

January 12, 2017

Lori Coyner, MA
Medicaid Director
Oregon Health Authority
421 SW Oak Street, Suite 875
Portland, OR 97204

Dear Ms. Coyner:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend Oregon's section 1115(a) Medicaid demonstration, entitled "Oregon Health Plan (OHP)" (Project Number 21-W-00013/10 and 11-W-00160/10). Approval of this extension is under the authority of section 1115(a) of the Social Security Act, and is effective from January 12, 2017, through June 30, 2022.

This extension allows the Oregon Health Plan demonstration to continue utilizing community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement. The extension will build on Oregon's progress and improve the coordinated care model, maintaining Coordinated Care Organizations' ("CCOs") focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and restraining costs.

This extension maintains Oregon's commitment to a sustainable rate of cost growth and adopts a payment methodology and contracting protocol for CCOs that advances the use of value-based payments and that promotes CCO flexibility and innovation. Specifically, the extension authorizes Oregon to provide new performance incentive payments to primary care providers under the "Patient-Centered Primary Care" medical homes and "Comprehensive Primary Care Plus" initiatives. The extension clarifies that health-related services (previously known as flexible services) delivered by CCOs that meet the regulatory definition of "Activities that Improve Health Care Quality" as specified at 45 CFR 158.150 or "Expenditures related to Health Information Technology and Meaningful Use Requirements" as specified at 45 CFR 158.151 will be included in the numerator of the Medical Loss Ratio as required under 42 CFR 438.8 and 42 CFR 438.74. The extension also transitions hospital pay for performance payments into the CCO program. The Hospital Transformation Performance Program will have a transitional one year extension through June 30, 2018, during which Oregon expects that any hospital pay for performance payments will be built into the 2018 CCO contracts.

The extension expands the coordinated care model to Medicaid and Medicare dual-eligible

members. Medicare and Medicaid dually eligible individuals who choose to enroll in the Oregon Health Plan may be passively enrolled by the state into a CCO. They retain the option to opt out and return to the fee for service system at any time.

The extension maintains and strengthens important services and protections for American Indians and Alaska Natives in Oregon. The extension maintains the services paid for under the Tribal uncompensated care (supplemental) payments while converting the program into a Medicaid benefit.

CMS approval of this extension is conditioned upon continued compliance with the STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to your written acknowledgment of the award and acceptance of the STCs within 30 days of the date of this letter. A copy of the revised STCs and expenditures are enclosed along with a copy of the waiver list.

Your project officer for this demonstration is Linda Macdonald. Ms. Macdonald is available to answer any questions concerning your section 1115 demonstration. Her contact information is as follows:

Centers for Medicare & Medicaid Services Center
for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-3872
Email: Linda.Macdonald@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Macdonald and to Mr. David Meacham, Associate Regional Administrator in our Regional Office. Mr. Meacham's contact information is as follows:

David Meacham
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Operations
701 Fifth Avenue, MS RX-200
Seattle, WA 98121

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director of the State Demonstrations Group in the Centers for Medicaid & CHIP Services at (410) 786-5647.

Demonstrations Group in the Centers for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,



Vikki Wachino
Director

Enclosures

cc: Mr. David Meacham, Associate Regional Administrator, Region X

NUMBER: 21-W-00013/0 and 11-W-00160/0

TITLE: Oregon Health Plan (OHP)

AWARDEE: Oregon Health Authority

All requirements expressed in Medicaid and Children’s Health Insurance Program (CHIP) laws, regulations and policies apply to this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. The waiver and expenditure authority provided to Oregon through this demonstration promote the objectives of title XIX. Such deviations from Medicaid requirements are limited in scope to expenditures related to the following populations affected by the demonstration:

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project. Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable Oregon to carry out the Oregon Health Plan (OHP) beginning with the approval of this demonstration period through June 30, 2022. When the state amends its Medicaid state plan to include some or all of these populations after that date, the state will submit an amendment to the demonstration updating the populations that will be affected by the demonstration.

1. Statewideness/Uniformity

**Section 1902(a)(1)
42 CFR 431.50**

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

2. Amount, Duration and Scope of Services

**Section 1902(a)(10)(A)
1902(a)(10)(B)
42 CFR 440.230-250**

To enable the state to offer different benefits for individuals whose eligibility is determined based on modified adjusted gross income (MAGI) (other than children 0-1 years of age and pregnant women and individuals enrolled in an alternative benefits package benefits) which are consistent with a prioritized list of conditions and treatments, subject to certain exceptions for protected benefits.

3. Early and Periodic Screening, Diagnosis,

Section 1902(a)(10)(A)

and Treatment (EPSDT)

and 1902(a)(43)(C)

To allow the state to restrict coverage for treatment services identified during an EPSDT screening for individuals above age 1 to the extent that such services are not consistent with a prioritized list of conditions and treatments. (Applies to all Medicaid state plan populations, except population 23.)

4. Retroactive Eligibility

Section 1902(a)(34)

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

5. Freedom of Choice

**Section 1902(a)(23)(A)
42 CFR 431.51**

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

**6. Disproportionate Share Hospital (DSH)
Reimbursements**

Section 1902(a)(13)(A)

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

7. Prepaid Ambulatory Health Plan Enrollment

**Section 1902(a)(4) as
implemented in 42 CFR
438.56(c) and 438.52**

To enable managed care entities to permit enrollees eligible through Medicaid or the CHIP state plan, a period of only 30 days after enrollment to disenroll without cause, instead of 90 days, except beneficiaries newly entering a managed delivery system. All beneficiaries newly entering a managed delivery system receive 90 days to disenroll. Beneficiaries newly entering a managed delivery system are individuals who have never had Coordinated Care Organization -enrollable Oregon Health Plan eligibility. (Applies to all Medicaid state plan populations listed in Attachment D.)

To the extent necessary to permit the state to enter into contracts with a single prepaid ambulatory health plan (PAHP) for the delivery of dental services, including preventive care, restoration of fillings, and repair of dentures, through Dental Care Organization in accordance with 42 C.F.R. § 438.52.

(Applies to all fee for service Medicaid state plan populations not enrolled in a CCO listed in Attachment D.)

To the extent necessary to permit the state to enter into contracts with a single prepaid inpatient health plan (PIHP) for the delivery of outpatient and acute inpatient mental health services, through Mental Health Organization in accordance with 42 C.F.R. § 438.52.

(Applies to all fee for service Medicaid state plan populations not enrolled in a CCO listed in Attachment D.)

Title XIX - Costs Not Otherwise Matchable (CNOM)

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

The expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Expenditure authorities 2, 3, 5, and 7, promote the objectives of title XIX by increasing overall coverage of low-income individuals in the state.
 - Expenditure authorities 2, 3, 5, and 7, promote the objectives of title XIX by increasing access to, stabilizing, and strengthening, providers and provider networks available to serve Medicaid and low-income populations in the state.
 - Expenditure authorities 3, 6, and 7, promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the state.
 - Expenditure authorities 1, 3, 4, 5, 6, and 7, promote the objectives of title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks.
1. Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in an MCO.
 2. Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.

3. Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.
4. Designated State Health Programs (DSHP). Subject to the conditions outlined in paragraph 51 and as described in section IX, a limited amount of expenditures for approved designated state health programs (DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues from tuition or high risk pool health care premiums. This expenditure authority will expire on June 30, 2017.
5. Expenditures for primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority that were restricted or eliminated from coverage effective January 1, 2010 for non-pregnant adults enrolled in OHP.
6. Hospital Transformation Performance Program (HTPP): Beginning July 1, 2014, through June 30, 2018, expenditures for incentive payments to participating hospitals for adopting initiatives for quality improvement of the Oregon health care system and the measurement of that improvement. The expenditures are limited to \$150 million total computable for each demonstration year. HTPP expenditures are further limited pursuant to Section XI. This expenditure authority will expire on June 30, 2018.
7. **Patient Centered Primary Care Homes (PCPCH) and Comprehensive Primary Care Plus (CPC+).** Subject to conditions outlined in Attachment K Comprehensive Primary Care Plus Protocol, expenditures for payments to PCPCH and CPC+ providers, that include both a capitated and performance-based incentive component (or an alternative payment methodology), for attributed Medicaid beneficiaries who are served through the state's fee-for-service delivery system.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

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

TITLE: Oregon Health Plan

AWARDEE: Oregon Health Authority

I. PREFACE

The following are the special terms and conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children’s Health Insurance Program Section 1115 (a) Medicaid demonstration extension (hereinafter referred to as “demonstration”). The parties to these STCs are the Oregon Health Authority (state) and the Centers for Medicare & Medicaid Services (“CMS”). The STCs set forth in detail in nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The STCs are effective through June 30, 2022, unless otherwise specified.

The STCs have been arranged into the following areas:

- I. Preface
- II. Program Description, Objectives, Historical Context;
- III. General Program Requirements;
- IV. The Oregon Health Plan;
- V. Delivery System Transformation;
- VI. Capitation Rates and Performance Measures;
- VII. Measurement of Quality of Care and Access to Care;
- VIII. Calculating the Impact of Health Systems Transformation and Reductions in Designated State Health Program Funding;
- IX. Designated State Health Programs;
- X. Hospital Transformation Performance Program;
- XI. Monitoring and Reporting Requirements;
- XII. General Financial Requirements for Title XIX;
- XIII. Monitoring Budget Neutrality for the demonstration;
- XIV. Evaluation of the demonstration; and
- XV. Schedule of the State Deliverables of the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Quarterly Report Guidelines
- Attachment B: Evaluation Guidelines
- Attachment C: Glossary of Terms
- Attachment D: Summary Chart of Demonstration Populations
- Attachment E: Menu Set of Quality Improvement in Focus Areas

Attachment F: Coordinated Care Organizations Services Inventory
Attachment G: DSHP Claiming and Documentation Protocols
Attachment H: Calculating the Impact of Health Systems Transformation
Attachment I: Model Tribal Engagement and Collaboration Protocol
Attachment J: Hospital Metrics and Incentive Payment Protocol
Attachment K: Comprehensive Primary Care Plus Protocol

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

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

Objectives

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

- Providing a basic benefit package;
- Insuring broad participation by health care providers;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Structuring benefits (what is covered), using a prioritized list of health care conditions and treatments.
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
 - Improving the individual experience of care;
 - Improving the health of populations; and
 - Reducing the per capita costs of care for populations through such improvements.
- Expanding the scope of services available through IHS and tribal health facilities, stabilizing the IHS and tribal health system and improving health outcomes for Medicaid and low income populations utilizing these facilities.

Historical Context: Demonstration Extensions and Amendments

1994 Initial Demonstration Approval

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

1998 Demonstration Extension

The OHP was extended by CMS for a three (3) year period through 2001.

2002 Demonstration Extension and Amendment

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

2005 Demonstration Amendment

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

2007 Demonstration Extension

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

2009 Demonstration Extension and Amendment

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

In addition, the last CMS approval authorized expanded coverage for parents and childless adults (populations 14, 17, and 18) participating in premium assistance under FHIAP from 0 up to and including 200 percent of FPL; changed the methodology for use of a 'reservation list' to be used in the management of adults waiting to enroll in the Oregon Health Plan-Standard insurance

program; and limited OHP Plus adult dental and vision services for all OHP Plus non-pregnant adults, age 21 and older effective January 1, 2010.

2012 Demonstration Amendment

As reflected in these STCs, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and a reduction of other benefits (reflected in 13 lines of the Prioritized List of Health Services for FFY2012-2013). This amendment is effective January 1, 2012.

2012 Demonstration Extension and Amendment

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

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

The design and implementation of the Oregon demonstration was driven locally; overall, the amended 1115 demonstration achieved two equally important and inter-related goals:

- **Goal 1: Medicaid Statewide Spending Growth Reduction.** The demonstration bent the Medicaid cost curve to achieve a 2 percentage point reduction in Medicaid per capita trend by June 30, 2015 of the demonstration. Progress toward and ultimate achievement of this goal was measured by reviewing the state and federal cost of purchasing care for individuals enrolled in Coordinated Care Organizations (CCOs).
- **Goal 2: Improving Statewide Care Quality and Access.** Oregon Medicaid beneficiaries experienced improved access to care and quality of care over the five-year program period of July 2012 – June 2017, compared to a baseline level of performance.

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

Oregon sought to achieve these goals without any diminution of eligibility or benefits. Instead, the state pursued several different approaches, or “levers” to drive savings and quality improvement:

- Lever 1: Improved care management experienced by beneficiaries in CCOs
- Lever 2: Administrative efficiencies in CCOs

- Lever 3: Integration of physical and behavioral health for beneficiaries in CCOs
- Lever 4: Improved care coordination experienced by beneficiaries aligned with patient-centered primary care homes (PCPCH)
- Lever 5: Use of flexible services

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

2013 Demonstration Amendment

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

2014 Amendment

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

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

2015 Amendment

In June 2015, CMS approved another extension of the uncompensated care payments to IHS or tribal health facilities operating under the ISDEAA 638 authority. This program will operate through the remaining demonstration period of June 30, 2017.

2016 Amendment

In May 2016, CMS approved an extension of the HTPP for one year, from July 1, 2016 through June 30, 2017.

2017 Demonstration Extension

In January 2017, CMS approved an extension to continue and enhance Oregon's Health System Transformation approved in 2012.

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

The demonstration seeks to improve the coordinated care model to meet the following key goals:

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

The extension of the demonstration also includes the following targeted changes:

- Extension of HTPP, from June 30, 2017 through June 30, 2018. The quality measurement period will be January 1, 2017 through December 31, 2017 and the hospital incentive payments will be made by June 30, 2018. This program will expire on June 30, 2018. Hospital pay for performance payments will transition under managed care through the CCO contracts after January 1, 2018 and if applicable will align with the requirements of 42 CFR 438.6.
- Conversion of the Tribal uncompensated care payments to a Medicaid benefit.
- Clarifying health-related services that meet the requirements as specified at 45 CFR 158.150 or 45 CFR 158.151 will be included in the numerator of the Medical Loss Ratio as required under 42 CFR 438.8 and 42 CFR 438.74.
- Allowing passive enrollment of Medicare and Medicaid dually eligible individuals into CCOs with the option to opt out at any time.
- Specifying the demonstration will not impact American Indian and Alaska Natives (AI/AN) rights to exemption from managed care, or the requirements to comply with the Medicaid

Managed Care Regulations published April 26, 2016, including the AI/AN specific provisions at 42 CFR section 438.14.

- Providing for incentive payments for Patient Centered Primary Care Homes (PCPCH) and Comprehensive Primary Care Plus (CPC+) providers that reflect provider performance in these programs for Medicaid beneficiaries who are served through the state's fee-for-service delivery system.
- Establishing minimum requirements, such as inclusion of the Model Medicaid and CHIP Managed Care Addendum for Indian Health Care Providers, and a Model CCO Tribal Engagement and Collaboration Protocol for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care Providers.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as non- applicable, must apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state thirty (30) days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

- b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the date such state legislation becomes effective, or the date such legislation was required to be in effect under federal law.
5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. Reimbursement of managed care providers will not be limited to reimbursement described in the state plan.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, reservation list, sources of non-federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in these STCs must be submitted to CMS as amendments to the demonstration (and as amendments to the state plan, if eligibility under the state plan is changed). All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. In certain instances, amendments to the Medicaid state plan may or may not require amendment to the demonstration as well. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, required reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following: :
 - a. An explanation of the public process used by the state to reach a decision regarding the requested amendment including the tribal consultation. The state must provide documentation of the state's compliance with the tribal consultation requirements outlined in STC 15. Such documentation shall include a summary of the tribal comments and identification of proposal adjustments made to the amendment request due to the tribal input;
 - b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level though the approval period using the most recent actual expenditures, as well as summary and detailed

projections of the change in the “with waiver” expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

- c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions

8. Extension of the Demonstration.

- a. Should the state intend to request an extension of the demonstration under section 1115(a) or 1115(f), the state must submit an extension request no later than six (6) months prior to the expiration date of the demonstration. A request to extend an existing demonstration under 1115(e) must be submitted at least twelve (12) months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9 of this section.
- b. Compliance with Transparency Requirements of 42 CFR 431.412. As part of the demonstration extension requests, the state must provide documentation of compliance with the transparency requirements of 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 15 of this section regarding Public Notice, Tribal Consultation and Consultation with Interested Parties. The financial data described in 42 CFR 431.412(c)(2)(v) must include five years of recent historical expenditure and enrollment data for the Medicaid and demonstration populations that are to be included in the demonstration extension, and a proposed budget neutrality test for the extension period based on recent data.

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

- a. *Notification of Suspension or Termination.* The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received, the state’s response to the comment and how the state incorporated the received comment into the revised phase-out plan.

- b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.
- c. *Phase-out Plan Requirements.* The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those eligible individuals, as well as any community outreach activities.
- d. *Phase-out Procedures.* The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- e. *Federal Financial Participation (FFP).* If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. Expiring Demonstration Authority and Transition. For demonstration authority affecting an individual's eligibility or covered benefits that expires prior to the overall demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six (6) months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. *Expiration Requirements.* The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. *Expiration Procedures.* The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

- c. *Federal Public Notice.* CMS will conduct a thirty (30) day federal public comment period consistent with the process outlined in 42 CFR §431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the thirty (30) day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the plan.
- d. *Federal Financial Participation (FFP).* FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

11. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal closeout costs. CMS will promptly notify the state in writing of the determination and the reasons for suspension or termination of the demonstration, or any withdrawal of an expenditure authority, together with the effective date;

12. Finding of Non-Compliance. The state does not relinquish either its rights to challenge the CMS finding that the state materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

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

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

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements

in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7 are proposed by the state.

- a. *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations.* In states with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 State Medicaid Director letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).
- b. *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments.* In states with Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.
- c. *Public Notice.* The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

16. The 1115 demonstration will have no impact on American Indian and Alaska Natives (AI/AN) rights to exemption from enrollment in managed care organizations, or the requirements for CCOs and other managed care entities to come into compliance with the CMS 2390-F, regulations regarding Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability published April 26, 2016, including the AI/AN specific provisions at 42 CFR section 438.14.

17. **Indian Health Care Providers.** Pursuant to 25 U.S.C. § 1647a(a)(1), the state will accept an entity that is operated by Indian Health Service (IHS), an Indian tribe, tribal organization, or urban Indian health (collectively referred to as Indian Health Care Providers or "IHCP") program as a provider eligible to be enrolled with Oregon Medicaid and receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity attests that it meets generally applicable state or other requirements for participation as a provider of health care services under the program.

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

IV. THE OREGON HEALTH PLAN

19. **Overview of the Oregon Health Plan (OHP).** OHP provides health care coverage to low-income Oregonians through programs administered by the Oregon Health Authority (OHA). All individuals eligible under the Medicaid state plan, including those eligible through mandatory and optional groups, will receive either the OHP-Plus benefit plan or the Alternative Benefits Plan approved in the Medicaid state plan, except that individuals eligible through the Breast and Cervical Cancer Treatment Program will receive full state plan benefits.

- a. **OHP Populations.** The state will provide health care coverage through the OHP programs defined within these special terms and conditions (STCs) to the Medicaid mandatory and optional groups under the Oregon state plans, as defined in the “**Summary Chart of Demonstration Populations**” (Attachment D).
- b. **Applicability of Medicaid Laws and Regulations.** All requirements expressed in Medicaid laws, regulations and policies apply to all the populations affected by this demonstration except as expressly waived or referenced as not applicable to the expenditure authorities. Those population groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration
- c. **Summary of OHP Benefit Structure.** The Oregon Health Plan demonstration has two components, offered directly through OHP Plus and the Alternative Benefits Plan. Most beneficiaries under either program receive services through managed/coordinated care delivery systems.

All beneficiaries other than individuals eligible through the Breast and Cervical Cancer Treatment Program receive the OHP Plus benefit (populations 1, 3, 4, 5, 6, 7, 8, 9 and 23 in Attachment D) which consists of:

- i. All benefits covered under the approved state plan that are also included on the prioritized list of health services (described in e. below);
- ii. For children at or over 1 year and younger than 21 years old, all EPSDT medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered, in accordance with 1905(r) of the Social Security Act that are also included on the prioritized list. Children under 1 year of age receive all EPSDT medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions, in accordance with 1905(r) of the Social Security Act.
- iii. For pregnant women, the entire Medicaid state plan Services Benefit Package, subject to necessary pre-authorization for services not in the prioritized list.

- iv. Services of traditional health workers (see n. below);
- v. Primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority, that were restricted or eliminated from coverage subject to the Prioritized List effective January 1, 2010 for non-pregnant adults enrolled in OHP;
- vi. Services of person centered primary care homes (see i. below); and
- vii. The following Medicaid benefits to the extent otherwise provided under the state plan:
 - 1. Mental Health Facility – DSH Adjustment Payments;
 - 2. Long Term Care Services;
 - a. Nursing Facility Services
 - b. Home- and Community-Based Services
 - c. Community Supported Living Services
 - d. Programs of All-Inclusive Care Elderly
 - 3. ICF/MR Services; and
 - 4. Medicare Premium Payments and Medicare cost sharing.
- d. **Prioritized List of Health Services.** One of the distinguishing features of the OHP demonstration is that OHP Plus benefits are based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services.
- f. **Oversight -- The Health Evidence Review Commission (HERC)** - The Health Evidence Review Commission (HERC) prioritizes health services for the Oregon Health Plan. The HERC is administered through the Health Policy & Analytics Division. The Commission consists of thirteen members appointed by the Governor, and includes five physicians, two health consumers, one dentist, one behavioral health representative, one complementary and alternative medicine representative, one insurance industry representative, one retail pharmacist and one public health nurse. The Health Evidence Review Commission performs a biennial review of the Prioritized List and will amend the List as required.
- g. **Modifications to the Prioritized List.** Modifications to the Prioritized List require federal approval through submission of an amendment, as described in STC 7 in order to ensure the Prioritized List is comprehensive enough to provide Medicaid beneficiaries with an appropriate benefit package. A current version of the prioritized

list of health services is maintained by the state of Oregon at the following website: <http://www.oregon.gov/oha/herc/Pages/PrioritizedList.asp>.^x During the demonstration period and as specified below the state will not reduce benefits.

- h. Ordering of the Prioritized List.** The Prioritized List is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness, cost of treatment and public values obtained through community meetings in ordering the list. In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g. common colds); (b) are primarily cosmetic in nature (e.g. benign skin lesions); or (c) have no effective treatments available (e.g. metastatic cancers).
- i. Updating the Prioritized List.** The Commission is charged with updating the list for every regular legislative session occurring in odd-numbered years. The Oregon State Legislature determines how much of the list to cover (subject to federal approval), thus setting a health care budget. Under current statutes, the Legislature can fund services only in numerical order and cannot rearrange the order of the list.
- j. Non-covered Condition and Treatment Pairs.** In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.
- k.** The state must adopt policies that will ensure that before denying coverage for a condition/treatment for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual could be furnished coverage for the problem under a different covered condition/treatment. In the case of a health care condition/treatment that is not on the prioritized list of health services, or is not part of the benefit package but is associated with a co-morbid condition for an individual with a condition/treatment that is part of the benefit package, if treatment of the covered condition requires treatment of the co-morbid condition, providers will be instructed to provide the specified treatment. The state shall provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.
- m. Changes to the Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

 - i.** The state will maintain the cutoff point for coverage at the same position on the List relative to the 2012-2013 List for the remainder of the demonstration as noted above in subparagraph (g). For a legislatively directed line change to increase

benefit coverage or a legislatively approved biennial list with substantive updating of benefits due to new evidence, an amendment request (in compliance with STC 7 will be submitted to CMS and consideration by the CMS medical review staff. Any increase in the benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in Section XIII.

- ii. For interim modifications and technical changes to the list as a result of new and revised national codes, new technology, diagnosis/condition pairing omissions, or new evidence on the effectiveness or potential harm of a service already appearing on the List, CMS will be notified of changes.
 - iii. For a change to the list not defined above that meets the terms of STCs 6 and 7, an amendment request.
- n. **Traditional Health Workers (THW).** THWs are community health workers; personal health navigators; peer support specialists; peer wellness specialists; and doulas. THWs may serve individuals currently enrolled in CCOs, and/or through the state's FFS delivery system.
- o. **Patient Centered Primary Care Homes (PCPCH):** The state includes PCPCH services in the OHP Plus Benefit Packages. The PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP participants whether they are enrolled with a CCO or served through the FFS delivery system. PCPCHs are responsible for identifying the FFS OHP enrollees that will be served under the PCPCH. CCOs are responsible for working with PCPCHs in identifying CCO enrollees that will be served under the PCPCH. PCPCHs are responsible for patient engagement.
- p. **Comprehensive Primary Care Plus (CPC+):** CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. Under this model, developed by the Center for Medicare & Medicaid Innovation (CMMI) in CMS, CPC+ practices are paid for attributed Medicare beneficiaries while states pay CPC+ practices for attributed Medicaid beneficiaries. CPC+ builds upon and enhances the PCPCH model. The state will comply with the conditions outlined in Attachment K Comprehensive Primary Care Plus Protocol.
- q. **Cost Sharing under OHP Plus**
- i. For OHP Plus, individuals may be liable for nominal copayments. No copayment liability will be imposed on pregnant women or children under the age of 19.
 - ii. The approved copayments are included in the Title XIX state plan.

- iii. Oregon uses the state plan amendment process to make changes to its OHP Plus copayment policies.

- 20. **Alternative Benefits Plan.** The mandatory state plan group, new adult group (Population 23 in Attachment D), will receive a benefits package provided through the state's approved alternative benefit plan (ABP) in the Medicaid state plan. Under the authority for Secretary-approved coverage as an ABP, CMS is approving a package of benefits for that the state determined includes at least all essential health benefits as defined using the required process, and other benefits that are both: 1) covered in accordance with the traditional benefit package under the approved state plan and 2) included on the state's prioritized list, as approved by the Secretary, to the extent that the state has authority under its section 1115 demonstration to apply the prioritized list to coverage.
- 21. **Breast and Cervical Cancer Treatment Program (BCCTP).** Individuals determined to be eligible as specified in the state plan for BCCTP services (population 21 in Attachment D) will be enrolled in the Oregon Health Plan.

V. DELIVERY SYSTEM TRANSFORMATION

Health System Transformation

- 22. Health care services authorized under this demonstration may be provided through (1) fee for service (FFS) for beneficiaries who are not required to enroll into a CCO or (2) managed care organizations called Coordinated Care Organizations (CCOs). Individuals who are not required to enroll into a CCO or who may disenroll from a CCO in accordance with 42 C.F.R. § 438.52 or who do not have another CCO option in their geographic area, will receive their services through a FFS delivery system.
 - a. Individuals receiving covered health care services through the FFS delivery system may be required to receive dental and mental health services through a managed care delivery system, specifically:
 - i. Dental Care Organizations, prepaid ambulatory health plan as defined in 42 C.F.R. § 438.2, for the provision of dental services including preventive care, restoration of fillings, and repair of dentures; and
 - ii. Mental Health Organizations, prepaid inpatient health plan as defined in 42 C.F.R. § 438.2, for the provision of outpatient and acute inpatient mental health services.
 - b. Patient Centered Primary Care Homes (PCPCH): the PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be

available to OHP beneficiaries whether they are enrolled with a CCO or served through the FFS delivery system.

23. The majority of health care services are provided through a managed care delivery system, CCOs. The CCOs provide medical, behavioral health services and dental services. The state contracts with CCO's.

a. Enrollment of OHP Populations into CCOs

- i. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.
 1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.
- ii. Tribal members must make an affirmative voluntary choice for CCO enrollment (i.e., cannot be auto-enrolled).
- iii. Dually eligible individuals must make a voluntary choice for CCO enrollment via passive enrollment.
- iv. Beginning January 1, 2018, dually eligible individuals will be voluntarily enrolled in a CCO via passive enrollment pursuant to 438.54(c) with the option to opt out and return to FFS at any time. Passive enrollment of dual eligible individual will only begin when each CCO has been determined by the state and CMS to meet certain readiness and network requirements.
 1. Dually eligible individuals will receive a ninety (90) day notice regarding passive enrollment in a CCO, where sufficient capacity exist.
 2. Dually eligibles who live in an area with two CCOs will be enrolled using the same process as other OHP members, which is based on previous enrollment, enrollment of other family members, and CCO area capacity limit.
 3. Dual eligibles who are enrolled in a dual eligible special needs plan (D-SNP) will be assigned to the affiliated CCO. Additionally, dual eligibles who are enrolled in a Medicare Advantage plan will be assigned to the affiliated CCO.
- v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.
- vi. OHA member transition strategies for FFS members with special considerations include:

1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:
 - Care management requirements based on the beneficiary's medical condition;
 - Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations;
 - Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services);
 - Availability of medically appropriate medications under the CCO formulary; and
 - Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team.
2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.
3. For dually eligible, CCOs will be required to provide a minimum 90 day continuity of care period.

Description of Delivery System Transformation

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

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

i. Governance and Organizational Relationships.

1. **Governance.** Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active

practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see 2 below); and at least two members from the community at large to ensure that the organizations decision making is consistent with the community members' values.

2. **Community Advisory Council (CAC).** The CCOs are required to convene a CAC that include representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be ongoing bodies and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.
3. **Clinical Advisory Panel.** The CCOs must establish an approach to assure best clinical practices. This approach may result in the formation of a Clinical Advisory Panel. If a Clinical Advisory Panel is formed, one of its members must serve on the governing board.
4. **Partnerships.** The CCOs are required to establish agreements with mental health authorities and county governments regarding maintenance of the mental health and community mental health safety net for its CCO enrollees and with county health departments and other publicly funded providers for certain point-of-contact services.
5. **Community Health Needs Assessment.** Every CCO must develop a shared community health needs assessment that includes a focus on health disparities in the community. The state encourages CCOs to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

b. CCO quality and access measurement. CCOs will be accountable for metrics for quality and access as described in Section VII and Attachment E, including measures to track progress in the quality improvement focus areas, measures to track quality broadly, and measures to track access. Specific measures, timeframes, and CCO reporting requirements will be determined by the state in consultation with CMS.

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

list below. The state will update the Performance Improvement Projects in Attachment E within 90 days of the demonstration approval. .

1. Reducing preventable rehospitalizations.
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by “super-utilizers”.
4. Integrating primary care and behavioral health.
5. Ensuring appropriate care is delivered in appropriate settings
6. Improving perinatal and maternity care
7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home model of care throughout the CCO network.

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

i. Health IT:

1. CCOs must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data with providers outside their organizational and systems’ boundaries. If providers do not currently have this technology, there must be a plan in place for adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program and Medicare programs with Health IT components.
 2. CCOs are required to demonstrate their capacity to use EHRs by reporting and meeting thresholds for clinical quality metrics (CQMs) and other EHR-based measures. OHA in conjunction with the Metrics and Scoring committee will continue to monitor the CCOs’ progress and use of EHRs.
 3. The state will support communities’ Health IT infrastructure efforts in all regions (e.g., counties or other municipalities) to exchange health information.
 4. These state efforts and any requirements for CCOs must align with Oregon’s state Medicaid Health IT.
- d. **Innovator Agents and Learning Collaboratives.** State shall utilize innovator agents to serve as an immediate line of communication between the CCO and the Oregon Health Authority. The innovator agents are critical in linking the needs of OHA, the

community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of the health resources in the CCO. To support the demonstration's goals of improving quality and access while managing costs, the state will:

- i. Define the innovators' roles, tasks, reporting requirements, measures of effectiveness, and methods for sharing information.
- iii. Establish a required frequency for learning collaborative meetings and require each CCO to participate. To the extent that certain CCOs are identified as underperforming (as described above), the state will plan and execute intensified technical assistance.
- iv. The information in (a) and (b) above will be incorporated into the CCO contracts.

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

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

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

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

- a. **Mandatory Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive benefits pursuant to Sections –IV and V of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR 438 and approved by CMS. Enrollees who have a choice of CCOs will be locked in to the CCO of their choice for the period of up to twelve (12) months. Table 2 below illustrates the mandatory and affirmative choice (i.e., “opt-in”) populations under the OHP.

Table 2. Populations Enrolled in CCOs.

Population	Description	In/Out of CCOs	Disenrollment Options Given ¹
1, 3, 5, 6, 7, and 8	Individuals of the identified populations other than those footnoted. ²	Mandatory in	Other CCO if available; FFS with cause
21	Breast and Cervical Cancer Treatment Program	Mandatory in	Other CCO if available; FFS with cause
23	New eligible adults	Mandatory in	Other CCO, if available; FFS with cause
1-11, and 13	Individuals of the identified populations who have Third Party Liability	Out, pending further consideration	N/A
1-11, 21	Individuals who do not meet citizenship or alien status requirements	Out	N/A
Medicaid state plan	Individuals who are receiving non-OHP Medicare (QMB, SLMB, QI)	Out	N/A
Medicaid state plan	Individuals who are eligible only to receive an Administrative Examination	Out	N/A
Medicaid state plan	Individuals who are Transplant Rx only	Out	N/A

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

Disenrollment or Opt Out Options	
With Cause	Members may change plans or disenroll to FFS at any time with cause, as defined in 42 CFR Part 438.

¹ See (b) below for more information on disenrollment/plan change options and timelines.

² Exceptions include individuals who are American Indian or Alaska Native who are permitted to enroll, but not mandatorily enrolled. Dually eligible for Medicare and Medicaid will be passively enrolled with the option to opt out and return to fee-for-service at any time.

Eligibility Redetermination	Members may change plans, if another plan is available, any time case eligibility is redetermined (at least once a year).
30-Day	Individuals auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the enrollment.
90-Day	First-time eligible members may change plans, if another plan is available, within 90 days of their initial plan enrollment.
Dually eligible individuals and tribal members can change plans or disenroll to FFS at any time.	

29. **Network Adequacy and Access Requirements.** The state must ensure that any CCO complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the OHP population. Providers must meet standards for timely access to care and services, considering the urgency of the service. Detailed standards for various levels of care (e.g., emergency care, urgency care, well care, etc.) provided by medical, dental, mental health and chemical dependency providers are those required by Oregon Administrative Rule OAR 410-141-0220 and OAR 410-141-3220 and will be reflected in the state’s quality strategy required by 42 CFR 438.204.

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

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

32. **Enrollee Communication.** In addition to beneficiary information required by 42 CFR 438.10, 42 CFR 438. 3(j) and 42 CFR 431.20, the state may allow the use of electronic methods for the beneficiary and provider communications as required by:

- 42 CFR 438.10(c) – Special rule for mandatory enrollment states – timeframes for providing information;
- 42 CFR 438.10(e) - Information for potential enrollees;
- 42 CFR 438.10(f)(2) and (3) - Right of enrollee to request and obtain information;
- 42 CFR 438.10 (g)(2) and (3) – Information for enrollees-Enrollee handbook, Other plan information, including PIPs;
- 42 CFR 438.10(h)(2), (3) and (4) – Information for enrollees-Provider directory, including PIPs;
- 42 CFR 438.100(b)(2)(iii) - information on available treatment options and alternatives; and
- 42 CFR 438.102(b)(1)(i) and (ii) – state policies on excluded services.

a. The state may allow the use of such electronic communications only if all of the following are met as required by 42 CFR 438.10(c)(6):

- i. The format is readily accessible;
- ii. The information is placed in a location on the state, CCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's website that is prominent and readily accessible;
- iii. The information is provided in an electronic form which can be electronically retained and printed; and
- iv. The information is consistent with the content and language requirements of this section; and.
- v. The enrollee is informed that the information is available in paper form without charge upon request and provides it upon request within five (5) business days.

33. Transparency/Public Reporting.

- a. The state must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO).
- b. The state shall publish data regarding CCOs' performance on state-selected quality measures on its website, by CCO but at aggregate levels that do not disclose information otherwise protected by law and data that measures the state's progress toward achieving the two primary goals of this demonstration.

34. State Oversight of the CCOs. The state Agency must have in effect a monitoring system for all managed care programs as required per 42 CFR 438.66 in its entirety, as well as ensure through contracts between the State and a CCO, PIHP, or PAHP the collection of encounter data as required by 42 CFR 438.242(4)(c).

35. Tribal Engagement and Collaboration Protocol. The state, with tribes, Indian Health Service facilities, and urban Indian Health Programs, must develop and submit to CMS for approval of a Model Tribal Engagement and Collaboration Protocol (Attachment I) no later than 90 calendar days after the demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment I of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs.

CCOs will be required to adopt either the state's Model CCO Tribal Engagement and Collaboration Protocol or a policy agreed upon in writing by the CCO and every tribe and Indian Health Care Provider (IHCP) in the CCO's region. The model protocol establishes minimum requirements, such as inclusion of the Model Medicaid and CHIP Managed Care Addendum for IHCPs, and protocols for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and IHCP.

In addition to adopting the Model CCO Tribal Engagement and Collaboration Protocol, CCO governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on tribes in their region and IHCPs and on

the needs of both tribal and urban Indian populations.

Further specifications for engagement and collaboration among (a) tribes, IHS facilities, and urban Indian health programs and (b) CCOs and the state, will be described by the Model CCO Tribal Engagement and Collaboration Protocol (Attachment I).

VI. CAPITATION RATES AND PERFORMANCE MEASURES

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

- a. The state will transition to a payment system that rewards health outcomes improvement and not volume of services. As part of this transition, the state will ensure through its CCO contracts that value-based payment (VBP) arrangements, structured to improve quality and manage cost growth, are used by CCOs with their network providers. The state will develop a VBP plan that describes how the state, CCOs and network providers will achieve a set target of VBP payments by the end of the demonstration period. The VBP plan will provide a broad definition of VBP and include a schedule that ensures phased-in implementation over the course of the demonstration. The state will work with CCOs and network providers to develop this VBP plan. To the extent that the state requires specific payment mechanisms that direct CCOs' expenditures under the contracts between the State and the CCOs, the state shall comply with 42 CFR 438.6(c).
- b. The state will employ "global budgets" to compensate CCOs. A global budget will represent the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services.
 - i. No payment will be made for CCO enrollees to Dental Care Organizations, if dental services are included in the CCO benefit package. No payment will be made for CCO enrollees to Mental Health Organizations, if mental services are included in the CCO benefit package.
 - ii. Attachment F provides a proposed schedule of inclusion of services into the CCO global budgets. CCOs will be at risk for services included in Attachment F. While the intent is to include as many services as possible within the PMPM payment methodology, the state will work in collaboration with CMS to determine the most appropriate methodology for adding any additional services to the global budget.
- c. The state will implement a three-year rolling Medical Loss Ratio (MLR) standard, where:
 - i. CCOs calculate and report their MLR annually and in line with state requirements and federal requirements, as described in 42 CFR 438.8 and 438.74;

- ii. Each year, a three-year average MLR is calculated based on the CCOs' MLRs from the previous three years;
 - iii. This three-year average is compared against the state's MLR standard; and
 - iv. CCOs with a three-year MLR below the state's standard must rebate to the state an amount equal to: (the difference between the CCO's three-year MLR and the state's standard) multiplied by (the CCO's adjusted premium revenue, as defined in 438.8(f)(1), for the year).
- d. The state will update the CCO contract language to require the CCOs to consider using alternative services including, "in-lieu of services" pursuant to 438.3(e)(2), "health-related services" "flexible services," and "non-encounterable services." CCOs are always at liberty to offer any additional value added services at their discretion, as allowed under 42 CFR 438.3(e)(1)(i). Since enrollees may need or benefit from additional services that are not in-lieu-of services, but could ultimately improve the enrollee's health, CCOs should consider providing these services as necessary.
- i. For purposes of this STC, an "in lieu of service" is a setting or service that is determined by the state to be a medically appropriate and cost effective substitute for a service or setting covered under the state plan. In-lieu of services must meet the requirements of 42 CFR 438.3(e)(2).
 - ii. For the purposes of these STCs, "health-related services" include "flexible services," which are cost-effective services offered as an adjunct to covered benefits, and "community benefit initiatives," which are community-level interventions focused on improving population health and health care quality.
 1. Health-related services are not considered Medicaid covered services;
 2. Health-related services are intended to promote the efficient use of resources and, in many cases, target social determinants of health; unlike in-lieu-of services, health-related services are not substitutes for state plans services; and
 3. CCO expenditures for health related services must be paid for from the CCO's savings from improved health and more efficient use of resources, and will not be considered in setting capitation rates (except to the extent that such services may result in savings or performance based incentives as described in subparagraph (e)).
 - iii. The CCO contracts must not require CCOs to provide specific in-lieu of services or health-related services, although the contract may require the CCOs to consider the use of such services when it could improve an enrollee's health or promote the efficient use of resources.

1. An enrollee cannot be required to use an in-lieu of service or a health-related service. A CCO's offer to provide an in-lieu-of-service or health related service does not change the CCO's obligation to provide all covered services under the contract between the state and the CCO.
 2. The state must comply with the contracting, reporting and rate-setting requirements for in-lieu-of services as specified in 438.3(e)(2).
 3. The state will report on the health-related services provided through the CCO contracts, including the effectiveness of the services in improving health and deterring higher cost care.
 4. All of a CCO's expenditures under the contract between the state and the CCO shall be used to calculate the Medical Loss Ratio as described in 42 CFR 438.8 and as used for developing the capitation rate consistent with 42 CFR 438.4(b)(9). To the extent that expenditures for health-related services meet the definition for: (a) activities that improve health care quality, as defined in 45 CFR 158.150; or (b) expenditures related to health information technology and meaningful use requirements, as defined in 45 CFR 158.151, those expenditures shall be included in the numerator of the Medical Loss Ratio as described in 42 CFR 438.8(e)(3).
- e. The contract between the CCOs and state may include performance incentives to hold CCOs accountable for lowering the growth of per capita expenditures, while improving quality. That is, the contract may include incentives to encourage CCOs creative use of health-related service delivery to improve health outcomes and reduce growth in per capita expenditures.
- i. For each demonstration year, the state will include a 1-percent capitation rate withhold that will be returned to CCOs in the previous demonstration year's performance metrics which reward timely and accurate data reporting. A CCO that successfully meets the performance metrics of timely and accurate data reporting will receive the full capitation rate. A CCO that does not meet the performance metrics will not have the withhold restored, resulting in a 1-percent rate reduction. The state will continue to follow current practice for the performance standards of timely and accurate data reporting (as described in Attachment H).
 - ii. As CCOs provide flexible health care-related services that are more cost-effective than state plan services, the per capita growth rate for capitation rates should gradually decrease over the waiver period. The state will offset the decreases with changes in the methodology to develop capitation rates; the rates will be developed and documented consistent with requirements in STC 27. Specifically, the state will develop capitation rates with a profit margin that varies by CCO, as opposed to a fixed percentage of premium for each

CCO. The capitation rates for CCOs identified as high performing (i.e., those showing quality improvement and cost reduction in the previous years) will have a higher percentage of profit margin built into their capitation rates than lower performing CCOs. This aspect of the capitation rate development will be a separate mechanism from the incentive pool.

- iii. The state will establish an incentive pool. Incentives must be designed to reduce costs and improve health care outcomes. When developing the incentive pool, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume based billing. The incentive pool will comply with the relevant portions of 438.6. The state will alert the CCOs that the incentive pool will be tied to each CCO’s performance on the quality and access metrics established under Section VII, and that the whole incentive pool amount will be at risk. The state will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark, and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance.
- iv. Incentives must be correlatively reflected in the CCO/provider agreements to ensure that the incentives are passed through to providers to reflect the arrangement with the state-CCO contract.
- v. Consistent with the table below, each subsequent demonstration year’s capitation rates and incentives will be set in the demonstration year preceding the implementation in order to apply program experience as the program matures (e.g., demonstration year 16 rates and incentives will be set in demonstration year 15). The state will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

Demonstration Year	Time Period
15	July 1, 2016 – June 30, 2017
16	July 1, 2017 – June 30, 2018
17	July 1, 2018 – June 30, 2019
18	July 1, 2019 – June 30, 2020
19	July 1, 2020 – June 30, 2021
20	July 1, 2021 – June 30, 2022

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

37. Overview. Improving access and quality is a key component of the state health system transformation and measurement is necessary to determine whether the demonstration’s goal

of advancing the triple aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required.

38. **Metrics and Scoring Committee.** The state’s strategy for a robust measurement includes the Metrics and Scoring Committee. The Committee reviews data and the relevant literature, determine which measures will be included in the CCO incentive program, and establishes the performance benchmarks and targets to be used in this incentive program. The Committee will endorse specifications for each measure. In future years, the Committee will review earlier decisions and make adjustments as needed. The Metrics and Scoring Committee recommends metrics that will be used to determine financial incentives for CCOs.
39. **Additional Quality Measures and Reporting at the CCO Level.** The CCOs will be required to collect and validate data and report to the state on the metrics listed in this section, which may be revised or added to overtime as the demonstration matures . CMS also encourages the CCOs to report on the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP. .
- a. **Metrics to track quality improvement focus areas:** Pursuant to STC 20.a.ii), the state and CMS will ensure the collection and validation of measures to track progress in the quality improvement focus areas. (See Attachment E)
- b. **Core set of quality improvement measures.** The initial core measures will track the following:
- i. Member/patient experience of care (CAHPS tool or similar);
 - ii. Health and functional status among CCO enrollees;
 - iii. Rate of tobacco use among CCO enrollees;
 - iv. Obesity rate among CCO enrollees
 - v. Outpatient and emergency department utilization;
 - vi. Potentially avoidable emergency department visits;
 - vii. Ambulatory care sensitive hospital admissions;
 - viii. Medication reconciliation post discharge;
 - ix. All-cause readmissions;
 - x. Alcohol misuse-screening, brief intervention, and referral for treatment;
 - xi. Initiation & engagement in alcohol and drug treatment;
 - xii. Mental health assessment for children in DHS custody;
 - xiii. Follow-up after hospitalization for mental illness;
 - xiv. Effective contraceptive use among women who do not desire pregnancy;
 - xv. Low birth weight;
 - xvi. Developmental screening by 36 months; and
 - xvii. Difference in these metrics between race and ethnicity categories;

c. **Access improvement measures based on CCO data.** The state and CMS identified and agree to additional access measures. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.

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

d. **Access improvement measures based on state survey data.** The state identified and CMS will approve additional access measures, particularly measures based on survey data. Additional survey-based measures could include:

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

40. **Utilization of new services.** The state and CCOs must track discrete services whether it is a state plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement and as required by 42 CFR 438.242.

41. **Quality and Access Data Reporting from the State to CMS.** In accordance with STC 69, “Monitoring to Assure Progress in Meeting demonstration Goals,” the state will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the state will develop

commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 90 days of the demonstration approval, the state will submit and CMS will approve a reporting format.

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

- a. **Statewide quality, access, and expenditure monitoring and analysis.** The state, working with the CCO Innovator agents, shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The state must report to CMS any CCO issues impacting the CCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights
- a. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the state shall intervene promptly within thirty (30) days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to focused learning collaboratives and/or innovator agents, targeting underlying issues affecting outcomes, performance, access and cost.
- b. **Additional actions taken if goals are not achieved.** If the interventions undertaken pursuant to STC a.a do not result in improved performance in identified areas of concern within ninety (90) days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the state placing the CCO on a corrective action plan. The state must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the learning collaboratives and peer-support to the extent practicable.

43. External Quality Review Organization. The state is required to meet all requirements found in 42 CFR 438.364. The state will need to amend its current External Quality Review Organization (EQRO) contract to require the reporting of EQR outcomes information in the annual technical report related to findings on access and quality of care. The state must finalize the annual technical report by April 30th of each year, make available to CMS and post the most recent copy of the annual EQR technical report on the state's website as required under 438.10(c)(2) by April 30th of each year. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

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

This section establishes the parameters by which the state and CMS will annually measure the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved. Data specified in this section shall be reported on an annual basis as specified in STC 69. The state will update Attachment H within 90 days of the demonstration approval.

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

- Level 1: the per member per month expenditure to the state to *purchase* identified global budget services for populations to be mandatorily enrolled in CCOs and voluntarily enrolled CCO populations,
- Level 2: the per member per month total expenditure to the state to *purchase* services across all Medicaid service expenditures for populations that are mandatorily required to enroll in CCOs and voluntarily enrolled CCO populations regardless of whether the services are included in CCO global budgets, and

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

a. **Level 1: Global Budget Expenditures.**

These expenditures are for services identified in Attachment F for all individuals enrolled in eligibility categories that are required to enroll in CCOs (mandatory populations) and for individuals that voluntarily enroll in CCOs that are in non-mandatory enrollment populations (voluntary populations). Expenditures would also include any incentive payments, shared savings payments made to CCOs as well as wrap-around or supplemental payments for services identified in the global budget and provided to these populations. This expenditure level is the level against which the health care cost trend targets and the associated funding consequences described in STC 54 will be based.

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

These expenditures are for all Medicaid services provided to all individuals enrolled in mandatory eligibility categories as well as those individuals enrolled in voluntary populations who voluntarily enroll in CCOs. This expenditure level includes all payments described in level 1 plus all other Medicaid payments for services provided under the demonstration or the state plan to individuals described in level 1 during a demonstration year. These additional expenditures would include services such as long

term care services that are not included in the global budget service package but are provided to individuals described in level 1.

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

Population	Enrollment
Children	Mandatory
Non-disabled Adults	Mandatory
Disabled Adults	Mandatory
Dual Eligibles	Passive enrollment

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

- a. Level 1: The actual baseline PMPM will include all costs for global budget services plus all wrap-around payments for all populations whose enrollment is mandatory or voluntary (as defined in Table 2 in STC 28). The base costs for global budget services will be divided by the total applicable member months to create an aggregate PMPM.
- b. Level 2: The actual baseline PMPM will include all level 1 costs plus all other Medicaid service expenditures attributable to 2011 for all individuals in both mandatory and voluntary populations. The total base costs for global budget services will be divided by the total applicable member months.

The baseline PMPM in Level 1 will be the without Health System Transformation (HST) costs. The trend rate applied to the aggregate PMPM is 5.4% for each year in the demonstration.

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

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

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

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

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

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

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

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

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

47. **Calculation of Trend Reduction Targets:** The state must annually demonstrate the savings achieved under HST using the without HST PMPM and the HST PMPM for Level 1 expenditures each DY.

The PMPM savings percentages will be reported for each eligibility group and in the aggregate, although the savings reduction requirement will be applied only to the aggregate with and without HST expenditures. The aggregate HST PMPM must be below:

- a. The 5.4% without HST trend rate by 2 percentage points annually.

48. **Evaluating Impact on Medicare and Medicaid Expenditures for Dual Eligibles.** In addition to expenditure estimates in STCs 45, 46, and 47, CMS and the state will examine total expenditures on individuals who are dually eligible for Medicaid and Medicare who are enrolled in CCOs.

49. **Measurement of Quality and Access Under the Demonstration.** The state will also monitor and report annually on performance on metrics for quality of and access to care experienced by Medicaid beneficiaries, as described in Section VII and as required by STC 70. This reporting will help measure the extent to which the demonstration's goals are being achieved and ensure that any reductions in per capita expenditure growth are not achieved through reductions in quality and access.

Within 90 days of approval of the demonstration, the state will submit to CMS for review and approval a plan for specific quality and access measures that CMS and the state will use to monitor quality of and access to care for individuals enrolled in CCOs and for the state's

Medicaid population as a whole. The state quality and access reporting will take place on the same timeframes as the state’s annual expenditure review. Specific timeframes will be identified in the 90-day post-approval period.

IX. DESIGNATED STATE HEALTH PROGRAMS

50. Designated State Health Programs (DSHP). To support the goals of health system transformation, the state may claim FFP for the following state programs subject to the annual limits and restrictions described below through June 30, 2017, unless otherwise specified. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment G. These expenditures can be calculated without taking into account program revenues from tuition or high risk pool health care premiums.

51. Aggregate DSHP Annual Limits – Expenditure authority for DSHP between July 1, 2016 and June 30, 2017 (DY15) under the previous OHP approvals was limited to \$68 million in Federal Financial Participation (FFP).

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

Table 5. Limits on Allowable Designated State Health Programs

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

*See Table 6 for all approved programs.

- a. **Gero-Neuro.** The state may not begin claiming FFP for the Gero-Neuro program until the state begins the process to recertify the facility as an IMD meeting the inpatient

hospital requirements as set forth in 42 CFR section 440.140 which include by reference requirements for the hospital conditions of participation at 42 CFR 482. Medicaid and CHIP citizenship rules apply as a condition for receiving FFP.

- b. **Other CMS Approved DSHP.** For DY 15, the state may claim FFP for expenditures related to state health programs specified in the “other” category of Table 6 in STC 5353.

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

Table 6.

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

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

X. HOSPITAL TRANSFORMATION PERFORMANCE PROGRAM

54. **Description.** Beginning July 1, 2014, through June 30, 2018, the state will establish a hospital incentive pool, the Hospital Transformation Performance Program (HTPP), to issue incentive payments to participating hospitals for adopting initiatives for quality improvement of the Oregon health care system and the measurement of that improvement. During the administration of the HTPP, CMS and the state will continue to explore options to strengthen incentives that will accelerate health system transformation at the provider-level within the state's CCO structure. This program will expire on June 30, 2018. Hospital pay for performance payments will transition under managed care through the CCO contracts by July 1, 2018 and if applicable will align with the requirements of 42 C.F.R. § 438.6. Standard terms for the HTPP shall apply as follows:

- a. The non-federal share of payments to providers may be funded by a hospital reimbursement assessment compliant with the federal statute, regulation, and rules. All payments must remain with the provider and may not be transferred back to any unit of

government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

- b. The state must report to CMS on the funding of HTPP in a quarterly payment report, in coordination with the quarterly reporting required by STC 70 and 71, which must be submitted to CMS within sixty (60) days after the end of the each quarter.
- c. When the state claims FFP for the HTPP, the state will make available to the CMS Regional Office appropriate supporting documentation in order to determine the appropriateness of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.
- d. Changes to the HTPP are subject to amendment under STC 7.

55. Expenditure limits: The state may draw down up to the following expenditure limits in total computable expenditures through June 30, 2018:

- a. HTPP: Beginning July 1, 2014 through June 30, 2018, the state may claim HTPP payments up to \$150 million total computable.
- b. Annual Limits: The expenditure limits are calculated per year. Should the state be unable to exhaust the entirety of the annual limits, the funds cannot be rolled over into the following year.

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

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

- i. Metrics: The state shall hold hospitals to the appropriate CCO and hospital-specific metrics outlined in Attachment J, Hospital Metrics and Incentive Payment Protocol.
- ii. Incentive Payment: In demonstration years 15 and 16, the state shall make incentive payments to hospitals who have met the reporting and benchmark thresholds established by the state. Detail on incentive payment distribution methodology will be supplied through Attachment J, Hospital Metrics and Incentive Payment Protocol.
- iii. Trend Reduction: The state shall be held to the terms in Section VIII of the STCs until June 30, 2017. Section B, Expenditure Tracking for the Trend Reduction Test,

of Attachment H was updated and reflects the inclusion of the HTPP payments towards the trend approved by CMS as part of the HTPP 2016 amendment.

- iv. **Oregon Hospital Performance Metrics Committee:** The development of the hospital-specific metrics, which will be used to assess the HTPP payments, shall incorporate input from a state-convened committee, the Oregon Hospital Performance Metrics Committee. This committee comprised of members from the hospitals, coordinated care organizations, and researchers will work with the state and CMS to develop a set of hospital-appropriate benchmark metrics and targets for which the state can measure progress towards the state's health system transformation goals.
- v. The state must comply with revised Attachment J, Hospital Metrics and Payment Protocol approved by CMS on January 12, 2017 before payments can be made. Attachment J will include, at a minimum, the following information:
 - 1. Metrics that will be used in DY 13, 14, 15 and 16 and supporting narrative;
 - 2. Timeline for when performance targets will be set; and
 - 3. Timeline for when incentive payments will be made.

XI. MONITORING AND REPORTING REQUIREMENTS

- 58. **General Financial Requirements.** The state shall comply with all general financial requirements under Title XIX set forth in these STCs.
- 59. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.
- 60. **Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request, including revised budget and allotment neutrality spreadsheets consistent with these STCs.
- 61. **Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR Section 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.
- 62. **Post Award Forum:** Within six months of the demonstration's implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 69, associated with the

quarter in which the forum was held. The state must also include the summary in its annual report as required by STC 69.

63. **Submission of Post-approval Deliverables.** The state shall submit all required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (“deliverables”). The state will use the process stipulated by CMS and within the timeframes outlined within these STCs.
64. **Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state will work with CMS to:
 - a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
 - b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to are provided; and
 - c. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.
65. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS
66. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully and timely with CMS and its contractors’ evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required by the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section XI, STC 69.
67. **Deferral for Failure to Submit Timely Demonstration Deliverables.** The state agrees that CMS may issue deferrals in the amount up to \$5,000,000 (federal share) when deliverables are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS.
 - a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided.
 - i. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.
- c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
- f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

68. Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) will jointly develop the agenda for the calls. Areas to be addressed during the monitoring call include, but are not limited to:

- i. Operations and performance;
- ii. Transition and implementation activities;
- iii. Stakeholder concerns;
- iv. Operations and performance;
- v. Enrollment;
- vi. Cost sharing;
- vii. Quality of care;
- viii. Beneficiary access;
- ix. Benefit package and wrap around benefits;
- x. Audits;
- xi. Lawsuits;
- xii. Financial reporting and budget neutrality issues;
- xiii. Progress on evaluation activities and contracts;
- xiv. Related legislative developments in the state; and
- xv. Any demonstration changes or amendments the state is considering

69. Quarterly and Annual Progress Reports.

- a. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) days following the end of the DY.
- b. The Quarterly and Annual Reports shall provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report.
- c. The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.
- d. The quarterly report must at a minimum include the requirements outlined below:
 - i. Operational Updates - The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
 - ii. Performance Metrics – Progress any required monitoring and performance metrics must be included in writing in the reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.
 - iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated budget neutrality workbook with every report that meets all the reporting requirements for monitoring budget neutrality set forth in Section XII General Financial Requirements for Title XIX of the STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.
 - iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g.,

the state, health plan and provider level, and segmentation by population) to support rapid cycles assessment in trends for monitoring and evaluation of the demonstration.

- v. Enrollment Reporting. The state shall report by eligibility group (EG) and type for the title XIX and XXI state plan and populations quarterly. The state shall also report on the percent change in each category from the previous quarter and from the same quarter of the previous year.
- e. The Annual Report must include all items outlined in STC 69d. In addition, the Annual Report must at a minimum include the requirements outlined below:
- i. All items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;
 - ii. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
 - iii. Total contributions, withdrawals, balances, and credits; and
 - iv. Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.
 - v. The impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved.
 - vi. The state shall conduct surveys, at least every other year, of OHP enrollees and providers that assess the following information: enrollee health status; satisfaction with provider communication; and access to routine and specialty care. The surveys will be designed to allow analyses based on CCOs and benefit plans. The state will also monitor and report on disenrollment requests and the reasons for the requests. The state will submit changes of the survey design for CMS approval.

70. Monitoring To Assure Progress in Meeting Demonstration Goals: The state will submit to CMS a quarterly monitoring report to enable CMS to monitor the state's progress in meeting the goals of 1) Medicaid statewide spending growth reduction; and 2) Improvement of statewide quality of and access to care until June 30, 2017. After June 30, 2017, the state will continue to report annually as specified in STC 69 on the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement.

- a. **Reporting Format.** The data to be reported is specified in the following sections of the STCs:
 - i. Reducing Per Capita Expenditure Trend Growth: Section VIII (annual reporting only);
 - ii. Quality Improvement Metrics: Section VII(annual reporting only);
 - iii. Access to Care measures: Section VII (annual reporting only).

- b. **Timeframe for Reporting.** The state will submit the required annual reports within 90 days of DY15.

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

 - ii. Goal 2:
 - 1. Benchmarked metrics tied to incentive payments, including patient experience surveys;
 - 2. Data from the Medicaid billing system;
 - 3. Process Improvement Projects (PIPs);
 - 4. EQRO studies;
 - 5. Complaints and grievances;
 - 6. Health risk assessment data;
 - 7. Public health data;
 - 8. Health risk assessment data;
 - 9. Meaningful use attestation data;
 - 10. State CCO monitoring reports; and
 - 11. Additional data sources, including but not limited to evaluation of the duals demonstration.

XII. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

71. **Title XIX Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under section 1115 authority and subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not

exceed the pre-defined limits on the costs incurred as specified in Section XIII and X of these Terms and Conditions.

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

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Oregon must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual.
 - i. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver.
 - ii. Year 1 (DY 1) is defined as the year beginning October 1, 2002, and ending September 30, 2003. DY 2 and subsequent DYs are defined accordingly, through DY 9. DY 10 is defined as beginning November 1, 2011 and ending June 30, 2012. Beginning with DY 11, the Year is defined as beginning July 1, 2012 and ending June 30, 2013. DY 12 and subsequent DYs are defined accordingly. To simplify reporting, expenditures from the original Oregon Health Plan demonstration (11-W-00046/0) paid on or after October 1, 2002, shall be considered expenditures under OHP 2, and must not be reported on any Form CMS-64.9 Waiver or 64.9P Waiver for the original Oregon Health Plan demonstration.
 - iii. Up to and including the July-September 2008, QER, demonstration expenditures are to be reported on Forms CMS-64.9 Waiver and 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) in which payments were made for services.
 - iv. At the end of the demonstration, expenditures for which payment was made after the last day of the demonstration, but were for services or coverage provided during the demonstration period, are subject to the budget neutrality expenditure limit. These expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the demonstration project number assigned by CMS, with a project number extension equal to the DY number of the last year of the demonstration plus one. For example, if the last year of the demonstration is DY 8, the Forms CMS-64.9 Waiver and/or 64.9 P Waiver discussed here will bear the project number extension 09. The use of the last DY plus one as a project number extension is a reporting convention only, and does not imply any extension of the budget neutrality expenditure limit beyond the last DY.

- v. All title XIX service expenditures that are not demonstration expenditures should be reported on the appropriate Forms CMS-64.9 Waiver/64.9P Waiver for another demonstration or waiver, if applicable, or on Forms CMS-64.9 Base/64.9P Base.
- b. **Premium and Cost-Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the Eligibility Groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
 - c. **Cost Settlements.** For monitoring purposes, cost-settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver schedules, and allocated to forms named for the different EGs described in (e) below, as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to populations shall be offset against expenditures.
 - e. **Use of Waiver Forms.** The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.
 - i. “Current”: Base 1 EG expenditures;
 - ii. “New”: Expansion EG expenditures;
 - iii. “SSF”: Base 2 EG expenditures.
 - iv. DSHP Expenditures
 - v. CCO Expenditures
 - vi. Indian Health Service or tribal health facility expenditures
 - vii. Hospital Transformation Performance Program
 - f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term “expenditures subject to the budget neutrality expenditure limit” refers to (1) all title XIX expenditures with dates of service between

November 1, 2002 and the end of the OHP2 demonstration on behalf of individuals who are enrolled in this demonstration, net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse) and (2) expenditures with dates of service during the original Oregon Health Plan demonstration that are reported as OHP2 expenditures under STC 19.a.ii above. However, certain Title XIX expenditures, as identified in STC 18.c.vii, are not subject to the budget neutrality expenditure limit. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on **Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.**

- g. **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit. Nevertheless, the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10 P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration Year (DY) for which the costs were expended.
- h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the later two (2) year period, the state must continue to separately identify net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 Waiver forms, in order to account for these expenditures properly to determine budget neutrality.

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

- a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 69 of these STCs, the actual number of eligible member months for all Medicaid and demonstration Member-Month Reporting Groups (MMRGs) defined in the table below. The state must submit a statement accompanying the quarterly report, which certifies the member-month totals are accurate to the best of the state’s knowledge. These member month totals should include only persons for whose expenditures the state is receiving matching funds at the Title XIX FMAP rate. To permit full recognition of “in-process” eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

MMRG	Included Populations	Limitations
Base 1 - Direct Coverage		

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

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member months to the total. Two (2) individuals who are eligible for two (2) months each contribute two (2) eligible member months to the total, for a total of four (4) eligible member months.

74. **Standard Medicaid Funding Process.** The Standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures, consistent with the definition of an expenditure in 45 C.F.R. 95.13, made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

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

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

- c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.
- d. Tribal Health Program for Medicaid services received through an IHS and tribal health facility.
- e. Hospital Transformation Performance Program.

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

- a. CMS will review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.
- d. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the state for premiums paid by beneficiaries shall not be used as a source of state match for FFP

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

using the procedures described in STC 72. As described in STC 8(b), when the state submits its extension request, it must include five years of recent historical expenditure and enrollment data for the Medicaid and demonstration populations that are to be included in the demonstration extension, and a proposed budget neutrality test for the extension period based on recent data.

78. **Risk.** Oregon will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Oregon will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Oregon at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. .

79. **Budget Neutrality Ceiling.** The following describes the calculation of the yearly targets mentioned in STC 71. This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP through the end of the approval period.

- a. The Base 1 and Base 2 Subtotal is calculated by multiplying the actual number of member-months for each “Base 1” and “Base 2” MMRG by the appropriate PMPM cost estimate from the table in (c) below, and adding the products together.
- b. The annual limit is calculated as the sum of the Base 1 Subtotal and Base 2 Subtotal. The cumulative budget neutrality expenditure limit is equal to the sum of the annual limits over the entire period of the demonstration.
- c. The following table gives the projected PMPM costs for the calculations described above.

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

Medicaid Eligibility Group	Trend Rate	DY 16 07/01/17- 06/30/18	DY17 07/01/18- 06/30/19	DY18 07/01/19- 06/30/20	DY19 07/01/20- 06/30/21	DY20 07/01/21- 06/30/22
AFDC (Parent, Caretaker, Relative)	4.5%	\$632.45	\$660.92	\$690.66	\$721.74	\$754.21
PWO (Pregnant Women)	4.8%	\$2442.62	\$2559.86	\$2682.73	\$2811.51	\$2946.46
CMO (Children’s Medicaid Program)	3.8%	\$893.52	\$927.47	\$962.72	\$999.30	\$1037.28

BCCP	4.5%	\$3138.34	\$3279.57	\$3427.15	\$3581.37	\$3742.53
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ii. The Base 2 Eligibility Group consists of the following eligibility categories:

Medicaid Eligibility Group	Trend Rate	DY 16 07/01/17- 06/30/18	DY17 07/01/18- 06/30/19	DY18 07/01/19- 06/30/20	DY19 07/01/20- 06/30/21	DY20 07/01/21- 06/30/22
Old Age Assistance	3.6%	\$961.89	\$996.52	\$1032.40	\$1069.56	\$1108.07
Aid to Blind/Disabled	4.0%	\$3370.75	\$3505.58	\$3645.81	\$3791.64	\$3943.31
Foster Children	3.8%	\$1108.35	\$1150.46	\$1194.18	\$1239.56	\$1286.66
New ACA Adults	4.3%	\$671.77	\$700.65	\$730.78	\$762.20	\$794.98

Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage. The percentages for each EG and DY are determined based on how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer established managed care populations. In the OHP demonstration, the percentages below apply to all EGs in the same manner.

	DY 16 07/01/17- 06/30/18	DY17 07/01/18- 06/30/19	DY18 07/01/19- 06/30/20	DY19 07/01/20- 06/30/21	DY20 07/01/21- 06/30/22
Savings Percentage	25%	25%	25%	25%	25%

80. Future Adjustments to the Budget Neutrality Expenditure Limit.

- a. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under OHP. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health

care-related tax provisions of section 1903 (w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

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

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

82. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality agreement over the life of the demonstration, which will be from January 12, 2017 through June 30, 2022. CMS shall enforce the budget neutrality agreement over the life of the demonstration extension, which will be from January 12, 2017 through June 30, 2022. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration period of July 5, 2012 through January 11, 2017 (but not from any earlier approval period). To incorporate savings from the July 5, 2012 through January 11, 2017 approval period, Oregon must provide CMS a state certified and audited final assessment of budget neutrality for that period in which demonstration expenditures totals are consistent with the amounts reported by the state on the CMS-64 report (as summarized in the C Report).

83. **Exceeding Budget Neutrality.** If the budget neutrality expenditure limit defined in STC 77 has been exceeded at the end of the demonstration extension period (including Savings Phase-Out), the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XIV. EVALUATION OF THE DEMONSTRATION

84. **Independent Evaluator.** At the beginning of the demonstration period, the state must acquire an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made

in advance of running any data or due to mid-course changes in the operation of the demonstration.

85. Evaluation Design Approval and Updates. In the 90 days following the date of approval of this demonstration, the state shall submit for CMS approval a draft Evaluation Design. The state's Draft Evaluation Design may be subject to multiple revisions until the design is approved by CMS. The state must submit a revised Draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the Draft Evaluation Design, the document will be included as Attachment B to the STCs. Pursuant to 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation research and submit their evaluation implementation progress in each of the Quarterly Reports and Annual Reports as outlined in STC 69.

86. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

87. Evaluation Requirements.

- a. The demonstration evaluation will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.
 - i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.
 - ii. The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

88. Evaluation Design Requirements. The Evaluation Design shall include the following core components to be approved by CMS:

- a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of the demonstration such as improving access, improving quality of care thereby

leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for robust assessment of cost effectiveness. The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. The demonstration will result in improved access to care;
- ii. The demonstration will result in improved quality of care;
- iii. Value-based payment models will promote appropriate use of resources;
- iv. Improved access to preventive care will result in lower overall costs for the healthcare delivery system;
- v. Improved access to primary care will result in positive health outcomes; and
- vi. Enhanced care coordination will promote timely access to needed care.

These hypotheses should be addressed in the demonstration reporting described in STC 48 with regard to progress towards the expected outcomes.

89. Separately Evaluate Components of the Demonstration. The outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding all components.

- a. At a minimum, the Draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in subparagraph (b). The draft design shall discuss:
 - i. The outcome measures that must be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;
 - ii. It shall discuss the data sources and sampling methodology for assessing these outcomes; and
 - iii. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.
- b. The evaluation must outline and address evaluation questions for all of the following components:
 - i. A discussion of the demonstration hypotheses that will be tested, focusing on key areas of the state's health system transformation, including its impact on the patient experience of care, population health, and reduction in cost growth and additional demonstration outcome measures;

- ii. An analytical plan for assessing Oregon’s success in improving quality and access and reducing the growth in per capita expenditures for the Medicaid population relative to national performance and/or relative to a set of similar states.
- iii. Any other information pertinent to the state’s evaluative or formative research via the demonstration operations.
- iv. Describe the data sources and sampling methodology for assessing these hypotheses and outcomes; and
- v. Any other information pertinent to the state’s evaluative or formative research via the demonstration operations.

90. **Interim Evaluation Reports.** The state must submit a draft interim evaluation report for the completed years of the demonstration, compliant with the standards outlined in 42 CFR 431.424(d) one year prior to the current expiration date of the demonstration. In the event the state requests to extend the demonstration beyond the current approval period under the authority of Section 1115 (a), (e), or (f) of the Act, the state must submit an interim evaluation report. The state will provide a final report thirty (30) days after receiving comments from CMS.

- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration’s expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state requests changes to the demonstration, it must identify research questions and hypotheses related to the changes requested and an evaluation design for addressing the proposed revisions

91. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration’s current approval period represented in the STCs within eighteen (18) months following the end of the approved demonstration period. The Summative Evaluation Report must include the information in the approved evaluation design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within thirty (30) days of receiving comments from CMS.

92. **State Presentations for CMS.** The state will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 74. The state shall

present on its interim evaluation in conjunction with STC 90. The state shall present on its summative evaluation in conjunction with STC 91.

93. **Public Access.** The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within thirty (30) days of approval by CMS.
- a. For a period of twenty-four (24) months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party directly connected to the demonstration. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given thirty (30) days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

XV. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD

Date Specific	Deliverable	STC Reference
Within six (6) months of the demonstration’s implementation and annually thereafter.	Post Award Forum	Section XI, STC 62
120 days after approval	Submit Draft Evaluation Design	Section XIV, STC 85
Within sixty (60) days of receipt of CMS comments.	Submit Final Evaluation Design	Section XIV, STC 85
One year prior to current expiration date, June 30, 2022	Draft Interim Evaluation Report	Section XII, STC 90
Within 18 months of the end of the demonstration period (June 30, 2022)	Summative Evaluation Report	Section XIV, STC 91

Recurring Date	Deliverable	STC Reference
No later than October 1st	Annual Reports	Section XI, STC 69
Quarterly	Quarterly Reports	Section XI, STC 69
Quarterly	CMS-64 Expenditure Reports	Sections XI and XII, STCs 71 and 74
Annually (included in annual report submission)	State Quality Strategy	Sections V and XI, STC 29 and 61

Attachment A - Quarterly Report Guidelines

(Updated August 24, 2017)

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I. Introduction

A. Letter from the State Medicaid Director

Executive summary of report: This summary should provide a high level overview of important findings during the quarter, highlight the report's contents and key points.

B. About the Oregon Health Plan demonstration

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

C. State Contact(s)

Self-explanatory

II. Title

Title Line One – Oregon Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 11 – Quarter 1 (7/2012 – 9/2012)

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

III. Overview of the current quarter

The content in this section should provide a statewide overview of the effect, or impact, of changes – positive, negative or with neutral effect –that are noteworthy because they reflect trends, major policy modifications or planned or unforeseen occurrences that affect:

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

A. Enrollment progress

Narrative about enrollment strategies; progress or difficulties with enrollment; and interventions. Refers to Appendix A (Enrollment Reports). The state will explore the development of an enrollment dashboard to supplement reporting.

B. Benefits

Narrative about changes in benefit coverage resulting from HERC (for non-pharmacy coverage), P&T Committee (for pharmacy coverage), and other coverage changes resulting from legislative or federal mandates. Please ensure that the source of the resulting benefit change is clearly noted.

C. Access to care

Narrative should include an overview of relevant impacts on CCO and Fee-for-Service populations and delivery systems.

On an annual basis, the state will report on statewide workforce development. The state will provide a report on the number of certified Traditional Health Workers and THW programs (see tables 1 and 2). To the extent possible, the report will highlight improvements in outreach and mobilization of patients, community and cultural liaising, managing and coordinating care, assisting in system navigation, and health promotion and coaching, as a result of workforce development.

Table 1: Certified traditional health workers (THWs) (annual reporting)

THW Type	Greater Portland	Columbia Gorge	Willamette Valley	Oregon Coast	Central Oregon	Southern Oregon	Eastern Oregon
Community Health Workers (CHW)							
Personal Health Navigator (PSN)							
Peer Wellness Specialist							
Peer Support Specialist							
Other THW							
Total							

Table 2: THW programs that are active or in development (annual reporting)

Please visit [the THW website](#) for a list of all active programs including name, location and website.

Region	Active programs				In Development
	CHW	Peer Support	Peer Wellness	Other	
Greater Portland					
Columbia Gorge					
Willamette Valley					
Oregon Coast					

Central Oregon					
Southern Oregon					
Eastern Oregon					
Total					

D. Quality of care (annual reporting)

Narrative should include an overview of relevant impacts on CCO and Fee-for-Service populations and delivery systems (annual reporting). Reporting could include but is not limited to the following areas: Quality Assessment and Performance Improvement plan/Transformation Plan, improvements in quality of care measures, HERC evidence review process (e.g., coverage guidance).

E. Complaints, grievances and hearings

Narrative of significant trends and interventions.

1. CCO and FFS complaints and grievances

For CCOs, refer to CCO logs in Appendix B. Discussion to include:

- Rate of complaints and grievances per CCO and in FFS
- Trends across quarters, including total number of year to date complaints and grievances with percentages
- Interventions to resolve complaints and grievances trends

2. CCO and FFS appeals and hearings

For CCOs, refers to CCO logs in Appendix C. Narrative to include trends and interventions.

F. CCO activities

For each of the following areas, the narrative should describe the specific change; the effect on the delivery system and members; the number of CCOs affected; and the number of members affected.

1. New plans

Narrative should highlight any new plans serving the Medicaid population.

2. Provider networks

Narrative should highlight any relevant changes in physical health, oral health and behavioral health networks, including the purpose of the change and outcomes, if available.

3. Rate certifications

Narrative

4. Enrollment/disenrollment

Narrative

5. Contract compliance

Narrative should provide an overview of trends across the state (e.g., summary from MCO/CCO collaborative).

6. Relevant financial performance

Also refer to reporting on Lever 2.

7. Corrective action plans

Narrative about any corrective action plans put in place due to a lack of data reporting, quality and appropriateness of care reporting, contract compliance and reports for monitoring. The description should include:

- Entity name (CCO)
- Purpose and type of CAP
- Start/end date of CAP
- Action sought
- Progress during current quarter

8. One percent (1%) withhold

Narrative should provide an overview of any corrective action preceding a withhold application and/or withhold imposed on a CCO resulting from not meeting administrative data reporting requirements.

9. Other significant activities

Narrative should include any operational trends or activities that have a large impact on the

G. Health Information Technology

Narrative should include substantive changes and new activities/accomplishments in HIT program areas that are relevant to and/or impact CCOs, Medicaid providers, and/or Medicaid members.

H. Metrics development

Narrative should highlight any relevant committee work or other metrics development efforts impacting measure specifications. Description should include an overview of the goals and purpose of measure changes.

I. Budget neutrality

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues. Refer to Appendix E (Neutrality Reports).

J. Legislative activities

Narrative about any legislative activity specific to achieving demonstration goals or impacting the demonstration.

K. Litigation status

Narrative

L. Public forums

For any public forums (e.g., Oregon Health Policy Board, Metrics and Scoring Committee, Medicaid Advisory Committee) held during the quarter, include public comment and summary report.

IV. Progress toward demonstration goals

Primarily narrative section focusing on the levers that are expected to drive quality improvement and cost trend reduction under the waiver, and results available to date regarding progress toward demonstration goals. Discussion of progress to date on waiver goals: reducing per-member cost growth, and improving quality, access, member experience and health outcomes.

A. Improvement strategies

To meet the goals of the three-part aim, Oregon's coordinated care model and FFS delivery systems rely on six key levers to generate savings and quality improvements and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that the Oregon Health Authority will take in the form of the stimuli and supports described below, they comprise a roadmap for achieving Oregon's vision for better health, better care and lower costs.

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes (PCPCH).
- Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes.
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care.
- Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources.

- Lever 5: Implementation of health-related services aimed at improving care delivery, enrollee health, and lowering costs.
- Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Transformation Center

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes (PCPCH)

This is a narrative providing an overview of the current quarter’s: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) overview of progress of evaluation activities and interim findings, including key milestones accomplished, as well as other challenges encountered and how they were addressed; and 3) trends, successes, or issues. Improvement strategies noted in the quarterly reports may include, but are not limited to the following:

Patient-Centered Primary Care Homes

Certified Community Behavioral Health Clinics

Tribal Care Coordination

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

This is a narrative providing an overview of the current quarter’s: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) overview of progress of evaluation activities and interim findings, including key milestones accomplished, as well as other challenges encountered and how they were addressed; and 3) trends, successes, or issues. Improvement strategies noted in the quarterly reports may include, but are not limited to the following:

CCO Financial Reports

Narrative should include a description of VBP use among CCOs and innovative payment arrangements between CCOs and sub-contracted service delivery network.

Quality pool – CCO incentives (semi-annual reporting)

Disbursement of the CCO quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures. Funds from the quality pool will be distributed on an annual basis, with the calendar year payment made by June 30 of the following year.

Federally Qualified Health Center Alternative Payment Methodology Program

Comprehensive Primary Care Plus (CPC+)

Value-Based Payment Innovations and Technical Assistance

Progress towards meeting VBP targets outlined in the VBP Framework (annual reporting)

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

This is a narrative providing an overview of the current quarter's: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) overview of progress of evaluation activities and interim findings, including key milestones accomplished, as well as other challenges encountered and how they were addressed; and 3) trends, successes, or issues. Improvement strategies noted in the quarterly reports may include, but are not limited to the following:

Statewide Performance Improvement Project

Behavioral Health Collaborative Implementation

Roadmap to Oral Health

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

This is a narrative providing an overview of the current quarter's: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) overview of progress of evaluation activities and interim findings, including key milestones accomplished, as well as other challenges encountered and how they were addressed; and 3) trends, successes, or issues. Improvement strategies noted in the quarterly reports may include, but are not limited to the following:

Sustainable Relationships for Community Health program

Process Improvement (workflow) Technical Assistance

Reporting Simplification Efforts

Innovator Agents

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

This is a narrative providing an overview of the current quarter's: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) overview of progress of evaluation activities and interim findings, including key milestones accomplished, as well as other challenges encountered and how they were addressed; and 3)

trends, successes, or issues. Improvement strategies noted in the quarterly reports may include, but are not limited to the following:

Health-related services

Updates about CCO use of health-related services, including flexible services and community-benefit initiatives. Include health-related services provided broken out by:

- Services that are not Medicaid state plan services but do have encounter data (e.g., alternative providers)
- Services that are not reflected in encounter data (e.g., air-conditioners, sneakers)

CCO Performance Improvement Projects

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

This is a narrative providing an overview of the current quarter's: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) overview of progress of evaluation activities and interim findings, including key milestones accomplished, as well as other challenges encountered and how they were addressed; and 3) trends, successes, or issues. Improvement strategies noted in the quarterly reports may include, but are not limited to the following:

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

Community Advisory Committee activities

Narrative

Transformation Center activities

Narrative that includes any relevant activities during the quarter related to CCO and tribal technical assistance or other activities (e.g., metrics collaboration with community partners, untested models).

B. Lower cost

Narrative about progress in meeting this goal based on results and outcomes available during the quarter reported.

Two-percent test data (reporting on an annual basis)

Narrative providing a summary of Two-Percent Trend Reduction Tracking that explains OHA's progress in meeting spending growth reduction targets.

C. Better care and Better Health

Oregon proposes replacing the metrics table with a semi-annual submission of our public facing metrics report. Report would be similar to the report found at the following link:
https://www.oregon.gov/oha/analytics/Documents/LegislativeReport_Q2-Q3_2016.pdf.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately.

2. State reported enrollment tables

Enrollment	Month/Year	Month/Year	Month/Year
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14			
Title XXI funded State Plan			
Title XIX funded Expansion Populations 9, 10, 11, 17, 18			
Title XXI funded Expansion Populations 16, 20			
DSH Funded Expansion			
Other Expansion			
<i>Pharmacy Only</i>			
<i>Family Planning Only</i>			

<i>Enrollment current as of</i>	Month/Date/Year	Month/Date/Year	Month/Date/Year
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3. Actual and unduplicated enrollment

Ever-enrolled report

The percent change in each category from the previous quarter and from the same quarter of the previous year.

POPULATION		Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Expansion	Title 19	PLM Children FPL > 170%			
		Pregnant Women FPL > 170%			
	Title 21	SCHIP FPL > 170			
Optional	Title 19	PLM Women FPL 133-170%			
		Title 21	SCHIP FPL < 170%		
Mandatory	Title 19	Other OHP Plus			
		MAGI Adults/Children			
		MAGI Pregnant Women			
QUARTER TOTALS					

* Due to retroactive eligibility changes, the numbers should be considered preliminary.

OHP eligible and managed care enrollment

The number and percentage of eligibles enrolled in managed/coordinated care

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB* *	CCOE* *	CCOG* *	DCO	MHO
Month	Total						
Month	Total						
Month	Total						
Qtr Average	Total average number						
	Average percentage						

**Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/ Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.*

***CCOA: Physical, Dental and Mental Health; CCOB: Physical and Mental Health; CCOE: Mental Health only; CCOG: Mental and Dental*

B. CCO complaints and grievances

Report will be attached separately that will provide a summary of statewide complaints and grievances reported by the CCOs for the relevant quarter. A report will not be attached if there is no activity during the relevant quarter.

C. CCO appeals and hearings

Report will be attached separately that will provide a summary of appeals and hearings for the relevant quarter. A report will not be attached if there is no activity during the relevant quarter.

D. Neutrality reports

Budget monitoring spreadsheets

Attached separately. The state currently provides three budget neutrality reports (Exhibits 1, 2, and 3). We propose to remove exhibit 1 because it is a summary of information already included in Exhibits 2 and 3. Moving forward, we will submit the following reports for budget neutrality purposes:

- OHP Section 1115 Demonstration (Expenditures)
- OHP Title XXI Allotment

E. DSHP tracking (through June 30, 2017)

Report will be attached separately.

Attachment A - Quarterly Report Guidelines

Attachment B – Evaluation Design

A. General Background Information

Demonstration Name: Oregon Health Plan – Project Numbers 11-W-00160/10 & 21-W-00013/10

Renewal Approval Date: January 12, 2017

Evaluation Period: Demonstration renewal period from January 12, 2017 to June 30, 2022

Demonstration History

Under the Section 1115 Oregon Health Plan (OHP) demonstration, Oregon promotes the objectives of Titles XIX and XXI of the Social Security Act. Since its establishment in 1994, the OHP demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth and saving the federal and state governments more than \$30.5 billion over the life of the waiver. Since the implementation of the sustainable rate of growth in 2014, Oregon has saved the Federal government more than \$1 billion through state fiscal year 2016 and is expected to save over \$7 billion cumulatively by the end of 2022.

The 1994 approval allowed the state to manage benefits and utilization through Oregon's unique Prioritized List of Health Services, which remains in use and has been an effective and efficient foundation of the OHP. It also marked the beginning of Oregon using managed care plans to serve the majority of OHP beneficiaries. The 2007 demonstration renewal allowed the state to broaden the population of children and adults served under OHP to 394,826 covered lives, and built the state's premium assistance program, the Family Health Insurance Assistance Program (FHIAP). In 2009, the renewal of the demonstration brought an important expansion in health care coverage for children in Oregon with the Healthy Kids programs (covered lives expanded to 498,450).

The 2012 demonstration renewal elevated the state's ability to integrate multiple aspects of care for beneficiaries and brought new approaches to value-based coverage for Oregon's delivery system. The 2012 demonstration was invaluable in helping build a firm foundation of quality and value-based care by transforming Oregon's health care delivery system to one of coordinated care, with 16 Coordinated Care Organizations (CCOs) – which geographically cover the entire state – now delivering physical, oral and behavioral health services to the approximately 90 percent of OHP members who are enrolled in a CCO (covered lives expanded to 667,854). The combination of the 2012 waiver and Oregon's expansion of Medicaid eligibility under the Affordable Care Act (ACA) has led to remarkable results:

1. Oregon's transformation efforts established by the previous renewal allowed the state to stand up a new model of care before the ACA expansion. Since then, the state has enrolled 402,000 newly eligible Medicaid enrollees into a new model of care, a 65 percent increase. This model of care – the coordinated care model – is more financially sustainable and has already created significant savings for the federal government, which pays the greater portion of costs for the expansion;

2. The OHP and the providers that support its delivery system reform reach over 1.1 million Oregonians, approximately 25 percent of Oregon's population;
3. With nearly 95 percent of Oregonians now enrolled in health care coverage, Oregon has one of the lowest uninsured rates in the nation: 5.3% in 2015; and
4. The federal government and the Oregon state government saved \$1.4 billion in Medicaid costs since 2012, meeting the goals of the previous demonstration: to lower the rate of growth of per capita costs, provide better care and improve health.

Oregon will continue to build on the coordinated care model and provide evidence-based, increasingly integrated services to OHP members through CCOs. For the demonstration renewal period, Oregon will expand and refine strategies in some key areas, while leaving the major components of Oregon's health system transformation in place for populations eligible under the demonstration renewal. Populations 1, 3, 4-9, 21, and 23 are eligible under the demonstration renewal.

2012-2017 Demonstration Strategies and Accomplishments

In its 2012 demonstration waiver, Oregon articulated six levers (approaches) that served as a roadmap for health system transformation and moved OHP towards achieving the Triple Aim goals of: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.³

- Lever 1: Improving care coordination at all points in the system with an emphasis on patient-centered primary care homes (PCPCHs)
- Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care
- Lever 4: Increased efficiency through administrative simplification and a more effective model of care
- Lever 5: Use of flexible services (now known as health-related services) to improve care delivery or enrollee health
- Lever 6: Testing, accelerating and spreading effective innovations and best practices

The Oregon Health Authority (OHA), CCOs, and a wide-ranging group of partners made significant progress implementing these levers from 2012-17, resulting in notable improvements for beneficiaries and the delivery system. Evaluation results from the 2012-17 demonstration, a few of which are noted below, point to the effectiveness of Oregon's health system transformation:

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

- Clinics participating in the patient-centered primary care home program cut health care costs by 4.2 percent, a savings of \$240 million, from 2012-2014. Per-person spending for primary care services and pharmacy increased, while per-person spending for specialty, inpatient, and emergency department care decreased. For every \$1 increase in primary care spending under the program, there was \$13 in savings in downstream costs.⁴ Close to 90% of CCO members are now enrolled in a patient-centered primary care home. (Lever 1)
- Medicaid funding streams for behavioral and oral health were incorporated into CCO budgets, along with non-emergency medical transportation, addiction services, and children’s wraparound services. These services were not part of the prior managed care model. A review of transformation among Oregon health plans (including all CCOs) found a significant amount of integration activity; many described investing in programs that either co-locate physical or mental health, or offering care coordinators or healthcare navigators to help bridge silos. In one example, a hospital partnered with counties and mental health providers to fund a mental health crisis center.⁵ (Lever 3)
- OHA’s Transformation Center has been an invaluable resource supporting CCO and community work on health transformation. By mid-2016, the Transformation Center had convened more than 80 sessions across six learning collaboratives, and more than 90 percent of participants reported they found sessions valuable. Annual cohorts of Clinical Innovation Fellows have implemented successful community health improvement projects and have helped to build the capacity of health system transformation leadership in the state. (Lever 5)

Sustaining and Refining Transformation in the 2017-2022 Demonstration Renewal

Oregon will continue to employ the original levers to drive health system transformation and move toward attainment of the Triple Aim. In the demonstration renewal period, the state will strengthen and refine its work in key areas to demonstrate more substantial results. Specifically, Oregon will:

- **Reinforce its commitment to the integration of behavioral health and oral health with physical health.** Improved coordination and integration of care are core elements of Oregon’s coordinated care model and of CCOs’ missions. Good coordination has been directly related to improved patient experience of care and to better outcomes.⁶ CCOs have made significant progress in linking behavioral, physical, and oral health but it will take additional time, effort, and coordination among different sectors (e.g., health care, corrections systems, counties, other agencies) to fully integrate health services. For

⁴ Gelmon, S., Wallace, N., Sandberg, B., Petchel, S., and Bouranis, N. (2016). Implementation of Oregon’s PCPCH Program: Exemplary Practice and Program Findings. Portland State University. Accessed at: goo.gl/pL6QeQ

⁵ Wright, B., Broffman, L., Rinaldi, J. (2015). Tracking Transformation: Assessing the Spread of Coordinated Care in Oregon. Center for Outcomes Research and Education, Providence Health and Services. Accessed at: goo.gl/Nyy5zC.

⁶ Dr. Robert Bree Collaborative (2017). Behavioral Health Integration Report and Recommendations. Washington State, Bree Collaborative. Accessed at: <http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf>.

example, a preliminary evaluation of the integration of dental funding showed moderate reductions (<1%) in access to dental services. These results may be explained by the fact that oral health integration was implemented at the same time as Medicaid expansion; the preliminary result showing moderate reductions may be resolved by allowing additional time for CCOs to integrate dental care into the delivery system.⁷ Similarly, behavioral health integration efforts could benefit from additional time to ensure true integration of behavioral health services. An analysis of CCOs' transformation efforts found that integration was the most common focus for planned activity in the CCO Transformation Plan, but approximately one-third of CCO's benchmarks for integration had not been met by July 2015.⁸ Some key actions that OHA and CCOs will take during the demonstration renewal period are:

- Implement and support models of care that promote integration, such as the Certified Community Behavioral Health Clinics Demonstration project.
- Support Oregon's Behavioral Health Collaborative workgroups in developing and implementing a behavioral health framework that addresses the systemic and operational barriers to integration of mental health and substance abuse services. The workgroups will concentrate in five areas: governance and financing; peer-delivered services; standards & competencies; workforce; and information technology.
- Implement recommendations from the December 2016 Oral Health Roadmap, including integrating oral health into patient-centered primary care home standards and practices, and enhancing internal coordination on oral health within OHA.
- **Encourage and support CCOs to invest in health-related services (HRS).** HRS are services not covered under Oregon's State Plan and are intended to improve care delivery and overall member health, well-being and satisfaction. HRS can be used to address social determinants of health with the goal of alleviating health disparities. In the previous demonstration period, accounting policies gave CCOs little incentive to invest in health-related services that might be counted as administrative spending or might reduce utilization of state plan services and negatively impact future capitation rates. The waiver renewal clarifies that HRS meeting the definitions of an activity that improves health care quality can be counted in the numerator of the medical loss ratio for CCOs and toward rate development in the non-benefit load, and allows CCOs to earn financial incentives if they improve quality and reduce costs using HRS.
- **Expand access to coordinated care for individuals dually eligible for Medicare and Medicaid.** While more than 55% of dual eligibles have voluntarily enrolled in a CCO for some in this population there has been a lack of clarity about local care delivery opportunities and choices. For example, where partial enrollments for dental and/or behavioral health have taken place, beneficiaries may have received more than one proof

⁷ Young, J., Kushner, J. McConnell, J. (2016). The Impact of Dental Integration in Oregon's Medicaid Program. Oregon Health and Science University, Center for Health System Effectiveness. Accessed at: goo.gl/JCPdgT.

⁸ Broffman, L., Royal, N., Rinaldi, JB, Robinson, C., Campbell, A., Tran, S. (2016). Transforming Health Care in Oregon: CCO Strategy, Activity, and Progress. Center for Outcomes Research and Education, Providence Health and Services. Accessed at: goo.gl/8p6a1g.

of eligibility, at times leading to confusion about their physical health plan membership. This renewal authorizes the state to passively enroll dual eligibles into a CCO, although members may choose to return to fee-for-service at any time. Regional transition to auto-enrollment will begin in 2018. A 2016 analysis found that CCO enrollment improved quality of care for dual eligibles to some degree, but the effects were small during the study period.⁹

- **Support increased use of value-based payments (VBP) among CCOs and their contractors.** Oregon will work with CCOs and health system contractors to develop a VBP roadmap that describes how the state, CCOs and network providers will achieve a set target of VBP payments by the end of the demonstration period. The VBP plan will provide a broad definition of VBP and include a schedule that ensures phased-in implementation over the course of the demonstration.

The state's goals for the demonstration renewal period reflect these policy changes and areas of expanded activity. As outlined in section II of the STCs, key goals for 2017-2022 are:

1. Enhance Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance driven system;
2. Encourage CCOs to address the social determinants of health and improve health equity;
3. Commit to an ongoing sustainable rate of growth, advance the use of value-based payments, and promote increased investments in health-related services; and
4. Continue to expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

Theory of Change

Since Oregon will continue to rely on the same levers as in the previous demonstration period, the driver diagram in Appendix A, titled "Medicaid Theory of Change did not need substantial revisions from the 2012-2017 demonstration period. The diagram has been revised to update OHA and CCO actions and to include the key goals for the 2017-2022 demonstration renewal.

The diagram illustrates how OHA- and CCO-level actions will drive the six levers for transformation. Those levers are directly connected to the goals for the demonstration renewal period, and are intended to produce outcomes that align with the Triple Aim, including improved quality, increased access, improved experience of care, better health, and reduced PMPM costs. For example:

- OHA actions to remove barriers to integration of care (e.g. obstacles to information sharing between substance abuse service providers and others) and CCOs' efforts to offer increasingly integrated services (e.g. co-locating services, participating in health

⁹ Kim, H., Charlesworth, C. (2016). Assessing the Effects of Coordinated Care Organizations on Dual-Eligibles in Oregon. Center for Health System Effectiveness, Oregon Health and Science University. Accessed at: goo.gl/bKsEZ2

information exchange, contracting with new kinds of providers) will help advance integration of physical, behavioral, and oral health care (Lever 3). Better integration should lead to fewer missed opportunities to provide appropriate care, improved quality (e.g. fewer ED visits for dental pain), as well as increased access (e.g. metabolic screening for individuals with mental illness).

- Automatic enrollment of dual eligibles into CCOs and CCOs' efforts to engage new members and coordinate their care across different sectors will spread best practices (Lever 6) and help create more integrated models of care (Lever 3). For dual eligible individuals, better coordination should improve the patient experience and result in better quality of care (e.g. timely blood glucose testing for individuals with diabetes)
- OHA guidance on implementation and tracking of health-related services (HRS) and the opportunity for CCOs to obtain incentives for providing HRS that improve quality and reduce costs will increase adoption of HRS (Lever 5). Input from Oregon's Medicaid Advisory Committee on priorities for addressing social determinants of health via HRS will help promote health equity (a key goal for this demonstration renewal period). By providing cost-effective health-related services instead of more intensive and expensive care, CCOs will help control per-capita cost growth.

B. Evaluation Questions and Hypotheses

Evaluation Priorities

Oregon's evaluation priorities for the renewal period stem from the policy changes and areas of expanded activity for 2017-2022. The state will focus its efforts on evaluating:

- Continued integration of behavioral, oral, and physical health care;
- Implementation and impact of health-related services, including the degree to which HRS are addressing social determinants of health; and
- The effects of transitioning to 'opt-out' CCO enrollment for dual eligible individuals, including the impact on total expenditures (per STC 48).

Oregon is committed to advancing the use of value-based payments (VBP) and will work with stakeholders to develop VBP performance targets over the course of the demonstration renewal period. The shift towards increased adoption of VBP will help contain growth in Medicaid per-capita costs. While VBP adoption will not be formally evaluated during this demonstration period, OHA will monitor the progress of CCOs and their network providers in meeting the VBP targets, and will report this to CMS in regular quarterly and annual reports.

In addition to focused evaluation work on the priorities listed above, Oregon will continue to monitor and report on a broad set of outcomes related to the overall demonstration effect. This will be accomplished via measurement of quality and access improvements (as outlined in section VII of STCs) and expenditure trend monitoring (as outlined in section VIII of STCs). See 'Additional Monitoring and Evaluation' for more detail. Collectively, these measurement,

monitoring, and evaluation efforts will help the state and CMS better understand how programs and populations are impacted by Oregon’s health system transformation.

In accordance with STCs 90 and 91, OHA will provide interim and summative evaluation reports that incorporate results from both the focused evaluations and broader monitoring of overall demonstration effects “into one program summary” (STC 89).

Evaluation Questions and Hypotheses

As referenced in section A, the state will strengthen and refine its work in key areas to demonstrate more substantial results in achieving the goals of the demonstration. In alignment with key goals and activities for the 2017-2022 waiver demonstration period, Oregon proposes the following evaluation questions and hypotheses. Methodological approaches are detailed in the next section.

1. What progress has been made in integrating behavioral and physical health care for Oregon’s Medicaid population? What effects has increased integration had on access, quality, and costs?
 - Hypothesis 1: Coordination of care for CCO members with behavioral health diagnoses will improve
 - Hypothesis 2: Ability to identify and refer members to substance abuse interventions will improve over time
 - Hypothesis 3: Integration of behavioral health services will improve access for CCO members with severe mental illness

2. What progress has been made in integrating oral and physical health care for Oregon’s Medicaid population? What effects has increased integration had on access, quality, and costs?
 - Hypothesis 1: Emergency dental visits for non-traumatic dental reasons will reduce over time for CCO enrollees
 - Hypothesis 2: Access to oral health services and dental care will improve for CCO enrollees
 - Hypothesis 3: Integration & coordination of oral health with other health services will improve for CCO enrollees

3. What degree of adoption of health-related services (HRS) has occurred? How do patients experience HRS and what impact does receipt of HRS have on quality and costs?
 - Hypothesis 1: Provision and utilization of HRS (previously known as flexible services) will increase over time
 - Hypothesis 2: Enrollees receiving HRS will report satisfaction with those services and better patient experience overall
 - Hypothesis 3: Use of HRS will be associated with reduced utilization of more intensive or higher-cost care
 - Hypothesis 4: Use of HRS will help address social determinants of health to improve individual and population health outcomes

4. What is the rate of uptake of CCO enrollment among dual eligibles (those who are newly eligible and those previously in fee-for-service)? What impact has CCO enrollment had on quality and costs for dual eligibles?
 - Hypothesis 1: The proportion of dual eligibles enrolled in a CCO will increase compared with past demonstration levels without loss of member satisfaction
 - Hypothesis 2: CCO enrollment will encourage appropriate use of clinical resources and ancillary care for dual eligible members

These evaluation questions focus on key goals for the demonstration renewal period but also address broader aspirations related to the state's commitment to the Triple Aim. Cost, access, and quality data will be used to support or disprove the hypotheses noted above.

Additional Monitoring and Evaluation

In addition to the evaluation priorities and approaches outlined in this attachment, OHA has a robust quality and measurement strategy described in attachment H. The quality strategy uses ongoing analysis and extensive measurement to drive improvement and monitor demonstration effects. CCO incentive measures and core performance metrics are reported semi-annually to the public and CMS. These measures capture topics including access, preventive care and population health, care coordination, beneficiary experience, quality of care, and health outcomes. Several incentive and performance program measures will be used when addressing specific evaluation questions; see the next section for more details. The impact of health systems transformation on per-member, per-month expenditures for different populations and categories is analyzed, as described in Attachment H, and reported annually.

In addition to regular measurement and reporting of quality and expenditures, Oregon's quarterly report to CMS will provide a progress update on the six levers for Medicaid transformation. For each lever, the report will describe: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) progress of evaluation activities and interim findings, including key milestones accomplished, challenges encountered and how they were addressed; and 3) trends, successes, or emerging issues.

When preparing the interim and summative evaluation reports, Oregon and/or its contractors will consider and synthesize results from all of these monitoring and measurement activities as well as the proposed evaluation projects focused on behavioral and oral health integration, health-related services, and dual eligibles. Together, the evaluation, quality, and measurement activities will assess Oregon's efforts to transform the Medicaid health care system.

C. Methodology

Proposed methods for addressing the evaluation questions and hypotheses listed above are described in the following tables. There are four tables total, one for each major evaluation focus areas. Please note that adjustments and refinements to these methods may occur in consultation with the independent evaluator(s), CCOs, or OHA staff, or as new data sources become available. Data for the evaluation period will be collected throughout the demonstration period.

The baselines are from a large number of sources and were used as reference points to set the benchmarks, including national baselines if local baselines do not exist. The benchmarks are aspirational targets and are different than annual improvement targets, which are set more conservatively once all baselines are known and measured. Several sources were referenced to develop the benchmarks included in the tables, including:

- Oregon Health and Science University Center for Health System Effectiveness. Summative Evaluation of Oregon’s Medicaid Waiver, 2017.
- Oregon Health Authority. Oregon Health System Transformation: CCO Metrics 2016 Final Report, 2017.
- Oregon Health Authority. Oregon’s Health System Transformation Quarterly Legislative Report, 2017.
- Oregon Health Authority. Oral Health in Oregon’s CCOs: A Metrics Report, 2017.
- Oregon Health Authority. Oregon Performance Plan October 2017 Data Report.
- Oregon Health Authority. Report to the United States Department of Justice: Report Regarding July 2015 Data, 2017.
- Sun B, Chi D, et al. Emergency Department Visits for Non-Traumatic Dental Problems: A Mixed-Methods Study, American Journal of Public Health, 2015.
- Okunseri C, Okunseri E, Thorpe JM, et al. Medications prescribed in Emergency Departments for Non-traumatic Dental Condition Visits in the United States, Med Care, 2012.
- Oregon Health Authority, Metrics and Scoring Committee. 2018 Benchmark Selection: Staff Recommendation, 2017.

OHA is committed to monitoring and addressing health disparities and proactively increasing opportunities for vulnerable or disadvantaged populations; this is reflected in the specific goals for this demonstration renewal. Wherever relevant and possible, evaluation efforts will address health equity for specific populations of focus via subpopulation analysis. Populations of focus are groups that have historically experienced disproportionately poor health outcomes, or that have been identified by Oregon’s leadership as appropriate populations on which to focus the state’s health improvement efforts. For the purpose of addressing evaluation questions, targeted health equity goals include:

- Improving quality and outcomes (e.g. emergency department (ED) visits for non-traumatic dental issues) for populations of focus over the demonstration period; and
- Reducing the quality or outcomes gap between populations of focus and a *reference population* during the demonstration period. A reference population is a group that has historically experienced favorable health outcomes relative to other groups with respect to the particular outcome or issue under examination.

Because the evaluation projects for HRS and dual eligibles already encompass obvious comparison groups (i.e. people who did not receive HRS, or people who are not dually eligible), subpopulation analysis will likely be most relevant for evaluation of behavioral and oral health integration. Nevertheless, subpopulation analysis may also be valuable for questions about uptake of the CCO model among dual eligibles, or receipt and experience of HRS among CCO members (e.g. utilization of HRS among members in rural and urban areas). Populations of focus and reference populations will be finalized in consultation with the independent evaluator(s) and

Oregon’s health policy leadership, and based on data availability. Equity subpopulation analysis is noted in the methodology tables below, if relevant.

Behavioral Health Integration Evaluation

Although the CCOs have made significant progress in the transformation area of integration of services, the behavioral health system as a whole continues to include fragmented financing and delivery systems that exacerbate poor health outcomes. Data shows consumers are not currently receiving sufficient or consistent behavioral health services throughout Oregon and there are opportunities for improvements in prevention. Health plans and their providers using the coordinated care model could better prevent and manage behavioral health and chronic conditions to help keep people healthy and out of high cost delivery settings, such as the emergency department.

Oregon will continue to build off current successes and infrastructure to help create a local governance framework for integrating mental health and substance use services. In the next phase of work, Oregon will leverage a model of community accountability, shared responsibility, transparency and open entry points for behavioral health access. CCOs, as local, patient-centered organizations, along with provider organizations, peer and family supports, and other community partners will be expected to align accountabilities and incentives within their mutual service area to accelerate integration and deliver improved population health outcomes. Oregon will continue to monitor progress towards integration.

Table 1: Behavioral Health Integration

Research Question for behavioral health integration	Outcome measures used to address the research question	Benchmark and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1: Coordination of care for members with behavioral health diagnoses will improve.					
1a. Will Emergency Department visits for physical health reasons decrease in members with severe and persistent mental illness?	- Rates of CCOs members with severe, persistent mental illness who visited emergency department (total and avoidable ED utilization) for illnesses outside the list of severe and persistent	Benchmark: Medicaid 90th national percentile for AMBED 87.75 per 1000 mm Prior Performance (2016): State: 111.7 Low CCO 77.9 High CCO 148.8	- Members with and without mental illness - Beneficiaries with both mental illness and a chronic illness such as diabetes, coronary artery disease and coronary obstructive pulmonary disease	- Medicaid fee-for-service (FFS) and CCO encounter records	- Univariate and bivariate statistics - Comparative statistics for group differences

Research Question for behavioral health integration	Outcome measures used to address the research question	Benchmark and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
	mental illnesses as defined by NQF metrics (CCO incentive measure)				
Hypothesis 2: Ability to identify and refer members to substance abuse interventions will improve over time.					
2a. Will techniques for screening of members with substance abuse issues result in more referrals?	<ul style="list-style-type: none"> - Members receiving screening, brief intervention and referral to treatment (CCO Incentive metric 2019) - Utilization rates of substance abuse intervention 	<u>SBIRT screening and referrals</u> <ul style="list-style-type: none"> - Benchmark: National 90th percentile 50.26% - Prior Performance: Medicaid national 50th percentile 40.78 - 75th percentile 44.99 - 90th percentile 50.26% 	<ul style="list-style-type: none"> - OHP members 	<ul style="list-style-type: none"> - Claims - EHRs (Clinical Quality Metrics Registry) - CCO rates of screening use 	<ul style="list-style-type: none"> - Univariate and bivariate summaries describing populations - Time-series analysis of cross sectional groups looking at change over time for the entire population
2b. Will higher referral rates correspond with increased interventions for substance abuse?	<ul style="list-style-type: none"> - Members receiving screening, brief intervention and referral to treatment (CCO Incentive metric 2019) - Population rates of substance abuse - Utilization rates of substance abuse intervention 	<u>SBIRT treatment utilization</u> <ul style="list-style-type: none"> - Benchmark: National 90th percentile 21.64% - Prior Performance (2016): Medicaid National 50th percentile 12.0% - 75th percentile 15.84% - 90th percentile 21.64% 	<ul style="list-style-type: none"> - OHP Members 	<ul style="list-style-type: none"> - Claims and encounter data - Enrollment information 	<ul style="list-style-type: none"> - Univariate and bivariate summaries describing populations - Time-series analysis of cross sectional groups looking at change over time for the entire population
Hypothesis 3: Integration of behavioral health services will improve access for CCO members with severe mental illness.					

Research Question for behavioral health integration	Outcome measures used to address the research question	Benchmark and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
<p>3a. How does the integration of behavioral health services relate to improvements in care utilization?</p>	<ul style="list-style-type: none"> - ED Utilization - Primary Care access - Access to Care (CAHPS) Other CCO metrics (to be decided) 	<p><u>CAHPS Access to Care</u></p> <ul style="list-style-type: none"> - Benchmark: 89.1% same as general Medicaid population - Prior Performance (2016): overall benchmark was 89.1% for general population <p><u>Access for primary care</u></p> <ul style="list-style-type: none"> - Benchmark: 60% - Prior Performance (2016): sliding 60% <p><u>CAHPS Access for ED Utilization</u></p> <ul style="list-style-type: none"> - Benchmark: 15% average rating improvement over course of 2017-2022 demonstration - Prior Performance: N/A 	<ul style="list-style-type: none"> - Individuals identified as having severe mental illness, severe emotional disorders, and/or SUD 	<ul style="list-style-type: none"> - Claims - CAHPS survey 	<ul style="list-style-type: none"> - Univariate and Bivariate analysis of association for integration and other outcome measures. - Multivariate regression analysis of covariates to predict utilization outcomes.

Research Question for behavioral health integration	Outcome measures used to address the research question	Benchmark and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
<p>3b. Will integration of behavioral health services improve treatment initiation and engagement?</p>	<ul style="list-style-type: none"> - Percentage of continuously enrolled members who seek treatment after screening - Percentage of members who received services in acute care settings that moved to lower acuity settings - Average duration of treatment at different acuity levels of care 	<p><u>Percentage of members who seek treatment</u></p> <ul style="list-style-type: none"> - Benchmark: Initiation 31.5% - Engagement 10.7% <p>Prior Performance (2016):</p> <ul style="list-style-type: none"> - Initiation 21.5% - Engagement: 7.7% <p><u>Change from high to low acuity</u></p> <ul style="list-style-type: none"> - Benchmark: Decrease baseline of crisis and inpatient rates by 5% for duration of years to lower acuity care <p>Prior Performance:</p> <p><u>Child</u></p> <ul style="list-style-type: none"> - Community Residential 483 (2%) - Community Treatment 25601 (91%) - Crisis 1284 (4.6%) - Inpatient 497 (1.8%) - Recovery 297 (1%) <p><u>Adult</u></p> <ul style="list-style-type: none"> - Community Residential 3081 (5%) - Community Treatment 46526 (77%) 	<ul style="list-style-type: none"> - Members who receive behavioral health services - Members receiving SUD treatment 	<ul style="list-style-type: none"> - Claims - EDIE 	<ul style="list-style-type: none"> - Multivariate regression analysis of covariates to predict utilization outcomes.

Research Question for behavioral health integration	Outcome measures used to address the research question	Benchmark and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
		<p>Crisis 4143 (7%) Inpatient 4178 (7%) Recovery 2381 (4%)</p> <p><u>Duration of treatment</u></p> <p>Benchmark: Average length of stay in acute psychiatric facility = 10 days. Number of people who stay longer than 20 days in psychiatric facility decreased by 5%. Readmits rate for 180 days to psychiatric facility decrease by 5%.</p> <p>Prior Performance: Average length of stay in acute psychiatric hospital = 11.0 days. Number of people who stay longer than 20 days = 459 members. Readmission rates for 180 day psychiatric facility = 22.7%</p>			

Hypothesis 1: Coordination of care for CCO members with behavioral health diagnoses will improve

Previous studies have shown that people with behavioral health issues are often not clinically managed for other illnesses such as diabetes, coronary artery disease or cancer.¹⁰ Specialists tend to only treat in their area of specialization and physical health care needs remain uncoordinated because roles and responsibilities for primary care management may not be known or discussed among the care team.¹¹ If behavioral health integration occurs as intended, then care for physical ailments should also improve. A comparative analysis of members with and without severe and persistent mental illness as defined by HEDIS 2017 specifications will be performed to test this hypothesis.

Hypothesis 2: Ability to identify and refer members to substance abuse interventions will improve over time

Screening, brief intervention and referral for substance abuse services (SBIRT) is being evaluated to become a CCO incentive metric for 2019. A time series analysis will be used to determine how identification of substance use disorders will impact referrals and whether those referrals result in actual service delivery. To track service delivery after an SBIRT screening, OHA will track utilization and penetration of substance use disorders services in MMIS. Over time, we would expect to see an increase in referrals and follow-up visits/treatment resulting from an SBIRT screening.

Hypothesis 3: Integration of behavioral health services will improve access to care for CCO members with severe mental illness

The implementation of the Behavioral Health Collaborative recommendations will result in further integration of behavioral, physical and oral health services. Integration, along with team-based care and care coordination, will improve services for all Oregonians. PCPCHs and CCBHCs have adopted tiered approaches to determine levels of integration of clinics. The analysis will use demographic, location and condition information as covariates together with this functional/structural integration score for a regression analysis to determine whether there are impacts on key utilization measures such as emergency department visits and outpatient visits. The analysis will define a set of people with severe mental illness and track their visits to primary care providers and health outcomes, as measured for OHP members without severe mental illness. Over time we should see a greater percentage of individuals with serious and persistent mental illness visiting primary care providers. In addition, the analysis will utilize Medicaid claims information about treatment initiation and engagement to determine treatment acuity 90 days after treatment initiation. Results will be able to demonstrate behavioral health and substance use treatment for a percentage of continuously enrolled members who disengage or change levels of treatment acuity from emergent care through recovery.

Oral Health Integration Evaluation

¹⁰ Agency for Health Research and Quality Publication No. 16-EHX027-EF. Disparities within Serious Mental Illness: Technical Brief No. 25, May 2016.

¹¹ Ibid.

Beginning on July 1, 2014, state legislation required CCOs to contract with any dental care organizations in CCOs’ service areas (ORS 414.625 Part 5). To evaluate dental integration, OHSU compared dental outcomes in two 18-month periods before and after this policy change controlling for relevant factors, such as age, that are associated with amount of dental service use.¹² After pre-post analysis it was reported that for three important measures of integration, overall findings were disappointing: access to dental services decreased slightly; visits for any procedure and core procedures decreased moderately; and emergency visits for non-traumatic dental conditions decreased moderately. Integration of oral health into the CCO delivery system is a challenge because of historic professional silos between medicine and dentistry. However, over time there has been increased recognition that overall health is also impacted by oral health.

Table 2: Oral Health Integration

Research Question for oral health integration	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1: Emergency dental visits for non-traumatic dental reasons will reduce over time for CCO enrollees.					
1a. Have non-traumatic dental visits to EDs among CCO members reduced over time?	<ul style="list-style-type: none"> - Percentage of members with ED visits with traumatic dental diagnosis - Number of ED visits for non-traumatic dental conditions per 1,000 Medicaid members 	<ul style="list-style-type: none"> - <u>Percentage of members with ED visits</u> - Benchmark: Reduce by 1% for all ED visits from Oregon baseline - Prior Performance: 2.5% in 2010 - <u>Number of non-traumatic ED visits for dental conditions</u> - Benchmark: Reduce by 10% for all non-traumatic ED visits for dental conditions from Oregon baseline - Prior Performance: 26.8% national estimate for 1997-2007 	<ul style="list-style-type: none"> - All attributed Medicaid beneficiaries with chronic conditions 	<ul style="list-style-type: none"> - Claims and Emergency Department Information Exchange - Dental registries from dentists 	<ul style="list-style-type: none"> - Comparative statistics for group differences over time

¹² Young, J., Kushner, J. McConnell, J. (2016). The Impact of Dental Integration in Oregon’s Medicaid Program. Oregon Health and Science University, Center for Health System Effectiveness. Accessed at: goo.gl/JCPdgT.

Research Question for oral health integration	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
1b. Do CCO enrollees receive follow-up care or interventions following a dental-related ED visit?	- Members with an oral health visit to the ED who receive follow up from their provider	- Benchmark: 71.4% for overall rate - Prior Performance (2016): Adult State 35.7%; Child State 53.0% - Overall CCOs – Low 26.1%; High 51.8%	- Children and adolescents under age 18 - Adults age 18 and over - General geographic locations of CCO: population density-high and low centers	- Claims data - Census data	- Univariate and bivariate statistics - Comparative statistics for group differences
Hypothesis 2: Access to oral health services and dental care will improve for CCO enrollees					
2a. Has access to oral and dental health improved over time?	- Percentage of OHP members who receive any dental service - Percentage of OHP members who received preventive visits for dental services - Dental sealants for children on molars all ages (CCO Incentive metric)	Percentage who receive any dental service (adults & children) - Benchmark: Adults 55.4%; Child 83% - Prior Performance: Adult State 33.7%; Low CCO 27.7%; High CCO 37.9% Child State 54.8%; Low CCO 41.5%; High CCO 60.4% Percentage who receive preventive visit for dental services - Benchmark: Adults 34%; Child 92% - Prior Performance: Adult State 19.4%; Low CCO 11.5%; High CCO 24.1%	- Children and adolescents under age 18 - Adults age 18 and over - General geographic locations of CCO: population density-high and low centers	- Claims / encounter records - Census data	- Univariate and bivariate descriptive statistics / process monitoring over time

Research Question for oral health integration	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
		Child State 50.1%; Low CCO 32.2%; High CCO 57.5% Dental sealants for children on molars all ages - Benchmarks: 43% - Prior Performance: State: 21.5%; High CCO 26.4%; Low CCO 17.1%			
2b. Do CCO enrollees have a regular dentist?	<ul style="list-style-type: none"> - Proportion of CAHPS respondents who report they have a regular dentist. - 	<ul style="list-style-type: none"> - Benchmark: Adult 73%; Child 95% - Prior Performance (2015): State Adult 57%; State Child 79% 	<ul style="list-style-type: none"> - Children and adolescents under age 18 - Adults age 18 and over - General geographic locations of CCO: population density-high and low centers 	<ul style="list-style-type: none"> - CAHPS Survey 	<ul style="list-style-type: none"> - Univariate and bivariate descriptive statistics and comparative statistics to examine group differences
Hypothesis 3: Integration & coordination of oral health with other health services will improve for CCO enrollees					
3a. Do most vulnerable CCO enrollees experience better integration of oral health over time?	<ul style="list-style-type: none"> - Oral health assessment for children in DHS custody (CCO incentive metric) - Dental care for adults 18-75 with diabetes or other chronic illness - 	<u>Oral health assessment for children in DHS custody</u> <ul style="list-style-type: none"> - Benchmark: 90% - Prior Performance: 74.4% <u>Dental care for adults 18-75 with diabetes or other chronic illness</u> <ul style="list-style-type: none"> - Benchmark: 53.8% - Prior Performance: 	<ul style="list-style-type: none"> - Children in foster care - Adults with diabetes 	<ul style="list-style-type: none"> - Claims / encounter records of most vulnerable groups older members with chronic conditions - DHS Registry of children in foster care 	<ul style="list-style-type: none"> - Descriptive statistics - Comparative analysis using group level comparisons to general OHP population.

Research Question for oral health integration	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
		State 24.1%; Low CCO 13.9%; High CCO 26.9%			

Hypothesis 1: Emergency dental visits for non-traumatic dental reasons will reduce over time for CCO enrollees

Non-traumatic dental conditions are dental issues that could be treated in a regular dental office rather than the emergency department (ED) – in other words, avoidable ED use for dental care. If oral health is increasingly integrated into the physical health setting and care coordination improves, we should expect to see reduced rates of emergent care visits as patients gain increased access to oral health providers for restorative care needs and preventive care visits become more routine. When hospital emergency visits for non-traumatic issues occur, follow-up care within a reasonable time frame can ensure appropriate dental treatment and prevent future ED visits. Analysis on this question will look at improvements in follow up after emergency department visits for caries and the overall rate of emergency department visits for oral health ailments. Because dentistry access may be a consideration in some locations of the state, geographic location will be used as a covariate in addition to age and chronic conditions diagnoses such as diabetes. Comparative significance tests will be performed for these groups utilizing either analysis of variance (ANOVA) or linear regression to look at how covariates impact emergency department visits as well as follow up for these visits.

Hypothesis 2: Access to oral health services and dental care will improve for CCO enrollees

One of the major challenges for some communities in remote areas of the state, is access to oral health services. Using claims data and Consumer Assessment of Health Plan and Systems (CAHPS) data, we will examine increased penetration of oral health services within various CCO geographic communities over time, particularly for children and low-density population centers. Access to preventive services is particularly critical as oral diseases are largely preventable. We will look at how access to oral health preventive services improves, including application of dental sealants for children (a CCO incentive metric for 2018).

Hypothesis 3: Integration & coordination of oral health with other health services will improve for CCO enrollees

Improved integration of oral health services into the physical health setting should result in improved use of oral services for adults with chronic illness, as physical health providers recognize the importance of oral health for managing chronic diseases like diabetes. Children in state foster care should show improved use of oral health services over time, as oral health assessments for foster children is part of a 2018 CCO incentive metric. Children in Department of Human Services (DHS) custody and individuals with chronic conditions will be compared to the general age specific OHP populations. In comparative statistical tests for DHS foster children as well as adults with diabetes and other chronic conditions, we will look for significant differences over time for the most vulnerable and complex members. Oral health integration will

likely have improved for all groups if we find that oral health integration has improved for the most complex cases within CCOs.

Health-related Services Evaluation

A qualitative-quantitative exploratory study of CCOs was conducted to determine how “flexible services” were utilized during the previous demonstration period.¹³ During this study, we found that CCOs provided member specific flexible services and community level interventions and all CCOs had the opinion that health-related services made an impact (at least short-term) on the recipient. Flexible services, specifically authorized through the 2012 demonstration, are cost-effective services offered instead of or as an adjunct to covered benefits (e.g., home modifications and healthy cooking classes). Community Benefit Initiatives (CBIs) are community-level – as opposed to member-specific – interventions focused on improving population health and health care quality, such as investments in care management capabilities or provider capacity in line with the waiver’s goals. Flexible services have generally been funded through Medicaid capitation dollars while CBIs have generally been grant-funded and were not explicitly authorized by the 2012 demonstration. Since CCOs have been using flexible services and CBIs to address member and community needs, OHA is now collectively referring to both categories as health-related services for purposes of 2017-2022 waiver renewal demonstration period. Since 2012, CCOs have provided a wide range of member specific flexible services and community level services (e.g., memberships, shelter-related supports, social supportive programs) under the flexible services policy in the past. OHA also learned that CCOs use different approaches to track and report on these services and to decide how they are deployed to members.

Table 3: Health-related Services (HRS)

Research Question for health-related services	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1: Provision and utilization of HRS (previously known as flexible services) will increase over time					
1a. Has provision of HRS increased over time?	- Use of flexible and community-benefit initiatives	- Benchmark: Units of cost or units of hours of service or other metric increase over baseline - Prior Performance:	- CCO clinic geographic or virtual communities	- Medical Loss Ratio (MLR) reporting, All Payer All Claims Data Reporting Program’s Appendix G: Annual Supplemental Provider Level APM Summary reporting, CCO	- Quantitative spending analysis

¹³ Oregon Health and Sciences University: Center for Health System Effectiveness. Presentation on Waiver Evaluation: Preliminary Findings from Interviews with CCOs Regarding Flexible Services. Oregon Health Authority, Portland, Oregon, June 1, 2017.

Research Question for health-related services	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
		Prior use not measurable		financial reports, and rate development reporting	
Hypothesis 2: Enrollees receiving HRS will report satisfaction with those services and better patient experience overall					
2a. What is the member perception of care among CCOs spending more on HRS?	- Member perception of care by CCO	- Benchmark: 90 th percentile or 67% - Prior Performance: National general overall ratings tend to be approximately 60-67% for 90 th percentile who say "always"	- Sample: CCOs that have increased spending in HRS matched to their member perception of care based on CAHPS survey - Comparisons: CCOs that have not increased spending in HRS	- Aggregate member perception of care using CAHPS surveys and tracking of HRS spending using MLR reporting, All Payer All Claims Data Reporting Program's Appendix G: Annual Supplemental Provider Level APM Summary reporting, CCO financial reports, and rate development reporting	- Perform nonparametric linear regression for each of the outcomes compared to utilization rates for HRS spending. Will adjust for disease burden based on risk factor score for CCO.
Hypothesis 3: Use of HRS will be associated with reduced utilization of more intensive or higher-cost care					
3a. Do CCOs that increase utilization of HRS spend less on more expensive care?	- Utilization of ED services - Hospitalizations - Post-acute care rehab - Outpatient specialist visits	<u>Reductions in costly care such as hospital, outpatient, specialty care and other similar services</u> - Benchmark: Reduced ED visits by 4 visits per 1,000 member months within CCOs - Reduced outpatient visits by 20	- Sample: CCOs that have increased spending on HRS - Comparisons: CCOs that have not increased spending on HRS	- Claims/encounter data - Enrollment records	- Perform nonparametric linear regression for each of the outcomes compared to utilization rates for HRS spending. Will adjust for disease burden based on risk factor score for CCO.

Research Question for health-related services	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
		visits per 1,000 member months within CCO Prior Performance (2011-2015): Overall group ED visit rate reduced 3.5 per 1,000 member months Outpatient visits reduced 31.9 per 1,000 member months			

Hypothesis 4: Use of HRS will help address social determinants of health to improve individual and population health outcomes

4a. Do CCOs use HRS to address social determinants of health (e.g., food insecurity, housing, etc.)?	- Operational descriptions for decision-making to use health-related services by clinics during course of care or to develop programs.	Benchmark: Overall positivity in comments for effectiveness of health-related services Prior Performance: N/A	- CCO clinics	- OHA will work with evaluator to develop appropriate interview protocol to be utilized in structured focus group collection of data. The topics touched on for data collection will include information regarding HRS and their impact on social determinants, including members' perception/ understanding of this work.	- Qualitative process analysis of whether CCOs are using services to address social determinants of health
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Hypothesis 1: Provision and utilization of HRS will increase over time

Questions related to delivery of care and types of health-related services will be answered by this hypothesis. To look at changes over time, the State will use existing mechanisms (e.g., MLR reporting, All Payer All Claims APM/VBP reporting, CCO financial reports, and rate development reporting) to track HRS provided through the CCOs in the demonstration renewal

period. The information collection burden is not trivial and all attempts will be made to align information requests with what most CCOs are already doing. We will explore the percentage of members who have received HRS over time to determine whether use is growing and types of services provided to individuals/families. For community benefit initiatives, we will look at spending for development and deployment. In addition, we will use informants to describe how decisions are made to use individual services and when during the course of care. Because HRS policies and definitions have changed under the 2017-2022 waiver renewal, it would be helpful to explore how HRS have been offered during the care delivery process and whether the services are readily available or whether some providers are more willing to use them than others.

Hypothesis 2: Enrollees receiving HRS will report satisfaction with those services and positive patient experience overall

We will track spending on type of service in aggregate by CCO and compare the aggregated information to member perception of care by CCO using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. The CAHPS surveys ask consumers to report on and evaluate member experiences with health care and are linked to membership utilization. Typically, members with more illnesses or more severe illness are not as satisfied with services and will give less positive satisfaction ratings.¹⁴ For this reason, it will be important to control for illness severity by examining claims for chronic illness diagnoses (e.g., chronic obstructive lung disease, asthma, congestive heart failure, coronary artery diseases, diabetes) within the analysis. It is possible, for example, to subject the data set to a regression analysis that would adjust for CCO burden of chronic disease using a risk factor score to look at spending on HRS, while controlling for risk, and perception of care by CCO.

Hypothesis 3: Use of HRS will be associated with reduced utilization of more intensive or higher-cost care

We will study how these services are used to avoid more expensive care for different groups. We will look for significant differences between per member per month payments for HRS and per member per month payments/spend on more costly services like inpatient and emergency department visits.

Hypothesis 4: Use of HRS will help address social determinants of health to improve individual and population health outcomes

HRS are intended to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. We will look at how HRS are used to address and overcome various types of social burdens that often affect people's health yet are sometimes considered outside the typical scope of medical care. HRS will be studied to determine how their deployment is intended to address the challenges faced by patients when trying to maintain their health.

Dual eligible Evaluation

¹⁴ Hall, JA, Milburn, MA, Roter, DL, Daltroy, LH Why are sicker patients less satisfied with their medical care? Health Psychology, 1098, vol 17, 1, 70-75.

According to an evaluation conducted by OHSU, dual eligible enrollment in a CCO increased the probability that dual eligibles received physical, occupational, or speech therapy services, outpatient mental health visits, and long-term services and supports and improved quality of care across several measures.¹⁵ CCOs improved some aspects of care quality but did not lead to any meaningful changes in health service use among dual eligibles. The initial evaluation was based on limited data and could benefit from additional years of data to provide a better picture of long term trends on the impact of quality of care and health service use for dual eligibles.

Table 4: Dual Eligibles

Research Question for individuals eligible for both Medicare and Medicaid (duals)	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1: The proportion of dual eligibles enrolled in a CCO will increase compared with past demonstration levels without loss of member satisfaction					
1a. What proportion of individuals with dual eligibility in Medicare and Medicaid are enrolled in CCOs?	<ul style="list-style-type: none"> - Overall population of dual eligible enrolled and changes over time - Proportion qualifying on disability - Proportion qualifying on age - Change over time from FFS to CCOs 	Changes in enrollee rates of dual eligible into CCOs and qualifying status description (i.e., age, disability) Benchmark: Improvements in dual eligible enrollment in CCOs from year to year of 15% of all baseline FFS members Prior Performance: N/A	<ul style="list-style-type: none"> - OHP population 	<ul style="list-style-type: none"> - Enrollment records - Claims-based data 	<ul style="list-style-type: none"> - Descriptive statistics / process monitoring over time on annual basis - Univariate and bivariate statistical tests of difference and change
Hypothesis 2: CCO enrollment will encourage appropriate use of clinical resources and ancillary care for dual eligible members					
2a. Do dual eligibles enrolled in CCOs receive timely, appropriate care?	<ul style="list-style-type: none"> - Access to outpatient visits - Hospitalization rates - Readmission rates - Psychiatric hospitalizations - Other utilization of specialist care 	<u>CAHPS member satisfaction</u> Benchmark: National 90 th percentile 67% Prior Performance: National general overall ratings tend to	<ul style="list-style-type: none"> - Dual eligibles enrolled members - Prior years of dually-enrolled members who were in FFS compared to CCOs 	<ul style="list-style-type: none"> - Claims-based/encounter data. - Census designations - CAHPS 	<ul style="list-style-type: none"> - Univariate-bivariate statistical tests of change over time and in comparison to prior year.

¹⁵ Kim, H., Charlesworth, C. (2016). Assessing the Effects of Coordinated Care Organizations on Dual-Eligibles in Oregon. Oregon Health and Sciences University: Center for Health Systems Effectiveness. Accessed at: goo.gl/bKsEZ2.

Research Question for individuals eligible for both Medicare and Medicaid (duals)	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
		<p>be approximately 60-67% for 90th percentile who say "always"</p> <p><u>Reduction in costly care such as hospital, outpatient, specialty services, and other similar services</u></p> <p>- Benchmark: Reduced ED visits by 2 visits per 1,000 member months within CCOs</p> <p>Reduced outpatient visits by 10 visits per 1,000 member months within CCOs</p> <p>- Prior Performance (2011-2015): Overall group ED visit rate reduced 3.5 per 1,000 member months</p> <p>Outpatient visit reduced 31.9 per 1,000 member months</p>	<p>- Geography as access factor</p>		<p>- Linear and Logistic regression</p>

Research Question for individuals eligible for both Medicare and Medicaid (duals)	Outcome measures used to address the research question	Benchmarks and Prior Performance	Sample or population subgroups to be compared	Data Sources	Analytic Methods
2b. How is CCO enrollment associated with long-term support services (nursing home, adult foster home) and other post-acute care facilities (skilled nursing, inpatient rehabilitation)?	- Service utilization for dual eligibles across care service spectrum.	- Benchmark: Descriptive measure only to track	- Dual eligible enrolled - Prior years of dually-enrolled members who were in Fee for Service compared to CCOs - Geography as access factor	- Claims based/encounter data - Census designations	- Univariate-bivariate statistical tests of change over time and in comparison to prior year. - Linear and Logistic regression

Hypothesis 1: The proportion of duals enrolled in a CCO will increase compared to past demonstration levels

Questions for this hypothesis are related to the growing demographic group and the profile of citizens qualifying under various definitions for disability and older age. The analysis will focus on understanding the categorical eligibility status (e.g., Aged Blind and Disabled, SSI eligibility) and health needs of the dual eligible will be identified and the change over time for several groups will be calculated.

Hypothesis 2: CCO enrollment will encourage appropriate use of clinical resources and ancillary care for dual eligible members

Timely and appropriate care will be investigated by looking at measures related to utilization of services in both urban and remote areas of the state for several outcomes measures including outpatient visits, hospitalization, readmission rates, psychiatric hospitalization, and specialist care for differently qualifying groups as well as a comparison to prior years without CCO saturation in the population. The impact of CCO enrollment penetration for this population will also be studied to see whether it is associated with changes to longer-term support services and post-acute care facilities

Statistical Methodology

Much of the methodology involves both qualitative and quantitative analysis. Informants and surveys will provide the qualitative data for thematic processing and organizing based on the phenomenology of the experiences reported. These will be organized to inform the quantitative data collected through claims, ratings from surveys, vital statistics, Census population reports and enrollment records. Since these data are administratively collected, they may not adhere to

the assumptions of parametric statistics. If, after examination of distributions, variables are skewed, then transformations may be required such as Bayesian or Logarithmic transformation to conduct the hypothesis testing using regression techniques. In order to deal with threats to internal validity, where possible, Oregon citizens will serve as a control group, such as would be the case using commercial healthcare payers, other matched CCO members not in the group of interest, or by using multiple time periods in combination with appropriate comparison groups. Please note that the statistical methodology may change once a contractor is selected to complete the evaluation.

D. Methodological Limitations

Limitations and threats to the evaluation relate to historical impact on all insured members that are beyond the focus of the waiver, such as national health policy changes or reform efforts. Although these potential policy changes cannot be anticipated, it is hoped that historical changes will affect both comparison groups in an equal manner and therefore not differentially contaminate one analytic group but not the other. In addition, for all comparative analyses of groups, there is a potential limitation of continuous enrollment of members over time and similar exposures to the service, particularly for variables that are encounter-related and not claims-based. The potential for churn in continuous enrollment can lead to limitations in the ability to create cross-sectional groups who have been similarly exposed to the services for the same duration of time. This concern can be overcome for claims-based variables by setting some type of enrollment threshold of a certain number of months. Another limitation to the evaluation is the potential for differential, unequal penetration rates of the integration efforts for different geographical regions of the state either due to distance or due to “message fatigue” about all the potential changes to health care policies and quality efforts. Where possible, all efforts will be made to overcome these limitations such as multiple communication channels, better clarified information and regular back-and-forth community briefings.

Analytic Challenges

Oregon has been on the cutting edge of health system transformation, has been awarded several federal grants, and undertaken a number of activities to help facilitate health system transformation process. However, because there are numerous initiatives impacting Medicaid enrollees, it is difficult to isolate the impact of this demonstration, even within specific Medicaid populations. Factors in Oregon that may complicate efforts to identify the unique impact of Oregon’s 1115 Medicaid demonstration waiver include, but are not limited to:

- **Medicaid health care providers in Oregon.** Nearly 85 percent of physicians in Oregon serve Medicaid clients and changes in care delivery at the provider level are likely to have some spill-over effects to the non-Medicaid population.
- **State Innovation Model (SIM) Grant.** This grant has been instrumental in helping to facilitate progress towards achieving the goals and milestones of health care transformation in Oregon by supporting the adoption and spread of the coordinated care model beyond Medicaid to commercial populations.

- **Comprehensive Primary Care Plus (CPC+).** CPC+ is a regionally based, multi-payer advanced medical home model offering an innovative payment structure to improve healthcare quality and delivery. This a five-year federal program beginning in January 2017, and CMS has selected 20 payers and 156 practices in Oregon to participate in CPC+. The practices are diverse and vary by size, organizational structure, geographic location and practice type. Nearly 90 percent of the practices are recognized patient-centered primary care homes and all practices are required to become PCPCHs. This additional support will make it challenging to determine whether the CPC+ program or efforts from the CCOs are affecting outcomes of interest.
- **Certified Community Behavioral Health Clinics (CCBHC).** Oregon applied and was accepted to participate in the SAMSHA 2017-2019 CCBHC Demonstration Program. CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs during a federal demonstration program with participating states. CCBHCs provide a comprehensive array of services that are necessary to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and addictions. CCBHCs also integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. These additional services through CCBHCs may make it difficult to understand the impact of CCO integration efforts underway.
- **Medicare Access and CHIP Reauthorization ACT (MACRA).** Oregon continues to actively engage in the Quality Payment Program using both Merit-Based Incentive Payment Systems (MIPS), and Advanced Alternative Payment Models (APMs) making it challenging to determine if Medicare payment reform or incentive payments may be affecting the behavior of providers who also serve Medicaid patients. Additionally, Medicare payment reform and incentive payments may be affecting the behavior of the CCOs and their ability to or interest in adopting VBPs for services.
- **National transformation efforts.** Many other states are also conducting their own transformation efforts. This could make it difficult to find a control state for comparison.
- **Shifting federal landscape.** Amendments to the Affordable Care Act and other federal policy changes currently under consideration may significantly impact how OHP services are provided and complicate efforts to assess the impact of this demonstration.

Oregon will work with the independent evaluator(s) to develop appropriate study designs and data analysis plans to help overcome these challenges.

E. Evaluation Procedures

Procurement of Independent Evaluator

Per STC 84, an independent evaluator will be acquired to conduct validation of key evaluation analyses.

OHA is establishing an intergovernmental agreement with Oregon Health & Science University's Center for Health System Effectiveness (CHSE), the evaluator for the 2012 summative evaluation, to carry out an independent evaluation of the 2017-2022 waiver.

No Conflict of Interest

The focused evaluations and preparation of the summative evaluation report will be conducted by OHA with validation by an independent third party reviewer that will be selected by some means other than sole source contracting and will follow applicable state procurement, selection and contracting procedures. The party selected for the validation will be screened to assure independence and freedom from financial conflict of interest. The assurance of such independence will be a required condition by the State in awarding the validation effort. The selected party will be required to sign a "no conflict of interest" confirmation statement.

Evaluation Budget

According to STC 86, an evaluation budget is to be included in the evaluation plan. The proposed overall evaluation budget is \$650,000. This includes four projects focused on health-related services; oral health integration; behavioral health integration; and dual eligibles. We have developed this estimated budget based on the costs of previous evaluation projects conducted using independent contractor(s) and factored in inflation.

Deliverables and Timeline

Over the course of the 2017-2022 waiver demonstration period, there will be several evaluation reports delivered to CMS. The timelines for these reports are listed below.

1. **Interim evaluation report.** As outlined in STC 90, this report will discuss evaluation progress and present findings to date. This will include work on the dual eligible (STC 48), health-related services, and behavioral and oral health integration evaluations.

As stated in STC 90, the interim evaluation report must be completed one year prior to the current expiration date of the demonstration; therefore a draft report will be delivered to CMS for review and feedback by the end of June, 2021. The final interim evaluation report will be submitted within 30 days of receiving comments from CMS.

2. **Summative evaluation report.** Similar to the interim report, the summative evaluation report will review and synthesize results from each of the topic-specific evaluations. It will also include information from the wide range of quality measurement activities and waiver expenditure trend review. As stated in STC 91, the draft summative evaluation report will be submitted to CMS within 18 months following the end of the approved demonstration period, which would be December 2023. The final summative evaluation report will be submitted within 30 days of receiving comments from CMS.
3. **Reports for specific topics.** The timing of reports for specific topics has yet to be finalized.

All four reports will be delivered to CMS by the end of the demonstration period, if not before.

CMS Notification of Reports and Publications

As stated in STC 93, final approved evaluation reports will be posted on the State Medicaid website within 30 days of approval by CMS. For a period of twenty-four months following CMS approval of the reports, CMS will be notified prior to the public release or presentation of any of these reports and related journal articles, by the state, contractor, or any other third party directly connected to the demonstration. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

Dissemination

Oregon will disseminate the results from all stages of the evaluation widely, as part of the state's commitment to feedback and continuous improvement. Key pathways for dissemination and use of evaluation findings beyond the required reporting to CMS include:

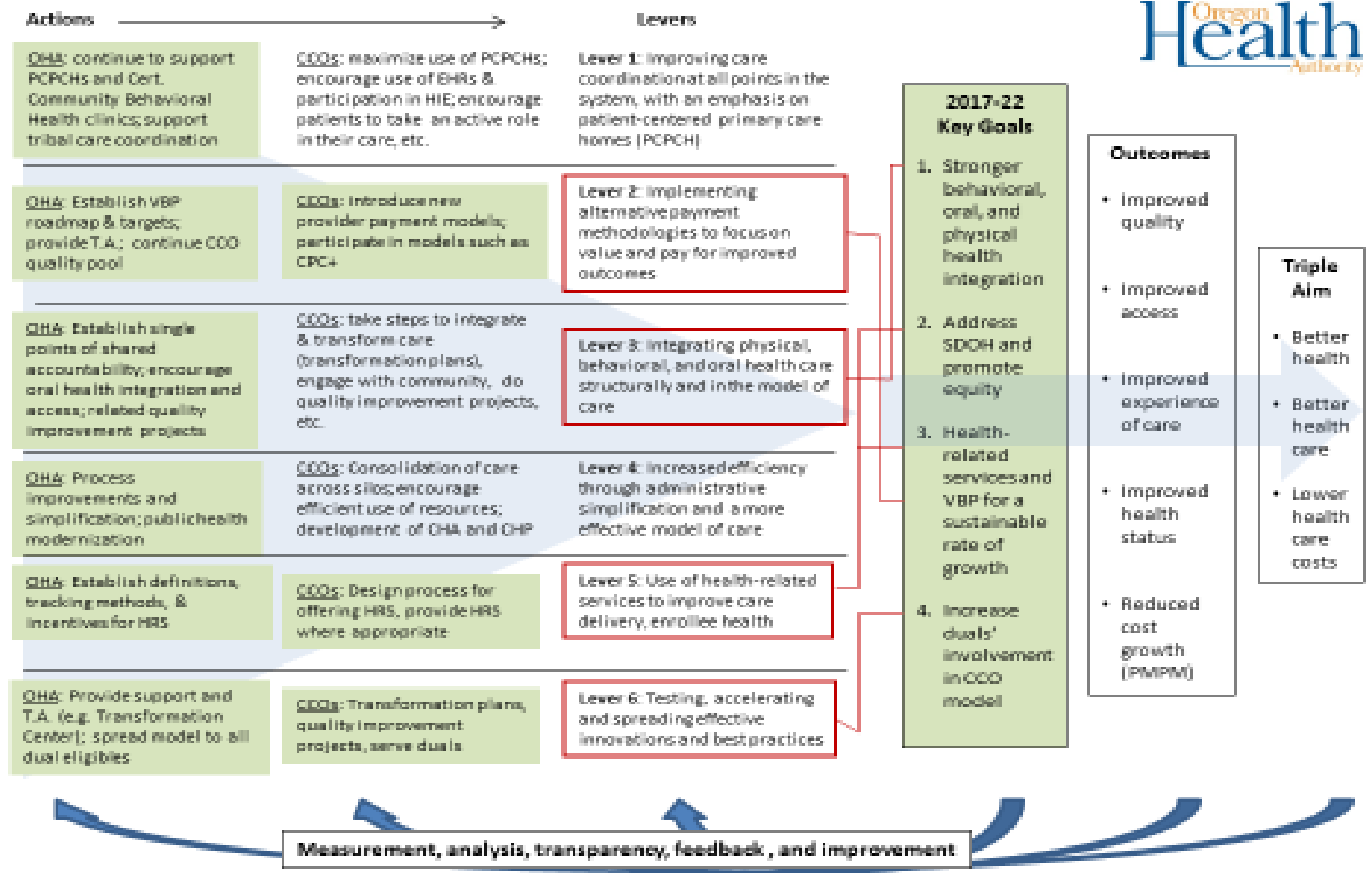
- The Oregon Transformation Center, which acts as the state's hub for innovation and improvement. The learning collaboratives to be convened by the Transformation Center will be a primary venue for sharing evaluation information, posing additional analytic questions, and sharing best practices or potential solutions to problems;
- The state's innovator agents, who are expected to help CCOs review their own data and identify opportunities for improvement;
- Formal publications and presentations aimed at a variety of different audiences, including service providers, beneficiaries, communities and their members, as well as OHA advisory committees, such as the Oregon Health Policy Board and the Medicaid Advisory Committee; and
- Internal reporting for OHA leadership and program personnel.

This evaluation plan was developed by a cross-division team of OHA staff with experience in evaluation, research, and demonstration planning. It was also reviewed by OHA leadership, an external consultant who helped develop the 2012-2017 demonstration evaluation plan, and staff at the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

Conclusion

In conclusion, OHA will provide a broad overview of the waiver demonstration's effects on key outcomes, as well as targeted examinations of health-related services, behavioral and oral health integration, and dual eligible enrollment in CCOs. Collectively, these efforts will examine specific programs and sub-populations to gauge how they are impacted by Oregon's health care transformation, and will help Oregon test its progress toward the overall goal of better health, better health care, and lower costs.

Appendix A. Medicaid Theory of Change



August 24, 2017

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

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

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

- **Healthy Kids:** Created by House Bill 2116 during Oregon’s 2009 Legislative Session, *Healthy Kids* provided s coverage for all uninsured children up to age 19 in the state. The plan offered comprehensive health care coverage that included dental, vision, mental health and physical health care. The objective of *Healthy Kids* was to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. *Healthy Kids* included three different program components:
 1. Existing CHIP and Medicaid direct coverage (OHP Plus);
 2. Premium assistance administered by the Office of Private Health Partnerships (family coverage under FHIAP for children up to and including 200 percent of FPL, and Healthy Kids ESI child only premium assistance for kids up to and including 300 percent of FPL);
 3. A private insurance component, Healthy KidsConnect, which was provided transitioned to the CHIP state plan direct coverage in 2013.

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

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

As of January 1, 2014: 1) Medicaid and CHIP eligible children who voluntarily elected to receive premium assistance under the FHIAP or Healthy Kids ESI components of the 2012-2017 demonstration period rather than enroll in the Medicaid or CHIP state plan, and 2) Parents and childless adults enrolled in FHIAP with income from 0 up to 133 percent of the FPL, were enrolled in a CCO as long as they met the applicable eligibility standards under the approved Medicaid or CHIP state plans. Individuals currently receiving premium

assistance who, based on an initial screening evaluation, did not appear to be eligible under the approved Medicaid or CHIP state plans were afforded a full eligibility determination prior to termination. Individuals denied continued benefits were offered the opportunity to have their information electronically transmitted to the state Affordable Insurance Exchange (Exchange) to be treated as an application for coverage and benefits through the Exchange.

- **Premium Assistance for children and families with incomes from zero up to and including 200 percent of FPL:** Subsidies were available to children in this income category through FHIAP or Healthy Kids ESI. Children determined eligible by DHS or OHA are referred to OPHP for enrollment and subsidy payment or go directly to OPHP and on the FHIAP reservation list. FHIAP paid premium subsidies ranging from 50 to 95 percent for adults. Both FHIAP and Healthy Kids ESI paid 100 percent of the premium for children in this income group. Individuals (adults and children) who enrolled in this program were subject to all other cost sharing provisions of the insurance plan. The children in this income group have the option of enrolling in FHIAP, Healthy Kids ESI, or CHIP direct coverage (OHP Plus), and children who chose FHIAP or Healthy Kids ESI could move back to state plan direct coverage at any time.
- **Healthy Kids ESI/Child Only Premium Assistance and Healthy KidsConnect for children in families with incomes above 200 up to and including 300 percent of FPL who have access to ESI:** Subsidies were available to children in this income category through ESI or the state's private insurance option, Healthy KidsConnect. Children in families with incomes above 200 percent FPL were not eligible for CHIP direct coverage (OHP Plus) prior to January 1, 2014. Sliding scale subsidies were available for children who are able to enroll in the family's ESI.
 - Families with incomes above 200 up to and including 250 percent of FPL would receive state subsidies equaling about 90 percent of the child's monthly premium.
 - Families with incomes above 250 up to and including 300 percent of the FPL would receive state subsidies equaling about 80 percent of the child's monthly premium.
 - All other cost-sharing was subject to the cost of the employer plan.
- **Healthy KidsConnect:** This is a CHIP state plan direct coverage option provided under the state's separate child health program. Sliding scale subsidies are available to children who enroll in state-approved benefit packages developed and offered by private health insurers. Private insurers are selected through a competitive bid process. Approved benefit plans must be comparable to the CHIP direct coverage (OHP Plus) benefit package.
 - Families with incomes above 200 percent up to and including 250 percent of FPL will receive state subsidies equaling about 90 percent of the child's monthly premium; and

- Families with incomes above 250 percent up to and including 300 percent of the FPL will receive state subsidies equaling about 80 percent of the child’s monthly premium.
- Out of pocket costs (including premium) will not exceed the Title XXI cost-sharing cap of five percent.
- **Oregon Health Plan (OHP) Plus:** OHP Plus is a CHIP state plan direct coverage option provided under the state’s separate child health program. The state provides Secretary-approved coverage that is the same as coverage offered under the state’s Medicaid program. The state’s benefit package is based on the OHP Prioritized List of Health Services, which is a modified Medicaid benefit package as allowed under Oregon’s section 1115 Medicaid demonstration for its entire Medicaid population. Medically necessary services are defined in the Prioritized List. The benefit package includes mandatory services for children, including well-baby and well-child visits, immunizations and dental services. There are no premiums, co-payments, or deductibles for children in direct coverage.
- **FHIAP Reservation List:** Oregon uses reservation lists to manage enrollment in the premium assistance program. Only FHIAP-eligible families with income from 0 up to and including 200 percent of the FPL are subject to the reservation list.

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

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

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

I. Mandatory Medicaid Populations							
Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
1	Pregnant Women	Title XIX	Title XIX state plan and section 1115	0% up to 185% FPL	None	OHP Plus	Base 1
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL** Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus	Base 1
4	Children 0 through 18	Title XXI	Title XXI state plan and section 1115	134% up to 300% FPL	None	OHP Plus	Base 1
6	Medicaid mandatory section 1931 low-income families (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	\$2,500 for applicants, \$10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for	SSI Level	\$2,000 for a single individual, \$3,000 for a couple	OHP Plus	Base 2

			Medicare and Medicaid				
8	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	\$2,000 single individual; \$3,000 for a couple	OHP Plus	Base 2
21	Uninsured or underinsured under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program (BCCTP)	Title XIX	Title XIX state plan and Section 1115	Eligibility will be determined according to the State Plan criteria.	None	Case-by-case basis	Base 1
23	Low-Income Expansion Adults	Title XIX	Title XIX state plan and Section 1115	0% up to 133% FPL	None	ABP (OHP Plus)	Base 2

**Although Population 3 reflects mandatory coverage for children up to 133 percent of the FPL, the state also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185 percent of the FPL, as required by federal regulations, since the state has chosen to extend Medicaid coverage to pregnant women up to 185 percent of the FPL.

II. Optional Medicaid Populations

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	\$2,000	OHP Plus	Base 2
9	Former Foster Care Youth to age 26	Title XIX	Title XIX state plan and Section 1115	No FPL limit if in Oregon Foster Care at age 18	None	OHP Plus	Base 1

Attachment E: Menu Set of Quality Improvement in Focus Areas

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

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

Requirements

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

Monitoring

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

Modifications

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

Lessons from the 2012-2017 1115 demonstration

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

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

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

Goal	Example Measures	Example Interventions
	<p>period), and the hospital readmissions measures mentioned above, rate of ambulatory care sensitive hospitalizations (Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators); rate of avoidable Emergency Department (ED) visits; and outpatient and ED utilization.</p>	<p>community-based outreach programs (including in person programs beyond telephonic case management), nurse care coordination, home visits, same day appointments, and data sources adequate to target the super-utilizers. Additionally includes pieces of these, community health workers to help beneficiaries navigate the system and access resources; narcotics registries, targeted case management for frequent ED users, coordination with long-term care case workers and providers for individuals receiving long-term care and/or developmental disabilities supports and services; and CCO efforts to integrate information flow across providers. It is critical that a CCO appropriately target these services in order to realize improvements possible for this Focus Area.</p>
<p>4. Integration of health: physical health, oral health, and/or behavioral health</p>	<p>Screening for clinical depression & follow-up plan; screening and referral for alcohol or drug misuse; initiation and engagement with alcohol and drug treatment; follow-up after hospitalization for mental illness; mental and oral health assessment for children in DHS custody, chronic use opioid care strategies.</p>	<p>Global budget and single point of accountability for physical, behavioral and oral health; co-location of mental health and primary care which includes collaborations between the mental health and primary care providers to develop and execute a shared treatment plan, including coaching and counseling, improved systems for records sharing. Care coordination between physical health and oral health treatments (e.g. oral health care during pregnancy). Additional interventions targeted towards reducing chronic opioid use includes, but is not limited to, pain management schools in the community, and expansion of medication assisted treatment in primary care settings.</p>
<p>5. Ensuring appropriate care is delivered in appropriate settings</p>	<p>Rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); of avoidable ED visits; outpatient and ED utilization, Screening primary care access measures (including</p>	<p>Connect vulnerable patients with appropriate behavioral health, social services and community services. Increase utilization of preventive visits to minimize inappropriate utilization of ED/hospitals.</p>

Goal	Example Measures	Example Interventions
	Adolescent well-care visits).	
6. Improving perinatal and maternity care	Prenatal and Postpartum Care (Health Effectiveness Data Information Set (HEDIS)), Timeliness to prenatal care, preterm deliveries, perinatal measures such as screening for tobacco use, tobacco cessation counseling, breastfeeding at discharge.	Collaboration with Strong Start program on early elective delivery, interconception care, home visiting programs for first time mothers, connection with local WIC program, development of maternal medical home models.
7. Improving primary care for all populations	Proportion of individuals with a patient-centered primary care home (PCPCH) and proportion of certified PCPCHs in a CCO’s network, and level of certification; rate of ambulatory care sensitive hospitalizations (AHRQ prevention quality indicators); rate of avoidable ED visits; outpatient and ED utilization; ratio of primary care spending to specialty & hospital spending over time, well-child visits, tobacco use screening and cessation counseling for patients >12 years old, Body Mass Index recorded (and appropriate counseling), drug-to-drug and drug allergy checks, and maintain active medication list (including allergies)	CCO strategies to encourage their providers to attain highest levels of PCPCH recognition; development of community health workers to help increase access to culturally and linguistically appropriate primary care; CCO requirements for health assessments and person-centered care plans, certified Electronic Health Record (EHR) adoption and meaningful use; Patient Centered Primary Care Home participation incentives; shared incentives across primary, specialty, long-term, and acute care; improved access (e.g., after-hours physician availability, 24/7 access to a Nurse Practitioner (NP) or doctor); PHRs; open-access scheduling and sick hours.
8. Addressing social determinants of health	Food insecurity screening, supportive housing services, kindergarten readiness	Community partnerships is key in developing a broad project which addresses the social impacts to health outcomes. Coordinating with local

Goal	Example Measures	Example Interventions
		<p>community resources in practice screening and documentation in electronic health record. Intervention strategies could include collaborating with local food bank, early learning hubs, education system partners, regional health equity coalitions, and community advocates. Development and sharing of standard screening tools and methods for documentation, creating community referral pathways, and coordination of community resources to support members are integral for overall community health improvement.</p>

Attachment F: CCO Services Inventory

(updated January 12, 2017)

This attachment provides the schedule for inclusion of new services into CCO global budgets and reflects OHA's planning as of December 2016. Oregon will notify CMS if contract amendment schedule is revised.

Pursuant to STC 43b, the inclusion of additional services in the global budget will be mutually agreed upon by the state and CMS and phased in over the course of the demonstration. Oregon will submit proposed changes to the Regional Office as part of draft CCO contracts or contract amendments at least 45 days in advance of their effective date. Services outlined in Attachment F will generally be included in CCO global budgets as capitated services. For any services not paid as capitation, the state will identify the rate (referencing the state plan methodology or describing the rate methodology to CMS) and the rates will be subject to CMS review and approval.

	Program Area	Program/Service/Function	Per Capita Trend Monitoring			Per Capita Trend Monitoring	
			Jan 1 2017	July 1 2017 – July 1 2018	Not currently planned	2% pmpm growth test	Program wide monitoring only
1	Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	X			Yes	Yes
2	Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities)	X			Yes	Yes
3	Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	X			Yes	Yes
4	Mental Health	Children's Statewide Wraparound Projects	X			Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring			Per Capita Trend Monitoring	
			Jan 1 2017	July 1 2017 – July 1 2018	Not currently planned	2% pmpm growth test	Program wide monitoring only
5	Mental Health	Exceptional Needs Care Coordinators	X			Yes	Yes
6	Mental Health	Non-forensic intensive treatment services for children(Inpatient Psychiatric Facility Services for Individuals Under age 21)	X			Yes	Yes
7	Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	X			Yes	Yes
8	Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	X			Yes	Yes
9	Mental Health	Supported Employment and Assertive Community Treatment	X			Yes	Yes
10	Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)			X	Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring			Per Capita Trend Monitoring	
			Jan 1 2017	July 1 2017 – July 1 2018	Not currently planned	2% pmpm growth test	Program wide monitoring only
11	Addictions	Youth residential alcohol and drug treatment (OHP carve out)	X			Yes	Yes
12	Addictions	Adult residential alcohol and drug treatment (OHP carve out)	X			Yes	Yes
13	Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)			X	Yes	Yes
14	Targeted Case Management	HIV/AIDS Targeted Case Management			X	Yes	Yes
15	Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon			X	Yes	Yes
16	Maternity Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)		X		Yes	Yes
17	Transportation	Non-Emergent Medical Transportation	X			Yes	Yes
18	Mental Health	Adult Residential Mental Health Services			X	Yes	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring			Per Capita Trend Monitoring	
			Jan 1 2017	July 1 2017 – July 1 2018	Not currently planned	2% pmpm growth test	Program wide monitoring only
19	Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)			X	Yes	Yes
20	Dental	OHP dental coverage	X			Yes	Yes
21	Mental Health	Young Adults in Transition Mental Health Residential			X	Yes	Yes
22	Mental Health	Personal Care 20 Client Employed Provider			X	No	Yes
23	Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)			X	No	Yes
24	Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)			X	No	Yes
25	Long Term Care	Long term care institutional and community supports			X	No	Yes
26	Mental Health	State Hospital Care - Forensic			X	No	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring			Per Capita Trend Monitoring	
			Jan 1 2017	July 1 2017 – July 1 2018	Not currently planned	2% pmpm growth test	Program wide monitoring only
27	Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations			X	No	Yes
28	Mental Health	State Inpatient for forensic kids (includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program)		X		Yes	Yes
29	Mental Health	State Inpatient non-forensic kids (SCIP/SAIP/STS) - Payment for services Note: Team assessment of need included in GB		X		Yes	Yes
30	Mental Health	OHP-covered mental health drugs			X	No	Yes
31	Other	Hospital Leverages: GME, Pro-Share, and UMG			X	No	Yes
32	Other	FQHC Full-Cost Settlements (*exceptions specified in <i>Expenditure</i>)			X	Yes*	Yes

	Program Area	Program/Service/Function	Per Capita Trend Monitoring			Per Capita Trend Monitoring	
			Jan 1 2017	July 1 2017 – July 1 2018	Not currently planned	2% pmpm growth test	Program wide monitoring only
		<i>Tracking for Trend Reduction Test attachment)</i>					
33	Other	A & B Hospital Facilities Settlements			X	No	Yes
34	Targeted Case Management	Early Intervention services or Early Childhood in Special Education (Targeted Case Management)			X	No	Yes
35	Targeted Case Management	Child Welfare Youth (Targeted Case Management)			X	No	Yes
36	Targeted Case Management	Self-Sufficiency Jobs for Teens and Adults (Targeted Case Management)			X	No	Yes
37	Targeted Case Management	Tribal Targeted Case Management			X	No	Yes
38	Other	DSH			X	No	Yes
Note: All services are state plan services with the overlay of the Section 1915(b) waiver for transportation and the Section 1115 demonstration that includes application of the Prioritized List of Health Services.							

36										
37										
38										

Attachment G
Attachment G will sunset June 30, 2017
Reimbursement and Claiming Protocol for Oregon Designated State Health Programs
Determination of Allowable DSHP Costs Per Waivers 21-W-00013/10 and 11-W-00160/10

Acronyms:

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

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

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

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

All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

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

addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding. For purposes of expenditures claimed under this protocol, the state cannot utilize provider-related donations as a source of the non-federal share.

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



PROGRAM GROUP: AMH—Addictions and Mental Health

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #51. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #51, Table 5, from the statewide Financial Management Application (SFMA), the states’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—There is no interface sub-system for the AMH non-contract program group as services paid for are a direct charge into SFMA.

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

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services.

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

For each program in this group that involves contractual services, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #51. The payments and associated claimed expenditures for the following programs must be commensurate with actual services delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the states’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #49-52, paid to the vendor. The interface sub-system for the AMH Contractual Services Program Group is R-Base.

Step 4b—When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA. After data is entered into the accounting system for payment, it receives a second approval by the supervising manager.

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services.

- Source data is from the AMH R-Base data base system (R-Base), a contract database subsidiary system for accounting data to the SMFA accounting system, the official ‘book-of-record’ for the state. The R-Base system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so those services with state Funds only will be so identified. Coding tables in R-Base are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure.

The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

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

Program: Mental Health (MH) Non-Residential Adult Services

- **Brief Description:** MH services delivered to persons diagnosed with serious mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. The following services are provided via this program:
 - Vocational and social services
 - Medication and medication monitoring
 - Counseling for emotional support
 - Individual/family and group counseling and therapy
 - Support to locate and obtain housing
 - Coordination of care services

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

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

Program: MH Children and Adolescent

- **Brief Description:** Mental health services for children and adolescents with primary mental, emotional or behavioral conditions. The following services are provided via this program:
 - Provision of screening
 - Assessment and Level of Service Intensity
 - Referral and care coordination services
 - Skills training
 - Crisis planning
 - Respite care
 - In-home support.

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

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

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

Program: MH Regional Acute Psychiatric Inpatient

- **Brief Description:** Stabilize, control or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the individual to a less restrictive environment. The following services are provided via this program:
 - Ancillary services such as regional coordination and enhancements to County, Community Mental Health Program (CMHP) ; treatment plan development that include identification of goals, strengths, target behaviors, methods for change; coordination of care, evidence-based interventions with families, advocates, representatives of community agencies; and medication management; individual and group therapy that addresses issues identified in the treatment plan.
 - Services that serve to expedite the movement (including secure transportation) of individuals into and out of facilities where inpatient psychiatric services are delivered and to divert persons from acute care services, collaboration with families, parenting support, crisis planning, skills training for client and family members, continuum of care plan to move client to less restrictive settings.
- **Eligible Populations:** Individuals in need of inpatient psychiatric services who are uninsured and/or indigent and are not eligible for Medicaid. These are individuals who suffer from an acute mental illness, or other mental or emotional disturbance posing a danger to the health and safety of the individual or others.

Program: MH Residential Treatment for Youth

- **Brief Description:** Services for individuals needing continued long-term services to avoid hospitalization. The following treatment services are provided via this program:
 - Medication and Medication monitoring supervision)
 - Vocational and social services
 - Individual and family group counseling
 - Counseling emotional support
 - Coordination of care services
 - Services delivered on a 24-hour basis.

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

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

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

Program: MH Adult Foster Care

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

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

Program: MH Older and Disabled Adults

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

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

Program: MH Special Projects

- **Brief Description:** These are projects that provide enhanced services, services to enable service delivery expansion, peer delivered services, and, educational and employment support services. The following services are provided via this program:

- Peer delivered services (PDS): is the social, emotional and instrumental support offered or provided by persons with a mental health condition, to others who share a similar mental health condition in order to bring about a desired social or personal change. This overall service includes an array of agency or community-based services and supports provided by peers and peer support specialists. Included is assistance for people with Serious Mental Illness (SEMI) to meet their education and/or recovery goals and/or become gainfully employed through the education and training acquired during postsecondary education.
 - Skill training
 - Counseling for emotional support
 - Community integration
 - Crisis support
- **Eligible Population:** Adults and Children with mental illness in unique condition situations who need special mental health services. These individuals are not eligible for Medicaid.

Program: MH Community Crisis

- **Brief Description:** This program provides immediate MH crisis intervention (24/7) and assessment; triage and intervention services (psychological treatment services and crisis counseling services) delivered to individuals experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. This program also includes the following psych services which can be rendered at a hospital or a non-hospital facility. Services are of limited duration and are intended to stabilize the individual and prevent further serious deterioration in the individual's mental status or mental health condition.
- **Eligible Population:** Adults and Children in a crisis situation who are not eligible for Medicaid.

Program: MH Support Employment

- **Brief Description:** This program includes the following services which are delivered to individuals to enable them to obtain and maintain employment:
 - Supervision and job training
 - On-the-job visitation
 - Consultation with the employer
 - Job coaching
 - Counseling
 - Skills training
 - Transportation

- Transitional employment services: On-the-job skills development for the next level—to obtain a better job, job counseling.
- **Eligible Population:** Individuals 18 years or older with chronic mental illness needing to obtain and maintain employment. These individuals receive non-residential adult services and need evidence-based supported employment services. These individuals are not eligible for Medicaid.

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

- **Brief Description:** This program provides transitional services to a supported environment, i.e., treatments services, housing/living environments that maintain and reinforce the client’s recovery efforts. This program provides a broad range of transition services that include:
 - Outreach services
 - Screening and diagnostic treatment services
 - Habilitation and rehabilitation services
 - Community MH services, A&D treatment services
 - Staff training
 - Case management services
 - supportive and supervisory services in residential settings
 - Referrals for primary health services
 - Job training
 - Educational services
 - relevant housing assistance services (locating and securing housing)

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

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

Program: MH Residential Treatment for Adults

- **Brief Description:** This program includes crisis stabilization and intervention services, including:
 - Behavior management
 - Daily living activity coordination
 - Crisis stabilization services
 - Crisis intervention services
 - Residential treatment services determined upon individualized assessment of treatment needs and development of plan of care
 - Management of personal money and expenses
 - Supervision of daily living activities

- Life skills training
 - Administration and supervision of medication
 - Provision or arrangement of transportation
 - Management of behavior
 - Diet management.
- Services are delivered on a 24-hour basis to individuals who need continuing services to remain in the community and to avoid higher levels of services or hospitalization or who are a danger to themselves or others or who otherwise require continuing care to remain in the community.

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

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

Program: MH Non-Residential, Designated

- **Brief Description:** These individuals in this program have low frequency, high intensity needs above the standard non-residential structure. Services include:
 - Vocational and social services
 - Support to obtain and maintain housing (locating and securing housing)
 - Medication and medication monitoring
 - Emotional support
 - Individual, family and group counseling and therapy
 - Case management services
- **Eligible Population:** Adults 18 years old or older, who are uninsured needing mental health services delivered to designated persons (adults) diagnosed with serious, chronic mental illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others. These individuals are not eligible for Medicaid.

Program: A & D Special Projects

- **Brief Description:** This program includes the following treatment enhancement activities:
 - Early screening and assessment for alcohol and drug problems
 - Facilitation of collaboration between schools and partner agencies in developing and maintaining screening and referral processes
 - Outreach
 - Case management

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

Program: A & D Residential Treatment, Adults

- **Brief Description:** This service is to support, stabilize and rehabilitate individuals and to permit them to return to independent community living. Services provide a structured environment for an individual on a 24-hour basis consistent with chemical dependency placement, continued stay and discharge criteria Level III-services (twenty-four hour supervision is needed using a structured 7-day-a-week therapeutic environment to achieve rehabilitation). The services within this program address the needs of diverse population groups within the community. This program helps people stabilize physically and mentally so they are able to transition to a lower level of care including self-directed recovery management.
- **Eligible Population:** Individuals 18 years of age or older who are unable to live independently in the community and cannot maintain even a short period of abstinence and are in need of 24-hour supervision, treatment and care. These individuals are for non-OHP eligible and must be indigent status with income at 100 percent or lower of the federal Poverty Level (FPL). These individuals are not eligible for Medicaid.

Program: A & D Continuum of Care

- **Brief Description:** This program provides outpatient substance abuse disorder treatment including medication-assisted treatment (primarily methadone). This program also includes non-hospital detoxification, case management and wrap around services such as:
 - Peer mentoring
 - Child care
 - Transportation
 - Relapse prevention
 - Healthy eating and wellness counseling
 - Connection to social support groups

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

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

PROGRAM GROUP: Children, Adults and Families (CAF)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #52. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the states’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #49-52, paid to the vendor. The interface sub-system for the CAF program group is Oregon Kids System (OR-KIDS).

Step 4b—When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services.

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

Program: System of Care

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

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

Program: Community Based Sexual Assault

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

Program: Community-based Domestic Violence

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

Program: Family Based Services

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

Program: Foster Care Prevention

- **Brief Description:** This program consists of Child Welfare services for families with children at risk of out-of-home placement. The following services are provided via this program:
 - Therapeutic supports
 - In-home case management
 - Counselling
 - Referrals to families to help them transform their lives.

- **Eligible Population:** High risk families brought to the attention of Child Welfare. These families are at risk for having their children removed from their homes due to neglect or abuse.

Program: Enhanced Supervision

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

Program: Nursing Assessments

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

Program: Other Medical

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

Program: IV-E Waiver Demonstration Project

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

Program: Personal Care:

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

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

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #52. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the States’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #49-52, paid to the vendor. The interface sub-systems for the APD (formerly SPD) Program Group are the House Keeper System for Oregon Project Independence, and the CPMS and eXPRS interface sub-systems for Family Support and the Children’s Long-Term Support programs.

Step 4b—When program services are presented for payment in the interface sub-system, the sub-system data interfaces into SFMA using the coding element structure as described in Steps 1 – 3 above and a warrant for payment is produced by SFMA.

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services.

- **House Keeper System :** The process of the determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients, and entry of the data into the House Keeper system as they are then authorized for service payments to providers providing the designated client care services. In the Housekeeper system, the status identifies the client for Oregon Project Independence (OPI) services and the system generates provider payments. The system assigns SFMA accounting system coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code) that identify the clients’ services and related costs attributable for DSHP. Payment data is interfaced to the state SFMA system from which payment (expense) reports are produced. The accounting reports pull data directly from the SFMA system, and/or via standard system reports and custom designed reports using the accounting data uploaded weekly.
- **eXPRS System:** Payment source data is from the eXPRS system, an interface sub-system for accounting data to the SFMA accounting system, the ‘book-of-record’ for the state. The eXPRS system tracks payments against the contract amount. Contract data is entered and processed with appropriate data to access the coding structure. The system calculates the payment dates and computes the monthly payment amounts. Each service eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code,

Object/Transaction Code, Fund Code), so those services with state funds only will be so identified. Coding tables in eXPRS are accessed that assign in SFMA the coding structure and are interfaced to SFMA system from which provider payment warrants and expense reports are produced specifically identifying the DSHP allowable expenditure. The accounting reports pull data directly from SFMA via standard system reports, and custom designed reports using the weekly accounting data uploaded.

- **CPMS System:** The process of determining the allowable costs eligible for DSHP FFP begins with the eligibility determination of the clients and entry of the data into the CPMS system. A report is pulled from CPMS source data and reconciled on a quarterly basis with the payment as authorized by the eXPRS System and paid by SFMA. Only those services funded with state funds only are allowable for DSHP match.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Code and expenditures will be displayed.

Program: Oregon Project Independence (OPI)

- **Brief Description:** OPI provides in-home services to seniors who require the same level of care as people in nursing homes, but who do not qualify for Medicaid. Services can be received in their own homes, and include personal assistance, nursing tasks and help with housekeeping. Services may also include help with activities of daily living, memory and confusion, mobility and transfers, housekeeping and laundry, meal preparation or delivery, shopping and transportation, medical equipment, assistance with medications.
- **Eligible Population:** Eligibility for OPI is age (60 years of age or older or under 60 with a diagnosis of Alzheimer or related dementia) and a Client Assessment & Planning System assessment evidencing a service priority level (SPL) of 1-18. These services are provided statewide through Area Agencies on Aging local offices. Clients with net incomes between 100 percent and 200 percent of federal Poverty Level (FPL) are expected to pay a fee toward their service, based on a sliding fee schedule. Families with net incomes above 200 percent FPL pay the full hourly rate of the service provided.

Program: Family Support

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

assistance in determining needed supports, respite care, purchase of adaptive equipment; services are proactive, and are intended to help prevent families from going into crisis.

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

Program: Children Long-Term Support

- **Brief Description:** This program provides supports to a child with a developmental disability at risk of out-of-home placement (foster care, residential, etc.). Children are assessed for level of service by the local Community Developmental Disability Program Service Coordinator. With the family, the Service Coordinator assists in plan development that identifies supports needed for the child to stay in the home. Supports include:
 - In-Home Supports
 - Respite
 - Behavior Consultation
 - Family Training
 - Environmental Adaptations
 - Specialized Medical Equipment and Supplies.
- **Eligible Population:** Families who have children with developmental disabilities who are at risk for out of home placement. This is a capped program with a current caseload of approximately 180. The child must be 17 years of age or younger and have been determined developmentally disabled (DD) eligible and meet a crisis criteria of risk of out of home placement. These individuals are not eligible for Medicaid.

PROGRAM GROUP: Public Health Division (PHD)

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

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #52. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the States’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #49-52, paid to the vendor. The interface sub-system for the Public Health Division Program Group is the Oregon Statewide Payroll (OSPS) system.

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

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the ‘book-of-record’ for the state. The service that is eligible for DSHP allowable funds has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses with state funds only will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All PHD expenditures are processed directly in the SFMA system.
- **Payroll System:** Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses (OPE) directly to the PHD programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination is entered to ensure their time is properly allocated to DSHP. Coding tables in OSPS are accessed that assign an SFMA coding structure and are interfaced to SFMA system.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Codes and expenditures will be displayed.

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

- **Brief Description:** The Health Care Regulatory & Quality Improvement Section (HCRQI) is statutorily mandated to regulate, inspect, license and provide certification approval for the following entities and individuals: Ambulatory Surgical Centers, Birthing Centers, Dialysis Facilities, Hemodialysis Technicians, Home Health Agencies, Hospice Agencies, Hospitals, In-Home Care Agencies, Special Inpatient Care Facilities, Trauma Hospital designations. HCQRI is responsible for the entire licensure and certification processes for each of the above-listed individuals or entities. HCRQI also provides licensing information to the public and other agencies. This program’s allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.
- **Eligibility:** HCRQI does not provide direct care to Oregonians so there are no eligibility criteria. However, the ultimate beneficiaries are Oregonians who are able to find access to safe, high-quality and patient-centered health care because of HCRQI’s efforts. All Oregonians benefit from having a wide access to health care. The program ensures that the health care will be safe, of high quality, and meet or exceeds and federal standards.

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

- **Brief Description:** The OSPHL General Microbiology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The

primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.

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

Program: PHD OSPHL Virology/Immunology Testing Program

- **Brief Description:** The OSPHL Virology/Immunology Testing Program performs tests of public health significance for epidemiologic purposes and for patient care. The primary purpose is to prevent the spread of diseases throughout the community - prevention to keep people healthy.
- **Eligibility:** Clients seen in local health departments; community clinics; migrant clinics; private non-profit clinics; and by private submitters. OSPHL accepts specimens from any Oregon public or private submitter. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds

Program: State Support for Public Health

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

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

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

- **Brief Description:** The Northwest Regional Newborn Screening Program conducts screening of all newborn infants to prevent mental retardation and premature death in children through early detection and treatment of congenital disorders by: screening and testing for selected diseases and conditions; serving as the regional center for newborn screening; contracting for the medical consultation needed for the initial clinical follow-up; and maintaining a data base of all screened infants for use in follow-up, tracking, and monitoring disease incidence. Oregon designates practitioners as being responsible for specimen collection. The definition of "practitioner" includes physicians, nurses, and midwives who deliver or care for infants in hospitals, birth centers or homes. Also, parents are responsible to ensure that their infants are tested.
- **Eligibility:** Newborn screening activity is not divided among specific eligibility groups within Oregon newborn infants. It is a population-based service applicable to all newborn infants in the state. Oregon statutes require that every infant be tested. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees and driven by volume or amount of tests received by the Lab for which they receive test fee revenues.

Program: Prescription Drug Monitoring Programs (PDMP)

- **Brief Description:** Oregon-licensed pharmacies are required to report to the Oregon Health Authority PDMP system all Schedule II – IV controlled substances dispensed to patients. The system must be accessible by healthcare providers and pharmacists 24/7. The intent behind the PDMP is to help improve patient management particularly among pain patients. Health improvements include pain care, addictions treatment and reduced overdose.
- **Eligibility:** Services are provided to any Oregonian who requests a copy of their own patient record. Services are provided to any authorized PDMP system user that can include any Oregon-licensed healthcare provider who prescribes controlled substances or any Oregon-licensed pharmacist who dispenses controlled substances. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

Program: HIV Community Services

- **Brief Description:** The HIV program provides case management and support services (case managed, treatment and support plan) for people already tested and living with an HIV diagnosis.
- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable HIV This program’s allowable expenses for DSHP participation is limited to the extent that services are only funded by Other Fund fees.

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

- **Brief Description:** The HST program works with local health authorities and community based organizations to provide guidance on the delivery of services to the populations impacted by HIV, STD, and TB. This program is administered by local health authorities that primarily screen, treat or control the transmission of those diseases. As well, this program provides support administration, prevention, TB case management and medications for STD’s and TB
- **Eligibility:** Clients limited to those residing in Oregon with a positive test for reportable STD’s TB or HIV This program’s allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds.

Program: Sexually Transmitted Disease

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

PROGRAM GROUP: Oregon Youth Authority (OYA)

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #52. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the States’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—There is no interface sub-system for the OYA Program Group as services paid for are a direct charge into SFMA.

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

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the State in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services. The Waiver approval for DSHP included mental health and A & D treatment services funded through state funds only. The Protocol identifies the allowable state fund only funding stream(s) for these DSHP allowable services and expenditures for non-Medicaid eligible youth. The youth receiving and benefiting from these services (mental health and A & D) may be placed in the custody of the OYA, but are not incarcerated in a close custody setting. DSHP does

not allow nor include expenditures for services rendered to youth in a close custody setting, in other words, for incarcerated youth. Expenditures for which DSHP is claimed are community based, delivered in the youth's place of residence or in a licensed professional provider's office or clinic. Youth are living at home or in an out-of-home non-secure placement (not a residential treatment facility), where youth are free to leave the premise. The youth are not incarcerated, not associated with the prison system, not in secure facilities operated by OYA and are not in the physical custody of OYA. The youth may be in the custody of OYA, e.g. adjudicated youth served by county probation or diversion programs, are not Medicaid eligible, and are receiving mental health and A & D treatment funded by state funds only.

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

Program: Alcohol & Drug Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Alcohol and drug abuse treatment provided to youth in community settings occurs through community service contracts for non-Medicaid eligible youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: alcohol and drug abuse treatment services in the community include: assessment, group treatment, individual treatment, individual care coordination, recovery, maintenance and relapse prevention.
- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for alcohol and drug treatment services. These individuals are not Medicaid eligible.
- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

Program: Mental Health Treatment Services

- **Brief Description:** OYA delivers evidence-based and research-informed treatment customized for each youth's needs. Each youth offender placed in OYA's custody receives a Risk Needs Assessment (RNA). Results from the RNA determine the treatment and education services each youth receives in his or her case plan. Mental health services provided to youth in community settings occurs through community service contracts for non-Medicaid eligible youth. These services are provided by licensed practitioners who have been approved to provide community based treatment services to OYA youth and to youth being served through county juvenile departments. This program's allowable DSHP expense is limited to: mental health treatment services in the community include: assessment of mental health needs, psychotropic medication management, group treatment, individual treatment, individual care coordination, crisis intervention and family therapy.
- **Eligible Population:** Youth served by county juvenile departments or in the custody of OYA who are identified as needing treatment based on individual identified needs (risk needs assessment) for mental health treatment services. These individuals are not Medicaid eligible.
- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are NOT in the physical custody of OYA and are NOT considered to be incarcerated.

e.

PROGRAM GROUP: DMAP – Division of Medical Assistance Programs

- **Funding Sources:** State General Funds

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #52. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the States' official Book of Record.

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

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

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

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

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

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

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

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #49-52, paid to the vendor. The interface sub-system for the DMAP Program Group is MMIS.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests that funds expended per STC #49-52 are used for DSHP allowable program services.

- Source data is from the MMIS data base system that contains the requirements (i.e., edits) for processing claims for this population. MMIS is a subsidiary system for accounting data to the state SFMA accounting system, the ‘book-of-record’ for the state. From client and related payment data entered in MMIS, payments to providers are produced. The payment/expenditure data is interfaced to SFMA from which provider payments and expense reports are produced that identify the relevant category in which the DSHP allowable expenditure is incurred. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly. The SFMA accounting system coding structure (i.e., Index/Program Account Code,

Object/Transaction Code, Fund Code) identifies the program, funding, and client are entered with the MMIS data. The coding is mapped to specific service tables that include each service funding source, thereby isolating the claims and associated payments for this population. The coding generated by the MMIS interfaces to SFMA. For this program, those services that match to state Funds only, will be allowable for FFP. The accounting reports pull data directly from SFMA, or via standard system reports and custom designed reports using the accounting data uploaded weekly.

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

Program: Formerly Medically Needy (Organ Transplant) Clients

- **Brief Description:** The program provides limited drug coverage for individuals receiving post-transplant services, formerly eligible for the Medically Needy program, which ended in 2003. Oregon Administrative Rule (OAR) 461-13-120-1195, chapter 461 filed with the Secretary of State, 9-30-2011, defines the population and covered services. This program's allowable expenses for DSHP participation is limited to the extent that services are only funded by State General Funds and limited to 22 identified individuals.
- **Eligible Population:** This program provides services for 22 identified individuals receiving post-transplant services who were participating in the formerly Medically Needy program, as of January 31, 2003.

PROGRAM GROUP: Workforce Development and Education

- **Funding Sources:** State General Funds, Tuition and Fees

Expenditures for DSHP allowable Workforce Development Training expenditures are defined in the Waiver agreement, as those incurred by universities, colleges, and community colleges in the course of workforce training of health professionals in fields likely to benefit Medicaid beneficiaries. Source data elements are used to support the expenditures and payments of DSHP allowable Workforce Development Training and for the certification of DSHP allowable expenditures. The source data elements are:

- **Audited Financial Statements**
- **Invoices**
- **Payroll data**
- **Funding Source (ensures restriction to state only funds through the accounting elements and structure)**

Each university/college entity uses an integrated accounting system. Though they are not all the same system, they accumulate, process, and employ coding structures in similar formats for reporting and audit processes. These systems are the 'book of record' for each entity. They are complete systems with modules devoted to accounting, purchasing, accounts payable, fixed

assets, grants, and budget development. The charts of accounts structures have these primary coding structure elements: Fund, Organization, Account, and Program. Transactions in the systems require these coding structures to store, process, and report out expenditures for all programs, including DSHP. The coding structure elements are hierarchical and roll up from lower data entry levels to higher summary levels. The DSHP expenditures roll into the regular monthly and annual final statements. Typically these types of expenses are tracked at a lower level of the accounting system coding structure and while they are not visually displayed in annual financial reports, they are included in the respective Instruction line displays in the financial statements.

For each Workforce Development Training program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #51(b). The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – Original source data is identified where data from the source documents is reviewed, and approved for coding and entry into the appropriate financial accounting sub-system for each Workforce Development Training program (e.g., accounts payable, payroll-personnel).

Step 2 – The financial data accumulation begins with initial entry into source data systems for the following:

- Invoices received for services and set up in the accounting system accounts payable module: invoices reviewed, services received verified, payment amounts approved, specific coding verified for programs and unique projects (e.g., DSHP - Instruction)
- Employee data set-up in the payroll system: Personnel payment data, pay rates, default cost center to be charged, etc. Specific coding identified for additional programs/projects to where employee work time should be charged. Time sheet data, for time and effort recording, including proper employee and supervisory verifications/authorizations.

Step 3 – Source data systems access internal data and coding tables, and based on entry data, assigns to expenses the accounting coding element structures (i.e., codes: Fund, Organization, Account, Mission, Object). *See Table 1*, below.

TABLE 1 – Coding Elements

Oregon Health Sciences University

- *Fund code:* University General Fund 0151
- *Organization code:* Identifies the Schools: Medicine 54000-54999, Nursing 58000-58999, Dentistry 60000-69999.
- *Mission code:* Non-Sponsored Instruction & Training 11; Student Admin and Services

- *Object code:* Functional description of expenditures, Wages 5100-5199; Supplies 5300-5399; Cost of goods 5400-5499; Purchased services 5500-5599
- A combination of the above codes identifies DSHP allowable expenses.***

Oregon University System

- *Fund code:* College General Fund
 - *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
 - *Account code:* Specific financial transactions, e.g. revenues, expenses by natural class
 - *Program code:* Function that the transaction is related to i.e., Instruction
- A combination of the above codes identifies DSHP allowable expenses.***

Department of Community Colleges and Workforce Development

- *Fund Type:* College General Fund
 - *Organization code:* Identifies the budgetary unit, i.e. Academic Instruction departments
 - *Account code/Account Type:* Specific financial transactions, e.g. revenues, expenses by natural class
 - *Program code:* Function that the transaction is related to i.e., Instruction
- A combination of the above codes identifies DSHP allowable expenses.***

Step 4 – Source data systems compile data during the system scheduled maintenance runs for interface to the financial accounting system, the ‘book-of-record’, source for all financial audits (e.g. general; A-133; other audits).

Step 5 – Accounting system processes are compiled, interfaced data configured according to the system processing design and the internally established chart of accounts. It matches the coded expense data to the internal chart of accounts (See **Table 3 – OUS Example** below). At period end close, the Overhead Cost Allocation module is run, charging indirect cost expenses (e.g. Administration and General (A & G)) to revenue producing cost centers, based on standard, approved cost allocation principles (See **Table 2 – Cost Allocation**, below). Closed period end financial data is downloaded to a database system (e.g., a financial services ‘datamart’) that can be queried using specific general ledger established accounting coding elements to pull out DSHP expenditure data (see **Table 1 – Coding Elements above**).

TABLE 2 – Cost Allocation

DSHP approved program expenditures can include direct charged costs as well as indirect costs (i.e., a cost necessary for the functioning of the organization as a whole, but which cannot be directly assigned to one service or product, and therefore must be allocated). Very similar to the Medicare cost finding principles, cost allocation is a process, to identify common costs (e.g., A & G—executive staff, accounting, legal, human resources, etc.) to the courses of health care professionals in fields likely to benefit Medicaid recipients. The entity can determine those costs that can be accurately direct charged, or charge them to an allocation cost center for charging via the allocation process. --Medicare Reimbursement Manual form 2552-10, 40-93

Step 6 – Report queries are run against the financial services datamart using the coding element structures unique to the DSHP program/project. (*See Table 1, Coding Elements above*)

Step 7 – Expense Reports for DSHP expenditures are run after the accounting period end close. Accounting period close may be monthly, quarterly or annually.

Step 8 – Certification of Public Expenditures (CPE) form, certifying allowable DSHP expenditures per STCs #55 – 58 are represented in the expense reporting, will be sign by the appropriate and authorized college or university authority and provided to the State.

If an expenditure made under DSHP Workforce Training Program Group is found, in a future audit or financial review requiring corrective action, the prior period transaction(s) will be reconciled in the current DSHP claiming period using CMS 64 established guidelines. The CMS 64 reporting will reflect this reconciliation.

Accounting System, DSHP Expense Report Crosswalk to Financial Statements: DSHP Workforce Training expenditures, processed through the respective accounts payable and/or payroll systems are coded with organization department and instruction program coding elements (described in the preceding individual protocol narratives) that will identify DHSP allowable expenditures, per STCs # 55-58.

DSHP expenditures are a small subset of the overall individual operation of each university, college and community college. Expenditures to be claimed as DSHP, per STCs #55-58, are included in the annual year end audited statements as specific amounts at a lower level than displayed on the Instruction report line. These expenditures can be audited down to individual transactions for which original source documents can be pulled. Table 3 below illustrates this process.

Agreements will be in place between OHA and workforce entities to include allowance for audit by OHA of DSHP allowed expenditures. DSHP Expense Reports will be certified, and the amounts on the DSHP expense reports can be directly tied to the individual university, college and community college audited financial statements.

The total computable amount to be claimed to the federal government begins with the amount recorded for Instruction within the university, college or community college's audited financial statement. The financial statements may include the amount applicable to Instruction for one institution, or multiple institutions, depending on the structure of the university/college system.

In support of the total computable amount to be claimed under DSHP, supporting documentation will include the university's/college's expenditure report/account detail. The expenditure report classifies expenditures (as detailed in Table 1 – Coding Elements) by code, including fund code, organizational code, mission code and object or program code. The organization and fund type level codes will be primarily used to distinguish between aggregate expenditures applicable to Instructions and expenditures applicable to Instruction eligible under DSHP, per STCs #55-58.

Categorical Examples of Workforce Development Training DSHP allowable programs

School of Medicine
School of Nursing
School of Dentistry
Clinical Laboratory Science
Radiologic Technology/Diagnostic Imaging
Respiratory Care
Clinical Care
Medical Assistant
Dental Assistant/Dental Hygienist
EMT/Paramedic
Nursing Education/Certified Nursing Assistant
Pharmacy Technician

The examples above are not intended to be an exhaustive list of each course offered by the individual college or university. Rather, they are an example by category of the type of DSHP allowable graduate and undergraduate workforce training programs available at the colleges and universities.

Upon receipt of the specific college and university expenditure report, OHA will verify the expenses reported are for health-care and health-care related fields of education and training. The specific listing of the DSHP allowable health-care and health-care related course offerings will be made available to OHA by each college or university, and will become a part of the DSHP report to CMS Region X for purposes of claiming via the CMS 64 Report. By keeping the specific list(s) apart from, yet referenced herein Attachment G, as a college or university changes, adds or deletes a DSHP allowable course, it would not be necessary to amend Attachment G.

Verification of the DSHP allowable course may be accomplished in a three-fold manner using the 1) published course offering/calendar of the college or university; 2) through enrollment information, and; 3) through the college and university expenditure reports.

- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for Workforce Training will be computed without taking into account program revenues from tuition. However, to the extent the above universities and colleges receive funds that are directly used to support Workforce Training applicable offsets will be made to the amount claimed to the federal government as an allowable DSHP expenditure per the above referenced STCs.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the Workforce entities accounting systems databases. Codes and expenditures will be displayed

Table 3 – OUS Example

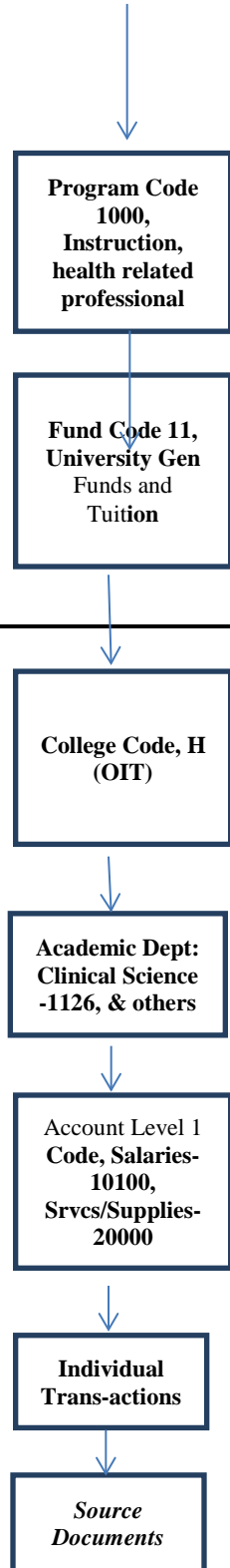
Highest Level -- Financial Statements: Includes all accounting

**Financial
Statements—All
Codes**

data codes. To reconcile to financial statements, the report query would not restrict to specific codes; all would be pulled.

Program Codes: Report query, restrict codes to program code 1000 for Instruction Courses of health care professionals in fields likely to benefit Medicaid recipients.

Funds: Further restrict report query to fund code 11, university general funds (incl tuition).



College Codes: Further restrict report query to college code H for OIT

Organization Codes: Further restrict report query to academic codes, 1126 & others.

Functional Codes: Further restrict report query to account level one codes for personnel, materials & supplies, etc.

Lowest Level -- Transactions: Further restrict to the lowest level Transactions that identify vendor/payee and personnel/staff payee.

Documents Level -- Based on the transaction list pulled (i.e., showing the amounts entered, vendor, other identifying data; payroll time & effort data) supporting documents can be pulled.

PROGRAM GROUP: Oregon Medical Insurance Pool (OMIP)

- **Funding Sources:** State General Funds
- Per, the July 27, 2012, letter from the Office of Management and Budget (OMB), expenditures for the Oregon Medical Insurance Program will be made without considerations for high risk pool healthcare premiums.

For each program in this program group, the state must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #52. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the States’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—There is no interface sub-system for the OMIP Program Group as services paid for are a direct charge into SFMA.

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

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

The state attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services.

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

Program: Oregon Medical Insurance Pool

- **Brief Description:** The Oregon Medical Insurance Pool (OMIP), administered by the state Office of Private Health Partnerships (OPHP), is the high-risk health insurance pool for the state established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions. OMIP also enables continuance of insurance coverage for those who exhaust COBRA benefits and have no other options. The funding for OMIP comes from two sources. Premiums paid by enrollees currently cover about 52% of program costs. Statutory requirements for establishing premiums limit them to no more than 125% of average market premiums for comparable benefits. The remaining 48% of the costs are funded from assessments the OMIP Board charges the licensed Oregon commercial health insurers on a per covered life basis.
-
- **Eligibility:** Enrollees must be residents of Oregon when they enroll and, once enrolled, they must demonstrate that they have lived in Oregon for at least 180 days during each benefit year. It does have a six-month pre-existing condition waiting period for which enrollees can get credits if they have had prior comparable coverage. To be eligible for portability coverage, they must not have access to a commercial portability insurance plan.

PROGRAM GROUP: Oregon State Hospital (Gero-Neuro)

- **Funding Sources:** State General Funds

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #52. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

Step 1 – State identifies DSHP allowed program from STC #52, Table 6, from the Statewide Financial Management Application (SFMA), the States’ official Book of Record.

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

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

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

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

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

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

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

Step 4a—Each interface sub-system contains vendor and program service detail that identifies the DSHP allowable expenditure, per STC #49-52, paid to the vendor. The interface sub-system for the Oregon State Hospital Program Group is the Oregon Statewide Payroll (OSPS) system.

Step 4b—As payment documents are received they are coded into the accounting system using the coding element structure as described in Steps 1 – 3 above.

Step 5 – Allowed DSHP expenditures, per STC # 49-52, are paid to the provider of the service.

Step 6 – The state submits a claim for FFP based on the total computable expenditure incurred by the state in making the eligible payment to DSHP provider. The expenditure claims must be claimed in accordance with STC #49-52 and the individual DSHP program as allowed by Waivers 21-W-00013/10 and 11-W-00160/10.

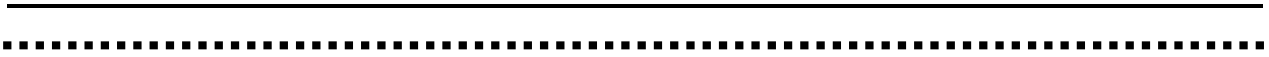
The State attests expenditures used are correct and verifiable as DSHP allowable. The state further attests state fund only funds expended per STC #49-52 are used for DSHP allowable program services.

- Source data is from the State SFMA accounting system, the ‘book-of-record’ for the state. The service eligible for DSHP has a unique coding structure (i.e., Index/Program Account Code, Object/Transaction Code, Fund Code), so expenses specific to DSHP will be so identified. Expenditures, prior to purchase, are approved by staff with approved delegated authority and processed with appropriate coding structure. All Hospital expenditures are processed directly within the SFMA system.
- **Payroll System:** Staff working in the DSHP allowed programs are assigned an Index/PCA code in the Oregon Statewide Payroll System (OSPS), that directs their time and other personnel expenses (OPE) directly to the various Hospital programs. Actual time and effort recording is entered for each work day with the coding structure to identify the specific program. Based on the time worked and coding, the related costs are charged/allocated to the DSHP program. For those who may work in more than one program, a different Index/PCA combination can be entered to ensure their time is properly allocated to DSHP.
 - The Hospital is accounted for as an enterprise fund where all costs for the program are recorded as one fund source. However, any resources from insurances (e.g., Medicaid, Medicare, Private pay) are identified to the various wards and are subtracted to record the State Only Fund expenditures that are allowable under the DSHP Waiver amendment. Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.
- **Report Format:** Report design is based on the unique coding structure to pull out the DSHP allowable expenditures. The data will be compiled and reported from the SFMA accounting database. Coding and expenditures will be displayed.

•
Program: Gero-Neuro Wards at the Oregon State Hospital (MH, Psychiatric)

- **Brief Description:** This program is for patients who require a hospital level of care for dementia, organic brain injury or mental illness. Patients in this program require physically secure, 24-hour care that is not available through community programs. These patients often have significant medical issues. Some are either civilly committed or voluntarily committed by a guardian because they are a danger to themselves or others, or are unable to provide for their own health and safety needs. Some patients who require significant medical care come through the criminal court system. Those admitted under criminal commitments are excluded, are not approved for DSHP federal Funds Claiming. The program's goal is for everyone to return to a community-care setting. From the day of admission, the treatment team works with the patient toward this goal. The program uses the following treatments:
 - Sensory and behavioral therapy
 - Recreation
 - Coping and problem-solving skills learned through group and individual therapy in the treatment mall setting.
- Those admitted under criminal commitments are excluded as expenditures are not approved for DSHP participation.

- **Eligibility:** Elderly persons with a mental health diagnosis that requires hospital level of care, or all ages with special needs due to related neurological impairment. Inpatient services are available to older adults who have major psychiatric disorders and adults older than 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive community care nursing home system environment. The inpatient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical-surgical hospital.



Attachment H: Calculating the Impact of Health Systems Transformation

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

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

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

Section A: Oregon Accountability Plan

Part I: Support for Health System Transformation

Introduction

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

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

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

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

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

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

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

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

Transformation Center

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

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

Activities to be performed by the Transformation Center

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

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

For more information, see Appendix A.

Learning Collaboratives

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

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

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

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

Convening Stakeholders

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

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

Technical Assistance

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

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

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

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

In addition, the Center intends to dedicate more resources to supporting oral health integration within CCOs. Due to the fact that oral health was integrated into the CCOs’ global budget in July 2014, which was almost two years after CCOs were stood up, the CCOs are not as far along with their oral health integration efforts. Consequently, the Center plans to provide technical assistance related to integration, with a possible focus on value-based payment for oral health. Target populations for this technical assistance will focus on integrating physical and oral health care for people with mental illness and diabetes. The Center is also considering developing a learning collaborative for CCOs and their oral health providers to collectively identify strategies for enhancing integration.

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

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

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

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

Regional Behavioral Health Collaborative Technical Assistance Process

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

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

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

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

Measures of Effectiveness

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

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

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

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

Innovator Agents

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

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

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

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

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

Innovator Agent Role

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

1. Serve as a point of contact between OHA & CCOs to provide an effective line of communication and streamlined reporting, reducing the duplication of requests and information, and identifying and facilitating resolution on CCO questions and issues with OHA.
 - a. Facilitate problem solving between OHA and CCOs.
 - b. Facilitate the flow of information between OHA and CCOs through regular contact with OHA and CCO leadership.
 - c. Partner with HSD Account Representatives to ensure positive customer service for CCOs.
2. Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. Attend Community Advisory Council meetings. Provide assistance for the development of the CCO's Community Health Assessment. Provide resources, consultation and support in addressing local health disparities.
 - a. Attend all CAC meetings and work with CCO staff and CAC chair on work associated with the CAC.
 - b. Actively participate in work related to the CHA, CHIP, and Transformation and Quality Strategy.

3. Innovator Agents will work in collaboration with the Transformation Center to identify key technical assistance needs and develop strategies to effectively spread the rate of transformation throughout the state and to ensure that learning and improvement strategies are identified and implemented.
 - a. Engage with Transformation Center and facilitate technical assistance and training needs for CCO.
 - b. Provide regular updates on transformation happening both nationally and locally.
 - c. Attend in person Innovator Agent meetings monthly and virtually twice weekly with OHA leadership and stakeholders
 - d. Collaborate and share best practices with other Innovator Agents, CCOs, community stakeholders and/or OHA.
4. Inform and work in partnership with OHA leadership and staff regarding opportunities and obstacles related to system and process improvements propose solutions, and track opportunities, recommendations, and results.
 - a. Partner with OHA Managed Care Delivery System unit to ensure positive customer service for CCO.
5. Assist and support the CCOs in developing and implementing their transformation plans as stipulated in the CCO/OHA contract.
 - a. Actively participate in work related to the Transformation Plan, including the CHA and CHIP.
6. Assist CCOs in the implementation of innovative projects and pilots.
 - a. Ensure rapid-cycle stakeholder feedback to identify and solve barriers.
 - b. Assist with adapting innovations to simplify and/or improve rate of adoption.
 - c. Engage and facilitate stakeholder involvement.
7. Support the CCO in developing strategies to support quality improvement and the adoption of innovations in care through facilitating collaboration and knowledge sharing across the state.
8. Participate in community meetings or other gatherings that are required or beneficial to OHA and the CCO.

- a. Build and facilitate partnerships and collaboration between OHA, the CCOs, stakeholders, and other government entities to support effective innovation.
9. Assist the CCO in managing and using information to accelerate innovation, quality and health system improvement.
 - a. Actively participate in work related to the CHA, CHIP, and Transformation Plan.
 - b. Engage with Office of Equity and Inclusion on health equity related work.
 - c. Work directly with Health Analytics in OHA and CCO to assist with problem solving and clarification of OHA incentive metrics.
 - d. Actively participate in CCO quality strategies and implementation.
 10. Attain and maintain knowledge about health system innovation in consultation with state and national leaders and models.
 - a. Provide regular updates on transformation happening both nationally and locally to CCO and OHA.
 - b. Disseminate information and models of transformation locally and nationally.
 11. Actively participate in collaboration and projects related to population or member health that intersects with other agencies such as public health, seniors and people with disabilities, child welfare, community safety, housing, etc.
 - a. Provide best practice information that is occurring in other communities around the state.
 - b. Provide updated information from OHA and other agencies.

Methods for Sharing Information

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

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

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

Office of Equity and Inclusion

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

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

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

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

Traditional Health Worker Program

Traditional health workers (THWs) include five primary worker types, including: Community Health Workers (CHWs), Peer Support Specialists (PSS) (e.g., addictions and mental health),

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

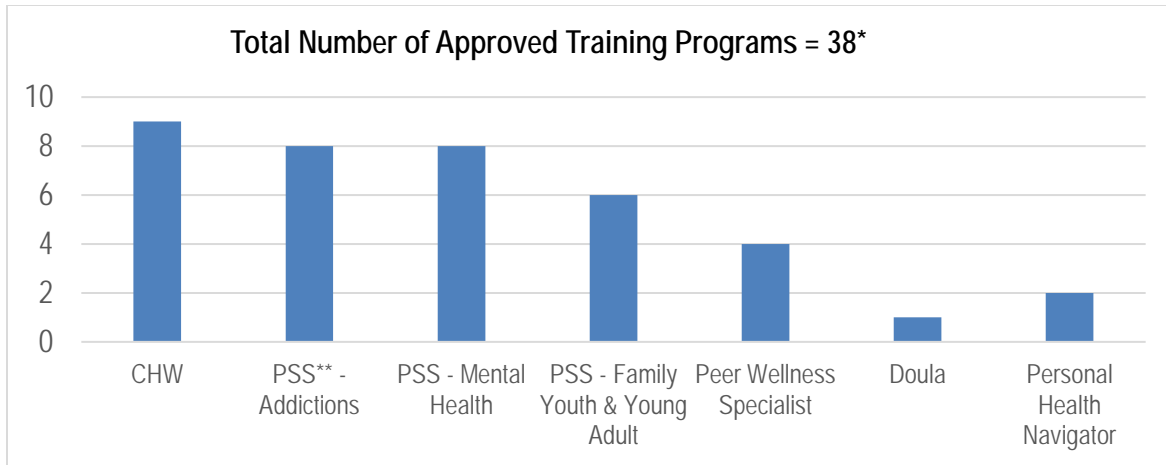
Key focal areas for THWs in Oregon include pursuing strategies to integrate THWs into the CCOs, advancing community engagement opportunities, and developing and implementing ongoing revisions to the THW scope in the context of health system transformation. These targeted areas require engagement of CCOs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

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

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

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

Traditional Health Workers Certified as of December 2016	
THW Program	Total number certified statewide
Community Health Workers (CHW)	422
Personal Health Navigators (PHN)	6
Peer wellness/support specialists	1011
Other THW (Doulas)	28
TOTAL	1506



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

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

Health Care Interpreter (HCI) program

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

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

The HCI Learning Collaborative was set up by OEI with support from a CMMI SIM grant and six learning collaboratives were held. Applicants to the learning collaboratives went through sixty hours of health care interpreter training that prepared interpreters to work effectively in a health care environment. Part of the sixty hours training was done online but a majority of this training is in-person. OHA/OEI has a list of approved trainers who partner with us to organize this training. Applicants who successfully completed their training were tested in English and the language they would interpret in after being qualified. Some of the trained interpreters would

also go for the certification test to complete the process of becoming Oregon certified health care interpreters.

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

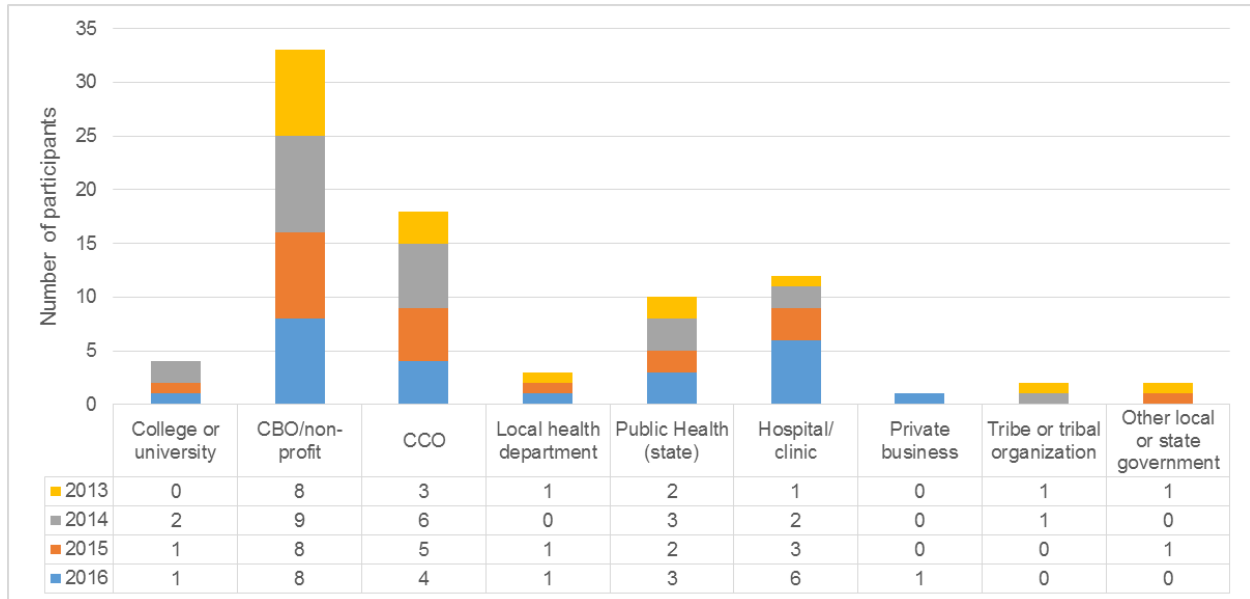
Venue	Number of Trainees	Completed Training	Target Language													
			Hispanic	Russian	Korean	Vietnamese	Arabic	Persian	Serbian	Burmese	Chinese	Somali	Amharic/Tigrinya	Cambodia	Hindi/Punjabi	
Bend	17	17	16						1							
Portland	39	35	21	3		4	2	2			1	2				
Pendleton	21	21	18	2	1											
Medford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

Developing Equity Leadership through Training and Action (DELTA)

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

Upon completion of the program, this cohort will act as drivers of equity and inclusion within Oregon’s health promoting systems. Cohort members are eligible for up to 42 Continuing Medical Education credits and apply the skills they acquire from the training to facilitate the development and institutionalization of health equity and inclusion strategies in their organizational settings. In doing so, health equity, diversity development and inclusion is built into planning, policies, programs, practices, and resource distribution of these organizations.

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



Regional Health Equity Coalitions

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

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

Regional Health Equity Coalition (RHEC)	RHEC Region	Coordinated Care Organization Involvement
Klamath Regional Health Equity Coalition (KRHEC)	Klamath County	<ul style="list-style-type: none"> • <i>Cascade Health Alliance</i>: RHEC leadership team and coalition membership • Provided feedback on the Cascade Health Alliance CHIP
Let's Talk Diversity (LTD)	Confederated Tribes of Warm Springs & Jefferson County	<ul style="list-style-type: none"> • <i>PacificSource</i>: RHEC membership • Provided input on the <i>PacificSource</i> CHA and CHIP • Provided health care interpreter training for <i>PacificSource</i> providers • This RHEC has participated in the <i>PacificSource</i> Health Equity Task Force
Linn Benton Health Equity Alliance (LBHEA)	Linn & Benton Counties	<ul style="list-style-type: none"> • <i>Intercommunity Health Network (IHN)</i>: RHEC leadership team and coalition membership • This RHEC has been participating in IHN's Delivery System Transformation (DST) group. • Collaborated with IHN on their CHA/CHIP work
Mid-Columbia Health Equity Advocates (MCHEA)	Hood River & Wasco Counties	<ul style="list-style-type: none"> • <i>Columbia River Gorge</i>: RHEC membership • <i>PacificSource Community Solutions</i>: RHEC membership • RHEC member appointed to <i>PacificSource</i> Community Solutions CAC
Oregon Health Equity Alliance (OHEA)	Multnomah, Clackamas & Washington Counties	<ul style="list-style-type: none"> • <i>CareOregon</i>: RHEC membership • This RHEC has a CCO Committee which is specifically focused on

Regional Health Equity Coalition (RHEC)	RHEC Region	Coordinated Care Organization Involvement
		fostering relationships between OHEA, its partners, and local CCOs to promote a health equity framework.
Southern Oregon Health Equity (SO Health-E)	Jackson & Josephine Counties	<ul style="list-style-type: none"> • <i>Jackson Care Connect</i>: RHEC leadership team and coalition membership • <i>AllCare Health</i>: RHEC leadership team and coalition membership

Patient-Centered Primary Care Home (PCPCH) Program

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

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

The impact of the PCPCH Program was evaluated through a multi-year study conducted by Portland State University.¹⁶ Key findings are:

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

¹⁶ Gelmon, S., Wallace, N., Sandberg, B., Petchel, S., and Bouranis, N. (2016). Implementation of Oregon’s PCPCH Program: Exemplary Practice and Program Findings. Portland State University. Submitted to the Oregon Health Authority.

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

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

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

Notable Achievements during 1115 Waiver Period

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

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

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

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

Accelerating the Spread of PCPCH

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

Looking Ahead to 2017 and Beyond

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

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

Other Support

Community Advisory Councils

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

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

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

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

Community Health Assessments and Community Health Improvement Plans

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

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

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

Internal Coordination and Coordination with Other State Agencies

OHA Public Health Division

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

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

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

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

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

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

Early Learning Council and Oregon Department of Education

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

attendance. The partnership has also supported effective collaboration around acute health concerns such as lead in the water of schools and childcare facilities.

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

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

Oregon Health Information Technology

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

1. Oregonians have their core health information available where needed so their care team can deliver person-centered, coordinated care.
2. Clinical and administrative data are efficiently collected and used to support quality improvement, population health management, and incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.
3. Individuals, and their families, access, use and contribute their clinical information to understand and improve their health and collaborate with their providers.

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

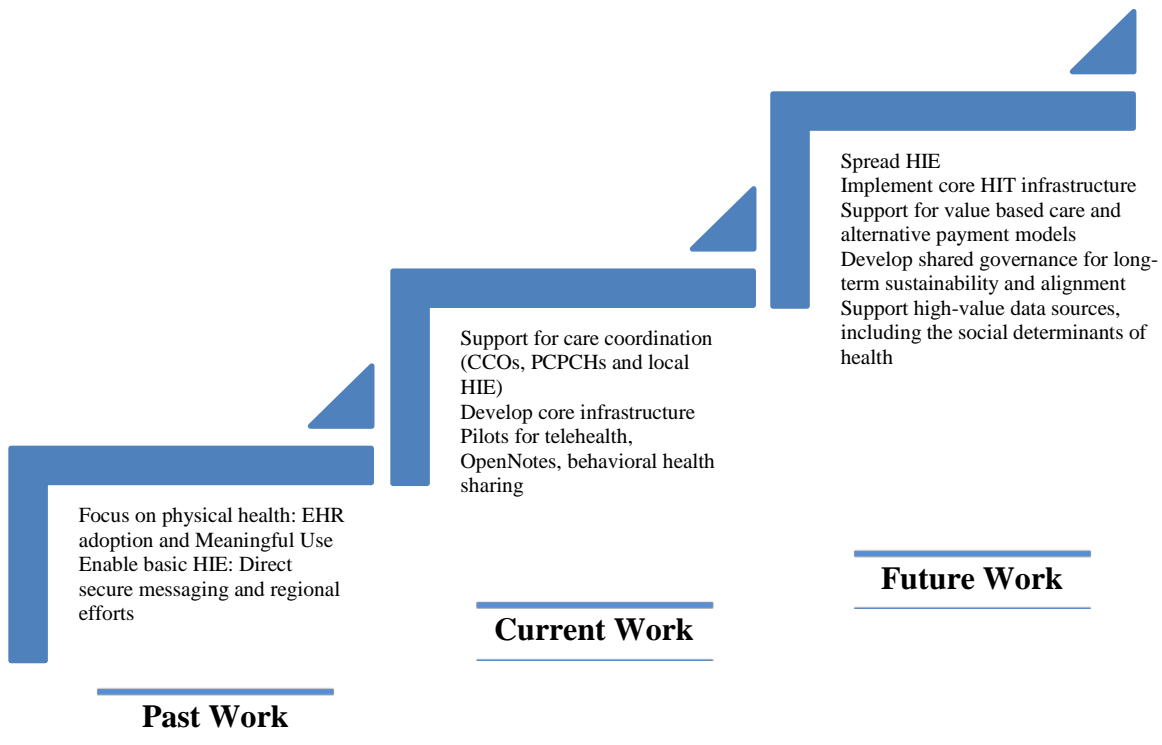
The vision of the coordinated care model is seamless care across providers and organizations. Thus, HIE is a key enabler for the coordinated care model, and there are significant opportunities

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

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

Oregon's Health IT Progress and Future Work

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



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

Overview of CCO Health IT Efforts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

reporting year, EHRs used in CCO reporting requirements must meet 2014 or 2015 Edition certification standards. OHA in conjunction with the Metrics and Scoring committee will continue to monitor the CCOs' use of EHRs. If CCOs fall below the minimum threshold or standards, a plan will be implemented to move the CCO(s) to achieve at least the minimum threshold. This could be in the form of a corrective action plan, reinstating the EHR adoption metric, and/or technical assistance. See Attachment H Part III: Measurement Strategy for details on measures and benchmarks.

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

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

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

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

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

- Ability to enter into agreements to support and provide funding for the appropriate Medicaid share of statewide health IT services.
3. Updates statute for Oregon’s Health IT Oversight Council (HITOC)
- Aligns HITOC under the Oregon Health Policy Board and solidifies its role in providing strategic and policy recommendations and oversight on the progress of Oregon health IT efforts.

Since HB2294 has been in effect OHA has established the new HITOC formally under the Policy Board with a revised charter and new membership. In 2017, HITOC completed an update to the three-year Health IT Strategic Business Plan¹⁷ to focus and align efforts to advance health IT across the state. HITOC intends to make yearly updates to the three-year plan to account for the fast-changing landscape of healthcare transformation and associated health IT needs. Throughout 2017-2022, HITOC will also provide ongoing oversight to the Oregon Health IT Program and continue to monitor the environment and health IT efforts across the state.

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

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

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

¹⁷ <http://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/OHA%209920%20Health%20IT%20Final.pdf>

	2017	2018-2020
Policy Topics	<ul style="list-style-type: none"> • Interoperability • Behavioral Health Information Sharing • Other Policy Board or HITOC-identified Topics 	<ul style="list-style-type: none"> • Support for behavioral health information sharing • Patient access, consent, and specially protected information • Data sharing needs related to social determinants of health (SDoH) • New priorities as determined by OHPB and HITOC
Strategic Planning	<ul style="list-style-type: none"> • Complete update to strategic plan • Develop behavioral health HIT workplan for the Behavioral Health Collaborative 	<ul style="list-style-type: none"> • Review and update strategic plan annually • Development or endorsement of strategies to support network of networks for HIE and HIT for Alternative Payment Methods (APMs) • Support HIT Commons and determine appropriate oversight and reporting roles
Oversight	<ul style="list-style-type: none"> • Oregon HIT Program (e.g. Provider Directory, Common Credentialing, Clinical Quality Metrics Registry, HIE Onboarding Program, etc.) • Behavioral Health Collaborative – HIT workplan • Advance data-driven measurement and milestones for HIT oversight 	
HIT Environment	<ul style="list-style-type: none"> • Behavioral health scan 	<ul style="list-style-type: none"> • Develop additional capacity for ongoing environmental scanning, with focus on new priorities (e.g., Long Term Services and Supports, SDoH, APMs, etc.)
Reporting	<ul style="list-style-type: none"> • Legislative Report in Summer 2017 • OHPB Report in Sept 2017 	<ul style="list-style-type: none"> • Annual reports to legislature and OHPB • Explore opportunities to create dashboards to measure statewide progress
Federal Policy	<ul style="list-style-type: none"> • Federal Law/Policy Considerations (e.g. ACA, MACRA, 21st Century Cures Act, ONC initiatives, Meaningful Use, privacy and security requirements (42 CFR part 2, etc.)) 	

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

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

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

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

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

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

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

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

determine roles and responsibilities for using EDIE/PreManage to support care coordination. Training and sharing of best practices for workflows and care guidelines is planned in 2018/2019.

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

- Seek opportunities to support innovations. Past grant-funded initiatives have supported telehealth and patient access to full clinical notes, including:
 - Telehealth pilots in five communities (funded, in part by CMMI SIM funds).
 - A telehealth resources and inventory website to link telehealth providers and purchasers (health plans, CCOs, etc.) to each other, through the Telehealth Alliance of Oregon (funded, in part by CMMI SIM funds).
 - An Oregon effort to promote OpenNotes to health care providers with EHRs not currently configured for OpenNotes, which allows full clinician notes to be available through an EHR's patient portal (funded, in part by CMMI SIM funds).
- Identifying and addressing barriers to behavioral health information sharing and care coordination. This work includes a 2017 behavioral health IT environmental scan and survey to identify the health IT tools, opportunities and challenges faced by Oregon's behavioral health providers; as well as support through a 2015-2017 \$2.2 million grant from the Office of the National Coordinator for Health Information Technology (ONC) to improve care coordination between behavioral and physical health care. Through the project, OHA's sub grantee, Reliance eHealth Collaborative (Reliance, formerly Jefferson Health Information Exchange), is focusing on consent management to enable coordination between primary care, behavioral health and emergency providers, by developing a common consent model that will be supported within the Reliance technology. In 2016, ONC awarded OHA and Reliance supplemental funds to expand multistate ADT notifications. The project supports the routing of EDIE ADT messages through Reliance to facilitate more actionable data across care teams, through encounter notifications and provider directory lookup, which improve patient outcomes and keep users within their workflows. OHA is a recipient of the ONC Advance Interoperable Health IT Systems to Support Health Information Exchange Cooperative Agreement program.
- Health IT also supports the shift from fee-for-service models of payment to alternative payment models that reward value and outcomes, which is crucial for health system transformation. These new payment models create requirements to track and report outcomes, and incentivize efforts to improve care coordination and health across populations. They also create an opportunity for aligned interests and shared need between health care payers and providers.
 - OHA is supporting care coordination, information exchange, and outcome reporting through strategies such as EDIE/PreManage, the HIE Onboarding Program, the Provider Directory, and the CQMR. Once these tools are fully implemented, they will support providers and CCOs in carrying out their work under the coordinated care model, as well as other value-based models, by giving them the ability to identify, share, and measure clinical data at the individual provider level. For example, OHA is exploring with other CPC+

- payers the opportunity to leverage the CQMR for CPC+ clinical quality measure data collection to reduce reporting burdens on providers.
- Current policy work at OHA is underway to develop a value-based payment roadmap and aligned strategies for primary care payment reform. As these policies are developed, OHA will work on developing additional support for the right health IT needed.
 - To support care coordination and population health efforts, initiatives will also explore opportunities to leverage high-value data sources, such as public health registries, and non-clinical sources of data that can be useful in addressing the social determinants of health. At the same time, work is needed to ensure patient confidentiality and address issues around stigma and privacy. Past work has focused on expanding electronic access to the Prescription Drug Monitoring Program (PDMP) and Physician Orders for Life Sustaining Treatment (POLST) registries. CCOs do not access the PDMP or POLST electronically but do support their covered clinics in having PDMP and POLST directly integrated into their workflows as it bolsters prevention, chronic illness management and person-centered care – aims of the CCO model of care. Future work will look at expanded opportunities for exchange and access of similar high-value data, including electronic access to CCOs where appropriate.
 - Integration of PDMP data into health IT systems has been identified as a national best practice. Access to accurate and timely PDMP information at the point of care can help health care professionals make better-informed clinical decisions and improve patient care. Successful legislation was passed in 2016 to allow authorized practitioners or pharmacists and their delegates to access PDMP information through their health IT system and within their electronic workflow. The Oregon PDMP connected to health IT systems through a PDMP Gateway service in 2017. The PDMP Gateway is in the early adoption phase with the first integrations taking place with hospitals who have integrated EDIE into their EHRs. Two health systems with eleven hospitals have connected to the PDMP Gateway to allow PDMP data to flow within their EDIE notifications. Plans for a statewide PDMP Gateway subscription and statewide roll out are in development.
 - The CCOs model is designed to better coordinate services and focus on prevention and management of chronic conditions; PDMP data can provide a more complete medical profile on each patient including additional prescribers that they have been treated by and medication they have received. This information can be vital to coordinating care. With PDMP Gateway integration this tool is more accessible and more easily utilized.

- Electronic access of POLST forms ensures patient orders are easily accessible across care settings and that processing times for POLST forms happen in a timely manner to ensure the most recent form is available. OHA awarded a grant to the Oregon POLST Registry in December 2016 to support EHR and health IT system integration with the registry. The goal was to enable electronic POLST form completion and bi-directional query by health systems, hospitals, and others to support patient care from their EHR or health IT system. The upgrade has been completed to the electronic POLST (ePOLST) system and bidirectional data flow is now possible. Additionally, POLST forms will become available for EDIE users to view electronically within their workflow in 2018. The implementation of ePOLST has cut the number of paper submissions by more than half thus far. ePOLST availability for CCOs means member end-of-life wishes are known and executed in a way that respects the member. It also supports ease of access and integrated information for care providers. CCOs do not have access to ePOLST, but have supported their covered clinics in gaining access electronically.

New funding to Support Access to Health Information Exchange

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

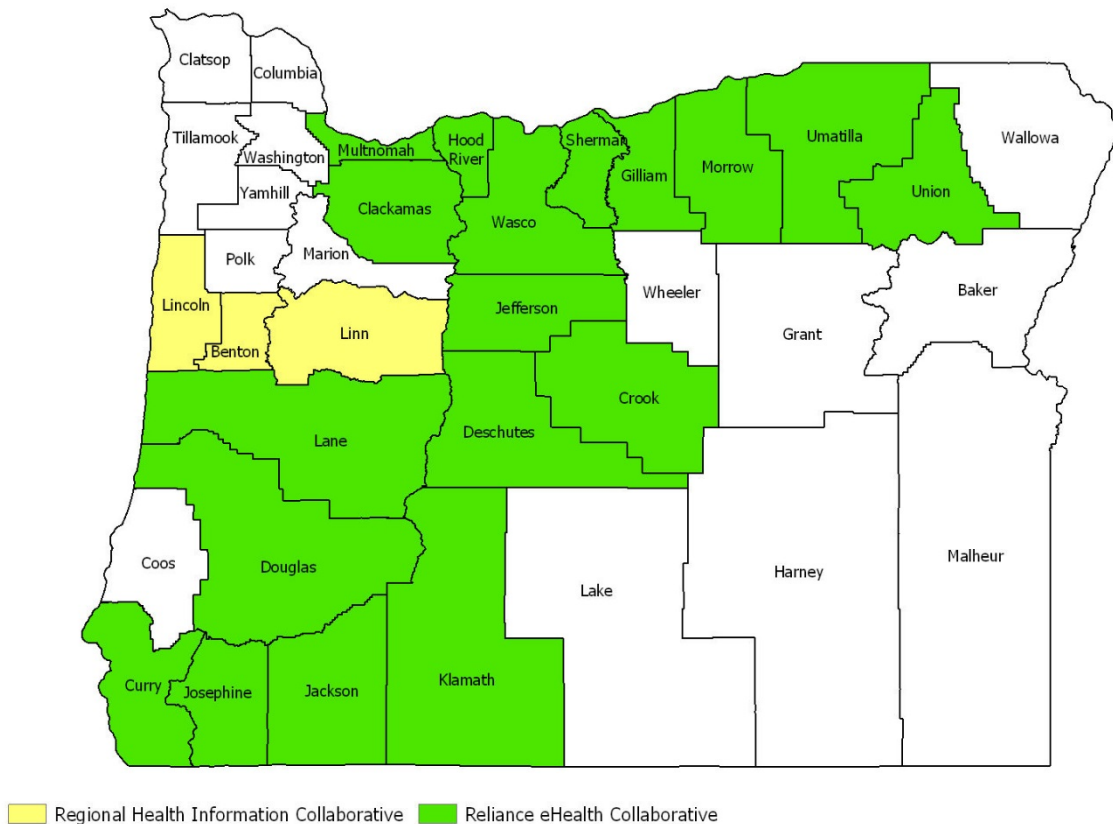
The goals of the HIE Onboarding Program are:

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

Oregon currently has several regional HIEs concentrated in the southern, central, and mid-valley areas of the state. The Program will leverage Oregon HIE entities' existing footprints, facilitate

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

Regional Health information Exchanges in Oregon



December 26, 2017

New Public/Private Partnership to Support Health IT Efforts

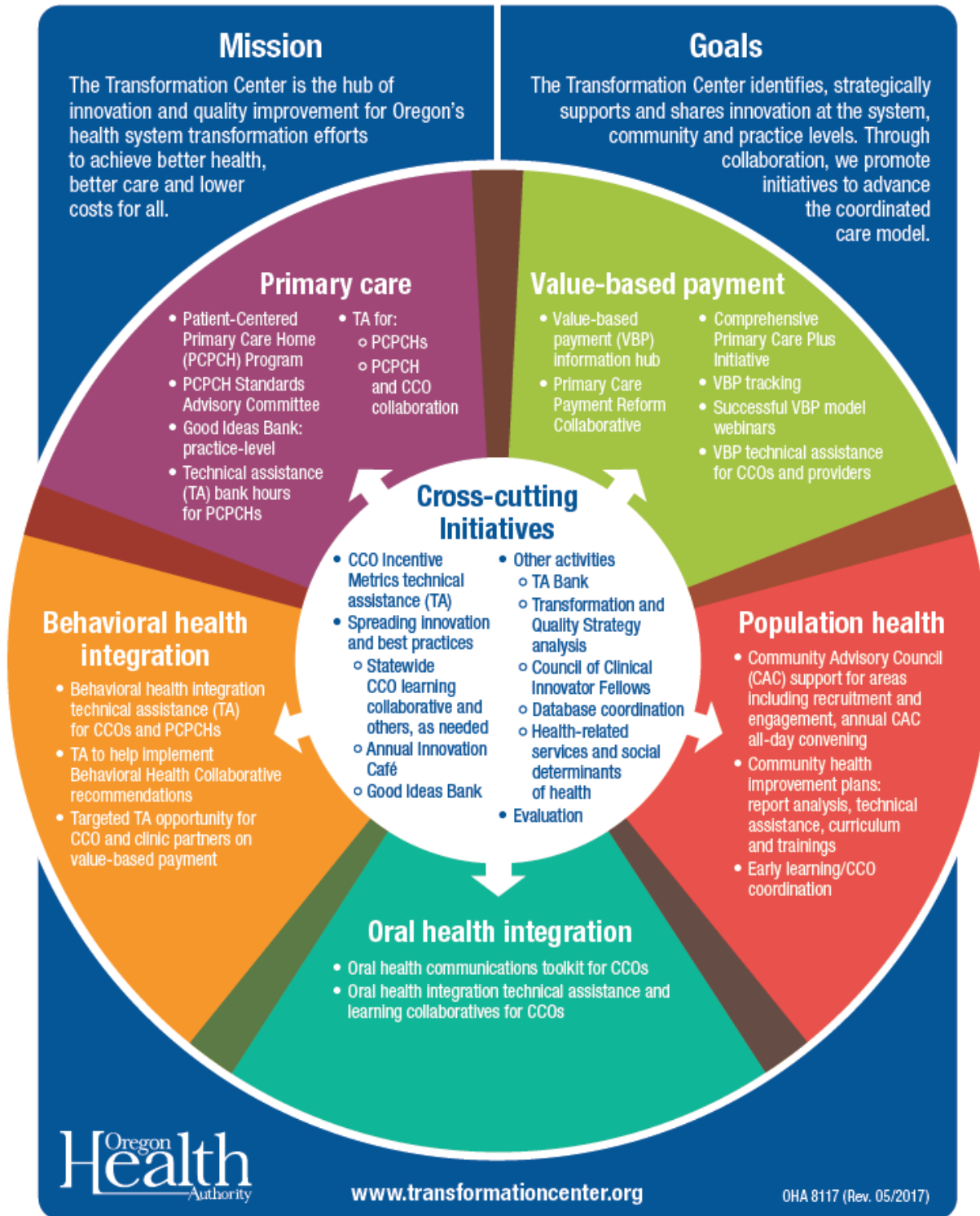
Building on the success of the EDIE Utility, OHA is working with stakeholders, including CCOs, hospitals, health systems, payers, and others, to launch a public-private partnership, HIT Commons, to advance health IT in Oregon. The new health IT governance effort will convene stakeholders, coordinate and standardize data sharing and trust framework agreements, leverage

existing and future investments in health IT, and support the expansion of HIE efforts. Key goals include accelerating access to HIE across the state and enabling health system transformation efforts such as alternative payment models and population health.

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

Appendix A: Transformation Center

Transformation Center



Part II: Quality Strategy

Monitoring the gains we've made

Introduction

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

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

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

Quality structure

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

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

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

- Health Delivery Systems
 - Quality and Health Outcomes Committee
 - Health Evidence Review Committee

Accountability

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

- Oregon Health Authority
 - a. Oregon Health Policy Board – develops strategic direction of health systems
 - b. OHA Quality Council – monitors clinical quality performance, health transformation and quality improvement
 - c. Managed Care and CCO Collaborative – monitors the client experience, through enrollment trends, complaints and grievances, appeals, and utilization trending
 - d. Quality Management / Contract Compliance - monitors managed care organizations and CCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud, waste, abuse)
- Health Delivery System (partnership committees with health delivery system and OHA)
 - a. Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation
 - b. Health Evidence Review Committee – review and development of evidence based practices for all managed care entities (including FFS)

Methods and resources for monitoring

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

reporting. See Attachment H, Part III: Measurement Strategy for more detailed description of data sources.

Framework for Quality

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

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

Improvement Strategies

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

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

Overview of 2012-2017 PIPs:

Under Oregon’s 1115 2012-2017 demonstration waiver, CCOs developed performance improvement projects (PIPs) in a few key areas: high utilizers, maternal care, increased patient assignment within PCPCH medical homes, and diabetes care for individuals with serious and persistent mental illness. Development of effective coordination strategies across health systems, primary care, specialty care and hospital systems, for high utilizers and reducing re-

hospitalizations is an ongoing effort. The PIPs initially focused on breaking down the silos of care and expanding care delivery to team based approaches. A few key lessons learned from adolescent well visits and maternal health have been helpful in providing for the patients social determinants of health (food insecurity, stable transitions, supportive services); therefore, an additional focus area has been added for CCOs to test new models in the area of social determinants of health.

Advancing PIPs:

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

PIP Focus Areas:

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

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

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

Quality Management Plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance. The newly developed Transformation and Quality Strategy will incorporate all components of the Quality Assessment and Performance Improvement (QAPI) program. To ensure a robust quality program in accordance with best practice and CFR will be monitored with documentation of the activities and studies undertaken during both the certification process and regular External Quality Review (EQR) reviews. The QAPI will be incorporated into the CCO's Quality Strategy and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. See "Expectations of CCOs" section below for further details.

Performance Monitoring

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

Monitoring

On-site operational reviews

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

On-going focused reviews

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

management, and data collection problems. Another example of a focused review is an on-going review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

Appointment and availability studies

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

Marketing and materials review

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

Quarterly and annual financial statements

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

Network Adequacy

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

Credentialing

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

providers must verify regularly through the Office of Inspector General and SAMHSA for compliance with conflict of interest standards.

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

Complaints and Grievances

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

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

Equity

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

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

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

Compliance

Accountability Team Reviews

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

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

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

Fraud and Abuse

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

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

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

External Quality Review Organization (EQRO) Activities

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

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

Technical Report

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

Enforcement

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

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

List of conditions that may result in sanctions

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

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

Expectations for CCOs

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

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

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

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

health plan, and provider service organization contracts, and/or Operational Protocol where this requirement is addressed.

Review of Quality Strategy

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

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

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

* Committees including consumer representatives.

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

Appendix B.: Contract Compliance

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

Required Component	Contract Provision
<p>438.206 - Availability of services</p> <ul style="list-style-type: none"> • Delivery network, maintain and monitor a network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled. • Provide female enrollees direct access to women’s health specialists. • Provide for a second opinion. • Provide out of network services when not available in network. • Demonstrate that providers are credentialed. • Furnishing of services, timely access, cultural competence. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, Part 4, Section 3.a. • Exhibit B, Part 4, Section 2.m • Exhibit B, Part 4, Section 2.n. • Exhibit B, Part 4, Section 3.a. (6) • Exhibit B, Part 4, Section 3.b. • Exhibit B, Part 4, Sections 2.a. and 2.g.
<p>438.207 - Assurances of adequate capacity and services</p> <ul style="list-style-type: none"> • MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment. Submit the documentation in a format specified by the state at time of contracting and any time there is a significant change. 	<p>Model Contract</p> <ul style="list-style-type: none"> • Exhibit B, Part 4, Section 3.b(1)
<p>438.208 - Coordination and continuity of care</p> <ul style="list-style-type: none"> • Each MCO must implement procedures to deliver primary care to and coordinate health care services to enrollees. • State must implement procedures to identify persons with special health care needs. Special health care needs are defined as: high health care needs, multiple chronic conditions, mental illness or substance use 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, Part 4, Section 2. • Exhibit B, Part 4, Section 2.f.

Required Component	Contract Provision
<p>disorder and either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.</p> <ul style="list-style-type: none"> • MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions. • State must have a mechanism to allow persons identified with special health care needs to access specialty care directly, (standing referral). 	
<p>438.210 - Coverage and authorization of services</p> <ul style="list-style-type: none"> • Service authorization process. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, Part 2, Section 3.a.
<p>438.214 - Provider selection</p> <ul style="list-style-type: none"> • Plans must implement written policies and procedures for selection and retention of providers. • State must establish a uniform credentialing and recredentialing policy. Plan must follow a documented process for credentialing and recredentialing. • Cannot discriminate against providers that serve high risk populations. • Must exclude providers who have been excluded from participation in Federal health care programs. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, Part 4, Section 3.b.
<p>438.218 - Enrollee information</p> <ul style="list-style-type: none"> • Plans must meet the requirements of 438.10 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit J
<p>438.224 - Confidentiality</p> <ul style="list-style-type: none"> • Plans must comply with state and federal confidentiality rules. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, Part 4, Section 1.b.

Required Component	Contract Provision
<p>438.226 - Enrollment and disenrollment</p> <ul style="list-style-type: none"> Plans must comply with the enrollment and disenrollment standards in 438.56. 	<p>Model Contract:</p> <ul style="list-style-type: none"> Exhibit B, Part 3, Section 6
<p>438.228 - Grievance systems</p> <ul style="list-style-type: none"> Plans must comply with grievance system requirements in the Federal regulations. 	<p>Model Contract:</p> <ul style="list-style-type: none"> Exhibit B, Part 3, Section 5
<p>438.230 - Subcontractual relationships and delegation</p> <ul style="list-style-type: none"> Plan is accountable for any functions or responsibilities that it delegates. There is a written agreement that specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor's performance is inadequate. 	<p>Model Contract</p> <ul style="list-style-type: none"> Exhibit D, Section 18
<p>438.236 - Practice guidelines</p> <ul style="list-style-type: none"> Plans must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically. Guidelines must be disseminated. Guidelines must be applied to coverage decisions. 	<p>Model Contract:</p> <ul style="list-style-type: none"> Exhibit B, Part 4, Section 6
<p>438.240 - Quality assessment and performance improvement program</p> <ul style="list-style-type: none"> Each MCO and PIHP must have an ongoing improvement program. The state must require that each MCO conduct performance measurement, have in effect mechanisms to detect both underutilization and overutilization, have in effect a mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs. Measure and report to the state its performance using standard performance measures required by the state. Submit data specified by the state to measure performance. 	<p>Model Contract:</p> <ul style="list-style-type: none"> Exhibit B, Part 9

Required Component	Contract Provision
<ul style="list-style-type: none"> • Performance improvement projects. Each plan must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the state the results of each project. • The state must review at least annually, the impact and effectiveness of the each program. 	
<p>438.242 - Health information systems</p> <ul style="list-style-type: none"> • Each plan must have a system in place that collects, analyzes, integrates, and reports data and supports the plan’s compliance with the quality requirements. • Collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system. • The plan should ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the state and CMS. 	<p>Model Contract:</p> <ul style="list-style-type: none"> • Exhibit B, Part 7

Part III: Measurement Strategy

Framework for Measurement

Introduction

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

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

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

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

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

care into the delivery system.¹⁸ Due to professional silos, a delay in implementation, and increased difficulty in integrating oral health services, CCOs will require additional time and resources to fully integrate the delivery of oral health services. As outlined in Part I of Attachment H and in Attachment B, Oregon will engage in several key actions during the demonstration period to support models of care delivery that promote integration (e.g., additional oral health incentive measures, a suite of oral health communication materials for primary care providers and outreach workers, CCO oral health integration learning collaboratives and targeted technical assistance, Certified Community Behavioral Health Clinics, Behavioral Health Collaborative efforts).

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

In this demonstration period, Oregon will begin to passively enroll dual eligibles into a CCO, although members may choose to return to fee-for-service at any time. More than 55% of dual eligibles have voluntarily enrolled in a CCO. A preliminary internal analysis indicated that dual eligibles enrolled in a CCO had fewer hospitalizations and lower expenditures. A 2016 analysis found that CCO enrollment improved quality of care for dual eligibles to some degree, but the effects were small during the study period.¹⁹ For some in this population there has been a lack of

¹⁸ Young, J., Kushner, J. McConnell, J. (2016). The Impact of Dental Integration in Oregon's Medicaid Program. Oregon Health and Science University, Center for Health System Effectiveness. Accessed at: goo.gl/JCPdgT.

¹⁹ Kim, H., Charlesworth, C. (2016). Assessing the Effects of Coordinated Care Organizations on Dual-Eligibles in Oregon. Center for Health System Effectiveness, Oregon Health and Science University. Accessed at: goo.gl/bKsEZ2

clarity about care delivery choices, and Oregon aims to improve care coordination and access to services for this population through CCO passive enrollment.

2017-2022 Measurement Strategy

Measurement and evaluation are necessary to determine whether Oregon's health system transformation efforts and goal of advancing the Triple Aim is met. This attachment describes Oregon's robust measurement strategy, including continued monitoring of the quality of and access to care for Oregon's Medicaid population, as per STCs 39 and 41, the CCO incentive metrics program, data sources and validation, and commitments to transparent reporting. Most measurement activities are carried forward from the 2012-2017 measurement strategy, with minor updates to reflect current approaches and emerging areas of focus. Additional measurement through the Hospital Transformation Performance Program is described in Attachment J.

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

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

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

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

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

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

Committees

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

CCO Metrics and Scoring Committee

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

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

Health Plan Quality Metrics Committee

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

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

The Committee is charged with prioritizing measures that:

Technical Advisory Workgroups (TAG)• Utilize existing state and national health outcome and quality measures, including measures adopted by CMS, have been adopted or endorsed by other states or national organizations, and have a relevant state or national benchmark;

- Are not prone to random variations based on the size of the denominator;
- Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden;
- Can be meaningfully adopted for a minimum of three years;
- Use a common format in the collection of the data and facilitate the public reporting of the data; and
- Can be reported in a timely manner and without significant delay so that the most current and actionable data is available.

The HPQM Committee will take into consideration previous measure alignment efforts, including Oregon’s HB 2118 Health Plan Quality Metrics Workgroup (2013), which identified 28 measures that are relevant for Oregonians enrolled in CCOs, Qualified Health Plans available through the exchange, and PEBB and OEGB’s contracted health plans, the Institute of Medicine’s Core Metrics for Health and Health Care Progress (2015) set of 15 standardized measures, and the Oregon Health Policy Board’s Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics (2011). The Committee will also consider measure alignment efforts in other states, including Washington, Rhode Island, and several other SIM-funded states.

Technical Advisory Workgroups (TAG)

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

Measure Sets

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

1. Quality improvement focus areas described in Attachment E
2. Population health and health outcomes
3. Integration
4. Behavioral health and substance use
5. Oral health and oral health integration

6. Social deterrents of health and health equity
7. Collaboration with other systems, particularly early learning and housing.

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

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

Performance Measures for Children and Adults in Medicaid/CHIP

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

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

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

Child & Family Well-being Measures Workgroup

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

The workgroup developed a 67-item child and family well-being measures library, as well as specific subsets of measures recommended for state level monitoring, and accountability measures that could be used as incentive or contract management measures with Coordinated

Care Organizations and Early Learning Hubs. These measures, particularly the accountability measures, may be incorporated into future measure sets.

Behavioral Health Mapping

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

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

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

Measure Alignment

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

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

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

In addition, Oregon will monitor CMS and other national measure specifications to ensure implementation remains current and aligned. This includes updating measures to incorporate

annual Quality & Access Monitoring changes in HEDIS and CMS specifications, and potentially removing measures from measure sets described here if national measure stewards retire or significantly change measures.

Measure Development

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

As these measures are likely to be developmental and require testing before fully adopting them into the measurement framework, or incentive program(s), Oregon intends to establish a glide path for measure development and adoption, similar to California's Medi-Cal 2020 demonstration plan for testing innovative measures.

Measures may be adopted as pay-for-reporting, or monitoring measures during the testing process, until they have been sufficiently vetted to be pay-for-performance metrics for CCOs, or incorporated into the quality and access measure set for ongoing reporting to CMS.

Developmental measures may be utilized in other processes, such as performance improvement projects, where they can continue to be refined before being more formally adopted into pay-for-performance structures. The Metrics TAG workgroup described above will be a critical partner in developing and testing innovative measures.

Quality & Access Monitoring

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

Original Test (2012-2017)

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

reductions in a portion of Designated State Health Program (DSHP) funding to the state, as described in the 2012 Standard Terms and Conditions.

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

Quality and Access Reporting (2017-2022)

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

Measure Inclusion/Exclusion

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

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

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

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

Good reasons to exclude a measure are:

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

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

Reporting Timeframe

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

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

CCO Incentive Measure Program

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

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

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

To be assured of successful transformation in care quality, CCOs will typically subset and target between 3 to 5 incentive metrics for improvement in any calendar year. This is because of the major logistical effort required to transform patient care work procedures, electronic health record reporting and communication plans across hundreds of providers geographically spread across large distances within the state, as is the case for many CCOs. For this reason, no more than 17 to 18 measures are selected in a public process every year with a great deal of emphasis on standardized specifications and definitions for the measures in order that each CCO is assured of reliable comparisons across CCOs. Each metric must satisfy at least two to three levers of the transformation plan or they are not included on the list. If the national benchmark is met or exceeded by many of the CCOs, that metric is removed from the incentive list and tracked as part of the state quality measures. The incentive process has become highly standardized as the years have progressed so that CCOs understand how improvement targets and national benchmarks are set by their Metrics and Scoring Committee. Because the incentive measurement program garners major attention and focus from CCOs, it is a very effective mechanism for health system transformation.

Support for Medicaid Theory of Change

In its 2012 demonstration waiver, Oregon articulated six levers (approaches) that served as a roadmap for health system transformation and moved OHP towards achieving the Triple Aim goals of: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.²⁰ The incentive measure program align with the six levers and help drive health system transformation and attainment of the Triple Aim. For example, percentage of members enrolled in a Patient-Centered Primary Care Home is one of the incentive metrics and tied to Lever 1. Some metrics are associated with multiple levers such as “Effective Use of Contraception” which is a unique state measure of best practices for women. It is tied to Lever 2 and Lever 6 as Oregon moves toward exploring best payment strategies for excellent care in this service category. Other metrics are meant to support integration of behavioral and oral health services into CCO care (Lever 3.) These include metrics such as depression screening, dental sealants and follow up

²⁰ Berwick, D., Nolan, T., and Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs*: Vol. 27, no. 3. Accessed at: <http://content.healthaffairs.org/content/27/3/759.abstract>

after Measure Selection hospitalization for mental illness. The follow up after hospitalization metric also supports Lever 4 since it is meant to emphasize increased coordination across the spectrum of the delivery system. Assessments for children in DHS custody covers physical, oral and dental visits, Lever 3, but is also meant to address the social determinants of health in Lever 4 as well. Lever 5 calls out the health-related services that may be used to address social barriers or other access issues that impact health. These are typically discovered during developmental screening in the first 36 months of life and during adolescent well-care visits. In this manner, every incentive metric is connected to the six levers to promote transformation.

Measure Selection

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

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

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

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

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

To ensure continuous quality improvement, the Committee has developed robust measure selection and retirement criteria to help guide measure selection each year, and continues to pursue measures that will help drive health system transformation. Each year, the Committee

will Benchmark Selection consider additional measures as potential incentive measures as priorities evolve and new measures are developed.

CCO incentive measures	2013	2014	2015	2016	2017
Adolescent well-care visits	x	x	x	x	X
Alcohol or other substance misuse screening (SBIRT)	x	x	x	x	²¹
Ambulatory care: emergency department visits (per 1,000 mm)	x	x	x	x	X
CAHPS composite: access to care	x	x	x	x	X
CAHPS composite: satisfaction with care	x	x	x	x	X
Childhood immunization status				x	X
Cigarette smoking prevalence				x	X
Colorectal cancer screening	x	x	x	x	X
Controlling high blood pressure	x	x	x	x	X
Dental sealants			x	x	X
Depression screening and follow-up plan	x	x	x	x	X
Developmental screening (0-36 months)	x	x	x	x	X
Early elective delivery	x	x			
Diabetes: HbA1c poor control	x	x	x	x	X
Effective contraceptive use			x	x	X
Electronic health record adoption	x	x	x		
Follow-up after hospitalization for mental illness (FUH MI 7 day)	x	x	x	x	X
Follow-up for children prescribed ADHD medication	x	x			
Health assessments within 60 days for children in DHS custody	x	x	x	x	X
Patient-centered primary care home enrollment ²²	x	x	x	x	X
Timeliness of prenatal care	x	x	x	x	X

Benchmark Selection

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

The Committee reviews CCO performance data, improvement over prior year's performance, distribution of the quality pool, and emerging areas of need to help determine the right

²¹ The SBIRT measure has been removed from the 2017 measure set due to underlying challenges with coding for a claims-based measure. An EHR-based measure is in development and will be reinstated as part of the incentive measure set for a future measurement year.

²² The current CCO incentive measure looks at the percent of CCO members who are assigned to a recognized patient-centered primary care home. As the PCPCH program standards are changing, the measure will need to be modified to reflect the new tiers.

combination of incentive measures and benchmarks to help improve quality, access, and outcomes for Medicaid beneficiaries. Incentive measures will be added in subsequent years, and it is likely that other measures will be retired from the set.

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

Future Priorities

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

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

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

For-Service Measurement

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

Oregon will primarily base this measurement and reporting on the *2016 Access Monitoring Review Plan*²³(AMRP) that was submitted to CMS in accordance with 42 CFR 447.203. The AMRP includes Oregon's strategy for monitoring FFS access to specified services for Oregon Health Plan members, to ensure sufficiency of access to care across several categories:

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

The *Access Monitoring Review Plan* establishes baselines for FFS member complaint rates and utilization rates, and then tracks these variables on a quarterly basis to determine if complaint

²³ <https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/or-amrp-16.pdf>

rates increase above a threshold, or utilization rates decrease below a threshold. The threshold will trigger Oregon to research if there is an access issue for FFS members in the regions that crossed the threshold.

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

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

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

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

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

Data Sources and Validation

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

Data Sources

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

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

Administrative Data – All CCOs and FFS providers are required to submit encounters to the Medicaid Management Information System (MMIS) and the All Payer All Claims data system

(APAC). MMIS and APAC data provide a source of comparative information and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, monitoring and developing quality and performance indicators, studying special populations and priority areas, and cost-effectiveness analysis.

Oregon follows all federal regulations regarding claims submission and processing.

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

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

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

Electronic Health Records – Oregon is building CCO and provider capacity to report on measures from their electronic health records. CCOs work with their provider network to develop and extract reports from their EHRs, where possible aligning with national standards for EHR certification and quality measure reporting. OHA will be launching a clinical quality metrics registry in 2018 which will enable electronic submission of EHR-based measures.²⁴

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

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

Focused Clinical Studies – Focused clinical studies, conducted by the state and EQRO, usually involve medical record review, or surveys and focus groups. Plans and FFS providers are required to participate in mutually agreed upon focused clinical studies. Results of focus studies are distributed to plans and reports are published on the department website.

Race/Ethnicity Data – In MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Ethnicity is currently defined as Hispanic/non-

²⁴ Oregon's Clinical Quality Metrics Registry website: <http://www.oregon.gov/oha/OHIT/Pages/COMR.aspx>

Hispanic. Oregon does not have data on multiple races. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

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

Validation

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

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

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

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

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

Data Analysis

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

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

Data will be used to track program goals, address disparities, and drive quality improvement through the financial incentives, performance reporting, and rapid cycle feedback processes

described in Appendix C. Data from selected measures will also be used to inform the evaluation questions described below.

Subpopulation Analysis

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

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

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

Reporting and Transparency

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

Public Reporting

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

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

CCO Reporting

In addition to the ongoing public reporting described above, Oregon has also developed a monthly metrics dashboard for reporting interim results to CCOs. This dashboard allows OHA and CCOs to have an ongoing conversation about metrics, including understanding

specifications, identifying potential issues with performance and areas for improvement, and allows CCOs to make course corrections as needed to meet benchmarks or improvement targets.

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

Appendix C: Quality Pool

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

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

CCO Quality Pool Structure and Distribution

The Oregon Health Authority intends to continue its CCO incentive metrics program and quality pool, as established in 2012 and continued in the 2017 extension (STC 37.e.iii). Originally, Oregon’s strategy was to annually increase the percentage of CCO payment at risk for performance, from 2 percent of the global budget in 2013 to 5 percent in 2017.²⁵

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

Quality Pool Size

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

Rate Setting Impact

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

²⁵ The quality pool is financed at a set percent of the aggregate value of the per member per month (PMPM) CCO budget, not including several specific payments (the prior year’s quality pool payments, the federal Health Insurers Fee, Targeted Case Management, and Hospital Reimbursement Adjustment payments). Additional details about the annual quality pool composition are available in the “reference instructions” online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

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

Quality Pool Distribution

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

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

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

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

The current stage one and two distribution mechanisms are described below; however these are under review with the Metrics & Scoring Committee and may be modified for future years, to better accommodate any structural changes (such as a core / menu measure set concept), and other priority areas, such as “must pass” measures. The quality pool distribution methodology is documented online and updated annually.²⁶

Stage One Distribution

Distribution based on performance on all incentive measures

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

²⁶ Quality Pool Reference Instructions, available online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

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

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

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

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

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

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

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

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

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

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

Table 3: Current quality pool distribution (2016)

Number of benchmarks or improvement targets met	Percent of the quality pool payment for which the CCO is eligible
At least 13 and (at least 60% PCPCH enrollment)	100%
At least 13 and (less than 60% PCPCH enrollment)	90%

Stage Two Distribution

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

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

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

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

Stage Two Distribution

Challenge Pool

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

Historically, the challenge pool has been a subset of the incentive measures, those measures that the Committee believed were “most transformational.” CCOs that performed well on those measures received both the stage one distribution, and any challenge pool dollars.²⁷

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

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

²⁷ Additional details about the challenge pool calculation and distribution to date are available in the “reference instructions” online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Section B: Expenditure Tracking for Trend Reduction Test

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

Description of Costs

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

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

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

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

- Expenditures associated with voluntary populations who are not enrolled in CCOs are not included in Level 1 or 2, including those for non-enrolled duals, individuals with third party coverage, and tribal members.
- Wrap payments for RHC/FQHCs established on or after July 1, 2011, as well as incremental increases in wrap payments for any RHC/FQHCs due to an increase in the scope of services will be included in this category of expenditure.

Description of Elements in the Work Book

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

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

Expenditure Trend Review Workbook

Tab 1: PMPM Targets

PMPM WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGET		TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
	Without HST Baseline Growth (Per ST&Cs)	5.40%	5.40%	5.40%	5.40%	5.40%
	Without HST Baseline Growth PMPM	\$ 591	\$ 623	\$ 656	\$ 692	\$ 729
	With HST Spending Reduction Growth Target	3.40%	3.40%	3.40%	3.40%	3.40%
Level 1: Global Budget	Capitation					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation PMPM					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
Targeted Case Management						
Federally Qualified Health Center and Rural Health Center Wrap						
Hospital Transformation Performance Program						
	Global Budget PMPM	\$ 580	\$ 611	\$ 644	\$ 679	\$ 715
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative ²					
	Hospital Presumptive Eligibility					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation PMPM					
Footnote:						
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.						
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.						

Tab 2: Expenditure Targets

TOTAL EXPENDITURES WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGETS		TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	Capitation					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
Targeted Case Management						
Federally Qualified Health Center and Rural Health Center Wrap						
Hospital Transformation Performance Program						
Global Budget	\$ -	\$ -	\$ -	\$ -	\$ -	
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative ²					
	Hospital Presumptive Eligibility					
	Health Insurer Fee (HIF)					
Services Outside of Capitation + NOT Subject to Evaluation	\$ -	\$ -	\$ -	\$ -	\$ -	
Footnote:						
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.						
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.						

Tab 3: PMPM Actuals						
PMPM ACTUALS UNDER HEALTH SYSTEM TRANSFORMATION		TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	Capitation					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation PMPM					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
Targeted Case Management						
Federally Qualified Health Center and Rural Health Center Wrap						
Hospital Transformation Performance Program						
Global Budget PMPM						
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative ²					
	Hospital Presumptive Eligibility					
	Health Insurer Fee (HIF)					
Services Outside of Capitation + NOT Subject to Evaluation PMPM						
Total Expenditures PMPM						
Footnote:						
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.						
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.						

Tab 4: Expenditure Actuals

TOTAL ACTUAL EXPENDITURES UNDER HEALTH SYSTEM TRANSFORMATION		TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	Capitation					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)					
	Incentive Payment Pool					
	Total Capitation					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget					
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative ²					
	Hospital Presumptive Eligibility					
	Health Insurer Fee (HIF)					
Services Outside of Capitation + NOT Subject to Evaluation						
Footnote:						
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.						
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.						

Tab 5: Caseload

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

Tab 6: State Fiscal Year 2018

State Fiscal Year 2018 Detail		Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	Capitation							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
Total Caseload								
Global Budget PMPM								
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative ²							
	Hospital Presumptive Eligibility							
	Health Insurer Fee (HIF)							
Services Outside of Capitation + NOT Subject to Evaluation								
Footnote:								
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.								
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.								

Tab 7: State Fiscal Year 2019

State Fiscal Year 2019 Detail		Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	Capitation							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
Targeted Case Management								
Federally Qualified Health Center and Rural Health Center Wrap								
Hospital Transformation Performance Program								
Total Global Expenditures								
Total Caseload								
Global Budget PMPM								
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative ²							
	Hospital Presumptive Eligibility							
	Health Insurer Fee (HIF)							
Services Outside of Capitation + NOT Subject to Evaluation								

Footnote:

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

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

Tab 8: State Fiscal Year 2020

State Fiscal Year 2020 Detail		Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	Capitation							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
Total Caseload								
Global Budget PMPM								
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative ²							
	Hospital Presumptive Eligibility							
	Health Insurer Fee (HIF)							
Services Outside of Capitation + NOT Subject to Evaluation								
Footnote:								
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.								
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.								

Tab 9: State Fiscal Year 2021

State Fiscal Year 2021 Detail		Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	Capitation							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
	Targeted Case Management							
	Federally Qualified Health Center and Rural Health Center Wrap							
	Hospital Transformation Performance Program							
	Total Global Expenditures							
	Total Caseload							
Global Budget PMPM								
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative ²							
	Hospital Presumptive Eligibility							
	Health Insurer Fee (HIF)							
Services Outside of Capitation + NOT Subject to Evaluation								
Footnote:								
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.								
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.								

Tab 10: State Fiscal Year 2022

State Fiscal Year 2022 Detail		Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	Capitation							
	Total Managed Care							
	Total Fee For Service (for equivalent CCO services)							
	Incentive Payment Pool							
	Total Capitation							
	Services Outside of Capitation + Subject to Evaluation							
	Babies First							
	Adult Residential Mental Health Services							
	Cost-sharing for Medicare skilled nursing facility care							
	Young Adults in Transition Mental Health Residential							
Targeted Case Management								
Federally Qualified Health Center and Rural Health Center Wrap								
Hospital Transformation Performance Program								
Total Global Expenditures								
Total Caseload								
Global Budget PMPM								
Level 2	Services for CCO clients Outside of Capitation¹ + NOT Subject to Evaluation							
	Mental health remaining in fee-for-service							
	Long Term Care							
	School Based Health Services							
	Behavioral Rehabilitative Services (BRS)							
	Personal Care 20 Client Employed Provider							
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011							
	Mental Health Habilitative ²							
	Hospital Presumptive Eligibility							
	Health Insurer Fee (HIF)							
Services Outside of Capitation + NOT Subject to Evaluation								
Footnote:								
¹ QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.								
² Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.								

Appendix D: Measurement Crosswalk

1115 CMS Waiver
Measurement and Quality Crosswalk

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

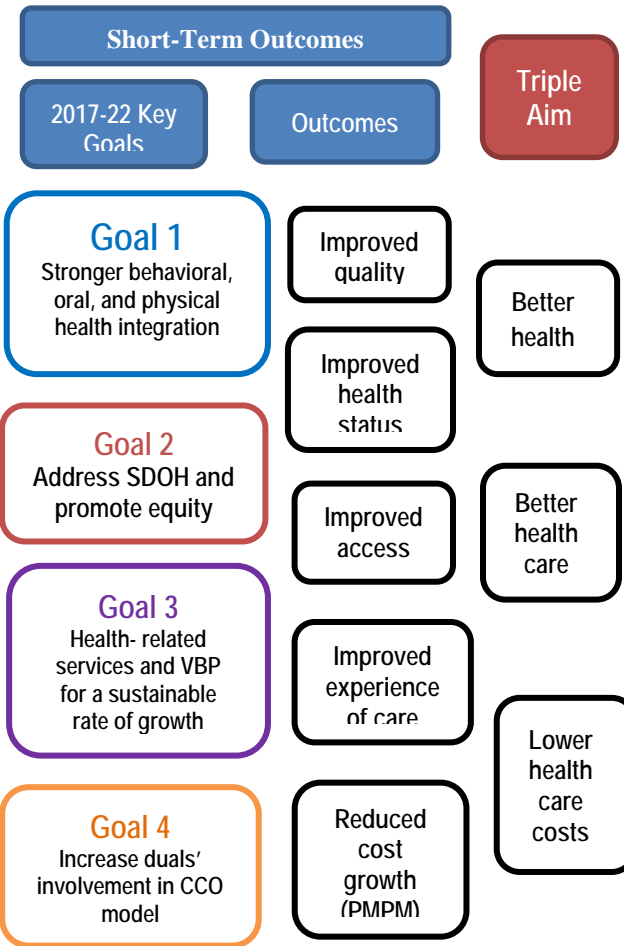
1115 CMS Waiver
Measurement and Quality Crosswalk

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

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

Appendix E

Inputs	Activities	Outputs CCO activities	Transformation Levers
Technology: <ul style="list-style-type: none"> Business Objects Regional HIE EDIE PreManage Webinars 	Continue to support PCPCHs and CCBHCs; support tribal care coordination <ul style="list-style-type: none"> Incentive payments Quality pool PCPCH tiers 	Maximize use of PCPCHs; encourage use of EHRs & HIE participation; encourage patients to take an active role in their care	1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)
Staff: <ul style="list-style-type: none"> OHA staff Innovator agents TA consultants EQRO 	Establish VBP roadmap & targets; provide technical assistance (TA); continue CCO quality pool (incentive metrics) <ul style="list-style-type: none"> Bonus payments 	Introduce new provider payment models; participate in models such as CPC+, achieve targets, performance measure reporting	2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes
Partners: <ul style="list-style-type: none"> OHSU Oregon Health Policy Board Stakeholder committees Technical Advisory Groups Medicaid Advisory Committee 	Establish single points of shared accountability; encourage oral health integration and access; related quality improvement projects <ul style="list-style-type: none"> HIE platforms and onboard program EDIE PreManage Quality registry 	Take steps to integrate & transform care (transformation plans), engage with community, do quality improvement projects, etc.	3: Integrating physical, behavioral, and oral health care structurally and in the model of care
	Process improvements and simplification; public health modernization <ul style="list-style-type: none"> Webinars Business objects 	Consolidate care across silos; encourage efficient use of resources; develop CHA and CHP	4: Increased efficiency through administrative simplification and a more effective model of care
Money: <ul style="list-style-type: none"> Global Budget Quality Pool 	Establish definitions, provide TA, tracking methods, & incentives for HRS	Design process for offering HRS, provide HRS where appropriate	5: Use of health-related services to improve care delivery, enrollee health
Federal and state rules and regulations	Provide support, TA, learning collaboratives and other convenings (e.g. Transformation Center); spread model to all dual eligibles	Transformation plans, quality improvement projects, serve duals	6: Testing, accelerating and spreading effective innovations and best practices



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

Attachment I – Model Tribal Engagement and Collaboration Protocol

A. Definitions

1. **Indian or American Indian/Alaska Native (AI/AN).** Indian and/or American Indian/Alaska Native (AI/AN) means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).
2. **Traditional Health Workers (THW).** THW is defined as provided under OAR 410-180-0300 through 410-180-0380.
3. **Tribe.** Tribe means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
4. **Tribal Organization.** Tribal organization means the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: *Provided*, that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant
5. **Urban Indian Health Program (UIHP).** Urban Indian Health Program means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.
6. **Indian Health Care Provider (IHCP).** Indian Health Care Provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

B. General Provisions

1. **Tribal Consultation Policy.** The state will work with tribes to develop an agreeable Tribal Consultation Policy related to activities under this demonstration.
2. **Tribal Technical Advisory Board.** Through ongoing communications (e.g., emails) and during a standing meeting on a quarterly basis, the state will solicit advice and guidance from the Board on policies, guidelines, and programmatic issues affecting the delivery of health care for tribal members and to ensure that

Indians receive quality care and access to services. The role of the Tribal Technical Advisory Board will be included in the Tribal Consultation Policy and is not meant to replace the tribal consultation process.

3. **Formal Linkages.** Formal linkages between the tribes, UIHP and CCO networks will continue to be developed, and the tribes and UIHP will take an active role in advising the state around improvements to ensure effective collaboration between tribes, UIHP, health care providers, and CCOs. This collaborative effort between the various tribal and health care delivery system partners will positively affect access to health care services and provider reimbursements.
4. **Medicaid Issues Resolution.** State will create a list of designated contacts to work with IHCPs to resolve issues with managed care and fee for service (FFS) related to enrollment, prior authorization processing, billing, claims, and payment as issues arise for the IHCP.
5. **Mandatory and Optional Benefits.** Notwithstanding any other provision in this demonstration, the state may reimburse tribal health programs for all Mandatory and Optional benefits in the Medicaid State Plan.
6. **Transformation Center.** IHCPs will have access to Transformation Center supports, including but not limited to, access to targeted technical assistance on behavioral and physical health integration and technical assistance and participation in Oregon's Project Extension for Community Healthcare Outcomes (ECHO) initiative, which is a national tele-mentoring model that provides primary care providers an opportunity to learn from specialists to better manage complex conditions and patients in their practices.
7. **Health Information Technology Efforts.** IHCPs will have opportunities around engagement and participation in Health IT projects and programs sponsored by the state, including but not limited to technical assistance; health information exchange; provider data; and the Medicaid Electronic Health Record Incentive Program. As OHA develops Health Information Technology strategies, the state will continue to involve tribes. See Attachment H for further information on HIT projects and programs.

C. Coordinated Care Organizations

1. **Contracts with IHCP.** The CCOs are required to offer contracts to all Medicaid eligible IHCPs (as set forth below in STC 2 – Model IHCP Addendum) and to provide timely access to specialty and primary care within their networks to CCO-enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the CCO/MCO network.
2. **Model IHCP Addendum (see Appendix A).** Any contract between the state and a CCO under Oregon's 1115 demonstration shall require the CCO to offer contracts to all IHCPs in the area they serve using, at a minimum, the provisions in the CMS "Model Medicaid and Children's Health Insurance Program (CHIP)

Managed Care Addendum for Indian Health Care Providers (IHCPs)” approved by the tribes and UIHP (Model IHCP Addendum in Appendix A). CCOs will be required to adopt either the Model IHCP Addendum or an addendum agreed upon in writing by the CCO and every tribe and Indian Health Care Provider (IHCP) in the CCO’s region. The Model IHCP Addendum or alternate addendum to be used by CCOs will assure that CCOs comply with key federal laws that apply when contracting with IHCP providers, minimize potential disputes, and lower the perceived barriers to contracting with IHCP. IHCPs may agree to include additional provisions in the Model IHCP Addendum.

3. **Timeline for Contracts with CCOs.** CCOs and IHCPs interested in entering into a contract will reach an agreement on the terms of the contract within six months, unless an extension is agreed upon by both parties. If the CCO and IHCP do not reach an agreement on the terms of the contract within six months, the IHCP may request the assistance of a state representative to assist with negotiation of the contract with a CCO. The state will use the informal process to facilitate an in-person meeting with the CCO and IHCP to assist with the resolution of issues and to facilitate an agreement between the CCO and IHCP. If an informal process does not lead to an agreement, the CCO and IHCP will use the existing dispute resolution process (OAR 410-141-3269), which will be used as guidance and will not be binding on the IHCPs. The state will use the existing process to facilitate an in-person meeting with the CCO and IHCP to assist with resolution of issues between CCO and IHCP and to facilitate an agreement between the CCO and IHCP. The CCOs and IHCP must finalize and approve the contract within 60-90 days of reaching an agreement.
4. **No Obligation for IHCP to Contract.** IHCP are under no obligation to contract with CCOs or plans.
5. **Community Health Needs Assessment (CHA).** Beginning with the 2019 CCO contracts, the state will require CCOs to 1) include tribes and IHCP in the area to gather and contribute data on health disparities; 2) allow IHCPs to review and provide input on the CCO’s community health needs assessment; and 3) provide tribes and IHCP with the final community health needs assessment, including data relevant to the tribal population. The state will encourage the CCOs to include the tribes and IHCP in the CHA process, as described above, upon approval of the tribal protocol in 2017.
6. **Community Health Improvement Plan (CHIP).** Beginning with the 2019 CCO contracts, the state will require CCOs to 1) engage IHCP participation in the CCO’s process to identify the Community Health Improvement Plan priorities; and 2) allow IHCPs to review and provide feedback to the draft Community Health Improvement Plan before it goes to the CCO board for approval; IHCP review and feedback will need to occur in a timeframe that does not delay CCO approval processes for the CHIP. The state will encourage the CCOs to include tribes and IHCPs in the CHIP process, as described above, upon approval of the tribal protocol in 2017.

7. **Cost Sharing.** Any contract between the state and a CCO shall prohibit the CCO from imposing any enrollment fee or premium on an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under Purchase/Referred Care (PRC). No deductible, copayment, coinsurance or similar cost sharing for any Medicaid covered service shall be imposed against an AI/AN who has ever been furnished an item or service directly by the IHCP or through referral under contract health services. Payments due to the IHCP or through PRC for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.
8. **IHCP Network Adequacy.** As referenced in 42 CFR 438.14(b)(1) and §457.1209, any contract between the state and a CCO must require the CCO guarantee that there are a sufficient number of IHCPs in the network to ensure timely access to Medicaid services for Indian enrollees eligible to receive such services.
9. **Payment requirements.**
- a. Per 42 CFR 438.14(c)(1) and §457.1209, when an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the CCO, it must be paid an amount equal to the amount the CCO would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the CCO pays and what the IHCP FQHC would have received under FFS.
 - b. Per 42 CFR 438.14(c)(2) and §457.1209, when an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of CCO entity or not, it has the right to receive its applicable encounter rate published annually in the **Federal Register** by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.
 - c. Per 42 CFR 438.14(c)(3) and §457.1209, when the amount an IHCP receives from a CCO is less than the amount required by paragraph (b) of this subsection, the state must make a supplemental payment to the IHCP to make up the difference between the amount the CCO entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.
10. **Timely Payment to IHCP Providers.** CCOs and/or state must make timely payments to IHCP whether such IHCP is a participating provider or non-participating provider. Under this section, timely payments means that IHCP must be paid the agreed upon rate with a CCO within 30-90 calendar days of billing, as referenced in OAR 410-141-320 (rule subject to change which may alter requirement for timely payment).
11. **IHCP Right of Recovery.** The state affirms its agreement to comply with Section 206 of the Indian Health Care Improvement Act (IHCIA) as codified in 25 U.S.C. § 1621e, and with 42 CFR 438.14 regarding the right to payment of

IHCPs, and will take all reasonable actions to require the CCOs to comply with said provisions in a timely manner.

- 12. No Auto-Assignment for Indians.** Auto-assignment will not apply to Indians, and they will be eligible to select an IHCP as their primary care provider whether they opt into managed care or not.
- 13. Non-participating IHCP Referral.** As required by 42 CFR 438.14(b)(6), CCOs must permit out-of-network IHCPs to refer a CCO-enrolled Indian to a network provider for covered services without having to obtain a referral from a participating CCO provider.
- 14. Exemption of Certain Property from Resources for Medicaid and CHIP Eligibility.** Notwithstanding any other provision in this waiver, the state shall disregard the property listed in 42 U.S.C. 1396a(ff) from resources for the purposes of determining the eligibility of an individual who is an Indian for medical assistance under Oregon's 1115 demonstration.
- 15. Care Coordination:** Several tribes and UIHP are developing or implementing strategies to support enhanced care coordination given Oregon's health system transformation, CCO development, and recent CMS February 26, 2016 State Health Official letter expanding federal funding for services received through IHS or Tribal facility. In partnership with tribes, the state is exploring expanded opportunities for effective care coordination for Indians. The state will continue to collaborate with the IHCPs on delivery of care coordination services to Indians in Oregon.
- 16. Corrective Action.** The state will engage in corrective action with a CCO and subject a CCO to penalties or other appropriate sanction, as set forth in the CCO-state agreement or administrative rules if: the CCO fails to perform any obligation under the CCO-state Agreement; or the CCO fails to ensure that eligible Indians are afforded timely access to care, rights, and benefits an IHCP's right to timely payment.
- 17. CCO Tribal Liaison.** The state will encourage CCOs to designate a Tribal Liaison to facilitate resolution of any issue between the CCO and an IHCP. The Tribal liaison's function may be an additional duty assigned to existing CCO staff. The CCO will make the Tribal liaison available for training by tribes and UIHP in the CCO's service area.
- 18. Conflict Resolution.** The state will work with the IHCP to develop a process for conflict resolution which will include a provision for IHCP to submit concerns to the state regarding issues not resolved between the IHCP and CCO; and assist with facilitation and resolution of issues.
- 19. Historical Trauma/Intergenerational Trauma and Cultural Competency.** The tribes and UIHP will work with the state tribal liaisons workgroup to develop and review the training on working with tribal governments and Indian

communities. The training will include content on tribal governments, historical trauma and intergenerational trauma and promote cultural competency. Once it is developed, it will be provided as online training to CCOs and providers. After completing the training, CCOs will be able to apply the acquired knowledge and principles that are foundational to working with and understanding tribes and Indian communities.

D. Fee for Service (FFS)

1. **Indian Individuals Excluded from Managed Care.** Individuals identified as Indian are excluded from managed care unless an individual chooses to opt into managed care and access coverage pursuant to all the terms and conditions of Oregon's 1115 demonstration. Individuals who are Indian and who have not opted into managed care will receive the Medicaid services generally available to them through a fee-for-service (FFS) system under the Medicaid State Plan.
2. **Notices.** Any notice regarding enrollment in a plan under Oregon's 1115 demonstration must include information explaining that Indians are excluded from managed care unless they opt-in and that Indians who have not opted in may still receive services through a FFS system, with access to covered benefits through an IHCP.
3. **Cost Sharing.** No enrollment fee or premium shall be imposed on an Indian who is eligible to receive or has received an item or service furnished by an IHCP or through referral under purchased and referred care (PRC). No deductible, copayment, coinsurance or similar cost sharing for any Medicaid covered service shall be imposed against an Indian who has ever been furnished an item or service directly by the IHCP or through referral under contract health services. Payments due to the IHCP or through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.
4. **Fee-for-Service Access Monitoring Plan Data for Indians.** Data gathered by the state related to state's requirement will be shared with IHCPs on a quarterly basis (or as often as required by law) to improve reporting and to address access issues for Indians.

Appendix A: Model Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the Managed Care Plan network IHCP agreement by and between _____ (herein "Managed Care Plan") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan’s network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.²⁸

2. Definitions.

For purposes of this Addendum, the following terms and definitions shall apply:

(a) “Indian” means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary.

The term “Indian” also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(b) “Indian Health Care Provider (IHCP)” means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(c) “Managed Care Plan” includes a Coordinated Care Organization (CCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or

²⁸ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(d) “Indian Health Service or IHS” means the agency of that name within the U.S. Department of Health and Human Services established by the IH CIA Section 601, 25 U.S.C. § 1661.

(e) “Indian tribe” has the meaning given in the IH CIA Section 4(14), 25 U.S.C. § 1603(14).

(f) “Tribal health program” has the meaning given in the IH CIA Section 4(25), 25 U.S.C. § 1603(25).

(g) “Tribal organization” has the meaning given in the IH CIA Section 4(26), 25 U.S.C. § 1603(26).

(h) “Urban Indian organization” has the meaning given in the IH CIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

IHS.

An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IH CIA.

4. Cost-Sharing Exemption for Indians; No Reduction in Payments.

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is

eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.

The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u-2(h)), 42 CFR 438.14((b)(3), and 457.1209.

6. Agreement to Pay IHCP.

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 CFR 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.

(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix B.

9. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification.

(a) Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA),

which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the Managed Care Plan network IHCP agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network IHCP agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network IHCP agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.

In the event of any dispute arising under the Managed Care Plan's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's

network IHCP agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCA (25 U.S.C. § 1675).

15. Claims Format.

The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCA (25 U.S.C. § 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims.

The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 U.S.C. §1396u-2(h)), 42 C.F.R. 438.14(c), and 457.1209, and shall pay at either the rate provided under the State plan in a Fee For Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service.

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.

Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan:

Date: _____

For the IHCP:

Date: _____

Appendix B: Applicable Provisions for IHCPs

(a) The IHS that is an IHCP:

- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act (“FTCA”), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 (“Privacy Act”), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) IHCAA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:

- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCAA, 25 U.S.C. § 1601 et seq.;
- (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:

- (1) IHCAA, 25 U.S.C. § 1601 et seq.
- (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (3) HIPAA, 45 C.F.R. Parts 160 and 164.

Attachment J: Hospital Metrics and Incentive Payment Protocol

Updated January 12, 2017

Attachment J will expire June 30, 2018

Introduction

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

Hospital Performance Metrics Advisory Committee

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

Incentive Measures

The Oregon Hospital Performance Metrics Advisory Committee has identified hospital-specific metrics, which will be used to assess the HTPP payments through June 30, 2018 from a share of Oregon's hospital assessment revenue. See Appendix A: Hospital Quality Pool Structure for a detailed description of the hospital quality pool design and funding algorithm. Building on work completed by the Metrics and Scoring Committee, the Hospital Performance Metrics Advisory Committee considered several core principles when selecting these measures. Among other principles, any selected measures should:

- Meet standard scientific criteria for reliability and face validity;
- Help drive system change;
- Be aligned with health system transformation underway by CCOs;
- Align with evidence-based or promising practices;
- Be nationally validated, a required reporting element in other health care quality initiatives, or align with national or other benchmarks for performance; and

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

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

Table 1: Agreed Domains and Measures

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

Benchmarks and Improvement Targets

The Hospital Performance Metrics Advisory Committee worked with OHA and CMS to develop a set of hospital-appropriate benchmarks and improvement targets for which the state can measure progress towards the state’s health system transformation goals. In year one, hospitals received payment for submitting baseline data to OHA (pay for reporting). In years two through four, hospitals will only receive payment for submitting data to OHA *and* achieving the established benchmarks or improvement targets. In years two through four, hospitals that do not meet the benchmark for a given measure will be assessed against their improvement from their

prior year's performance ("improvement target"). If hospitals meet either the benchmark or their improvement target on a given measure, they will be awarded the quality pool funds associated with that measure²⁹. As HTPP is meant to foster continuous improvement across all measures for all hospitals, all benchmarks in year two will be evaluated against year one baseline data and amended as appropriate to ensure continuous improvement. All benchmarks in year three will be evaluated against year two data. All benchmarks in year four will be evaluated against year three data. Details on the hospital measures, benchmarks, and improvement targets can be found in Appendix B.

²⁹ OHA will use the methodology established for the CCO improvement targets in calculating the hospital improvement targets. These improvement targets are based on the Minnesota Department of Health's Quality Incentive Payment System (hereafter referenced as the "MN method"). This method requires at least a 10 percent reduction in the gap between the baseline and the benchmark to be eligible for incentive payments. Detailed specifications on the improvement target calculations used can be found here: <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>.

Appendix A: HTPP Quality Pool Structure

Hospital Quality Pool Funding

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

Hospital Quality Pool Timing

HTPP funds will be distributed four times, with four measurement years. The first three years will span the federal fiscal year. The fourth year will span calendar year 2017.

The first measurement period is October 1, 2013 – September 30, 2014, which is the federal fiscal year 2014. For this period, hospitals will receive payment based on baseline data submission of all measures for that period. Year one data must be submitted to OHA by February 28, 2015, and OHA will issue the first payment by April 30, 2015.

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

The third measurement year will cover the period October 1, 2015 – September 30, 2016. Hospitals will submit data to OHA by March 31, 2017, and OHA will issue the third payment by June 30, 2017. Year three payment will be contingent upon performance across the hospital quality measures.

The fourth measurement year will cover the period January 1, 2017 – December 31, 2017. Hospitals will submit data to OHA by March 31, 2018, and OHA will issue the fourth payment by June 30, 2018. Year four payment will be contingent upon performance across the hospital quality measures.

Ensuring Continuous Improvement

OHA is committed to continuous improvement. OHA and the Hospital Performance Metrics Advisory Committee reviews hospital performance in relation to the established benchmarks to ensure that improvement targets and benchmarks are set to a standard that ensures continuous quality improvement. The hospital committee was reconvened to recommend benchmarks for the

fourth year of the program (see Appendix B below for the agreed-upon benchmarks for the program).

Hospital benchmarks are reviewed each year to ensure that hospital performance is appropriately stretched in order to receive any performance payment. Additionally, hospital measures which overlap with CCO measures will be aligned with any changes that occur in the CCO measure specifications.

While the years two, three and four benchmarks may be amended as needed to ensure quality improvement, the measure set itself will not be amended within the four years of the HTPP.

Allocation Methodology

OHA has set a floor such that each hospital will be eligible to earn \$500,000 in each year of the program, contingent upon maximal performance, defined as achieving credit for at least 75% of the measures (9 of 11). This strategy ensures that hospitals have sufficient motivations for making necessary investments in quality improvement. As with the funding available for HTPP as a whole, the availability of floor funds is subject to the amount allowed under the 2% test. The funds remaining after allocation of the possible \$500,000 per hospital floor will be allocated to each domain based upon weighting agreed with CMS (detailed further below). After this, the amount each hospital achieving a measure will actually receive will be weighted according to its Medicaid volumes, as below:

- Fifty percent will be based upon each hospital's total Medicaid discharges. In the first three years of the program this was for the 12 months ending September 2012 as a percent of all DRG hospital for that 12 month period; in the fourth year of the program this will be for calendar year 2015 as a percent of all DRG hospitals for that 12 month period.
- Fifty percent will be based upon each hospital's total Medicaid patient days. In the first three years of the program this was for the 12 months ending September 2012 as a percent of all DRG hospitals for that 12 month time period; in the fourth year of the program this will be for calendar year 2015 as a percent of all DRG hospitals for that 12 month period.

The discharge data are from the Hospital Inpatient Discharge Data hospitals are required to submit to OHA. This weighted distribution will be held constant for the three years that the hospital quality pool is in effect. Holding the weighted distribution constant avoids penalizing hospitals that reduce Medicaid discharges and/or inpatient days proportionally better than other hospitals, which would decrease their share of total Medicaid discharges and inpatient days. However, there were significant changes to the distribution of Medicaid patients seen at hospitals across the state after 2014. Therefore, discharge data from 2015 will be used in weighting payments in the fourth year of the program

The amount available for each hospital to earn will vary based upon the final total hospital quality pool availability, changes in the number of DRG hospitals in the HTPP program, and how each hospital performs against the quality metrics. Hospitals will only receive quality pool

payments for providing baseline data (in year one), or attaining benchmarks or improvement targets in years two, three and four.

This allocation methodology has been chosen as it is felt it is the most equitable in terms of hospital effort, performance, and size in terms of use by Medicaid members. OHA bases this on its experience with the CCO incentive metric pool. The inclusion of the improvement targets (in addition to the benchmarks) for the CCO incentive pool allowed CCOs which engaged in quality improvement activities to successfully achieve the measures and receive incentive payments. In the first performance year, all CCOs saw improvement on at least some measures, and 11 of 15 CCOs earned 100% of their quality pool. Furthermore, at least half of the CCOs met either the benchmark or the improvement target on most of the CCO incentive measures. OHA expects a similar experience with hospital performance and quality pool distribution.

Quality Pool Distribution

The quality pool distribution method occurs in two phases, for both the hospital focused and the hospital-CCO collaboration focused domains. Phase 1 involves determining whether a hospital is eligible for the \$500,000 floor (earned by achieving at least 75% of the measures [9 of 11]). Phase 2 involves allocating the remaining funds to hospitals based upon performance against each measure.

In cases in which a hospital does not have the relevant ward (e.g., hospitals without psychiatric wards for the follow-up after hospitalization for mental illness measure), OHA will utilize an attribution methodology in which the CCO rate will be applied to relevant hospitals during the pay-for-performance years two, three, and four. In cases in which a hospital does not have a relevant ward (e.g., hospitals which do not have emergency departments), and there is not a CCO rate that can be applied through attribution methodologies, the hospital will not be held accountable for that measure. The hospital will still have to meet 75 percent of the measures for which they are eligible (e.g., 7 of 9) to earn all of their available incentive funds.

Phase 1: Floor Allocation

The first step in distributing the hospital quality pool funds involves determining the number of instances in which a hospital has achieved a measure. In year one, achieving the measure is defined as submitting baseline data that meets OHA approval, and in years two, three and four it means achieving the improvement target or benchmark. Hospitals achieving at least 75% of the measures [9 of 11] will be allocated a \$500,000 floor. Phase I allocation is pass/fail; hospitals will not receive partial credit. Hospitals must achieve at least 75% of the measures (9 of 11) to be allocated the floor payment. This will impact the amount remaining in the pool for Phase II allocation. Table 1 illustrates how Phase 1 works:

Table 1: Example of Phase 1 Floor Allocation

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

Phase 2: Allocation per Measure Achieved

The portion of Phase 2 quality pool funds that a hospital receives is based on the number of measures on which it reports baseline data (in year one), or the number of measures on which it achieves an absolute benchmark or demonstrates improvement over its own baseline or performance in the previous year (“improvement target”) in years two through four. The benchmarks are the same for all hospitals³⁰, regardless of geographic region and patient mix (see Appendix B for measures and benchmarks).

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

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

³⁰ An exception to this is the HCAHPS patient discharge measure. Shriners’ Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriners’ performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey, and a separate benchmark has been established for Shriners.

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

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

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

Table 3, below, is an example of how the hospital quality pool distribution for the Readmissions domain would work in a scenario where there are only three hospitals, with total available HTTP funds the maximum \$150,000,000, and the assumption that two of the three hospitals achieved at least 75% (9 of 11) of the measures (meaning these hospitals are allocated the floor payment of \$500,000). This example operates in the same manner for years one through four: In year one, ‘achieving the measure’ is defined as providing baseline data that is approved by OHA. After

year one, 'achieving the measure' is defined as meeting either the benchmark or improvement target based on the previous year data.

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

Total HTTP Funds Available (one year)		\$150,000,000							
Number of Hospitals Achieving at least 75% of measures (eligible for floor allocation)		2							
Phase 1 Amount (floor allocation - 500,000*2)		\$1,000,000							
Funds Remaining for Phase 2 Allocation (total - floor)		\$149,000,000							
Readmissions									
Share of Available Funds		18.75%							
Base Amount - total available to earn for measure (share of funds*funds for Phase 2 allocation)		\$27,937,500							
Phase 2 Allocation per Hospital Achieving Domain (Readmissions Example)									
Hosp	Achieve Measure?	Discharges		Days		Adjustment Factor (% discharges*0.5) + (% days*0.5)		Amount Earned for Measure (Total Available for Measure * Adjustment Factor)	
		#	%	#	%				
A	Y	5,000	33.3%	2,000	20.0%	(33.3%*0.5) + (20.0%*0.5) = 0.27	0.27	\$27,937,500 * 0.27 =	\$7,450,000
B	Y	5,000	33.3%	1,000	10.0%	(33.3%*0.5) + (10.0%*0.5) = 0.22	0.22	\$27,937,500 * 0.22 =	\$6,053,125
C	Y	5,000	33.3%	7,000	70.0%	(33.3%*0.5) + (70.0%*0.5) = 0.52	0.52	\$27,937,500 * 0.52 =	\$14,434,375
Totals		15,000	100.0%	10,000	100.0%		1.00		\$27,937,500

Data Collection

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

Data Reporting

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

Monitoring hospital performance ties in with the overall evaluation and ongoing quality improvement efforts for the waiver. Moreover, this work has a direct impact on OHA's overarching health system transformation goals of better health, better care, and lower costs for all Oregonians.

Appendix B: Oregon Hospital Transformation Performance Program Measures Matrix

Note that in year one (October 1, 2013 – September 30, 2014), hospitals will receive payment for submitting baseline data that meets OHA approval. In year two (October 1, 2014 – September 30, 2015), hospitals will receive payment for submitting data to OHA and achieving the benchmark or improvement target. In year three (October 1, 2015 – September 30, 2016), hospitals will receive payment for submitting data to OHA and achieving the benchmark or improvement target. In year four (January 1, 2017 – December 31, 2017), hospitals will receive payment for submitting data to OHA and achieving the benchmark or improvement target. Here, however, all measures but follow-up after hospitalization for mental illness relate to patients from all payer-types; follow-up after hospitalization for mental illness relates only to Medicaid patients enrolled in a CCO. All benchmarks in year two will be evaluated against year one baseline data and amended as appropriate to ensure they foster continuous improvement. All benchmarks in year three will be evaluated against year two data and amended as appropriate to ensure they foster continuous improvement. OHA will update the benchmarks and improvement targets for years two and three with CMS approval by May 31, 2016. All benchmarks in year four will be evaluated against year three data and amended as appropriate to ensure they foster continuous improvement. The benchmarks and improvement targets for year four were updated with CMS approval by January 12, 2017.

Hospital Measures	Waiver Measure Set			Target Calculations		Targets				Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target ³¹	Year 2 Benchmark	Year 3 Benchmark	Year 4 Benchmark	
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) in the ED	√			Measure set broken down as follows: 1. Alcohol and Other Drug Use Screening in the ED- Patients in ED age 12+ screened for alcohol and other substance use using an age-appropriate,	Measure set broken down as follows: 1. Alcohol and Substance Use Screening - ED patients age 12+.	1. (a) Brief Screen: MN method with a 3 percentage point floor 1. (b) Full Screen: MN method with a 3 percentage point floor	1.(a) Brief Screen: 67.8% (75 th percentile from HTPP baseline for brief screens) 1.(b) Full Screen: 12.0% (alignment with CCO)	1. (a) Brief Screen: 90 th percentile from HTPP year 2 rate for brief screens. 1. (b). Full Screen: 90 th percentile from HTPP year 2 rate	1. (a) Brief Screen: 83.5% (.90 th percentile from HTPP year 2 rate for brief screens) 1. (b). Full Screen: 71.3% (90 th percentile from HTPP year 2 rate)	OAHHS will collect and report to OHA

³¹ For year 2, improvement targets were calculated from baseline year; in year 3, improvement targets are calculated based on year 2 performance unless otherwise noted.

Hospital Measures	Waiver Measure Set			Target Calculations		Targets				Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target ³¹	Year 2 Benchmark	Year 3 Benchmark	Year 4 Benchmark	
				validated instrument. 2. Alcohol and Other Drug Use Brief Intervention Provided – ED patients age 12+ who received a brief intervention.	2. Alcohol and Other Drug Use Brief Intervention Provided – ED patients age 12+ who screen positive for unhealthy alcohol or drug use.	2. N/A - reporting only (no target)	full screen benchmark) 2. N/A – reporting only (no benchmark)	2. N/A – reporting only (no benchmark)	2. N/A – reporting only (no benchmark)	
Follow-up after hospitalization for mental illness (modified NQF 0576)	√			Discharges for Medicaid members enrolled in a CCO age 6 years of age and above at hospital of interest who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization within 7 days of discharges.	Discharges from acute inpatient settings (including acute care psychiatric facilities) for members age 6 years of age and above at hospital of interest who were hospitalized for treatment of selected mental health disorders.	MN method with 3 percentage point floor (alignment with CCO improvement target; will change with any updates to CCO target)	National Medicaid 90 th percentile (alignment with CCO benchmark; 70.0%)	90 th percentile from HTPP year 2 performance	80.2% (90 th percentile from HTPP year 2 performance)	OHA MMIS – OHA will calculate rates for this measure through encounters/claims
Hospital-Wide All-Cause Readmissions		√		Number of readmissions, defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date	Admissions to acute care facilities for patients of all ages.	MN method with a 3% floor	8.0% (state 90 th percentile for DRG hospitals)	90 th percentile of Year 2 HTPP performance	8.0% (90 th percentile of Year 1 HTPP performance)	OAHHS will calculate and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets				Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target ³¹	Year 2 Benchmark	Year 3 Benchmark	Year 4 Benchmark	
				of an eligible index admission.						
Hypoglycemia in inpatients receiving insulin (American Society of Health Systems Pharmacist Safe Use of Insulin measure)			√	All patients with hypoglycemia (blood glucose of 50mg per dl or less)	All patients receiving insulin during the tracked time period	MN method with 1 percentage point floor	7% or below	5% or below	3.0% or below	OAHHS will collect and report to OHA
Excessive anticoagulation with Warfarin (Institute for Safe Medication Practices measure)			√	Number of patients experiencing excessive anticoagulation (INR > 6)	All inpatients receiving warfarin anticoagulation therapy during tracked period	Years 1-3: MN method with 1 percentage point floor Year 4: N/A (no improvement target)	5% or below	3% or below	2.0% or below	OAHHS will collect and report to OHA
Adverse Drug Events due to opioids (Institute for Safe Medication Practices measure)			√	Number of patients treated with opioids who also received naloxone	Number of patients who received an opioid agent during tracked period	Years 1-3: MN method with 1 percentage point floor Year 4: N/A (no improvement target)	5% or below	3% or below	2.0% or below	OAHHS will collect and report to OHA
HCAHPS, Staff always explained medicines (NQF 0166)			√	Number of clients reporting 'top box' responses for this measure domain.	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point floor	72.0% (National 90 th percentile, April 2014)	73.0% (National 90 th percentile, 2015)	73.0% (National 90 th percentile, April / May 2016)	OAHHS will collect and report to OHA
HCAHPS, Staff gave patient discharge information (NQF 0166)			√	Clients answering 'Y' to Q19 and Q20	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point floor <i>Shriners : MN method with 2</i>	90.0% (National 90 th percentile, April 2014) <i>Shriners: 90th percentile,</i>	91.0% (National 90 th percentile, 2015) <i>Shriners: 90th percentile,</i>	91.0% (National 90 th percentile, April/May 2016) <i>Shriners: 90th percentile, all</i>	OAHHS will collect and report to OHA

Hospital Measures	Waiver Measure Set			Target Calculations		Targets				Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target ³¹	Year 2 Benchmark	Year 3 Benchmark	Year 4 Benchmark	
						<i>percentage point floor³²</i>	<i>all PG Database Peer Group, 2/1/2014 – 7/31/2014 (92.7%)</i>	<i>all PG Database Peer Group TBD</i>	<i>PG Database Peer Group TBD</i>	
CLABSI in all tracked units (modified NQF 0139)			√	Total number of observed CLABSI in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	Total number of central line days in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	MN method with 3% floor	0.18 per 1000 device days (2010 NHSN Data Summary Report 50 th percentile from Partnership for Patients Scoring Criteria for CMS, 2014)	N/A – improvement target only	The calculation will change to the SIR and the Year 4 benchmark will be an SIR of 0.50 or lower	Years 1-3: OAHHS will collect and report to OHA Year 4: Hospitals report to OHA Public Health Division via NHSN
CAUTI in all tracked units (modified NQF 0754)			√	Total number of observed healthcare-associated CAUTIs in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	Total number of catheter days for all patients that have an indwelling urinary catheter in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	MN method with 3% floor	1.02 per 1000 catheter days (50 th percentile from HTPP baseline)	N/A – improvement target only	The calculation will change to the SIR and the Year 4 benchmark will be an SIR of 0.75 or lower	Years 1-3: OAHHS will collect and report to OHA Year 4: Hospitals report to OHA Public Health Division via NHSN
Hospitals share ED visit information with primary care providers			√	1. Number of outreach notifications to	1. Number of patients with five+	1. Years 1-3: MN method with 3	1. 78.6% (75 th percentile	1. 90 th percentile from HTPP	The calculation will change	Years 1-3: OAHHS will

³² Shriner’s Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriner’s performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey, and a separate benchmark has therefore been established for Shriners. The Press Ganey survey does not have a question about staff explaining medications, so Shriner’s is not eligible for the HCAHPS staff explaining medication measure in Years 1-4.

Hospital Measures	Waiver Measure Set			Target Calculations		Targets				Data Source
	Aligned with CCO Incentive Set	CCO State Quality	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target ³¹	Year 2 Benchmark	Year 3 Benchmark	Year 4 Benchmark	
and other hospitals to reduce unnecessary ED visits				primary care providers for patients with 5+ ED visits in past 12 months 2. Number of care guidelines completed for patients with 5+ ED visits in past 12 months	ED visits in the past 12 months 2. Number of patients with five+ ED visits in the past 12 months	percentage point floor Year 4: MN method with a 2 percentage point floor 2. N/A – reporting only	from HTPP (baseline) 2. N/A – reporting only	baseline TBD 2. N/A – reporting only	to the outcome-focused metric and the Year 4 benchmark will be 30.1% (90th percentile of Year 2 performance)	collect and report to OHA Year 4: OHA will collect data directly from the EDIE vendor

Appendix C: Rationale for Incentive Measures

Domain and Measures	Brief Description	Rationale for Domain/Measure
Readmissions – Hospital-wide All-Cause Readmission	This measure estimates the hospital-level, risk-standardized rate of all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients of all ages.	<p>Reducing readmissions has value as an indicator of quality. Unnecessary readmissions may reflect poor coordination of services and transitions of care at discharge or in the immediate post-discharge period.</p> <p>Reducing readmissions is a function of both hospitals and primary care; the measure will therefore incentivize more integrated care across the hospital outpatient continuum.</p>
<p>Medication safety –</p> <p>(a) Hypoglycemia in inpatients receiving insulin</p> <p>(b) Excessive anticoagulation with Warfarin</p> <p>(c) Adverse Drug Events due to opioids</p>	This measure focuses on preventing harm from high alert medication, which increases the risk of injury to patients if the dosage is not correct. The medications focused on are insulin, Warfarin, and opioids.	<p>Adverse drug events (ADEs) are defined as any injuries resulting from medication use, including physical harm, mental harm, or loss of function.</p> <p>ADEs comprise the largest single category of adverse events experienced by hospitalized patients, accounting for about 19 percent of all injuries. The occurrence of ADEs is associated with increased morbidity and mortality, prolonged hospitalizations, and higher costs of care.</p> <p>The Institute of Medicine (IOM) estimates that 1.5 million preventable ADE occur each year³³. The occurrence of ADEs in hospitalized patients varies between 2 and 52 ADEs per 100 admissions. An estimated 15% to 59% of these ADEs are considered preventable³⁴.</p>
<p>Patient experience –</p> <p>(a) HCAHPS, Staff always explained medicines (NQF 0166)</p> <p>(b) HCAHPS, Staff gave patient discharge information (NQF 0166)</p>	<p>This measure focuses on measuring patients' perspectives on hospital care. This is a composite measure that includes:</p> <ol style="list-style-type: none"> 1. Communication about medicine 2. Discharge information <p>The measure is the percent reporting positively in the above areas.</p>	<p>This is a national, standardized way of assessing patients' perspectives of hospital care. It is aligned with CMS public reporting, including the Hospital Value-based Purchasing Program.</p> <p>The measure creates an incentive for hospitals to improve quality of care and patient experience. It will support improvements in internal customer service and quality-related activities.</p>

³³ “How-to Guide: Prevent Harm from High-alert Medications.” Cambridge, MA: Institute for Healthcare Improvement, 2012. Web February 2013.

<http://www.ihp.org/knowledge/Pages/Tools/HowtoGuidePreventHarmfromHighAlertMedications.aspx>

³⁴ Cano FG, Rozenfeld S: Adverse drug events in hospitals: a systematic review. *Cad Saude Publica* 2009, **25** (Suppl 3):S360-S372.

Domain and Measures	Brief Description	Rationale for Domain/Measure
<p>Healthcare Associated Infections (HAIs) –</p> <p>(a) CLABSI in all tracked units (modified NQF 0139)</p> <p>(b) CAUTI in all tracked units (modified NQF 0754)</p>	<p>These measures focus on reducing infections patients can contract while receiving medical treatment in a healthcare facility. They include:</p> <ul style="list-style-type: none"> • Central-line associated bloodstream infection rate • Catheter-associated urinary tract infection rate 	<p>CDC’s HAI prevalence survey³⁵ shows:</p> <ul style="list-style-type: none"> –On any given day, about 1 in 25 hospital patients has at least one healthcare-associated infection. –Estimated 722,000 HAIs in U.S acute care hospitals in 2011 –About 75,000 hospital patients with HAIs died during their hospitalizations. –More than half of all HAIs occurred outside of the intensive care unit.
<p>Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits</p>	<p>Hospitals who have implemented the EDIE program in Oregon or other Health Information Exchange technology that allows hospitals to share ED visit information with primary care providers and other hospitals.</p> <p>The EDIE program allows clinicians to identify patients who visit EDs throughout the state more than five times in a 12 month period.</p>	<p>Coordination of care between systems such as outpatient services and hospitals is important for better management and care of patients, particularly for patients who are ‘high utilizers’ of the health care system. By promoting the use of EDIE or other technologies, hospitals can better inform primary care of patient visits to the ED. Additionally, hospitals and primary care providers can begin to identify patients who are regularly accessing the health care system through the ED and work to better meet their needs.</p> <p>One of the seven CCO focus areas is to reduce over-use of care by ‘super utilizers’. One focus of implementing the EDIE system is to reduce unnecessary use of the ED.</p>
<p>Behavioral health - Follow-up after hospitalization for mental illness (modified NQF 0576)</p>	<p>Percentage of Medicaid members age 6+ and mental health diagnosis with a follow-up visit within 7 days after hospitalization.</p>	<p>Oregon’s 2013 baseline for follow-up after hospitalization for mental illness is 67.6%, which is just under the 90th percentile nationally (68.0%, 2012 Medicaid benchmark).</p> <p>Research has found patient access to follow-up care within 7 days of discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmissions.³⁶ In addition to potential cost savings from reducing readmissions, focusing on the integration between physical and behavioral health is a key component of Oregon’s Health System Transformation.</p> <p>This measure will also help inform the statewide quality improvement focus area: integration of behavioral and physical health.</p>

³⁵ Magill SS, Edwards JR, Bamberg W, et al. Multistate Point-Prevalence Survey of Health Care–Associated Infections. *N Engl J Med* 2014;370:1198-208.

³⁶Fortney J, Sullivan G, Williams K, Jackson C, Morton SC, Koegel P. Measuring Continuity of Care for Clients of Public Mental Health Systems. *Health Services Research*.2003; 38: 1157-1175.

Domain and Measures	Brief Description	Rationale for Domain/Measure
Behavioral health – Screening for alcohol and drug misuse, brief intervention, and referral for treatment in the ED (SBIRT)	Percentage of patients age 12+ with an ED visit in the measurement year screened for substance abuse and referred as necessary.	This measure will help inform the statewide quality improvement focus area: integration of behavioral and physical health. Research shows that the ED can be an effective place to screen and refer patients for substance use services: One study found that 26% of patients screened in the ED exceeded the low-risk limits set by the National Institute of Alcohol Abuse and Alcoholism ³⁷ .

³⁷ Academic ED SBIRT Research Collaborative. The Impact of Screening, brief intervention and referral for treatment (SBIRT) on Emergency Department patients’ alcohol use. *Annals of Emergency Medicine*. 2007;50:699–710. <http://www.bu.edu/bniart/files/2011/02/SBIRT-emergency-alcohol.pdf>

Attachment K – Comprehensive Primary Care Plus Protocol

This protocol provides the conditions the state will operate the Comprehensive Primary Care Plus (CPC+). The state will submit for CMS approval updates to Attachment K as conditions outlined in this protocol change.

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. Under this model, developed by the Center for Medicare & Medicaid Innovation (CMMI) in CMS, CPC+ practices are paid for attributed Medicare beneficiaries while states pay CPC+ practices for attributed Medicaid beneficiaries. CPC+ builds upon and enhances the PCPCH model.

It includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options, (1) a PMPM payment and (2) a reducing PMPM payment with offsetting incentive payment, to meet the diverse needs of primary care practices in Oregon and support health transformation. The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign gives practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. Building upon the PCPCH model, CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to guide their decision making. Oregon was granted participation in the model by CMMI effective January 1, 2017 for a five-year period.

- i. CPC+ seeks to improve the quality of care patients receive, improve patients' health, and spend health care dollars more wisely. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.
- ii. To participate in this model as a CPC+ provider, providers must be a PCPCH provider (PCPCH provider requirements are specified in www.primarycarehome.oregon.gov) and be selected for participation by CMS.
- iii. CPC+ providers will be separated into two tracks: Track 1 and Track 2. Practices in each track must meet CMMI's CPC+ practice requirements, as specified by the CMMI Practice Care Delivery Requirements. Track 2 providers must meet all Track 1 practice requirements, plus additional requirements for higher level functionality to address higher acuity beneficiaries.
- iv. To support the delivery of comprehensive primary care, CPC+ includes three payment elements:

1. **Care Management Fee (CMF):** Practices in both tracks receive a non-visit based CMF paid on a PMPM basis for each Medicaid beneficiary attributed to the practice. For the Medicaid FFS population, the amount is adjusted for each practice to account for the intensity of care management services required for the practice's specific population. Each practice is assigned to a risk Tier (PCPCH Tiers 1-4, and PCPCH Tier 5-Star), which specifies CMF payment amount by Tier.
2. **Performance-based incentive payment:** The state for the Medicaid FFS population and participating CCOs for their Medicaid populations will prospectively pay and retrospectively reconcile a performance-based incentive based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. For the Medicaid FFS population, these payments will be made per Medicaid beneficiary attributed to each practice. The performance measures are annually determined based on experience and results to date and agreed upon by the state and CMMI as required in the CPC+ memorandum of understanding (MOU) between CMMI and the state. The retrospective reconciliation will be developed with assistance from CMMI and agreed to by the state and CMMI as required by the CPC+ MOU. Such payments will be broadly consistent with 42 CFR 438.6.
3. **Alternative Payment Methodology for more advanced CPC+ providers (Track 2) Comprehensive Primary Care Payment Methodology:** Track 1 practices continue to bill and receive payment from Medicaid FFS for the FFS population and the CCO service rate for the Medicaid CCO population as usual. Track 2 practices also continue to bill as usual, but the Medicaid FFS or CCO payment will be reduced to account for shifting a portion of Medicaid FFS or CCO payments into prospective Comprehensive Primary Care Payments (CPCP). Given expectations that Track 2 practices will increase the comprehensiveness of care delivered, the total amount of this CPCP hybrid payment will be larger than the FFS payment amounts they are intended to replace.

v. **Payment under the Medicaid Fee Schedule and Alternative Payment Methodology:** The CPC+ model for the Medicaid FFS population has the following reimbursement structure:

1. **Medicaid PMPM CMF rates for Track 1 clinics recognized under Oregon 2017 PCPCH criteria:**
 - PCPCH Tier 1: \$2
 - PCPCH Tier 2: \$4
 - PCPCH Tier 3: \$6
 - PCPCH Tier 4: \$8
 - PCPCH Tier 5-star: \$10

Medicaid PMPM CMF rates for more advanced CPC+ providers (Track 2) recognized under 2017 PCPCH criteria. Track 2 providers are paid at the Track 2 Tier 3/4/5 levels:

- PCPCH Tier 3: \$9
- PCPCH Tier 4: \$12
- PCPCH Tier 5-star: \$18

2. Performance based incentive payment, built into payment model; paid per attributed Medicaid beneficiary per month:

<i>Incentive Payment Amounts - Utilization (PMPM)</i>	<i>Quality (PMPM)</i>	<i>Total (PMPM)</i>
Track 1 clinics	\$1.00	\$2.00
Track 2 clinics	\$2.00	\$4.00

3. Alternative Payment Methodology for more advanced PCPCHs (Track 2)

- Track 2 providers under Medicaid FFS will be paid through an Alternative Payment Methodology (APM) that mirrors available payment options defined by CMS as an upfront payment (Comprehensive Primary Care Payment) and corresponding FFS claims reduction, together termed the “hybrid payment.” Practices will select a hybrid payment option each year, and can increase the upfront payment at their own pace. Practices must reach either 40% CPCP/60% FFS or 65% CPCP/35% FFS by 2019 as illustrated in the table below.

Track 2 Possible Payment Choices by Year

Payment ratio	2018	2019	2020	2021
CPCP%/FFS% options available to practices	25%/75%			
	40%/60%	40%/60%	40%/60%	40%/60%
	65%/35%	65%/35%	65%/35%	65%/35%

- Examples of more advanced CPC+ providers (Track 2): PCPCH 5-star clinics, Clinics with robust risk stratified population management and RN complex care management, Clinics with Behavioral Health Integration and/or Clinical Pharmacy Integration.