pending	Data Pending
Outpatient – Specialty Care	$21.61	$21.02	$13.08	$32.69
Outpatient – Mental Health	$20.02	$7.13	$11.54	$23.90
Outpatient – Emergency Department	$5.75	$8.47	$1.81	$8.72
Outpatient – Pharmacy Prescriptions	$31.91	$37.86	$35.98	$30.43
Outpatient – Labs and Radiology	$18.89	$21.77	$11.29	$19.86
Outpatient – Freestanding ASC Procedures	$2.31	$3.33	$1.14	$3.12
Outpatient – Health Related Services	$0.00	$0.00	$0.00	$0.00
Outpatient – Other Hospital Services	$21.09	$24.54	$13.86	$23.74
Outpatient – All Other	$18.97	$19.82	$10.80	$24.47

For footnote explanations, see page 94.

COST AND UTILIZATION DATA

Quarterly Data

COST DATA BY CCO, OCT.-DEC. 2012, TABLE 4 OF 4

CATEGORY	UMPQUA HEALTH ALLIANCE	WESTERN OREGON ADVANCED HEALTH	WILLAMETTE VALLEY COMMUNITY HEALTH	YAMHILL COUNTY CARE ORGANIZATION
COST PER MEMBER PER MONTH (PMPM)				
Inpatient – Medical / General	$29.94	$43.34	$22.61	$7.55
Inpatient – Medical / Rehabilitation	$0.00	$0.28	$0.24	$0.00
Inpatient – Surgical	$28.20	$25.25	$18.59	$11.16
Inpatient – Maternity / Normal Delivery	$5.89	$7.55	$5.96	$4.93
Inpatient – Maternity / C-Section Delivery	$3.56	$5.42	$2.66	$3.92
Inpatient – Maternity / Non-Delivery	$0.70	$0.46	$0.86	$0.53
Inpatient – Newborn / Well	$1.83	$2.28	$1.53	$1.49
Inpatient – Newborn / With Complications	$9.80	$10.44	$3.83	$4.30
Inpatient – Mental Health / Psychiatric	$4.25	$3.07	$1.63	$1.41
Inpatient – Mental Health / Alcohol and Drug Abuse	$0.10	$1.27	$0.27	$0.32
Outpatient – Primary Care	$23.67	$18.75	$27.98	$21.23
Outpatient – Primary Care / Supplemental Wrap-Around Payments	Data Pending	Data Pending	Data Pending	Data Pending
Outpatient – Specialty Care	$27.23	$18.68	$23.98	$18.73
Outpatient – Mental Health	$13.66	$10.36	$18.09	$16.72
Outpatient – Emergency Department	$13.78	$13.63	$7.20	$9.31
Outpatient – Pharmacy Prescriptions	$30.65	$33.36	$13.16	$26.54
Outpatient – Labs and Radiology	$18.45	$24.29	$18.34	$15.10
Outpatient – Freestanding ASC Procedures	$0.30	$1.57	$3.06	$0.98
Outpatient – Health Related Services	$0.00	$0.00	$0.00	$0.00
Outpatient – Other Hospital Services	$21.38	$48.55	$19.91	$17.50
Outpatient – All Other	$24.54	$17.66	$22.79	$10.06

For footnote explanations, see page 94.

FINANCIAL DATA
Footnotes

* Includes claim data received and processed through 12/27/13. At this point, there is no data on services that have happened, but have yet to be recorded or invoiced. This dashboard may be incomplete due to lags in submitting data to OHA. Future dashboards will be updated when more complete data is submitted.

** Oregon baseline measures are state-wide values from CY 2011 and are based on data before health transformation began and CCOs were formed.

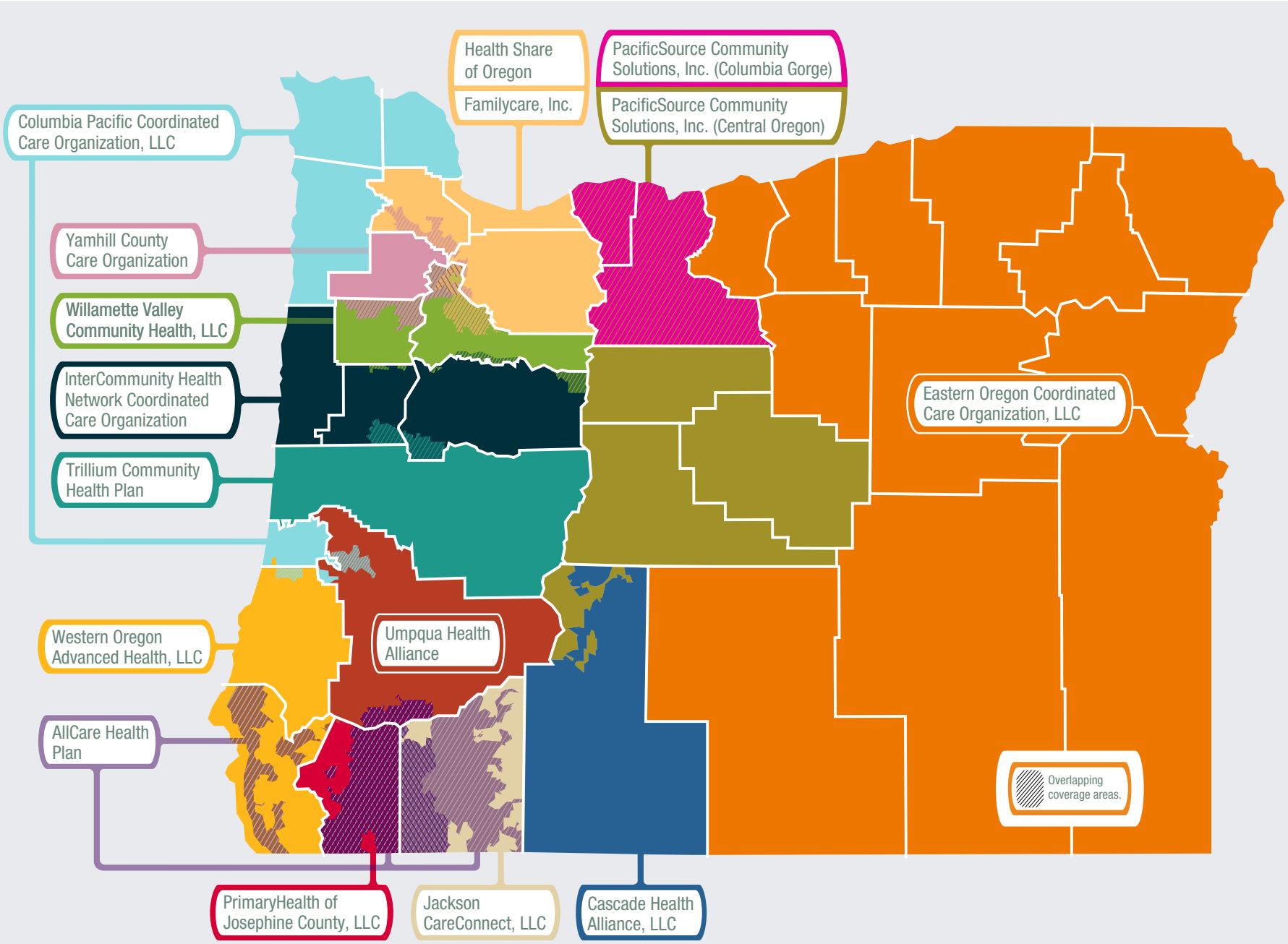
**** Benchmark in development

APPENDICES
Coordinated Care Organizations Service Areas

CCO Name	Service Area by County
AllCare Health Plan	Curry, Josephine, Jackson, Douglas (partial)
Cascade Health Alliance	Klamath County (partial)
Columbia Pacific Coordinated Care Organization	Clatsop, Columbia, Coos (partial), Douglas (partial), Tillamook
Eastern Oregon Coordinated Care Organization	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union Wallowa Wheeler
FamilyCare	Clackamas, Marion (partial), Multnomah, Washington
Health Share of Oregon	Clackamas, Multnomah, Washington
Intercommunity Health Network CCO	Benton, Lincoln, Linn
Jackson Care Connect	Jackson
PacificSource Community Solutions (Central Oregon Region)	Crook, Deschutes, Jefferson, Klamath (partial)
PacificSource Community Solutions (Columbia Gorge Region)	Hood River, Wasco
PrimaryHealth of Josephine County	Douglas (partial), Jackson (partial), Josephine
Trillium Community Health Plan	Lane
Umpqua Health Alliance	Douglas (most)
Western Oregon Advanced Health	Coos, Curry
Willamette Valley Community Health	Marion, Polk (most)
Yamhill County CCO	Clackamas (partial), Marion (partial), Polk (partial), Yamhill

APPENDICES

Coordinated Care Organizations Service Areas



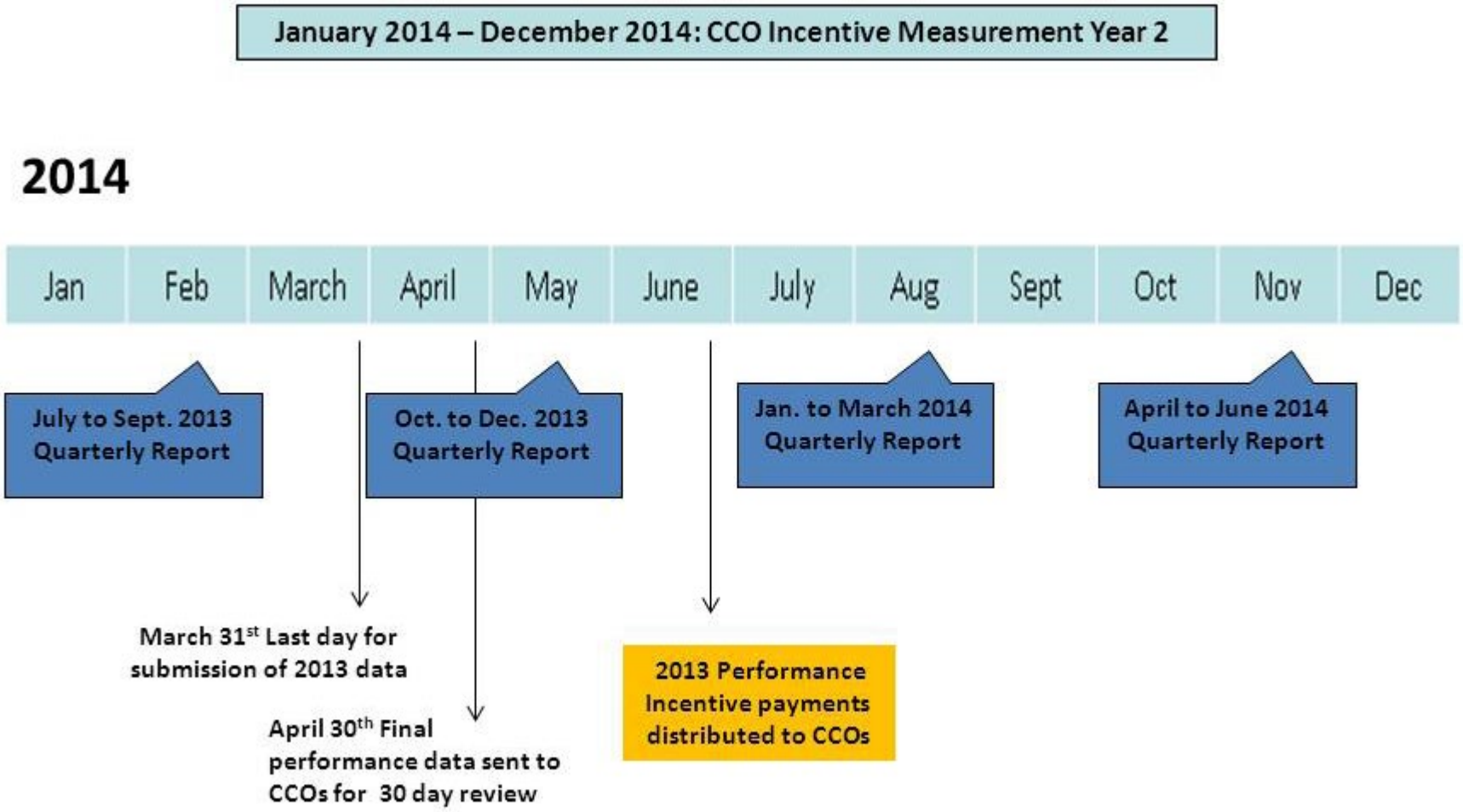
APPENDICES

Timeline: CCO Inventive Measures and Quality Pool Schedule, 2013-2014

January 2013 – December 2013: CCO Incentive Measurement Year 1

APPENDICES

Timeline: CCO Inventive Measures and Quality Pool Schedule, 2013-2014



APPENDICES

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For more information about baseline data and technical specifications for measures, visit:

http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

For more information about coordinated care organizations, visit:

www.health.oregon.gov

Oregon Health Authority

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Appendix E
Oregon State Innovation Model Project
April 2014 through September 2016 Timeline and Milestones, Revised April 2014

		April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec 2015	Jan-March	April-June	July-Sept	Dec-16
	Overarching Oregon SIM Aims and Goal	**Aim 1:** Spread key elements of the Coordinated Care Model to: State employees by January 2015; Dual eligibles and other Medicare beneficiaries by January 2016; Exchange participants and Oregon Educators by January 2016. **Aim 2:** Reduce per member, per month (PMPM) cost trend while maintaining or improving quality: Reduce Medicaid PMPM trend 2 percentage points (p.p.) by FY 2015; Reduce public employee PMPM trend 2 p.p. by FY 2016;									2 million or more Oregonians receiving coordinated care	
Transformation Center	**Cathy Kaufmann**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 5: Testing, acceleration and spread of effective deliver system and payment innovations	1. Establish initial learning collaboratives 2. Launch all payer Transformation Center Steering Committee 3. Launch Council of Clinical Innovators 4. Provide technical assistance		1. Operate a learning management system focused on rapid cycle learning by offering at least learning collaboratives 2. Improve rate of clinical innovation by conducting one clinical workshop/quarter 3. Provide technical assistance 4. Implement a Transformation Center sustainability plan				1. Operate a learning management system focused on rapid cycle learning by offering at least learning collaboratives 2. Improve rate of clinical innovation by conducting one workshop /quarter 3. Spread the CCM to other payers and populations 4. Ensure the sustainability of the Transformation Center				
		April-June 2014	July-Sept 2014	Oct-Dec 2014	Jan-March 2015	April-June 2015	July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016	July - Sept 2016	Dec-16
	Transformation Center Activities	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**	**Q8**	**Q9**	**Q10**	**Q11**	**Q12**	
Stakeholder Engagement	Conduct listening sessions with CCOs and partners	X				X				X		
	Launch Transformation Center All Payer Steering Committee, ongoing		X	X	X	X	X	X	X	X	X	X
Learning Collaboratives and Quality Improvement Training	Operate an ongoing system of rapid cycle learning (learning collaboratives), ongoing	X	X	X	X	X	X	X	X	X	X	X
	Establish and maintain an online learning platform. Ongoing	X	X	X	X	X	X	X	X	X	X	X

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
	Innovator Agent learning network, ongoing	X	X	X	X	X	X	X	X	X	X	X
	Learning collaborative #1, CCO Medical Directors and Quality Improvement Coordinators, ongoing	X	X	X	X	X	X	X	X	X	X	X
Learning Collaboratives and Quality Improvement Training (cont.)	Learning collaborative #2, Community Advisory Council	X	X									
	Learning Collaborative #3 Complex Care	X	X									
	Learning Collaborative #4 topic TBD			X	X	X	X					
	Learning Collaborative #5, topic TBD			X	X	X	X					
	Learning Collaborative #6, topic TBD			X	X	X	X					
	Learning Collaborative #7, topic TBD							X	X	X	X	
	Learning Collaborative # 8, topic TBD							X	X	X	X	
	Learning Collaborative #9, topic TBD							X	X	X	X	
	Collect and analyze Learning Collaborative evaluation data and provide a report	X		X		X		X		X		
	Provide training on health care improvement concepts and tools	X		X				X			X	
	Conduct Innovation Conference			X				X				
Clinical Innovation	Recruit and select cohort of clinical innovation champions for the Council of Clinical Innovators		X				X			X		
	Plan and implement Transformation Academy (training for Council of Innovators)		X	X			X	X		X	X	
	Deliver clinical innovation seminars or workshops, one per quarter	X	X	X	X	X	X	X	X	X	X	
	Complete hiring of outreach staff											
Technical Assistance and Outreach	Conduct outreach activities, ongoing	X	X	X	X	X	X	X	X	X	X	
	Collect and analyze outreach evaluation data and provide a report	X		X		X		X		X		
	Complete hiring of technical staff	X	X	X	X	X	X	X	X	X	X	X
	Transformation Center Sustainability Plan		X	X	X	X	X	X	X	X	X	X
Sustainability	Complete hiring for communications staff											
Communications	Maintain Transformation Center website, updates ongoing	X	X	X	X	X	X	X	X	X	X	

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
Alternative Payment Models	**Kelly Ballas, Jeanene Smith, Cathy Kaufmann**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes	1. Engage Oregon stakeholders in development of alternative payment methods relevant to the Oregon environment 2. Develop proposals for alternative payment mechanisms for clinics moving to patient centered primary care homes 3. Work with		1. CCOs implementing APMs as reflected in their Transformation Plans 2. Continue assessment of FQHC APM pilots for spread opportunities 3. Continue to work with Oregon Association of Hospitals and Healthcare Systems to prepare smaller hospitals for transformation.				1. CCOs implementing APMs as reflected in their Transformation Plan 2. Continue assessment of FQHC APM pilots for spread opportunities 3. APMs and cost control measures included in the qualified health plans offered on Cover Oregon 4. Coordinated Care key delivery elements included in qualified health plans and in Oregon Educators Benefit Board contracts				
	APM Activities											
	Consulting with payment reform experts to inform and advise the state and stakeholders on payment approaches	X										
Environmental Scan	Multi-Payer Strategy Workgroup, engagement on APMs starting with Primary Care Payment (begins 7/2013)	X	X	X	X	X	X					
Engaging stakeholders	Work with CCOs and private payer stakeholders to assess their need for information and assistance on	X	X	X	X	X	X	X	X	X	X	X
	CCOs implementing APMS per transformation plans	X	X	X	X	X	X	X	X	X	X	X
Implementing APMS	Continue assessment of FQHC alternative payment pilots for potential spread more widely	X	X	X	X	X	X	X	X	X	X	X

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
	APMs and cost control measures in QHPs on exchange								Jan	X	X	X
	CCM care delivery key elements in QHP and OEBB contracts								Jan	X	X	X
	Continue work with Oregon Association of Hospitals and Health Systems for prepare smaller hospitals for transformational changes	X	X	X	X	X	X	X	X	X	X	X
Preparing small hospitals for transformation	Technical Assistance to develop draft RFP											
Elements of Coordinated Care Model in Public Employees (PEBB) contracts for 2015 benefit year	PEBB RFP released											
	Proposals evaluated and selected	X										
	PEBB contract negotiated and executed		X									
	APMs and cost control measures in PEBB contracts				Jan	X	X	X	X	X	X	X
	Coordinated care delivery key elements in PEBB contracts				Jan	X	X	X	X	X	X	X
	Elements of coordinated care model included as contract amendment		X	X	X							
Elements of Coordinated Care Model in Oregon Educator Benefit Board contract renewals for 2016 benefit year	OEBB RFP Posted				X							
	APMs and cost control measures in OEBB contracts								Jan	X	X	X

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
Patient Centered Primary Care Home	**Nicole Merrithew**											

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
SIM Driver Alignment and Key Objectives by demonstration period	Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes	1. Provide technical assistance for practice transformation 2. Update technical specifications and guidance for recognition criteria 3. Develop online application system for updated criteria 4. Conduct 50 verification visits 5. Implement revised PCPCH payment for FFS Medicaid		1. Provide technical assistance for practice transformation 2. Health systems increasingly make use of recognized PCPCHs 3. Review and refine criteria 4.Conduct 50 verification visits 6. 500 Clinics recognized at PCPCHs				1. Provide technical assistance for practice transformation 2. Health systems increasingly make use of recognized PCPCHs 3.Conduct 50 verification visits 4. 600 Clinics recognized at PCPCHs				
	PCPCH Activities											
	PCPHC Institute launched providing	X	X	X	X	X	X	X	X	X	X	X
Technical assistance	Execute contract and coordinate ongoing technical assistance, including PCPCH Learning Collaboratives, through Patient-Centered Primary Care Institute	X	X	X	X	X	X	X	X	X	X	X
	Health systems make increasing use of recognized PCPCHs					X	X	X	X	X	X	X
	Update and align PCPCH communications plan and stakeholder engagement strategy			X				X				
Communications	Maintain and update PCPCH web content	X	X	X	X	X	X	X	X	X	X	X
	Develop and launch relational PCPCH database for program administrative needs	X	X	X	X	X	X	X	X	X	X	X

		April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec 2015	Jan-March	April-June	July-Sept	Dec-16
Verification	Assess value of including clinical consultant role within site visit		X									
	Schedule, coordinate, and conduct at least 50 PCPCH verification site visits each year (Oct-Sept)	X	X	X	X	X	X	X	X	X	X	X
	Refine verification site visit process to align with updated recognition criteria and stakeholder feedback	X										
	600 clinics recognized as PCPCHs										X	
Evaluation	Develop annual PCPCH program report				X				X			
Health Information and Technology (OHIT)	**Susan Otter**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 1: Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes	1. Engage stakeholders 2. Develop materials and provide training on HIT 3. Begin preparations for telehealth pilots		1. Spread awareness of HIT 2. Launch telehealth pilots 3. Identify new technology and approaches and implementation for HIT/HIE Phase 2 business framework				1. Spread awareness of HIT 2. Evaluate telehealth pilots 3. Identify new technology and approaches and implementation for HIT/HIE Phase 2 business framework				
	OHIT Activities											
Stakeholder Engagement, including strategic planning and testing new HIT/HIE approaches	Stakeholder planning and engagement on governance, sustainability, Phase 2	X	X	X	X	X	X	X	X	X	X	X
	Develop materials and provide training on health information technology	X	X	X	X	X	X	X	X	X	X	X
Spread Awareness of HIT and Triple Aim	Spread awareness about HIT and how it can be used in various settings to	X	X	X	X	X	X	X	X	X	X	X
	Train other Transformation Center staff on HIT as a tool to accelerate transformation	X	X	X	X	X	X	X	X	X	X	X
	Work with the Office of Rural Health to implement telehealth/mobile device pilots.	X										

		April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec 2015	Jan-March	April-June	July-Sept	Dec-16
Provider directory, notifications and alerts	Contract with consultant(s) to identify new technology and provide expert advice on approaches and implementation for HIT/HIE Phase 2 business framework	X	X	X	X	X	X	X	X	X	X	
Long Term Services and Support(LTSS)	**Bob Weir**											
SIM Driver Alignment and Key Objectives by demonstration period	Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes	1. Establish cadre of long term care innovator agents to facilitate coordination between LTSS and primary care systems 2. Complete development of LTSS metrics 3. Begin data collection 4. Housing with		1. Foster collaboration between long term care innovator agents and transformation center innovator agents to identify opportunities for systems change 2. Begin reporting on LTSS metrics				1. Continue collaboration between long term care innovator agents and transformation center innovator agents to identify opportunities for systems change 2. Continue reporting on LTSS metrics 3. Conduct evaluation of housing with services pilot				
LTSS Innovator Agents	Hire LTC Innovator Agents, policy coordinator and admin assistant. Foster collaboration between LTSS and TC innovator agents.	X	X	X	X	X	X	X	X	X	X	
Sharing lessons from LTSS	Quarterly report on LTC/CCO MOU activities	X	X	X	X	X	X	X	X	X	X	
	Complete or negotiate exentions for MOU renewals	X				X	X			X	X	
	Develop an improvement project, engage in training to implement.			X	X	X	X					
	Quarterly meetings with TC Innovator Agents	X	X	X	X	X	X	X	X	X	X	
	Annual presentation to stakeholders			X				X			X	
	Annual progress report including successes, barriers, opportunities for			X				X				X

		April - June	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec 2015	Jan - March	April - June	July - Sept	Dec-16
LTSS coordination and outcomes-shared accountability	Metrics recommendations completed by stakeholder group	X										
	Metrics recommendations vetted by Metrics and Scoring Committee	X										
	Finalize LTSS metrics and plan implementation			X	X	X	X					
	Data Collection begins for LTSS Metrics	X	X	X	X	X	X	X	X	X	X	X
LTSS Congregate Housing Project	Bein collecting Housing with Services baseline data	X	X									
	Housing with services begins		X	X	X	X	X	X	X	X	X	
M/M Dual Eligible	**Trevor Douglass**											
SIM Driver Alignment and Key Objectives by demonstration period	Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes	1. Begin development of integrated appeals notices 2. Begin integration of plan summary info 3. Dual eligibles enrolled by choice to CCO and aligned Medicare Advantage plans		1 Dual eligible individuals enrolled by choice to Coca and aligned Medicare Advantage plans 2. Expand CCO model to Medicare 3. Medicaid/Medicare alignment without wavier achieved				1. Integrated appeals notices and streamlined plan info 2. Disseminate best practices for serving dually eligibles 3. Continue to align QIPs/PIPs and quality reporting requirements across Medicaid and Medicare				
	M/M Dual Eligible Activities											
	Complete hiring of Medicaid/Medicare Eligible staff	X										

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
Medicaid/Medicare alignment activities requiring waivers:	Integrated and streamlined plan summary info for enrollees and potential enrollees: o Approved template for plan use o Could either be a streamlined Summary of Benefits leveraging the template CMS has developed for the demonstrations, or a shorter (3-4 page) summary o Develop text/insert specific to dual eligible members to go in/with Medicare handbooks	X	X	X	X	X	X	X				
	Dual eligible individuals enrolled by choice to CCO and aligned Medicare-Advantage plans	X	X	X	X	X	X	X	X	X	X	
Delivery system reforms	CCO relationship with MA plan to meet contractual requirement to "demonstrate ability to provide Medicare benefits to full duals no later than 1/1/14… through a Medicare Advantage plan that is owned by, affiliated with, or contracted by the Contractor."											
Delivery system reforms (cont.)	Expansion of the CCO model to Medicare and use Innovator Agents to work with CCOs to disseminate best practices for serving dually eligible individuals	X	X	X	X	X	X	X	X	X	X	

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
	Appeals: Work to revise Medicaid information on notices/appeals (Timing TBD based on OHA feasibility and priorities): o Revise OHA/CCO (Medicaid) Notices of Action to duals not in aligned plans (or potentially all Medicaid clients) about the fact that they may get a separate notice from Medicare and what the two appeals processes are. o Improve information on appeals rights for dual eligibles – including information about Medicare process	X	X	X	X	X	X	X	X			
Medicaid/Medicare alignment activities not requiring waivers	Member Materials/Outreach: Maximize dual eligible enrollment in aligned arrangements. Examine barriers to enrollment. Pursue development of pamphlet/brochure on benefits in enrolling in aligned CCO/MA plans for use in field offices and SHIBA (Oregon's SHIP); Development of more detailed plan comparison tool by OHA that accurately represents plan benefits, cost-sharing and premiums for duals enrolled in aligned plans; add OHA-provided text or insert to CCO member handbooks with information specifically related to dual eligible members	X	X	X	X	X	X	X	X	X	X	
	Quality improvement/reporting: continue efforts to align QIPs/PIPs and quality reporting requirements for plans across Medicare and Medicaid	X	X	X	X	X	X	X	X	X	X	

		April - June	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec 2015	Jan - March	April - June	July - Sept	Dec-16
Medicaid/Medicare alignment activities not requiring waivers (cont.)	Enrollment systems/processes: work within OHA, and with Plans and CMS to address any systems and process changes necessary to ensure accurate eligibility and enrollment information is available and shared appropriately	X	X	X								
	Integrated oversight: o Work with CMS regional office to coordinate plan oversight activities and share information	X	X	X								
	Continue to develop shared accountability approaches including metrics and shared financial accountability	X	X	X	X	X	X	X	X	X	X	
	Continue to analyze integrated Medicare/Medicaid data to better understand demographics, cost, and utilization of dually eligible individuals to inform future policy	X	X	X	X	X	X	X	X	X	X	
Health Equity	**Carol Cheney**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 1: Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes (PCPCH) Driver 3: Integrating physical, behavioral and oral health care with community health improvement	1. Launch DELTA cohort #2 2. Launch health care interpreter scholarship project. Train and certify 50 new interpreters 3. Select and launch three regional equity		1. Launch DELTA cohort #3 2. Train and certify 50 new health care interpreters 3. Conduct quarterly regional equity coalition site visits 4. Coalitions produce strategic plans				1. Launch DELTA cohort #4 2. Train and certify 50 new health care interpreters 3. Conduct quarterly regional equity coalition site visits 4. Coalitions executing strategic plans				
	Health Equity Activities											
Equity Projects: DELTA Training and Regional Equity Coalitions (REC)	Launch DELTA cohort 2 (9 month training)											
DELTA Training Project	Launch DELTA cohort 3				X							
	Follow up coaching and mentoring		X				X				X	

		April - June	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec 2015	Jan - March	April - June	July - Sept	Dec-16
Regional Equity Coalitions Project	Ongoing REC site visits quarterly	X	X	X	X	X	X	X	X	X	X	
	Coalitions produce strategic plan					X						
Equity Health Care Interpreter Project	On hold pending CMMI Approval	X										
Community Health	**Michael Tynan**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 3: Integrating physical, behavioral and oral health care with community health improvement	1. Establish community prevention projects 2. Add data sets to OPHAT 3. Administer Medicaid BRFSS survey		1. Implement community prevention projects 2. Add data sets to OPHAT 3. Conduct data collection and analyze Medicaid BRFSS data 4. Administer Oregon Healthy Teens survey analyze data 5. Conduct data collection and analyze BRFSS racial/ethnic oversample				1. Evaluate community prevention projects 2. Disseminate Medicaid BRFSS results 3. Disseminate Oregon Healthy Teen results 4. Disseminate BRFSS racial/ethnic oversample results				
	Community Health activities											
Community prevention projects	Add datasets to the Oregon Public Health Analytic Tool (OPHAT), develop training plan for local users of the tool for the purposes of supporting community health assessments. Develop plan for adding new datasets to OPHAT by January 2015	X		X		X		X		X		
Oregon Public Health Analytic Tool	Conduct Medicaid BRFSS data collection	Admin	X	X	X	X						
Medicaid BRFSS	Weight and analyze Medicaid BRFSS data			X	X	X	X	X				
	Summarize and disseminate Medicaid BRFSS results								X	X		
	Conduct OHT data collection			Admin	X	X						
Oregon Healthy Teens	Analyze OHT data						X	X				
	Summarize and disseminate OHT results								X	X		
	Conduct data collection for BRFSS racial/ethnic oversample				X	X	X	X				
BRFSS Racial/Ethnic Oversample	Weight and analyze BRFSS racial/ethnic oversample					X	X	X	X	X		
	Summarize BRFSS racial/ethnic oversample results										X	

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
Health Evidence Review Commission	**Darren Coffman/Jeanene Smith**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 4: Standards and accountability for safe, accessible and effective care	1. Develop 3 sets of patient decision support materials		1. Develop 3 sets of patient decision support materials				1. Develop 4 sets of patient decision support materials				
	HERC Activities											
	Work with Oregon Health Sciences University, Center for Evidenced	X	X	X	X	X	X	X	X	X	X	
	Develop set of 10 Patient Decision Support Materials,:3 by Q4, 3 by Q 8, 4 by Q 12		X				X				X	
	Expanded production of evidence-based clinical decision tools begins 7/2013	X	X	X	X	X	X	X	X	X	X	X
Early Learning Council	**Dana Hargunani**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 3: Integrating physical, behavioral and oral health care with community health improvement	1. Develop at least two collaborations between CCOs and ELC		1. Develop at least two collaborations between CCOs and ELC 2. Achieve kindergarten readiness				1. Develop at least two collaborations between CCOs and ELC 2. Achieve kindergarten readiness				
	Early Learning Council Activities											
	Develop collaborations between CCOs and Early Learning Council to achieve kindergarten readiness	X	X	X	X	X	X	X	X	X	X	
	Coordination of screening, services, and data across CCOs and early learning hubs	X	X	X	X	X	X	X	X	X	X	
Testing, Analysis and Evaluation	**Kathleen Paul, Gretchen Morley, Lisa Angus**											

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
SIM Driver Alignment and Key Objectives by demonstration period	Driver 5: Testing, acceleration and spread of effective delivery systems and payment innovations	1. Integrate data across platforms 2. Begin data collection for spread and ROI		1. Apply analytic tools for improvement 2. Continue to publish CCO quarterly dashboard 3. Begin publishing multi-payer quarterly dashboard 4. Track degree and spread of CCM				1.Continue to apply analytic tools for improvement 2. Continue to publish CCO quarterly dashboard 3. Continue to public multi-payer quarterly dashboard 4. Contract for independent analysis of spread 5. Contract for independent analysis of association between CCM key elements and changes in cost or quality 6. Complete analysis and evaluation of individual initiatives				
	Data Analysis Activities											
Spearhead collection of key data elements needed for evaluation of CCM spread & ROI:	Analytic tools for improvement (e.g. hot spotter reports)		X	X	X	X	X	X	X	X	X	X
	Field Medicaid BRFSS / Medicaid oversample	X				X				X		
	Annual fielding of CAHPS survey, expand sample for CCO-level				X				X			
	Conduct 3rd round of Oregon Health Insurance Survey					X						
	1st CCO quarterly dashboard (May 2013), ongoing	X	X	X	X	X	X	X	X	X	X	X
Spearhead collection of key data elements needed for evaluation of CCM spread & ROI (cont.):	1st multi-payer quarterly dashboard, ongoing	X	X	X	X	X	X	X	X	X	X	X
	Regular reporting of multi-payer cost and quality metrics		X	X	X	X	X	X	X	X	X	X
	Integrated, accessible actionable data										X	X
Comprehensive Evaluation Activities	Quarterly tracking and reporting of quality and cost for Medicaid	X (May)	X (Aug)	X (Nov)	X (Feb)	X (May)	X (Aug)	X (Nov)	X (Feb)	X (May)	X (Aug)	
Evaluation Objective #1 Independent	Second Round after SIM Grant Ends											X
	Regular tracking of degree and pace of spread of CCM	X	X	X	X	X	X	X	X	X	X	
Evaluation Objective #2	Quarterly tracking and reporting of quality and cost for other payers & populations (details TBD)	X	X	X	X	X	X	X	X	X	X	

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
	Contract(s) for independent analysis of spread. Dates are tentative. Details TBD						X	X	X	X		
	Contract(s) for independent analysis of association between CCM key elements and changes in cost or quality. Dates are tentative. Details TBD.					X	X	X	X	X		
Specific initiatives	Pre-model data collection	X										
	Reports fro pre-model data		X									
	Post model data collection							X	X	X		
	Reports for post-model data										X	
	DELTA cohort process evaluation report			X				X			X	
	DELTA outcome evaluation report		X				X				X	
	REC outcome data analysis and report										X	
SIM Grant and Business Management	**Beth Crane**											
SIM Driver Alignment and Key Objectives by demonstration period	Driver 5: Testing, acceleration and spread of effective delivery systems and payment innovations	1. Ensure coordination of grant activities and communications 2. Ensure timely and accurate reporting to federal funders		1. Ensure coordination of grant activities and communications 2. Ensure timely and accurate reporting to federal funders 3. Provide tools for grant and program management				1. Ensure coordination of grant activities and communications 2. Ensure timely and accurate reporting to federal funders 3. Provide tools for grant and program management 4. Conduct grant close out activities				
	SIM Grant and Business Management Activities											
	Quarterly Progress and Financial Reporting	30-Apr	30-Jul	30-Oct	30-Jan	30-Apr	30-Jul	30-Oct	30-Jan	30-Apr	30-Jul	
	Submit Non-Competing Continuation Application		1-Aug				1-Aug					
	Submit Final Report											30-Dec
	Submit Risk Mitigation Plan	X										
	Conduct SIM Operations meetings, ongoing	X	X	X	X	X	X	X	X	X	X	

		April June	July Sept	Oct Dec	Jan March	April June	July Sept	Oct Dec 2015	Jan March	April June	July Sept	Dec-16
	Disseminate CMMI webinar and technical assistance products. Post Oregon products to CMMI collaborative site, ongoing	X	X	X	X	X	X	X	X	X	X	
	Develop, execute and monitor budget, ongoing	X	X	X	X	X	X	X	X	X	X	
	Provide monthly expense to budget reports, ongoing	X	X	X	X	X	X	X	X	X	X	X
	Provide SIM related human resource services for recruitment and hiring, ongoing through March 2014	X	X	X	X	X	X	X	X	X	X	
	Process SIM expenditures for payment, ongoing	X	X	X	X	X	X	X	X	X	X	X

APPENDIX F

State of Oregon
Quarterly Report Work Breakdown Structure
January 1, 2014 -March 31, 2014

Work Breakdown Structure				
Category	**Time**	**Description**	**Payments Received**	**Expenditure**
Salary	January-March	Transformation Center		$ 192,779.06
Salary	January-March	Analytics and Evaluation		$ 57,662.75
Salary	January-March	Equity and Inclusion		$ 32,754.29
Salary	January-March	Long Term Care		$ 67,530.67
Salary	January-March	PCPCH		$ -
Salary	January-March	Duals		$ 18,545.11
Salary	January-March	Public Health		$ 76,293.35
Salary	January-March	Early Learning Council		$ -
Salary	January-March	Grant Management		$ 86,565.94
Total Salary	January-March	All above		$ 532,131.17
Fringe	January-March	All above	None	$ 280,421.27
Travel	January-March	Long Term Care, Equity and Inclusion, Grants Management, Analytics and Evaluation, PCPCH, Public Health, Transformation Center	None	$ 28,164.63
Equipment	January-March	NA	None	$ -
Supplies	January-March	Long Term Care, Equity and Inclusion, Public Health, Transformation Center	None	$ 19,585.83
Contractual	January-March	Long Term Care, Early Learning Council, Equity and Inclusion, Analytics and Evaluation, HERC, OHIT, PCPCH, Public Health, Transformation Center	None	$ 785,623.28
Other	January-March	Long Term Care, Equity and Inclusion, Grants Management, OHIT, Public Health, Transformation Center	None	$ 39,190.40
Total Direct	January-March	NA	None	$ 1,685,116.58
Cost Allocation	January-March	NA	None	$ 438,900.23
Total	January-March	NA	None	**$ 2,124,016.81**