State Innovation Model Operational Plan

State of Oregon

Revised
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Oregon State Innovation Model Foreword

The resources CMMI has afforded Oregon through the State Innovation Model award supports the acceleration of health transformation in our state and fuels the spread of the coordinated care model from the Medicaid population to other payers and populations more quickly and effectively than if the SIM resources were not available to support our leading edge work. In this foreword, we identify the specific contributions SIM resources make to achieve the triple aim in Oregon.

Oregon's State Innovation Model (SIM) grant supports the Oregon Health Authority and its Transformation Center in coordinating implementation, spreading health care innovations and lessons learned, and evaluating the coordinated care model.

Elements of the coordinated care model include:
- Best practices to manage and coordinate care;
- Sharing responsibility for health;
- Measuring performance;
- Paying for outcomes and health;
- Providing information;
- Sustainable rate of growth.

Oregon's CMS waiver *allows* us to implement the coordinated care model with the Medicaid population, while SIM funding allows the work to go further, faster and touch more Oregonians. SIM also provides funding for a comprehensive evaluation to help other states learn what key steps and tools work to transform the delivery system and achieve the triple aim: better health, better car, and lower costs.

CCM elements – this is what we're doing and what we're testing

Through the Transformation Center, SIM funding is accelerating health system transformation across Oregon by spreading best practices among CCOs and other health plans. This includes supporting learning collaboratives and rapid cycle improvement.

Without SIM dollars, the Transformation Center would be unable to provide key support that enables good ideas to travel faster, as detailed below.
- If SIM funds were not available, Oregon would not be able to develop a robust Transformation Center and activities would be limited to the Innovator Agents and one statewide learning collaborative of the CCOs.
- Learning Collaboratives are available to CCO staff, Community Advisory Councils, and other payers. SIM funding allows the coordinated model to spread more quickly and with more success, with rapid sharing of evidence-based and emerging best practices, information and lessons learned through innovation. SIM funds are used to support the Learning Collaboratives Manager and Coordinator positions, as well as the outside expertise and consultant.

- SIM funds allow Oregon to provide a rich offering of tools and resources to support innovation and the development of a culture of innovation, outside of the Innovator Agents and modest support through various existing arms of OHA.
- Oregon's SIM demonstration period 2 target is to certify 500 clinics as PCPCH certified, which will engage approximately 43,000 primary care providers in the coordinated care model
- SIM funding allows Oregon to continue to assist primary care clinicians across the state by providing support to the Oregon Patient-Centered Primary Care Institute (OPCPCI), which works in collaboration with the Transformation Center to spread best practices and adopt the primary care home model, a core element of Oregon's model.
- Since payment drives change, SIM has made it possible to bring all of the commercial and public payers around the table to bring consensus on Oregon's multi-payer strategy to support primary care as we move into demonstration period 1.

With SIM funding, the Transformation Center efforts with transforming the delivery system will support the spread of the coordinated care model beyond Medicaid to state employees, Medicare and other payers across the state.

The funding also allows for a thorough assessment of the model as a whole, and of its key elements. This will allow us to understand innovations that are making a true difference in improving health while lowering costs – and then to further spread these innovations across the health system.

Oregon's SIM grant focuses on innovation in three areas: innovation and rapid learning, delivery models, and payment models. Work includes:
- Integrating and coordinating care among primary, specialty, mental and behavioral health, and oral health providers;
- Engaging patients and consumers in their own care for better outcomes;
- Engaging providers in health system transformation;
- Improving community health through local partnerships that support promotion and prevention activities;
- Implementing more effective health care payment models that incentivize better health;
- Encouraging consensus-building to support primary care payment reform, which now includes more than 25 payers, provider organizations and other key partners;
- Implementing and sharing across Oregon's health care sector those innovations and best practices that reduce health disparities;
- Supporting health information technology and exchange – building on other HIT funding in Oregon with SIM investments, technical assistance to ensure innovation and successful implementation;
- Funding pilot projects in local health departments to promote integration of public health and health care, innovation, and healthy communities;
- Improving quality and health outcomes for those eligible for both Medicaid and Medicare;
- Integrating long-term care – reviewing options for shared accountability between long-term care and CCOs.

Key activities that support transformation beyond Medicaid:
- Learning collaboratives;
- Council of clinical innovators;
- Bringing payers and providers together for alternative payments efforts initially in primary care and then spreading to broader payment approaches;
- Bringing together the hospitals across the state to coordinate care (SIM funding provides an opportunity to set up an Emergency Department Information Exchange (EDIE), a solution to exchange information among emergency departments to identify frequent users. Working with the primary care providers in their communities, the hospitals can create care plans to help those frequent emergency department utilizers to determine if there is a more appropriate care setting);
- Technical assistance in the areas of promoting health
- Technical assistance in the areas of promoting health equity, consumer engagement, and provider engagement (this includes providing operational support for the three additional regional health equity coalitions, supporting three new cohorts of participants in the Developing Equity Leadership through Training and Action program, or DELTA, and certifying 150 new health care interpreters;
- Working with the Patient-Centered Primary Care Institute, including trainings, webinars and provider-level learning collaboratives for all primary care providers in the state.
- Improving the state's analytic infrastructure and tools to allow for more integrated, linked and accessible data in a secure environment (this will support data analytics needs at multiple levels and improve transparency of health and health care data);
- Implementation and evaluation support for the housing with services program – a new model that would incorporate housing and social services to improve health outcomes for older adults and people with disabilities;
- Coordination with early learning councils and hubs, specifically concerning support of kindergarten readiness.

SIM funding allows for assessment of:
- Success of the overall model in Medicaid, as agreed to in the CMS waiver;
- Assessing key payment, delivery system and support elements individually to determine how much each contribute to the success;
- Testing the spread of the coordinated care model to other payers and populations, specifically public employees and Medicare;
- Best practices and learning for other states.

Oregon is in the unique position of being a national leader in health care reform efforts. On July 3, Governor Kitzhaber sent a letter to HHS Secretary Kathleen Sebelius and CMS Administrator Marilyn Tavenner to invite collaboration with CMS, CMMI and other state governor's to develop multi-payer strategies and develop a common set of core principles that focus on fiscal sustainability and changing the way care is organized. Specifically, Governor Kitzhaber invites collaboration on the following issues:

- Reduce the per capita rate of growth: A state commitment to achieve a reduction in the per capita growth rate of Medicaid spending, without reducing eligibility, benefits, quality, health outcomes or access.

- Federal investment: Depending on the particular circumstances and needs of the state, there will be a negotiated budget neutral federal investment so long as the state demonstrates a significant return on investment over 10 years.
- Payment for outcomes: Payment systems and or provider payment structures that shift from payment for procedures or encounters to a system of balanced incentives that reward improvements in health outcomes and promote transparency and accountability.
- Accountability: A commitment to quality measures is a key aspect of health system transformation and common transparent metrics must be used to provide both intra-and inter-state comparisons.
- Flexibility: Allowing local and regional flexibility to pursue delivery system changes that achieve the desired outcomes, provided that eligibility benefits and quality are not reduced and State Plan requirements that have not been waived are met.
- Coordinated and Integrated Care: Delivering higher quality, coordinated care through integration of benefits with a strong focus on primary care and home and community based care delivery.
- Multi-payer Strategy: A commitment to pushing health care reform efforts beyond Medicaid and into the commercial market.

Oregon is in a positive position to share our accomplishments and experience in health reform and support the efforts at the national, state and local levels to transform the health care delivery system that produces better health, better care at lower cost.

Section A	Governance, Management Structure and Decision-making Authority

Oregon's Health System Transformation has broad support from Oregon's Governor, the Legislature, state agencies and the private sector. The State Innovation Model (SIM) project aids and supports key next steps for Oregon to successfully transform its delivery system to achieve the three-part aim:

- Improve the lifelong health of all Oregonians.
- Increase the quality, reliability and availability of care for all Oregonians.
- Lower or contain the cost of care so it is affordable for everyone.

Oregon's commitment to the coordinated care model as outlined in our Health Care Innovation Plan (see Appendix P) submitted in September 2012 is demonstrated through an intentional coordinated and strategic multi-year planning and implementation process that included extensive public discussion across the state and active engagement by the Governor, the Legislature and the Oregon Health Authority (OHA), and in partnership with the Oregon Insurance Division and Oregon's new health insurance exchange, Cover Oregon. This high level of coordination in planning and implementation continues today, now fueled by the SIM grant, to extend the coordinated care model across the delivery system in Oregon.

Governor's Office engagement in oversight and implementation
Governor John Kitzhaber has actively and directly led development of Oregon's framework for delivery system redesign and implementation of the coordinated care model (CCM). His level of commitment is reflected not only in his hands-on executive leadership, but also in numerous interviews and articles (see Appendix A). He first initiated the policy design discussions in 2011 by creating a 45 member Health System Transformation team to develop the legislative concept that ultimately became the statutory authority for moving forward, which is summarized in Section G in this Operational Plan. The Governor's Office meets weekly with leadership from the Oregon Health Authority, the Department of Human Services, the Oregon Insurance Division and Cover Oregon (Oregon's health insurance exchange) to continue strategic policy development that will ensure that both public and private health care purchasing is increasingly aligned around the coordinated care model. Medicaid, which touches three-quarters of all providers in the state, has served as the initial pilot for the coordinated care model; part of the Governor's strategic approach is to extend the model next to the Oregon Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), the Qualified Health Plans in Cover Oregon and ultimately to commercial carriers in the health insurance market outside of Cover Oregon.

Support in the beginning stages
The first step in establishing the coordinated care model in Oregon was to implement the model in the state's Medicaid program, which required a significant amendment to the state's Medicaid 1115 demonstration waiver. The Governor was personally involved in negotiation of the waiver and continues to work closely with OHA on the Medicaid/Children's Health Insurance Program (CHIP) implementation of Medicaid's Coordinated Care Organizations (CCO), which are predicated on the coordinated care model. In order to support successful implementation of the coordinate care model, the Governor, OHA Director, and key OHA leadership meet with the

CEOs of the Coordinated Care Organizations every six weeks to share challenges and successes as implementation progresses.

The Governor is committed to the extension of the coordinated care model across Oregon's delivery system. The impetus for creating the Oregon Health Authority in 2009 was to bring most of the state's health care purchasing into a single agency and increase its ability to act as a strong purchaser. By aligning and spreading the coordinated care model across Medicaid and CHIP, the Public Employees' Benefit Board (PEBB), and the Oregon Educators Benefit Board (OEBB) as a strategic first step, OHA directly influences 25% of the insured market in the state.

The Oregon Health Authority is the lead agency for Oregon's SIM initiative, working closely with other public agencies, the Governor's Office, the Legislature and Oregon's delivery system and its stakeholders. The Legislature created OHA in 2009 not only to consolidate most state health purchasing, but also to integrate and oversee all aspects of health reform to ensure components of the three-part aim are reached in balance. This brought together purchasing for more than 850,000 lives through Medicaid/CHIP, state employees, and Oregon educators, the high-risk pool, and the premium subsidy program into a single agency, as well as integrating public health, addictions and mental health programs. This merging of state health care purchasing into a single agency gave the state the ability to align across a significant portion of the health care market to drive delivery system change. OHA Director Bruce Goldberg, M.D., along with the Governor and his staff work daily with health and health care stakeholders and the Legislature to support the Governor's vision of the coordinated care model across Oregon. As OHA Director, Dr. Goldberg is a member of the Oregon Health Leadership Council, which was formed in 2008 at the request of the Oregon business community and brings together health plans, hospitals and physicians to develop practical approaches to reducing costs while delivering high-quality health care. Finally, Dr. Goldberg holds a statutory seat on the Board of Directors for Oregon's health insurance exchange, Cover Oregon, further ensuring coordination between public and private purchasers.

Extending support through leadership and management
One of the Governor's health advisors is the current chair of the Public Employees' Benefit Board (PEBB), and the Governor has been working closely with PEBB board members, the unions and PEBB staff to ensure that the coordinated care model is incorporated into PEBB's request for proposals for benefit year 2015. A similar effort is under way regarding the Oregon Educators Benefit Board and their coverage for Oregon's school districts. Additionally, one of the Governor's health advisors is a member of the Oregon Health Policy Board (OHPB), the nine-member Governor-appointed oversight body for the Oregon Health Authority.

As Cover Oregon prepares to begin operations in October 2013, Governor Kitzhaber has been working closely with its board members (whom he appoints) to ensure that the 2015 qualified health plan request for proposals include attributes of the coordinated care model.

On June 3, 2013, the Governor delivered a letter to the Oregon Health Policy Board asking them to make recommendations by the end of the year to his office and the legislature about potential legislative or regulatory changes that may be needed to further align PEBB, OEBB and Cover Oregon around the coordinated care model (see Appendix B).

Further, Governor Kitzhaber's commitment extends beyond Oregon. He has agreed to join Governor Bill Haslam of Tennessee as co-chair of the Health Care Sustainability Task Force for the National Governor's Association (NGA). The stated purpose of the task force is to "… focus on state innovations that require the redesign of health care delivery and payment systems with the objectives of improving quality and controlling costs. Through the sharing of state experiences and best practices, the Task Force will work to identify areas where federal legislative or regulatory action is necessary to reduce barriers and further support state initiatives." (See NGA press release).[1] On July 1, the Governor sent a letter to Secretary Sebelius and Administrator Marilyn Tavenner stating his goal to work closely with the Centers for Medicare and Medicaid and other governors to develop a multi-payer strategy and a common set of core principles that focus on fiscal sustainability and changing the way healthcare is organized (see Appendix O). He identifies that SIM is a key player in Oregon's and other states' success.

Role of the Oregon Health Policy Board in transformation and SIM grant activities:
The Oregon Health Policy Board (OHPB) is the nine-member, citizen-led policy-making and oversight body for the Oregon Health Authority. Formed by the same legislation that created the health authority, OHPB has a broad mandate for health care transformation and its membership includes key leaders from the provider community, labor, large and small businesses, and insurance. The current members are:

- *Eric Parsons (OHPB chair)* — The board chair for StanCorp Financial Group Inc. and Standard Insurance Company, Mr. Parsons also serves as vice chair of the Oregon Health & Science University (OHSU) Foundation Board of Trustees; as a senior director of the Oregon Business Council; and as a board of directors and investment committee member for the Oregon Community Foundation.
- *Lillian Shirley, B.S.N., M.P.H., M.P.A. (OHPB vice chair)* — The director of the Multnomah County Health Department, Ms. Shirley is a board member for Community Health Partnerships and a member of the Portland Multnomah Sustainability Commission. She serves as vice president of the National Association of County and City Health Officials (NACCHO) and as vice chair of the Public Health Foundation Board in Washington, D.C.
- *Mike Bonetto, Ph.D., M.P.H., M.S.* — Currently one of the health policy advisors to Governor Kitzhaber, Dr. Bonetto has been vice president of Business and Community Development for St. Charles Health System; senior vice president of Planning and Development for Clear Choice Health Plans; director of the Oregon Health Policy Commission; senior policy advisor to the Oregon Senate Republican Caucus; and policy analyst for the Oregon Insurance Pool Governing Board.
- *Carlos Crespo, M.S., Dr.P.H.* — Professor and director of the School of Community Health at Portland State University, Dr. Crespo has more than 60 publications in the areas of exercise, minority health, obesity and nutrition. He also is a contributing author to five textbooks on minority health and sports medicine and more than 10 government publications. He received the 1997 U.S. Secretary of Health Award for Distinguished Service as part of the Salud para su Corazon campaign and in 2003 became a Minority Health Scholar from the National Institutes of Health.

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[1] Please note that live links have been inserted into this document to provide additional background information on specific topics.

- *Brian DeVore* — Director of Healthcare Ecosystem & Strategy at Intel, Mr. DeVore provides strategic guidance and oversees the national and local partnership efforts of Intel necessary to provide health care to its employees. He works with senior executives in the health care and technology industries as well as business and government leaders to drive the care, payment and data changes necessary to deliver improved quality at a repeatedly lower cost. Mr. DeVore represents Intel's views at the Pacific Business Group on Health, the Oregon Coalition of Healthcare Purchasers and two Oregon Business Healthcare task forces. He is a former alternate member of Health and Human Services Secretary Mike Leavitt's American Health Information Community (AHIC) and was an advisor to the National Governor's Association State Alliance for eHealth.
- *Felisa Hagins* — Political director for the Service Employees International Union (SEIU) Local 49, Ms. Hagins represents the largest union nationally with more than two million members and the largest union in Oregon with more than 50,000 members. SEIU Local 49 represents more than 7,500 janitors and health care workers who work in the private sector throughout Oregon.
- *Carla McElvey, M.D.* — A pediatrician in private practice at the North Bend Medical Center in Coos Bay, Dr. McElvey also is the immediate past president of the Oregon Medical Association. Previously, she served as medical director for Doctors of the Oregon Coast South, which managed the Oregon Health Plan for Coos County.
- *Joe Robertson, M.D., M.B.A.* — President of Oregon Health & Science University (OHSU), Oregon's academic medical center, Dr. Robertson holds a bachelor's degree from Yale and an M.D. from the Indiana University School of Medicine. He completed an ophthalmology residency at OHSU and fellowships in retina and vitreous disease and surgery at OHSU and Devers Eye Institute, Legacy Good Samaritan Hospital. He has served as the director of the Casey Eye Institute at OHSU and as the chair for the Department of Ophthalmology. Prior to becoming president of OHSU, he served as dean of the OHSU School of Medicine.
- *Nita Werner, M.B.A.* — President/CFO of Ornelas Enterprises Inc. (dba OEI), a contract electronic manufacturing company located in Hillsboro, Ms. Werner brings the small business perspective. She holds a bachelor's degree in accounting from Portland State University and a master's degree in organizational development from Marylhurst University.

The policy board played an integral role in the policy design and oversight of implementation of the coordinated care model in Medicaid/CHIP. OHPB built on the previous Oregon Health Fund Board's health reform design efforts in 2007–2009 to develop a comprehensive strategic plan, titled "Oregon's Action Plan for Health" in 2010, which laid out specific strategies and next steps for Oregon to achieve the three-part aim. The board also initiated work on the development of Oregon's Health Insurance Exchange. OHPB has been advised by stakeholder groups numbering more than 300 people who served on 20 committees, subcommittees, work groups, task forces and commissions in order to examine all aspects of the health and health care system transformation. More than 850 people attended six community meetings across the state to provide feedback to OHPB. Likewise, many organizations and groups, such as the Oregon Health Leadership Council (which includes the major health systems and commercial insurance carriers in the state), and small businesses and community groups provided extensive input. A majority of the action items identified by OHPB either have been implemented or are in the

process of being implemented, including the requisite legislation. Notable among these are the development of the coordinated care model, and the establishment of Cover Oregon, Oregon's health insurance exchange.

As stated previously, on June 3, 2013, Governor Kitzhaber directed the Oregon Health Policy to take action to align health transformation implementation activities across sectors. His letter requests the development of recommendations for statutory and regulatory changes necessary to ensure that Triple Aim goals are met, with a report back to the Governor by December 2013 ahead of the next legislative session in February 2014. Recommendations may include but are not limited to:

- Strategies to mitigate cost shifting, reduce health insurance premiums and increase overall transparency and accountability;
- Opportunities to enhance the Oregon Insurance Division's rate review process;
- Alignment of care model attributes within PEBB and OEBB contracts;
- Alignment of care model attributes within Cover Oregon's qualified health plans.

As the policy board tackles Governor Kitzhaber's new directive, it will apply the broad stakeholder engagement strategies it has used in the past for input on extending and aligning the coordinated care model across the delivery system. The chair of the PEBB Board and the executive director of Cover Oregon presented at the board's June 3, 2013 meeting about opportunities for alignment. A framework for recommendations will be developed over this summer and fall as work groups are constituted to address this assignment.

One of the OHPB work groups, the Coordinated Care Model Alignment workgroup, has been meeting monthly through the fall of 2013. The work group consists of two board members each from PEBB, OEBB, and Cover Oregon. Their work has been focused on understanding current alignment with the coordinated care model across the organizations, recognizing opportunities for future alignment and proposing ideas that will ensure continued collaboration. Current efforts towards alignment, as evidenced in contract language or in Request for Proposals (RFPs), have been mapped as a baseline. A final report with recommendations will be presented to the OHPB at the November 2013 board meeting. Please see Appendix II for current alignment, meeting agendas and summaries from this work group.

Additionally, OHPB has established a joint committee with the state's Early Learning Council (ELC)[2] to make recommendations for alignment of early learning and health system transformation. ELC recently adopted a statewide Kindergarten Readiness Assessment that launched in the fall of 2013. As kindergarten readiness depends on both health and education system innovations and processes, the Transformation Center, OHA and ELC will collaborate and test systems and supports that contribute to kindergarten readiness. Effective strategies will be shared jointly by OHA and ELC via learning collaboratives, technical assistance, and the Transformation Center's Innovator Agents (see Section G, "Levers to enable action" for a description of Innovator Agent roles). For example, Oregon's Transformation Center, in

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[2] Early Learning Council (ELC), a 19-member Governor-appointed committee responsible for assisting the Oregon Education Investment Board (OEIB) in overseeing a unified system of early learning services for the purpose of ensuring that children enter school ready to learn by kindergarten. The Early Learning Council also serves as the state advisory council for the purpose of the federal Head Start Act.

partnership with ELC, will use SIM funds to support community-level learning collaboratives that test innovative strategies for improving kindergarten readiness, particularly for low-income residents through coordination of services across CCOs and regionally based "Early Learning Hubs."

In addition, SB 436, which passed both legislative chambers in June 2013, requires that Oregon's Coordinated Care Organizations coordinate with the early learning system and other education partners in developing their community health needs assessments and community health improvement plans to further ensure optimal alignment between the two systems.

Governance of the SIM project activities
The OHA Office for Oregon Health Policy and Research (OHPR) houses and supports the management of the grant. OHPR Administrator and OHA Chief Medical Officer Jeanene Smith, M.D., is the SIM grant principal investigator and single point of accountability to CMMI for the SIM project. As the chief medical officer for OHA, with more than a decade of experience working in health policy design in Oregon, Dr. Smith brings knowledge and expertise in the development and initial implementation of the coordinated care model to this project. Working in partnership with the Transformation Center and its director of Clinical Systems Improvement and other OHA clinical staff, Dr. Smith and Dr. Goldberg will ensure that Oregon's providers and health systems are partners in innovation and sharing of best practices across the delivery system.

Along with one of the Governor's two health advisors, and OHA's chief financial officer, Dr. Smith also serves on the state PEBB as it addresses the spread of the model for state employees. She has worked during the past 11 years with the broad representation of health care stakeholders involved with the Oregon Health Care Quality Corporation (Q Corp) Board of Directors. Q Corp is a Robert Wood Johnson Foundation (RWJF) Aligning Forces for Quality grantee and a multi-payer, multi-health system and consumer-focused nonprofit that has worked on quality reporting and transparency across Oregon's delivery system, and is a key partner on several of the SIM grant activities.

Dr. Smith has extensive experience managing complex projects and grants, and will be responsible for ensuring that the project is meeting the scope, budget and timelines agreed to with CMMI. She will report to the Director of OHA and the OHA chief of policy on project progress and/or issues. A dedicated grants management team, led by Project Manager Beth Crane, EMPA reports directly to Dr. Smith, and will manage all administrative aspects of the project, ensuring that OHA cooperates with CMMI monitoring plans and that reports, data and other information requested by CMMI are submitted in a timely manner to allow for the evaluation of the project results.

To monitor and make decisions, governance of the SIM project activities includes executive sponsorship by OHA chief of policy Tina Edlund, with a Lean Project Management leadership team, the SIM Steering Committee. This leadership team meets at least monthly through the six-month implementation period, and will meet at least quarterly thereafter. The team will include Ms. Edlund and Dr. Smith as well as executive representatives from Medicaid, the Oregon Transformation Center, the director of Accountability and Quality, and the Office of Health

Analytics. The tasks described in the project plan will be the responsibility of lead staff for each major area of work. The project manager will work with lead staff and will report to the leadership team on status, issues and risks, as well as raise decisions impacting budget, timelines, or scope. The principal investigator will provide regular updates to the OHA Cabinet and the Oregon Health Policy Board. See Appendix C for a schematic of Oregon's SIM governance structure.

Mechanisms to coordinate private and public efforts
The Oregon Transformation Center, which is organizationally housed within the Oregon Health Authority, was created and designed to drive and support health system transformation and the extension of the coordinated care model across the entire health care delivery system in Oregon. The center's executive director directly reports to the OHA chief of policy and works closely with the principal investigator, Dr. Smith. The center and its director will staff a Transformation Steering Council, made up of representatives from CCOs, PEBB, Cover Oregon, commercial health plans, health systems, and providers. The council will advise OHA and the Transformation Center on the implementation of the coordinated care model and inform and assist in the model's acceleration and spread. The Oregon Transformation Center serves as a central hub around which public and private efforts to test key model elements will be coordinated.

Thanks to support from Oregon's SIM grant, the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC), convened a series of meetings July to September 2013 that brought together payers and other key partners from around the state to develop consensus-based strategies to support primary care homes in Oregon, facilitated and supported by the Center for Evidence-based Policy. To this end, a broad coalition of Oregon's major public and commercial payers, professional associations and providers has reached a pioneering agreement to coordinate their efforts to support primary care homes in Oregon. They have agreed to:
1. Use a common definition of primary care homes and levels of coordination, based on the State's PCPCH program.
2. Based on that definition, payers have agreed to provide payment models to practices in their network that are based on PCPCH participation and increasing levels of patient centered, coordinated care.
3. Utilize a common set of core metrics to measure progress toward achieving outcomes.
4. Find additional opportunities for meaningful collaboration that will support the long term sustainability of primary care homes.

SIM funding was instrumental in bringing together all of Oregon's major commercial and public payers with Oregon's primary care specialty organizations and providers by supporting the facilitation of this group. The participating organizations involved in the primary care strategy to be signed in November 2013 included:
- Aetna
- Care Oregon (partner in 5 CCOs)
- Childhood Health Associates of Salem
- CIGNA

- First Choice Health
- Grants Pass Clinic
- Health Net of Oregon
- HealthShare (a Medicaid CCO)
- Kaiser Permanente
- LifeWise
- Moda Health
- Oregon Academy of Family Physicians
- Oregon Association of Hospitals and Health Systems
- Oregon Health Alliance
- Oregon Health Authority
- Oregon Health Leadership Council (OHLC)
- Oregon Medical Association
- Oregon Nurses Association
- Oregon Pediatric Society
- PacificSource Health Plans
- Providence Health & Services
- Regence Blue Cross Blue Shield of Oregon
- Tuality Health Alliance
- Umpqua Health Alliance (a Medicaid CCO)

This means that nearly all commercial and public payers in Oregon will offer structured payments to support patient-centered primary care homes. Payers will establish the amount and type of payment with the providers in their networks. As purchasers, PEBB, OEBB and Medicaid are also aligning with this agreement through their contracting processes. The Oregon Health Authority and the OHLC have agreed to build on this momentum and convene broad payment reform discussions in 2014. Please see Appendix BB for the agendas, minutes and straw proposal this process produced.

Oregon's SIM activities include multiple other examples of multi-stakeholder collaboration. As we start into Test Year 1, an innovative example of one of our public-private partnerships is the housing with services project supported by SIM funds as well as other funding streams. Similar to some efforts in Vermont, the grant to Cedar Sinai to establish this programing has been executed and activities are underway to align social services with long term care. Please see Appendix V, for the contract between OHA and Cedar Sinai, on behalf of the consortia working to develop this promising pilot project.

Coordinating the transformation of Medicaid/CHIP
For Medicaid/CHIP transformation, each of the CCOs is assigned an Innovator Agent (IA) who acts as a change agent. Currently, each IA serves as a direct link between a Medicaid CCO and OHA, coordinating with internal operations of each and supporting the implementation of the CCO transformation plans. They provide support to the CCOs to develop strategies for quality

improvement and the adoption of innovations in care, and they work with both CCOs and their Community Advisory Councils to gauge the impact of health systems transformation on community health needs. The SIM grant is enabling the Transformation Center to provide the resources IAs need to connect communities, providers and CCOS to build a robust learning network.

Additionally, OHA staff meets monthly with CCO medical directors and quality improvement directors to share progress and opportunities for innovation both in the health care delivery system and within OHA. Please see Appendix T for detailed information about this and other learning collaboratives. Since the SIM grant was awarded, the Transformation Center's director and key OHA leadership team members have conducted listening sessions around the state with the executive leadership and managers of 15 CCOs to gain a better understanding of the leading CCO concerns as local communities are beginning this transformation. Each CCO has a distinct set of needs and priorities and the input gathered during the individual visits helped in designing the shape and structure of the Transformation Center. To date, areas of discussion have focused on approaches to learning collaboratives, needed expertise in areas such as alternative payment approaches between the CCOs and their provider network, provider and patient communication needs, discussion of a statewide Health Information Technology/ Health Insurance Exchange framework, and data analytic needs (especially as they relate to the incentive metrics and the CCOs transformation goals.)

Sharing strategies on payment reform
In April 2013, the Oregon Health Authority, in collaboration with a national payment reform expert, convened an initial discussion with CCOs and private payer stakeholders. The conversation centered around potential strategies for ensuring CCO success, the process to design and implement successful payment reforms and fostering dialog with community leaders to identify opportunities for early wins, potential barriers and areas of overlap and distinction between private payers and Medicare. This work will continue over the SIM project period, through the Transformation Center to convene payers, providers and other stakeholders around alternative payment approaches spread across the delivery system for primary care, specialty care and hospital care.

There are several private, federal and state initiatives in Oregon directed at supporting adoption of the primary care home model, but to date Oregon's overarching multi-payer strategy for broader implementation and sustainability of primary care homes is under development. As noted above, the Oregon Health Authority partnered with Oregon's major health plans, systems, hospitals, provider groups, and the Oregon Health Leadership Council to hold a series of multi-payer meetings through the Transformation Center. Facilitated by the Oregon Center for Evidence-based Policy, the attendees developed testable strategies for coordinated, sustainable support of patient-centered primary care homes (PCPCH) in Oregon. Please see Appendix BB for meeting agendas, minutes and the draft straw proposal. Please see Appendix BB for meeting agendas, minutes and the draft straw proposal. This is a critical next step for Oregon for sustaining primary care through payment reform as we face the end of the recent ACA-supported Health Home enhanced payments scheduled to sunset in September 2013. Please see Section G of our SIM Operational Plan for more detailed information about multi-payer strategies.

Payment reform strategies also are being developed and tested within a subset of Oregon Federally Qualified Health Centers (FQHCs). Through a State Plan Amendment (SPA) submission to CMS for alternative payments, Oregon is paying pilot clinics on a per-member, per-month (PMPM) basis instead of on a per-visit basis for individuals on the Oregon Health Plan. This divorces the payment from the doctor visit, which frees the FQHC to implement new and innovative ways to engage and manage patients. The goal is to help clinics recruit and retain doctors more easily by allowing for higher quality, longer clinic visits with patients. Since March 2013, four large FQHC clinics have begun using this alternative payment methodology (APM) for medical patients only (not dental or mental health in this first phase). The first quarterly dataset will soon be available for analysis, which will assess: (1) how the APM payment compares with the payment clinics would have received through the Prospective Payment System (PPS); (2) the volume of non-billable "touches" that were captured; and (3) quality measures, access measures, and satisfaction of members and providers for the pilot clinics and their patients. At the conclusion of the first year, if analysis shows that clinics were paid similarly or greater on APM as compared to PPS, and that quality, access, and satisfaction remained flat or improved, then the model can potentially be spread to other clinics, and mental health and dental care could begin integrating into the APM.

Oregon also has established an exploratory stakeholder process that will result in a report to the Centers for Medicare &Medicaid Services (CMS) regarding the opportunities and barriers to integration of Medicaid-funded long-term care (LTC) into Coordinated Care Organization (CCO) global budgets.[3] This CMS/LTC/CCO stakeholder work group is scheduled to collaborate monthly (the first meeting took place May 1, 2013). The group consists of a broad base of stakeholders and currently is working to develop potential models for integration and specific evaluation, measurement, and metrics for enhanced coordination.

In addition, OHA is working with the Oregon Association of Hospitals and Health Systems (OAHHS) Small and Rural Hospital Committee (SRC), which has established the Rural Health Reform Initiative (RHRI) to prepare Oregon's 32 type A/B[4] hospitals for transformational changes brought on by health reforms and market changes. These small rural hospitals currently receive cost-based payments that may not align with the goals of health system transformation. The goal of this work is to examine alternative payment and delivery models and to coordinate with both federal and state leaders to develop solutions not only in support of the financial sustainability of small rural hospitals, but also of the coordinated care model.

Finally, to further align with the goals of the coordinated care model, the Oregon Association of Hospitals and Health Systems has proposed a 1% quality incentive pool in Medicaid for Diagnosis Related Group (DRG) hospitals in the state[5]. Funds in the proposed incentive pool would be awarded according to achievement of outcomes/metrics designed to align with the coordinated care model. This initiative requires an amendment to Oregon's Medicaid 1115 demonstration waiver, which has been submitted.

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[3] Long-term care services and supports were legislatively excluded from CCO global budget in HB 3260 and SB 1580, the legislation that created CCOs.

[4] Type A and B hospitals are small, rural hospitals that receive cost-based reimbursement by Medicaid in Oregon. Many are also designated as Critical Access Hospitals (CAH) by Medicare.

[5] DRG hospitals in Oregon are primarily large hospitals in urban centers. Twenty-six of Oregon's 58 hospitals are DRG hospitals. The state also recognizes hospitals with fewer than 51 beds as type A or B hospitals, depending on their distance from other acute inpatient care facilities.

All of the current work is consistent with principles for payment reform articulated by the OHPB's Incentives and Outcomes Committee in 2010 and included in the OHPB's Action Plan for Health. Current payment reform initiatives also build on the foundation established by the Incentives and Outcomes Committee's recommendations. For example, the committee recommended standardizing payment methodologies for hospital and ambulatory surgical centers (ASCs) to improve transparency, reduce administrative costs, and to provide a foundation for aligning incentives in the future. This recommendation resulted in legislation (SB 204, 2011) that required the state to develop and implement a standardized payment methodology for hospital and ASCs. A work group met three times in late 2011 and made recommendations on standardized payments. The methodology has been implemented in most parts of the state.

Expanding the model beyond the Medicaid population
The Governor's vision and Oregon's SIM grant goal is to spread the coordinated care model across the state. A high-level visual depicting Oregon's ambitious goals and timeframe for model alignment across sectors can be found in Appendix D.

The Transformation Center will continue to work closely with CCOs throughout the SIM project period, but will extend its services and supports to the rest of the market from the beginning, involving providers and delivery system partners beyond the CCOs. The CCO efforts touch almost 80% of providers in Oregon who see Medicaid patients. The center will work closely with and build upon the foundation started by the Patient-Centered Primary Care Institute (PCPCI), which was launched in late 2012 to provide technical support for transformation to practices statewide to succeed at becoming primary care homes and meeting the state's Patient Centered Primary Care Home standards. The Patient Centered Primary Care Institute (PCPCI) is working "hands on" with 25 practices in a focused learning collaborative but also offers technical assistance webinars and other learning opportunities for all practices across the state. Topics so far have included best practices for coordinated care planning; shared decision making and strategies to increase adherence to care plans; and engaging patients and families as practice advisors. The Institute and the Transformation Center are working together to continue and spread clinic-level technical assistance and sharing of best practices, as the center works with payers and others to sustain primary care, a crucial component of the coordinated care model.

In the spring of 2014, the Transformation Center will appoint a multi-payer steering committee to guide the work of the center and act as champions of the spread of the Coordinated Care Model across systems and payers. The Transformation Center has hired a director of Clinical Innovation, who will reach out to clinicians, Patient-Centered Primary Care Homes, provider associations, and others to help shape the center's clinical transformation agenda and supports. Approaches for high utilizers and strategies for addressing patients with opiate addiction are potential topics for early work. The director also will convene a Council of Clinical Innovators, who, along with the medical directors of the CCOs and the commercial health plans, will serve as advisors and champions for the implementation of key innovations in the delivery and coordination of care. To further extend transformation, the council will build upon strong partnerships created during the development of the coordinated care model with the Oregon Medical Association, the Oregon Association of Hospitals and Health Systems, the Oregon Academy of Family Physicians and the Oregon Nurses Association, among others.

The PEBB Board also conducted listening sessions to understand beneficiaries' interests and concerns in the lead up to development of the PEBB RFP for the 2015 benefit year. Continued stakeholder engagement is ongoing through PEBB's discussions and regular public meetings. Initial discussion of spread of the model began in June at the Oregon Health Policy Board, which included overview of initial alignment of the coordinated care model with Cover Oregon, PEBB and Oregon educators in the SIM testing years. Please see Appendix U for the RFP and supporting documents for the PEBB 2015 benefit year.

The Transformation Center is instrumental in building on our existing multi-payer efforts and in creating learning systems to accelerate innovation and the spread of the model across all payers. Advancing the date of that tipping point of spreading the coordinated care model across markets and populations will ensure widespread and sustainable improvements in health status, enhanced patient experience and lower per capita cost trends.

The state has been working with stakeholders on reforming health and health care since 2007, when the Oregon Health Fund Board began its work. Regular communication with stakeholders was essential after passage of legislation that moved the coordinated care model forward for Medicaid participants in 2011 and 2012. These efforts included: (1) Oregon Health Policy Board (OHPB) meetings, work groups, and public comment; (2) the OHPB's targeted expert and stakeholder work groups (more than 130 participants); (3) OHA's Health System Transformation Community Meetings (more than 1,000 participants, eight cities); (4) tribal consultations with the nine federally recognized tribes in Oregon; (5) PCPCH development stakeholder groups; and (6) individual staff engagement with advisory councils, committees and other stakeholders to gain input and feedback throughout the process. There were more than 76 public meetings leading up to the development of the overall CCO implementation proposal and almost 350 key stakeholders and experts gave hours of their time to help build and refine the coordinated care model. These extensive, inclusive efforts will continue as part of the extension of the coordinated model of care to all payers. With the funding through the SIM, Oregon intends to maintain this level of public and stakeholder engagement throughout all of the SIM activities as the coordinated care model is spread. Please see Section Q, our Communications Management Plan and our revised Stakeholder Engagement plan (Appendix E), for additional information.

Legislative and other authority necessary for transformation and SIM activities
Oregon has fully integrated or aligned its planned transformation with existing legislative and executive authority. As outlined in Oregon's Healthcare Innovation Plan (see Appendix P), transformation in Oregon is the synthesis of three documents, four major pieces of legislation, an approved 1115(a) waiver renewal and amendment, and amendments to the Medicaid State Plan. These documents demonstrate Oregon's focus on, and emerging design for, health system transformation from 2007 through 2012:

Key documents
- Oregon Health Fund Board Report — Aim High: Building a Healthy Oregon, November 2008;
- Oregon Health Policy Board — Oregon's Action Plan for Health, December 2010;

- Oregon Health Policy Board ─ [Coordinated Care Organizations Implementation Plan Proposal](#), January 2012.

Enabling legislation
- [HB 2009 (2009 legislative session)](#): Created the Oregon Health Authority (OHA, Patient-Centered Primary Care Home (PCPCH) program, Oregon Health Policy Board (OHPB), directed creation of a plan for an Oregon Health Insurance Exchange, created the Health Information Technology Oversight Council (HITOC), health care workforce initiatives and created an all-payer, all-claims database (APAC).
- [HB 3650 (2011 legislative session)](#): Directed OHPB to create an implementation plan for health system transformation using Coordinated Care Organizations as a vehicle in Medicaid, to create a business plan for the Health Insurance Exchange, and to develop a plan for spreading this model to the Public Employees' Benefit Board (PEBB).
- [SB99 (2011 legislative session)](#): Marked legislative approval for the creation of a Health Insurance Exchange as a public corporation.
- [SB1580 (2012 legislative session)](#): Marked legislative approval for the creation of CCOs.

Waiver and State Plan Amendment Requirements
- [Section 1115(a) Waiver Renewal and Amendment:](#) Submitted March 1, 2012, approved July 5, 2012.
- ACA Section 2703 State Plan Amendment: Approved effective Oct. 1, 2011.
- [Non-traditional health care worker State Plan Amendment](#): Temporarily adopted until August 2, 2013, while permanent rules are drafted by the [NTHW Steering Committee](#).
- SB 436 (2013 legislative session): Requires each CCO to coordinate and align with school-based health centers in developing a community health needs assessment and a corresponding community health improvement plan by December 1, 2017.

Adoption of the coordinated care model for the Medicaid population is under way with legislative authorization in place and federal waiver authorities approved, and 15 CCOs operational. (See Appendix F for a brief profile of each CCO.) Oregon is confident that this model will achieve cost savings and has committed to the federal government to reduce the growth trend in per capita Medicaid expenditures by 2 percentage points through implementation of its health care innovation plan (see Appendix P).

Since the plan and application were provided to CMMI, additional work has been under way during the 2013 legislative session that concluded in July. New legislation includes:

- [HB 2279](#) allows local government entities to join PEBB or OEBB, potentially expanding the reach of Oregon's SIM activities.
- [HB 2118](#) requires Cover Oregon to establish a health plan quality metrics work group, with representation from the Oregon Health Authority and PEBB, among other organizations, to make recommendations on appropriate health outcomes and quality measures for Qualified Health Plans (QHPs) by May 2014.
- [HB 2216](#) directs OHA to establish a hospital performance metrics committee, with representation from hospitals, CCOs, and performance measurement experts. The group will recommend three to five quality measures and related benchmarks to be used to

reward hospitals for their performance and distribute funds from the hospital 1% quality incentive pool described above in "*sharing strategies on payment reform.*"

- HB 2013 specifies that OHA and Oregon's Early Learning Council shall work collaboratively with CCOs to develop performance metrics for prenatal care, delivery and infant care that align with early learning outcomes.
- HB 2859 establishes a work group to identify strategies to meaningfully engage Oregon Medicaid patients in their health care, and to set parameters for a grant program that would support CCO pilot projects focused on patient engagement and responsibility.
- SB 604 directs OHA to create a statewide database for health care provider credentialing. Related bills direct OHA to establish credentialing standards for telemedicine and to update credentialing review of mental health providers. Reducing administrative burdens for providers and removing waste in the system — as these bills aim to do — is part of Oregon's transformation strategy.

As mentioned above, the Governor's June 2013 letter to OHPB mandates continued work to spread the coordinated care model (in alignment with the high-level timeline for evolution of coordinated care models in Appendix D). The letter asks for recommendations regarding legislation or any other authorities to drive delivery system transformation. That report will be shared with CMMI by the end of 2013.

Section B	Coordination with Other CMS, HHS, and Federal or Local Initiatives

In Oregon, there are many CMS, HHS, CMMI and other federal initiatives that are already under way. Tying these initiatives into the work being done through SIM is a vital alignment that supports a more efficient, sustainable, and unified health care system. Coordination occurs through direction and guidance from advisory committees, public-private partnerships, the Governor's Office, and the Oregon Legislature, all supported by the Oregon Health Authority. See Appendix G for a visual representation of connections between key stakeholders for health systems transformation in Oregon.

Medicaid demonstration

CMS approved Oregon's 1115 Medicaid demonstration waiver on July 5, 2012, and the final Special Terms and Conditions on Dec. 18, 2012. The 1115 waiver supports the first, or pilot, stage of a strategic implementation of the coordinated care model. This first stage rolls out the coordinated care model in the Medicaid/CHIP population through integrated service delivery provided by 15 Coordinated Care Organizations, serving more than 650,000 low-income Oregonians (and an estimated additional 240,000 newly eligible in 2014). While the coordinated care model is optional for those dually eligible, approximately 55% are enrolled fully in CCOs and upcoming SIM activities will focus on alignment between Medicaid and Medicare for those who are dually eligible. The coordinated care model incorporates a number of design elements that are the focus of other federal initiatives and Oregon is an active participant in several of them. Participation in these initiatives, including those focused on population health through the CDC, and behavioral health integration efforts by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), builds additional momentum for transformation in Oregon's health system and will

enhance the spread of the coordinated care model by providing infrastructure for reform and generating evidence about best practices. In many cases, federal opportunities will directly support spread of coordinated care elements of the model to new payers or environments. OHA oversees implementation of many of these projects and will coordinate them with SIM-supported activities to promote alignment and avoid redundancy and waste. In addition, since 74% of Oregon providers see Medicaid/CHIP enrollees, efforts to fulfill our waiver obligations through the CCOs will echo throughout the delivery system and further support extension of the model across all payers.

Federal primary care initiatives: Health Homes and Comprehensive Primary Care
Oregon's Medicaid Health Home ACA Section 2703 program is just wrapping up but was integrated and aligned with the state's Patient-Centered Primary Care Home (PCPCH) recognition program. Participating health home clinics had to be recognized as primary care homes, and service provision is aligned with the state's PCPCH standards recognition criteria. Oregon's Medicaid program also currently participates in the Comprehensive Primary Care Initiative as a public payer, convener, and collaborative partner in this multi-payer federal initiative. For example, the OHA-facilitated agreement among Oregon's participating payers uses the state PCPCH recognition criteria as a requirement for the 67 participating CPCI primary care practices in Oregon. Current multi-payer discussions, funded by SIM, have discussed how the CPCI approach to paying collaboratively for primary care should be considered as they have developed their straw proposal multi-payer strategy to support primary care. Getting the investment to the practices and aligning accountabilities has been very successful in CPCI clinics, and payers want to build upon that model to help them understand the return on the investment as they work with businesses, and acknowledge that having Medicare at the table is vital to gain provider support for change.

OHA partnered with the regional Northwest Health Foundation on a variety of health system transformation efforts throughout the development of the coordinated care model, including establishing a PCPCH Implementation Task Force, which led to the development and public-private funding of Oregon's Patient-Centered Primary Care Institute (PCPCI). Initiated under Oregon's HRSA State Health Access Planning grant with continued funding through the SIM grant, PCPCI serves as practice-level technical assistance to further the PCPCH model adoption. OHA is coordinating with local non-federally funded state initiatives through the PCPCI's multi-stakeholder Expert Oversight Panel and its Technical Assistance Learning Network, a group composed of technical assistance experts working on various initiatives throughout the state, which includes representation from academic centers, public health, health plans, hospitals, and community-based organizations. Through a series of webinars, toolkits and hands-on expertise in best practices, it has been aiding the adoption of the PCPCH model across clinics, which aligns with the requirements of the CCOs in Medicaid and contractual requirements already under way in current contracts with PEBB health plans to increase access to PCPCHs across their provider networks.

With the new Transformation Center, the PCPCI is a critical resource possible through SIM funding into the test years to aid Oregon to meet its goal of giving 75% of Oregonians access to a primary care home by 2016. The PCPCI, in partnership with the OHA Transformation Center, is just completing a multi-stakeholder engagement process to develop its strategies for how best to

assist practices going forward to meet these goals. PCPCI is housed in Oregon's multi-stakeholder supported Quality Corporation which has aligned payers, health systems and providers, and consumers around quality measurement as a RWJF-funded Aligning Forces for Quality grantee for the past decade and is well-positioned and experienced to bring both public and private stakeholders together to implement a sustainable strategic plan to expand its technical assistance and resources to a broader set of practices across the years of the SIM grant and beyond. This is a critical resource to help primary care providers be successful at adopting and expanding the primary care home model, a vital component to Oregon's coordinated care model. It's first year work could only include 26 of the 50 clinics who applied for technical assistance, "hands on" at the clinical site due to its limited startup funding under another federal grant, though it did reach hundreds more providers and their staffs via their tool kits and webinars. SIM funding makes it possible for further "hands on" technical assistance directly to more sites each year and continued tools and information via its website and webinars to providers and their clinical staffs. This is invaluable to aid change management and to succeed at delivery system reform.

Other federal initiatives
Some of the other initiatives that closely align with and will help to advance the coordinated care model include:

- The Partnership for Patients: The program is a public-private CMS initiative to test different models for improving patient care and patient engagement in order to reduce hospital-acquired conditions and to improve care transitions in hospitals nationwide; 79 groups in Oregon have signed the Partnership Pledge.
- The Safety Net Medical Home Initiative: This initiative is a Commonwealth Fund/Qualis/MacColl grant to transition Federally Qualified Health Centers (FQHCs) into patient-centered medical homes. The Oregon Primary Care Association, Care Oregon and the Oregon Rural Practice-based Research Network have partnered on this initiative and serve as a Regional Coordinating Center for the initiative. Lessons are being shared about this initiative through the Patient-Centered Primary Care Institute.
- Safety Net APMs: An approved SPA submission to CMS for alternative payments for a pilot group of FQHCs in Oregon, where four clinics are being paid through a per-member, per-month basis in order to divorce the payment from the doctor visit, freeing the FQHC to implement new and innovative ways to engage and manage patients and recruit and retain doctors.
- Long-term Support Services (LTSS) initiatives: These include expansion of the Money Follows the Person program.
- Federal housing grant application: OHA is collaborating on a federal 811 housing grant application after building a sustainable partnership for housing care with Oregon Housing and Community Services through the CMS Real Choice Systems Change grant program.
- Investment in HIT: Extensive investment in HIT through ONC/HHS, which will allow for the secure use and sharing of patient medical records electronically to maximize care coordination. Further detail is available in Section E of our SIM Operational Plan, and Appendix AA.
- Rate review grant funding application: An application for Cycle III CCIIO rate review grant funding, which will expand on the successes of Cycle I and II by supporting further

health insurance rate review processes, and expansion of the health care pricing data that is collected, analyzed and displayed as part of the rate review activities.

- CDC grant: Oregon recently received both basic and enhanced funding under the CDC's State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health grant.

When Oregon's SIM application was originally submitted, a decision had not been made on whether to continue to pursue a CMS financial alignment demonstration to blend Medicare/Medicaid payments for dually eligible Oregonians, through a three-way contract between the state, CMS, and our CCOs. In October 2012, Oregon decided not to pursue the demonstration, due to concerns that the blended payment rates would be insufficient for CCOs to voluntarily participate in the demonstration, considering Oregon's high penetration of Medicare Advantage plans in the state. Many of the CCOs have close ties to those plans in their own partnering organizations. Oregon staff worked closely with a small group of CCO representatives and CMS to estimate the financial impact of the demonstration rates and found that several factors specific to Oregon combined to make the rates unworkable for our CCOs.

In lieu of a financial alignment demonstration, Oregon is exploring more incremental approaches to improving quality and outcomes for dually eligible Oregonians. The state will work with CMMI and the Medicare Medicaid Coordination Office (MMCO) to develop improved and integrated materials for dually eligible individuals enrolled in CCOs and affiliated Medicare Advantage plans (both SNP and non-SNP plans), leveraging the CMMI authority to waive the paperwork reduction act. Oregon also will work with CMMI/MMCO on improved alignments in other areas not requiring any formal waivers. In our next iteration of the Operational Plan due in October, we will provide more information about our alignment work to date.
SIM funding is fueling this work. In July, 2013, OHA hired a Medicare/Medicaid Analyst, funded by the SIM grant, to further initiatives identified in the agency's high-level work plan. Building on the work done to date under the previous Duals planning effort, and ongoing efforts on Medicaid and Medicare alignment, having focused staff will ensure Oregon will continue to progress to integrate the coordinated care model for dually eligible Oregonians.

In addition to improving and integrating materials for dually eligible individuals, initiatives identified in the work plan for implementation in 2014 and beyond include, but are not limited to, working with CMS to:

- Develop integrated appeals notices for individuals enrolled in aligned Medicare/Medicaid plans;
- Improve information on appeals rights and processes for individuals who are dually eligible;
- Develop templates for integrated and streamlined plan summary information for enrollees and potential enrollees that could be used by multiple entities for outreach; and
- Develop limited standard text for CCO handbooks or develop a template for a brief insert clarifying and addressing topics specific to individuals who are dully eligible.

Additionally, the Medicare/Medicaid Analyst, in collaboration with identified partners, will examine barriers to enrollment in aligned plans for dually eligible individuals and analyze

integrated Medicare/Medicaid data to help understand characteristics of individuals utilizing original Medicare and identify potential barriers to CCO enrollment. The Medicare/Medicaid Analyst will begin collaboration with Senior Health Insurance Benefits Assistance (SHIBA) and Aging and People with Disabilities (APD) to develop training and other supporting materials for caseworkers and benefit counselors to ensure the provision of accurate information to dually eligible individuals and encourage aligned enrollment. The Medicare/Medicaid Analyst also will continue work with DHS around identifying and implementing mechanisms for shared accountability between CCOs and LTSS, including support provided to CCOs and LTC offices during revisions of their memoranda of understanding.

State and local non-federally funded initiatives

Commercial health plan integration and communication
Many of the commercial health plans are already business partners with the state — offering coverage options for the Medicaid population or state employees. We envision that there will be a tipping point for transformation of Oregon's health care system when the coordinated care model's delivery system and payment innovations spread beyond Medicaid beneficiaries and state employees to more of the Medicare and commercial populations to create a truly transformed system. This spread of transformation will help to ensure that Oregon's delivery system and health care workforce is coordinated and ready for the new expansions of Medicaid and the Health Insurance Exchange, and will help ensure costs remain sustainable over time.

Oregon's insurance marketplace is concentrated but competitive, with seven major commercial domestic carriers accounting for 90% of the total commercial market.[6] Four of these are already engaged in the coordinated care model and its spread from Medicaid/CHIP, to PEBB and Medicare Advantage. Additionally, it is anticipated that these same plans will be offering products on the health insurance exchange, Cover Oregon. The synergy of these close linkages between payers of the target populations will be enhanced by the activities of the Transformation Center to bring these Medicaid/CHIP participating plans and other commercial plans together with Oregon's clinical providers and health systems to achieve payment reform at the clinical level. Oregon expects to start that work early in the grant period.

The Oregon Health Leadership Council (OHLC) is an important venue for collaboration and communication with the commercial market. The OHLC is a collaborative organization working to develop approaches to reduce the rate of increase in health care costs and premiums so health care and insurance are more affordable. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiencies and quality. With strong participation from OHA staff (including the OHA Director, who is a council member), the OHLC has convened a number of work groups over the past several years to develop and act on recommendations in four key areas:
- Payment and reimbursement reform: This work has focused on appropriate payment for medical homes and bundled payments for defined services.
- Evidence-based best practices: OHLC was a key actor in creating a community standard for reducing elective deliveries before 39 weeks in Oregon. More recently, the council

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[6] See: www.cbs.state.or.us/ins/health_report/3458-health_report-2012.pdf

work group launched a new pilot program to address the management of acute low back pain that offers access to physical therapy within two business days. They also have been discussing standards of care for opiate prescribing to reduce their inappropriate use.

- Value-based benefits: Several OHLC members are offering benefits on the basis of three tiers, a framework similar to a model developed by OHA staff and stakeholders in 2007 and 2008 as part of the Oregon Health Fund Board process that ties cost sharing to best evidence and prioritization of utilization of services.
- Administrative simplification: The OHLC has collaborated closely with OHA on developing an Oregon companion guide to standardize electronic data transactions (starting with claims submissions and remittances) in the state and adopted a best practices recommendation for prior authorizations. The council also has been the venue for exploratory conversations around common credentialing; their past work and continued input will be invaluable as Oregon works to develop a statewide credentialing database as mandated by SB 604 (2013).

Some specific strategies that OHA is employing to ensure close alignment with commercial payers include:
- *Purchasing and regulatory levers:* RFPs for next contracts for state employee coverage, Oregon educators coverage and next versions of Qualified Health Plans in Oregon's exchange and in the commercial marketplace that continue to incorporate key elements of the coordinated care model.
- *Innovation and spreading best practices:* The Oregon Transformation Center, which is envisioned as the state's hub, or integrator, for innovation and improvement, and is a key mechanism for implementing the coordinated care model successfully and rapidly across all markets.
- *Supporting and sustaining primary care:* Oregon's Patient Centered Primary Care Home (PCPCH) standards serve as a core around which many of the coordinated care model elements are built, and recent multi-payer discussions will tie payment reform for primary care to the PCPCH recognition and accountability
- *Emergency Department Information Exchange (EDIE):* EDIE is a solution to exchange information among EDs to identify frequent users and create care plans to help those frequent ED utilizers to determine if there is a more appropriate care setting. SIM carryover funds for EDIE would be granted to the OHLC, which would then add contributions from their organization and members as well as the hospitals to procure and implement the EDIE solution. The total amount of the grant would be $250,000 assuming that OHLC meets all three (3) milestones. Progress to date reflects active engagement by the OHLC with high likelihood to secure adequate participation and funding from the state's hospitals.

Alignment with reforms in Oregon's educational system
As mentioned in Section A, the opportunity to align health and education system reform in Oregon can dramatically contribute to short- and long-term improvements in health outcomes for children. The Governor has prioritized the goal of universal kindergarten readiness among Oregon children, which depends on both health and education system innovations and processes. Oregon's Early Learning Council recently adopted a statewide Kindergarten Readiness Assessment that will be broadly implemented in the fall of 2013. The CMMI grant provides the

opportunity to test systems and supports that contribute to kindergarten readiness and to disseminate effective strategies.

The Oregon Health Authority (via the Transformation Center) will partner with the Early Learning Council (ELC) to test innovative delivery models and payment innovations that result in improved kindergarten readiness, such as coordination of services across health care and education and mutually accountable payments. Effective strategies will be disseminated jointly by OHA and ELC so that they spread to benefit the population statewide. OHA will disseminate promising innovations via the Transformation Center's learning collaboratives, technical assistance efforts, and Innovator Agents. The ELC can spread successful reforms statewide via the Early Learning Hubs currently being established. The Hubs will provide a place for all the sectors that touch early childhood education – health care, early childhood educators, human and social services, K-12 school districts, and the private sector – to coordinate and focus their efforts, resources, and strategies. Seven hubs will be created initially, with up to 16 hubs covering all areas of the state by July 2014.

Connection with Community Advisory Councils
By statute, each Coordinated Care Organization is required to have Community Advisory Councils (CACs). Most CCOs have one CAC, but several CCOs have multiple CACs to reflect the diverse characteristics of the communities they serve. The CACs are the responsible parties for integrating and aligning other health transformation activities and initiatives at the local and regional level. While local aging and disability networks are not statutorily mandated to be members of Community Advisory Councils, increasing communication and coordination activities between CCOs and LTSS systems, in part as a result of MOUs, has led to increasing participation and membership by LTSS leaders on CACs. CACs lead the engagement of community benefit programs, local public health and community health agencies, and services that address the social determinates of health, such as anti-poverty, food security, housing, recreation and related services delivered at the community level. The CCOs are directed by statute to develop community assessment plans that align with the similar plans required by public, mental health county authorities and the hospitals in their regions, and address their regions' overall population health needs, and not focus exclusively on the Medicaid/CHIP populations they serve. Legislation was passed this session (2013) to better align statutory reporting requirements so that the various reporting entities can come together around their needs assessments and create a shared, community-level plan that crosses public health, mental health and Coordinated Care Organizations. This aspect of Oregon's transformation will fuel spread of the coordinated care model across communities.

OHA is convening a group of key stakeholders representing local public health authorities, local mental health authorities, Coordinated Care Organizations, nonprofit hospitals, education systems and OHA programs to develop timelines and appropriate processes to allow for maximum coordination between local entities charged with developing community health assessments and community health improvement plans (CHAs/CHIPs). The CHA/CHIP workgroup will convene in October 2013 and work will begin by having stakeholders share what has facilitated a collaborative CHA/CHIP process locally, as well as what barriers local entities have encountered. The goal of the CHA/CHIP workgroup will be to put the supports in place that local entities need to collaborate on required CHA/CHIP processes along a coordinated timeline.

OHA supports broad participation from local agencies in CHA/CHIP development, which will ensure analysis of and coordination with other local health-related activities and initiatives.

Please see Appendix H for a list of federal, state, and local initiatives under way that support and extend Oregon's health transformation efforts.

Section C	Outreach and Recruitment

Oregon is thinking about outreach and recruitment at multiple levels: outreach to systems and providers to encourage them to adopt policies and practices associated with the coordinated care model; outreach to consumers and potential enrollees of plans that are transitioning to coordinated care, in alignment with ACA implementation; and tools for clinicians and practices to use to help patients engage more actively in their own care.

Systems-level outreach
At the system level, the Transformation Center will be a hub of outreach and recruitment, as it works through the new Innovator Agents, health systems, health plans, and providers to spread best practices and engage the delivery system in transformation. Fueled by SIM, this is a new approach by Oregon to help to share and translate evidence based practices across the state that may be valuable for other states to increase engagement in transformation activities. Developing approaches to engage providers, in partnership with key stakeholders such as provider organizations and systems is not a traditional state agency role. The Transformation Center can act as a hub of connecting expertise to need across the delivery system, with a broad statewide view. SIM funding will allow the Oregon Health Authority to pull data and information together from its multitudes of databases, particularly the All-Payer All-Claims database, to aid outreach and engagement to help target areas of highest need for innovation and improvement.

Communication with public and private beneficiaries has been ongoing and extensive throughout the state, through a variety of media. SIM funding is critical to allow adequate staff and resources for success in communicating to the public and other stakeholders about transformation and spread of the coordinated care model. Publications include press releases, articles in newspapers, blog posts, and communications through the mail; radio interviews have been conducted; in-person meetings, presentations, and discussions have been held; and websites have been updated or created to better inform consumers.

Outreach by plans, payers, and programs
Payers implementing the coordinated care model through SIM are reaching out to existing and potential members to educate them about the model. The information below highlights three key examples: the Patient-Centered Primary Care Home Program (PCPCH), which provides the foundation for the coordinated care model; Medicaid CCO outreach efforts; and outreach being conducted by PEBB, which will be the first step towards spreading the model beyond individuals on the Oregon Health Plan.

Patient-centered primary care homes

Patient-centered care is a core tenet of Oregon's transformation. From seeking broad public and stakeholder input in health policy for over two decades, to the specific measures and accountability imbedded in standards, expectations and contracting arrangement, the individual and their family are at the center of the coordinated care model. Our State Innovation Model outlines the development of our statewide patient-centered primary care homes (PCPCH), with national attention placed on the person-centered language used to describe our PCPCH standards: i.e. "Be there when I need you to be" to describe having access to care. The requirements for the Medicaid CCOs and the new expectations outlined in the PEBB RFP further the expectation of actively engaging the individual and their family in their care, and engaging the community in the delivery system transformation. Please see Appendix U for the PEBB RFP and related documents.

Outreach and engagement activities for beneficiaries of the PCPCH Program are conducted via a consumer-friendly website, educational video, and interactive map of recognized primary care homes. For recognized clinics, posters, window decals, and patient brochures are available in seven languages. These brochures are used throughout the state by recognized primary care homes to explain the model of care and engage patients in their own health. The Patient-Centered Primary Care Institute involves consumers in a number of activities including membership on the Expert Oversight Panel, and as guest speakers in the PCPCH Learning Collaborative sessions for primary care practices.

Medicaid CCOs
In Medicaid, the required CCO transformation plans include discussion of outreach and recruitment including strategies to reach non-English speaking and other underserved populations. Several SIM activities are directed to aid improvements in health equity, such as establishing Regional Equity Coalitions and certifying community health workers and health care interpreters. The Community Advisory Council (CACs) for each CCO can advise CCOs on effective member engagement strategies and opportunities. Enhancing communications is a critical aspect of SIM activities including better information, education and resources for individuals and their families across diverse populations, facilitated by the new Oregon Transformation Center. Already published on the OHA website are a number of "Success Stories" highlighting how Oregon's health system transformation, including improved coordination, directly impacts consumers' health and health care.

Public Employees' Benefit Board (PEBB)
Anticipating the move to a coordinated care model in the 2015 contracts and the need for more and better communications, PEBB contracted with a communications group in fall 2012. PEBB received a series of recommendations about the types of messages to use, and how, when and where to communicate with members. PEBB created a message grid that supports more member engagement and the coordinated care model, and all communications with members are being updated to reflect those messages.

To begin the conversation with members this spring the PEBB Board, partnering with labor, held a series of eight local meetings in seven cities with PEBB members along with a live webinar and an online survey. More than 1,100 people participated and another round of similar meetings is planned for later this year. The PEBB website is also being updated to be more user- friendly

and PEBB staff is learning about a more member-focused orientation. The goal is to move beyond just being the "benefit administrators" in order to be true advocates for members' health and health care dollars, and also help them understand how their decisions about health and benefits have an effect on cost.

Patient outreach and education
In terms of assistance with patient engagement, Oregon's Medicaid Advisory Committee has just completed an extensive review of strategies and best practices for engaging individuals and their families and made several recommendations for the Oregon Health Plan, presenting them to the Oregon Health Policy Board at their July meeting. Their work will serve as the foundation for a new work group, established by HB 2859 (2013), that will consider any legislative efforts required to fuel involving Oregon Health Plan individuals and their families in their own care.

Alignment with 2014 expansion outreach and recruitment
The Oregon Health Authority and Cover Oregon are collaborating on extensive outreach and streamlined eligibility and enrollment processes for 2014. This includes:
- A single seamless eligibility system housed with Cover Oregon. Medicaid and CHIP clients will select a CCO in their region just as those who qualify for tax credits will choose a qualified health plan;
- A shared marketing plan that will direct all consumers to one website and help line;
- One agency processing all paper applications behind the scenes;
- A navigator program and application assistance and education strategies for both the exchange and Medicaid expansion populations, building on the success of Oregon's Healthy Kids outreach efforts; a fast-track Medicaid enrollment process for income-eligible adults who are already receiving food benefits through the Supplemental Nutrition Assistance Program (SNAP) or whose children are already receiving health care benefits for children through Healthy Kids/OHP. These individuals are receiving fast-track enrollment letters and need only fill out and return very brief form in order to get enrolled. Oregon sent out approximately 260,000 such letters beginning in late September and more than 56,000 have been returned to date. Enrolling these 56,000 people represents a 10% reduction in the state's uninsured rate as of January 1, 2014.

Oregon and the federal government have invested significantly in the development of a single eligibility platform between Cover Oregon and Medicaid to ensure seamless and continuous eligibility and enrollment processes. Like the federal portal and several other states, Oregon's exchange website has experienced some early technical problems but Cover Oregon intended to open for individual enrollment in November. . There will be one streamlined application for individuals and families to use to apply for Insurance Affordability Programs including Oregon Health Plan coverage provided by CCOs and private health plan coverage provided by qualified health plans along with financial assistance for those qualifying for tax credits and/or cost sharing reductions. People can apply online through the Cover Oregon website or they can complete a paper application. The two types of applications collect the same information and are intended to be as similar as possible. This application will replace the current Application for Oregon Health Plan and Healthy Kids.

The Cover Oregon website will offer a central marketplace where individual consumers and small employers can easily compare plans, enroll and receive help paying for coverage if they are eligible for subsidies. Cover Oregon recently added a calculator on its website where Oregonians can estimate how much they may be able to save through the tax credits and other assistance that will be available through the exchange in 2014. The calculator is available at http://Cover Oregon.com/calculator.php.

In addition to connecting Oregonians with financial assistance, the exchange will provide innovative plan options and simplified plan administration for small employers. Small employers with 50 or fewer employees can allow their employees to choose an insurance company and plan through a defined contribution model.

The extensive outreach and streamlined eligibility and enrollment processes for 2014 expansions of Medicaid and the new Health Insurance Exchange are indicative of the ways in which the collaboration between OHA and Cover Oregon has been successful. Enhancing communications are a critical aspect of SIM activities moving forward and will lead to better information, education and resources for individuals and their families across populations.

Outreach, education and recruitment in support of Oregon's health system transformation and spread of the coordinated care model are ongoing at multiple levels. SIM is providing key resources for these efforts in the form of Communications and Transformation Center staff in OHA and support for a very wide range of stakeholder convening opportunities. Please see Appendix E for the revised Oregon SIM stakeholder engagement plan.

Section D	Information Systems and Data Collection Setup

Information technology infrastructure
The Oregon Health Authority (OHA) has been working for several years to create a framework for enterprise architecture and enterprise data management, as well as establish a beginning practice around information management. The integration of standard client and claims data with unstructured data, and the integration of the necessary technology and infrastructure to make this possible, has been part of the agency's vision. Now as we look to spread the coordinated care model, plans for integrating data from external providers, such as electronic medical record (EMR) data and hospital discharge data, using health information technology (HIT), health information exchange (HIE), and Electronic Health Records (EHR) capabilities are being specifically explored with the Medicaid/CHIP Coordinated Care Organizations and with partners in both the public and private sectors. The state expects to finalize specific plans for an achievable, workable solution within the next six months (please see project plan under Section P). In the meantime, the incremental build-outs that are occurring on the infrastructure side are being staged to support the overall vision, which will emerge over the next several years.

Thanks to SIM funding for expert consultation and focused staff, the state has initiated planning and design at a high level to address data integration, data collection and data intake. The initial approach is to leverage current implementation activities to develop a starting point, which can then be expanded as the solution designs for the other related areas are completed. As an

example, the state is in the process of establishing a new data repository to address the need for clear traceability and ensure data integrity. This repository is the first step in the larger plan to allow data from multiple source systems to be effectively managed in aggregate, and also allows for standardization of baseline and reporting data.

As described in Oregon's SIM application, the Oregon Health Authority Office of Health Analytics, in cooperation with the Transformation Center, will be responsible for much of the ongoing data collection and tracking of SIM activities. As a statewide aggregator of health care data and statistics, the Office of Health Analytics provides unique and valuable resources to drive change across the health care system. The office leverages: all key health-related datasets containing claims/encounters; long-term supports and services (LTSS) and other services and supports outside of CCOs; surveys including Consumer Assessment of Health Care Providers and Systems (CAHPS) and the Oregon Health Insurance Survey; and integrated datasets such as the All Payer All Claims (APAC) database, and the Client Process Monitoring System (CPMS), which contains clinical data for mental health/chemical dependency treatment services.

Expertise and data resources within the Office of Health Analytics, particularly the APAC dataset, coupled with IT infrastructure improvements, will ensure that Oregon can report to CMMI, assess the progress of SIM project goals, and monitor the multi-payer environment. Specific data collection or infrastructure expansions currently under way include these examples:

- Medicare fee-for-service (FFS) data has been requested which will allow for Oregon to see the full state delivery system with the APAC data. In addition, OHA is developing the internal capacity to use the same treatment and episode groupers employed by the APAC vendor to analyze non-APAC data, in order to produce consistent analytics across payers and data sources.
- The state's Medicaid Management Information System (MMIS) receives and processes claims and encounters from plans, and also manages member enrollments and records. The data warehouse (DSSURS) is populated by MMIS data, and serves as the source for research data and historical baseline information. Other data sources provide detailed information regarding specialized programs. Oregon has been part of a CMS pilot program to implement Transformed-Medicaid Statistical Information System (TMSIS) for reporting. That work is progressing, and the implementation of the Informatica tool set is in its final stages. The state's intention is to meet the target timelines of using TMSIS for reporting in January 2014.
- At present, MMIS is being modified to receive specific data components as part of the encounters submissions, and is in planning and solution design phases for using other tools, as well. Pharmacy data related to children's use of psychotropic drugs is being actively reported to medical directors on a weekly or biweekly basis and pushed to them via a secure portal; this is the first step in getting to a fully integrated direct reporting/drill down mechanism. These are only some of the immediate steps that have been taken to keep forward motion as the longer term plans are evolving.
- The development of a new, integrated data repository (as described above) based on defined enterprise standards, a formal data dictionary, and including data from all baseline systems, will align data and reporting needs for immediate purposes, and stage the agency for the next level of integration. The ability to automate data submission,

collection and intake will be based on this initial data repository, and the related tools that will be used for analysis, reporting and modeling.

Mechanisms for data collection

Fueled by SIM funding, Oregon's APAC database is a key data collection mechanism for monitoring expenditures and utilization on a multi-payer basis, and for assessing spread of the coordinated care model. APAC is comprised of medical and pharmacy claims, and information from the member eligibility and provider files, as collected from health insurance payers for residents of Oregon. All carriers and licensed third-party administrators with at least 5,000 covered lives are required to report to APAC on a quarterly basis. It includes fully-insured, self-insured, Medicare managed care, and Medicaid data, and the state is pursuing Medicare fee-for-service data. More specifically, APAC includes paid claims data for each of the payer populations that Oregon is targeting for spread of the coordinated care model under the SIM grant:

- Public Employees' Benefit Board (PEBB) members (because PEBB and the Oregon Educators Benefit Board are part of the Oregon Health Authority, the state also has more direct access to paid claims data through those programs);
- Medicare lives (these data will be complete with the anticipated addition of Medicare FFS records, but are very useful even now because Oregon has one of the highest Medicare Advantage penetration rates);
- Commercial carriers offering plans on Oregon's Health Insurance Exchange. OHA is working with Cover Oregon on potential updates to the APAC data call to capture details of interest to the exchange, including a plan ID variable.

However, APAC, while an extensive database, excludes lines of business not currently required to be reported, such as carriers too small to report (fewer than 5,000 lives); TRICARE; Federal Employee Health Benefits program; uninsured and self-pay; stand-alone dental, vision, or prescription plans; medical care not included in the statutory definition of health insurance (e.g., Indian Health Service); and other forms of insurance, such as workers' compensation or medical liability auto insurance. APAC data will feed directly into key analytic products that will help propel and monitor improvements in care delivery, including a quarterly multi-payer dashboard with cost, quality and utilization data (see more about this product below), potential hot-spotting tools, and reports on geographic variation in cost and quality, and similar analyses.

In addition to the all-payer data, the state has been adding processes and requirements related to improving reporting and data collection from Medicaid plans and providers for more than a year. These changes, plus changes in the Oregon administrative rules, and the legislation driving health system transformation in the state, have helped create momentum for revising and expanding current processes and mechanisms for data collection.

One specific mechanism outlined in OHA's final agreement with CMS for the Medicaid 1115 demonstration is a 1% withhold to ensure timely and accurate encounter data submission. OHA is in the process of revising CCO reporting requirements to further ensure the timeliness of encounter data submission. Future submission requirements will be based on adjudication date

rather than service date. Effective Oct. 1, 2013, CCOs will be required to include adjudication date as part of their encounter data record submission. Then, as of the next CCO contract renewal date of Jan. 1, 2014, OHA is proposing to change the contract language to require CCOs to submit their encounter data within 60 days of adjudication date.

This change will serve two purposes. First, it will allow OHA to track the average number of days from service date to adjudication date, and the number of days from adjudication date to encounter data submission date, which is useful information from a performance standpoint. Secondly, the new rules will result in OHA receiving more timely data. Current Oregon Administrative Rules require that providers submit claims to CCOs within 120 days of service date and CCOs will, under the new rules, have 60 days to submit encounter data to OHA. Combined, this allows for up to 180 days from service date to encounter data submission date (assuming the claim is automatically adjudicated at time of receipt). However, the typical timeframe from service date to claim submission date is considerably less than 30 days. Thus, the new rules will effectively reduce the encounter data submission timeframe from the current 180 days from service to less than 90 days from service, without posing an additional burden for CCOs. OHA will provide support and technical assistance to CCOs in an effort to meet our mutual goal of high quality data.

Oregon plans to develop a state-level clinical quality metrics registry (CQMR), with requirements to be developed and an RFP process in 2014. The registry will be State-level infrastructure necessary to submit clinical data to the State and internally utilize aggregated clinical data for quality monitoring and reporting purposes. In the near-term, the registry will support:

- Collection and calculation of CCO clinical incentive metrics (starting with the three EHR-based metrics of depression screening, poor diabetes A1c control, and hypertension) and
- Meeting federal requirements for Meaningful Use incentive payments to providers.

OHA's vision is that CCOs are able to leverage certified electronic health record technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers. Using electronic clinical quality measure data, CCOs have the ability to conduct analytics and performance monitoring to support population health management, care coordination activities, and develop alternate payment methodologies.

OHA recognizes that federal standards change over time, and that not all CCOs are in the same place when it comes to electronic health record adoption, health information exchange, and meeting Meaningful Use. OHA's goal is that Oregon providers meet Meaningful Use Stage 2 requirements and that CCOs take action to move their networked providers towards Meaningful Use Stage 2. With SIM support, Oregon has a unique opportunity to invest in the infrastructure that will move us toward the vision for electronic reporting of clinical quality data.

With development of the registry, CCOs and health plans can leverage state infrastructure to meet reporting requirements and access/analyze aggregated clinical data on their providers' performance and their members' health outcomes.

The registry will leverage existing efforts. Some CCOs, health plans and local entities have current or planned investments in clinical data aggregation. These local aggregators ("data intermediaries") would submit data to the statewide registry and could receive data from the registry as appropriate to feed into their analytics and quality monitoring systems. Entities without local data aggregation capability would be able to have providers submit data to the registry, and receive data from the registry related to their members and providers.

Over the longer term, the registry could be used for analyzing aggregated data to allow for the development of dashboards and benchmarks, to support health plans' and CCOs' efforts for better targeting of patients, and to support development of new care models and alternative payment arrangements.

For information on the role of the registry in Oregon's larger HIT/HIE strategy and timeline, please see Section E 13 and the discussion of HIT/HIE Phase 1.5 services.

Population data
Beyond claims or encounter data, the Oregon Health Authority Public Health Division (PHD) operates numerous population health surveillance systems that will assist Oregon's providers and delivery systems in understanding the overall health of the communities they serve and help Oregon monitor the success of its transformation efforts. A number of these surveillance systems are listed below:

- The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing survey of Oregon adults statewide that provides information on health behaviors and preventive practices related to the leading causes of death and disability in the state. The BRFSS is governed by a steering committee and includes an advisory group. PEBB has been contributing for the past several years to gain information with an oversample of state employees to aid monitoring of their efforts towards the three-part aim. SIM grant funds are directed towards BRFSS data collection enhancements that will provide timely and reliable data on the health of priority subpopulations in Oregon through a Medicaid BRFSS and a BRFSS race oversample.
- The Oregon Healthy Teens (OHT) survey is an ongoing survey of eighth- and 11th-graders that provides information on the health of adolescents, specifically tobacco, alcohol and other drug use, safety, violence, nutrition, physical activity, sexual activity, health conditions and access to care. OHT is governed by a steering committee and includes an advisory group. SIM grant funds also will help support OHT data collection efforts.
- The Hospital Discharge Dataset (HDD) provides information on hospital discharges from all acute care hospitals in Oregon. The dataset includes admit and discharge dates, diagnosis and procedural codes, financial charges, primary payer, and patient demographic information.
- The Pregnancy Risk Assessment Monitoring System (PRAMS) collects data on maternal attitudes and experiences prior to, during, and immediately after pregnancy.
- The Vital Records Unit provides annual reports on Oregon birth and death data.

The Oregon Public Health Assessment Tool (OPHAT) currently is in development and will provide access to local level (county, ZIP code, or census tract, depending on the data source)

population health data using the data sources listed above. OPHAT will ensure that communities, providers, and coalitions, including CCOs, have access to population health data in order to inform their community health assessments and community health improvement plans.

All of these population databases will be invaluable to assess the impact of spreading the coordinated care model statewide and amidst multiple payers and populations.

What measures will be collected?
Given the wealth of claims, encounter, and population data available for multiple payers and populations in Oregon, the state has some flexibility in determining which measures to calculate and report for purposes of self-evaluation, reporting to CMMI, and related purposes. A range of claims-based quality measures, utilization and expenditure statistics can be calculated from the APAC data. Because the aim of Oregon's SIM grant activities is to extend the coordinated care model from Medicaid to other populations and payers, Oregon intends to align its SIM metrics with those measures already identified for monitoring and evaluating the Medicaid transformation efforts (described briefly below). There is a strong direction in the state to align health system performance and transformation measures overall, evidenced by recent legislation (e.g., HB 2118 creating a health plan quality metrics work group across agencies including PEBB, OEBB and Cover Oregon, Oregon's Health Insurance Exchange.

Oregon's [Medicaid measurement strategy (see Appendix L)](#), which will be the conceptual foundation for multi-payer measurement and reporting under SIM, is documented in detail online. Briefly, it includes:
- Seventeen quality metrics, such as depression screening, hypertension control, and CAHPS patient experience measures, as well as measures of EHR adoption and use of patient-centered primary care homes. CCOs are eligible to receive bonus payments based on their performance on these metrics;
- Sixteen quality and access measures in addition to the 17 CCO incentive metrics (for a total of 33) that CMS will use to hold Oregon's Medicaid program as a whole accountable for its performance. If Oregon achieves its Medicaid cost containment goals but quality and access (as measured by an aggregate score from the 33 measures) suffer, then the state faces significant financial penalties;
- A number of health improvement metrics to be reported to CMS for the Medicaid population including tobacco use, obesity rate, effective contraceptive use, low birth weight, and self-reported health status.

More discussion of SIM performance measures and measure alignment in Oregon can be found in Section I.

Measurement reporting mechanisms
As explained above, Oregon's all-payer all-claims database will be the primary reporting mechanism across payers. Participating entities, reporting frequency, data elements, and data cleaning and aggregation mechanisms are well-established. Other data sources, including those described above, will supplement the APAC data.

With respect to reporting on progress toward its transformation goals, Oregon has made a strong commitment to accountability and transparency. Starting with the fourth quarter of 2013 (Q1 of the first SIM testing year) Oregon intends to publish a quarterly, statewide multi-payer performance report with quality measures, utilization statistics, and expenditure trends, by major payer category. After the first publication, future editions will show changes over time.

The multi-payer report will build on one already created to monitor performance and progress among Oregon's CCOs and for the Medicaid program in aggregate. The first of these quarterly performance metrics reports was published in May 2013 and includes baseline data from 2011 for 11 of the 17 CCO incentive metrics and all 16 of the additional measures that make up the set of 33 statewide quality and access measures, described above. In the second report published in August, OHA continues to build the baseline data that is the starting point for progress. The measures reported in this update – 12 CCO incentive measures and 16 state performance measures – were chosen in an open and public process to represent the health care needs and challenges of Oregon's Medicaid population. For each incentive measure, the report shows CCO-specific baselines, the statewide average, and the benchmark set by the Metrics and Scoring Committee, which is typically based on national data for high-achieving Medicaid programs. Benchmarks are also being developed for the financial and utilization data, using vendor specifications for a "well-managed" population. Please see Appendix Z for both of these reports.

These initial Medicaid-focused quarterly reports will be prototypes of a statewide metrics and benchmarks reporting across populations and markets, fueled by the APAC and other data, incorporating more clinical data measures over time as technology allows. SIM funding is integral to taking Oregon on this next step of looking beyond Medicaid to assess the spread of the coordinated care model across all populations. This data alignment will also help Oregon monitor the impact of the SIM activities during the testing periods.

Section E	Alignment with State HIT Plans and Existing HIT Infrastructure

Oregon's coordinated care model hinges on access to essential tools that can improve care coordination and the quality, while reducing the cost of care. To ensure widespread adoption and meaningful use of electronic health records (EHRs), Coordinated Care Organizations (CCOs) must meet baseline requirements for access to health information exchange (HIE) for their providers, and the quality pool that was established as a requirement of Oregon's Medicaid 1115 waiver will include financial incentives starting in 2013. CCO incentive measures include metrics for meaningful use of EHRs. Many of Oregon's PCPCH standards that are recognition criteria align with state health information technology (HIT), including meaningful use measures and health information exchange. Elements of the coordinated care model are in the PEBB 2015 RFP asking potential bidders to demonstrate how they will be furthering electronic record adoption and health information exchange.

To support and accelerate statewide health information technology initiatives, OHA plans to offer CCOs and providers information and tools to support care coordination beyond basic HIE and EHR use, including identifying and spreading promising approaches for using HIT and HIE in care delivery, and supporting CCOs in their development of strategies to use HIT and HIE.

OHA also aims to facilitate awareness of and use of new HIE services as options become available such as real-time notifications of emergency department visits or hospital admissions, and access to a patient's care plan for each CCO member to be used by their CCO, providers, caregivers, families and the patients themselves to truly coordinate care as a "team." With almost 80% of providers seeing Medicaid patients, the impact through the CCOs will transform the delivery system. Pilots can help test innovative tools that improve person-centered care such as mobile devices, home monitoring tools, and tele-health technology.

HIT-related efforts are coordinated within and outside OHA. For internal coordination, OHA has created an HIT Policy and Program Steering Committee, in which agency leaders address alignment of HIT efforts across program areas, including HIE, the EHR incentive program, analytics, accountability, behavioral health, and public health. OHA closely coordinates with other statewide HIT initiatives, such as O-HITEC, Oregon's Regional Extension Center, which is responsible for direct technical assistance to providers and clinics in launching certified EHR technology and helping providers meet meaningful use requirements. OHA also coordinates with the Oregon Health Network (OHN), Oregon's FCC Rural Health Care Pilot Program grantee, which focuses on extending broadband connectivity to all areas of the state.

The Health Information Technology Oversight Council (HITOC), staffed by the OHA Office of Health Information Technology (OHIT), is a citizen body tasked with setting goals and developing a strategic health information technology plan for the state. There is a broad array of stakeholders on HITOC, with members representing organizations that include private and public health care delivery, health care IT, consumers, and private health care research and policy, from the local, state, and regional levels. HITOC addresses issues involving Oregon's public and private statewide efforts in HIT, EHR adoption and use, and HIE. HITOC also considers options to encourage provider adoption of EHRs and seeks to help Oregon meet federal requirements so providers may be eligible for Medicaid and Medicare EHR Incentive payments.

As the Medicare and Medicaid EHR Incentive Programs require providers to adopt and meaningfully use certified EHRs, Oregon providers have met these higher standards. Currently, Oregon is in the top tier of states for provider participation in the Medicaid and Medicare EHR Incentive Programs. In Oregon, 42% of all physicians, physician assistants, and nurse practitioners have received an incentive payment from Medicare or Medicaid. The Medicare EHR Incentive program has paid approximately 3100 Oregon providers and 23 hospitals for achieving meaningful use. Oregon Medicaid has paid approximately 1500 providers and 51 hospitals for adopting certified EHRs and, in some cases, achieving meaningful use. Oregon's Medicaid providers are reaching meaningful use at a higher rate than the national average: 31% (470 providers) of Oregon providers who received a Medicaid incentive for adoption also have been paid for meaningful use, compared to a national rate of 22.5%.

OHA is exploring opportunities for further support for EHR adoption, such as expanded technical assistance to ensure that providers can use HIT effectively. Oregon's statewide health information exchange, CareAccord™, funded under Oregon's Cooperative Agreement with the Office of National Coordinator for HIT, currently offers Direct Secure Messaging services at no cost to providers. At the same time, Oregon is engaged in a business planning process to evaluate the scope of second phase of HIT/HIE services, including key questions of scale and timing of

additional HIT/HIE services, governance, and multi-payer financing. Additionally, there is consideration on how best to assist connectivity with those not eligible for MU payments, such as behavioral health and long term care systems, which are critical to achieve the coordinated care model.

Oregon continues to make progress on implementing HIT/HIE services as anticipated within the ONC-approved Oregon HIE Strategic and Operational Plans. Oregon recently initiated, as discussed with ONC, a targeted effort to develop a business plan for Oregon's next phases of HIT/HIE. In particular, Oregon has used SIM funds to engage consultant Patricia MacTaggart of George Washington University, a national HIT/HIE expert, to support policy, program, technical assistance and strategy development for Oregon's HIT/HIE efforts across all payers/providers. The work includes engaging stakeholders and developing a plan to accelerate the emergence of HIT/HIE needed to support the coordinated care model, including necessary technical assistance, policies, guidance and other non-technical aspects of HIT/HIE. This work is underway in conjunction with technology consultants supported under Oregon's remaining ONC funds who are responsible for developing technology plans for the next phases of HIT/HIE.

The objectives are to provide the critical HIT/HIE services necessary to support Oregon's health system transformation, in particular:

- Exchange of clinical, patient information for care delivery, care coordination, and other state purposes such as supporting public health objectives;
- The ability to use clinical information for quality reporting and accountability purposes; and
- Supporting Medicaid Coordinated Care Organizations (CCOs) and Medicaid providers and supporting the spread of the coordinated care model to other payers.

Oregon's Phase 2 HIT/HIE business plan framework will seek to support health system transformation efforts with the right level of HIT/HIE services, and will align with activities envisioned under the SIM grant as well as Oregon's HIT Trailblazer efforts. To date, Oregon has developed various components of the needed HIT/HIE infrastructure, such as the infrastructure for point-to-point interfaces (Direct Secure Messaging) for referrals and other use cases to push data from one entity to another. Oregon's current HIT/HIE infrastructure is funded through the state's ONC State HIE Cooperative Agreement. Oregon has implemented the infrastructure required to support the Medicaid EHR Incentive Program through Medical Assistance Provider Incentive Repository (MAPIR), which leverages a Medicaid-funded cross-state approach. Oregon has also identified public health infrastructure needs that support the public health meaningful use requirements that providers must meet to be eligible for EHR incentive payments. The state is in the process of finalizing a Health Information Technology Implementation Advanced Planning Document Update (HIT-I-APDU) to submit to CMS for funding.

Oregon's approach to developing a Phase 2 HIT/HIE business plan framework is to work with stakeholders to identify what next steps will be most productive for providers, patients, CCOs, other health plans, health systems, and the state with the emphasis on each entity's needs. For example: sharing patient-level data to ensure continuity of care between physical and behavioral health; integrating information from providers often without an EHR such as dental and long-

term care; and/or ensuring more consistent, efficient quality measurement and reporting. Oregon's stakeholder process will identify and prioritize the information needs that will determine what HIT/HIE infrastructure will be required, and of that infrastructure, what is the state government role to provide and what should be facilitated at the local and/or provider level.

Since Oregon's submission of the initial Operations Plan, great strides have been made in identifying the next phases of HIT/HIE services needed. In particular, Oregon engaged in listening sessions with CCOs and other key stakeholders in summer/fall of 2013, leading to the Phase 1.5 efforts outlined below, and now is working with the HIT Task Force on Phase 2.0 planning. The HIT Task Force includes a diversity of stakeholders, including (but not limited to): major payers, health systems, hospitals, providers, local HIE efforts, the public sector, and advocates/consumers. The HIT Task Force also includes representation from Oregon's HITOC to ensure consistency with the HITOC's prior work and ongoing oversight role.

Oregon is aligning with and leveraging prior federal investments in health information exchange (HIE), meaningful use of electronic health records (EHRs), and potential strategies and approaches to improve use and deployment of HIT. Oregon's efforts are divided into near-term ("Phase 1.5") and longer-term ("Phase 2.0") efforts. Phase 1.5 is planned for 2013 to 2015, and Phase 2.0 is being planned for 2015 and beyond.

Overall approach and relationship to existing efforts:
- Create a statewide resource that supports providers, health plans and CCOs at different ends of the technology spectrum.
    - Statewide services would augment and support existing services, including local health information exchange organizations (HIOs) and community-based health records, as well as health plans and CCOs with more sophisticated HIT and analytics capabilities. Statewide services will "wrap-around" existing ones.
    - Statewide services would also serve providers, health plans and CCOs with little or no HIT/analytic capabilities with some foundational and high-value services
- Future financial sustainability and the approach to governance/operations of statewide services will be addressed by OHA's HIT Task Force, with options such as 2015 legislation related to financial sustainability, charging subscription fees for value-added services, and moving operations of statewide HIE services to a non-State entity.
- Providers, CCOs, health plans, and health systems also need guidance on laws and policies related to sharing of health information. OHA efforts to provide clarity in this area will be important for the success of any infrastructure in improving care delivery.

Phase 1.5 and related efforts – near term (2013-2015)
Oregon's Phase 1.5 strategy grew from review of the foundational work of the Health Information Technology Oversight Council (HITOC) and meetings with key stakeholders during the spring and summer of 2013. OHA has unanimous support from the CCOs on this near-term HIT/HIE development strategy to support health system transformation. As this work advances, OHA will seek support from additional private partners.

This phase of HIT/HIE services will build a foundation for future statewide interoperability and HIE, while supporting immediate coordination between providers seeking to exchange patient

information and the incremental use of aggregated clinical data to improve the delivery of care. Phase 1.5 includes six elements (which are bolded below):

- Building blocks of identifying to whom, by whom, and where care is delivered to facilitate exchange of patient information and analysis of aggregated data
    - **State-level provider directory**
    - Incremental development of a **state-level patient index**
- High value services that fill information gaps around expensive transitions of care
    - **Statewide hospital notifications** to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital
- Electronic connectivity of all members of the care team across organizational and technological boundaries ("push" first, build towards query/"pull" in Phase 2)
    - **Statewide Direct secure messaging** augments local capabilities to view or share information (where they exist) by bringing new members to the electronic care coordination circle, such as LTC and emergency medical services. Statewide Direct secure messaging also extends electronic communication to providers and communities with no local capabilities in place. Statewide connection of Direct secure messaging service providers (HISPs) will allow providers to meet federal requirements and connect from their EHRs to any other Direct user in the state.
- Reliable, actionable information created from aggregated clinical quality data to support quality reporting and quality improvement efforts, and enhance health plan and CCO abilities around population management, targeting of care coordination resources, and the development of new methodologies to pay for outcomes
    - **State-level clinical quality metrics registry** to collect and aggregate key clinical quality data, develop benchmarks and other quality improvement reporting, collect and calculate CCO clinical incentive metrics and meet federal requirements for Meaningful Use incentive payments to providers. Health plans and CCOs can leverage state infrastructure to meet reporting requirements to OHA and receive collected clinical data for their members for analytics/quality improvement.
    - **Technical assistance to providers** to help providers meet their Meaningful Use requirements while ensuring that clinical data for metrics captured in EHRs are accurate and complete. Technical assistance can improve credibility of EHR data underlying clinical quality measures, bolstering provider confidence in metrics.

These elements will leverage ONC's investment in Oregon's HIE (primarily supporting our statewide Direct secure messaging goal) and CMS's investments in adoption and meaningful use of EHRs to advance the coordinated care model and support health system transformation.

Concurrently with Phase 1.5, OHA will partner with the Oregon Health Leadership Council (OHLC) to support the availability of the Emergency Department Information Exchange (EDIE) service. EDIE is a solution developed by Collective Medical Technologies (CMT) to exchange information among EDs to identify frequent users and create care plans to help those frequent ED utilizers to determine if there is another care setting that is more appropriate.

EDIE is:
- A collaborative case management framework for all types of special needs patients.
- A targeted tool for proactively notifying interested parties and stake holders of relevant patient-specific events or behavior.
- A low-cost, automated solution for sharing actionable information to otherwise disparate parties.

SIM funds for EDIE would be granted to the OHLC, which would then add contributions from their organization and members as well as the hospitals to procure and implement the EDIE solution. The total amount of the grant would be $250,000 assuming that OHLC meets all three milestones. The first milestone is to have at least 75% of the hospitals in Oregon (44) sign the MOU to agree to contribute to implement EDIE. Once this mark is met, then OHA would release half of the grant funds ($125,000). The second milestone is that within 6 months of reaching milestone 1, 38% of hospitals (22) need to have implemented EDIE. Once this mark is met, then OHA would release another quarter of the grant funds ($62,500). The third milestone is that 75% of hospitals (44) have implemented EDIE within 12 months of reaching milestone 1. Once this mark is met, then OHA would release the remaining quarter of the grant funds ($62,500).

Timeline for Phase 1.5 and related efforts
OHA intends to direct Phase 1.5 implementation efforts with input and advice from the CCOs and key stakeholders. OHA anticipates development and implementation of Phase 1.5 and related efforts along the following timeline:

Spring/summer 2013	Listening sessions with key stakeholders
Fall 2013 – July 2015	Ongoing OHA efforts to support and leverage Direct secure messaging - Continue CareAccord® Direct secure messaging services for targeted providers - Facilitate and monitor connections between Direct secure messaging service providers - Participation in Trust Communities to ensure connection between Direct secure messaging service providers
Sept. – Nov. 2013	Establish health information technical advisory group (HITAG) for Phase 1.5; HITAG and OHA to identify requirements for contracting and develop implementation plan to specify phasing, timelines and scope
winter 2013 – spring 2014	- OHA to develop requirements for RFP/contracts with HITAG input - OHA to submit IAPDs to seek federal financial participation for Phase 1.5
2014	As certification standards for EHRs require use of Direct, support providers in achieving Meaningful Use, fitting Direct into workflows, and leveraging Direct for improved care coordination across care settings
2014	Contracting process(es) for Phase 1.5 services
Summer 2014	Initial services contracted and development begins for Phase 1.5

	elements
2014	Technical assistance supports Medicaid providers to achieve Meaningful Use, receive incentive payments, participate in Direct secure messaging and be ready to submit data to clinical quality metrics registry
Winter 2014	Using EDIE, emergency department doctors across Oregon have critical patient information on high utilizers
Beginning Spring 2015	Initial Phase 1.5 services operational
July 2015	Achieve statewide Direct secure messaging: Direct is in use to provide an on-ramp for connecting all members of the care team electronically and to facilitate economical exchange of clinical information - all HISPS in Oregon are connected - all care team members have an option to use Direct secure messaging, whether integrated into an EHR or accessed through a web portal
2015	Unnecessary utilization of emergency department is reduced
2015	Statewide resources (provider directory, notifications, patient attribution service) support local exchange and analytics efforts
2015	Clinical quality metrics registry is operational and used to produce CCO metrics
2015	Because of technical assistance support, clinical quality metrics registry data is increasingly valid and credible
2016	Clinical quality metrics registry includes dashboards and benchmarks

OHA will seek federal financial participation from the Centers for Medicare and Medicaid Services (CMS) to help fund Phase 1.5 activities.

Phase 2.0
Concurrently with the Phase 1.5 work, planning for the next phase of HIT/HIE efforts is underway. The OHA HIT Task Force – which began meeting in September and will continue through November 2013 – is charged with developing the Phase 2.0 business plan framework. The Task Force's charter, roster and meeting materials are publicly available (http://healthit.oregon.gov/Initiatives/Pages/Task-Force.aspx) and public comment is solicited at the Task Force meetings.

In 2015 and beyond, Oregon's statewide HIT/HIE efforts will be expanded to provide or support robust, interoperable health information exchange that supports both data "push" as well as data "query" (following the evolution of national standards) and more robust data aggregation. The OHA HIT Task Force will be charged with developing the Phase 2 business plan framework.

The Task Force will consider the stakeholder input, including the prior work of Oregon's Health Information Technology Oversight Council (HITOC), to make recommendations on a multi-year state business plan framework. The resulting plan will provide a foundational document for

OHA's efforts, as well as help set the work plan for the ongoing oversight and policy work of the HITOC.

Vision for a shared information infrastructure:
- Reduce gaps in patient information and create an even playing field ensuring each provider has relevant, actionable information at the time of care. To reduce gaps in patient information, every provider in the state must have access to the information they need to deliver high quality, person-centered care.
- Unify data collection and transparency to assure the health system (state, health plans, CCOs, health systems, payers and providers) is paying for value and health outcomes and not visits. Leverage aggregated data (utilization, cost, clinical, etc.) to identify individuals who can be helped by better care coordination and providers, clinics, and communities who can benefit from interventions, resources, and incentives.
- Improve understanding and engagement of patients in their health care and outcomes through access to their complete health record, including treatments and goals.

The Task Force will address these key health information technology questions:
- Which services or infrastructure should be offered statewide?
- What is the right role for the State including policy, standards, guidance, etc.?
- How can the State best partner with stakeholder organizations financially to build and support longer term needs?
- How should any statewide services be governed and operated (State-run, non-profit, etc.)?

The Task Force will focus particularly on longer term (2015 and beyond) solutions to the above issues, and will take into account current and near term state-level efforts in development. The timeline for Phase 2.0 is as follows:

Spring/summer 2013	Listening sessions with key stakeholders
Sept – Dec. 2013	Oregon HIT/HIE Business framework development: HIT Task Force
2014 – 2015	Phase 2.0 development and implementation planning, including HITOC policy work/oversight
2015	Phase 2.0 legislation possible and implementation begins

Section F	**Enrollment and Disenrollment Processes**

DOES NOT APPLY

Model intervention

Oregon's model being tested under SIM includes the following components: delivering technical assistance and support for health system transformation; analyzing and evaluating innovative delivery models; developing alternative payment methods; and spreading the coordinated care model to other payers and populations. Oregon has involved multiple constituencies to develop and implement the coordinated care model, using the executive, legislative and administrative arms of state government, partnering with CMS, private sector, organized labor, and most importantly, extensive public input over several years to develop the coordinated care model. Our efforts focus on *systems* innovations that produce better clinical outcomes, improved health and lower costs, while also supporting the providers and health systems in transforming care. (See Appendix I, Revised for Oregon SIM Driver Diagram).

Model implementation and delivery

Policies that set the groundwork for implementation
House Bill 2009 provided clear health policy direction for Oregon, laying the foundation for health system transformation. HB 2009 established the Oregon Health Authority, and also replaced the Oregon Health Fund Board (OHFB) with the citizen-led Oregon Health Policy Board and established the Patient-Centered Primary Care Home Program. OHPB serves in an oversight and advisory capacity to OHA, and initiated work on development of Oregon's Health Insurance Exchange. Furthering the vision of the Aim High report, the OHPB developed a comprehensive strategic plan in 2010, titled Oregon's Action Plan for Health, which laid out specific strategies and next steps for Oregon to achieve the Triple Aim. OHPB and OHA were advised by a broad stakeholder group of more than 300 people who served on 20 committees, subcommittees, work groups, task forces, and commissions to examine all aspects of the health and health care system. More than 850 people attended six community meetings across the state to provide feedback to OHPB. Likewise, many organizations and groups, such as the Oregon Health Leadership Council (which includes the major health systems and commercial insurance carriers in the state), and small businesses and community groups provided extensive input. A majority of the action items identified by OHPB based on this stakeholder process have either been implemented or are in the process of being implemented, including the requisite legislation. Notable among these are the development of the coordinated care model, and the establishment of Oregon's health insurance exchange, known as Cover Oregon.

In June 2011, as the first step to implement the coordinated care model, House Bill 3650 passed with broad bipartisan support (Senate 22–7, House 59–1), creating the legislative authority for the development of CCOs as the Medicaid delivery system, in support of the model and health system transformation. Essential elements of the transformation outlined in the bill are: integration and coordination of benefits and services; local accountability for health and resource allocation; health equity; standards for safe and effective care; and a global Medicaid budget tied to a sustainable rate of growth. Prior to final approval to implement, HB 3650 directed OHPB to bring back a CCO Implementation Proposal by January 2012. The CCO Implementation Proposal resulted in the enactment of SB 1580, which launched CCOs and directed the state to examine how to spread the coordinated care model to state employees. SB 1580 also garnered

broad bipartisan support, passing in the Senate 18–2 and in the House 53–7 in February 2012. Adoption of the coordinated care model for the Medicaid population is under way with legislative authorization in place and federal waiver authorities approved, and fifteen CCOs are operational as of November 1, 2012. One requirement of CCOs is to develop Community Advisory Councils (CACs), which must have 51% consumer representation. The role of the CACs is to advise CCOs on health transformation strategies most appropriate to each local community. Additionally CACs are tasked with developing community health assessments and the community health improvement plans that will guide their CCO's actions to improve health outcomes. Oregon is confident that this model will achieve cost savings and has committed to the federal government to reduce the growth trend in per capita Medicaid expenditures by 2 percentage points through implementation of its health care innovation plan (see Appendix P).

Simply put, CCOs are the pilot vehicle for delivering patient-centered care that is focused on improving health and lowering costs at every point in the health care system. They are the proof of concept. Each CCO is required to partner with or implement a network of PCPCHs and, over time, the state expects every Oregon Health Plan member to have access to a PCPCH. CCOs were required to outline efforts to achieve PCPCH access and how they will use alternative payment methods to incent and sustain the PCPCH model. Transformation relies on ensuring that CCO members have access to high-quality care beyond just PCPCHs, including care provided by other clinical and health professionals, such as the specialists and hospital providers and also nontraditional health care workers who can bring care outside the clinic setting and into the community. This will be accomplished by the CCO through a provider network capable of meeting health systems' transformation objectives and ensuring that members experience enhanced care coordination among members of the network to meet their needs.

Spreading the model
Oregon, with the support of SIM, is now well-poised to spread the coordinated care model to other populations and payers. As stated earlier, OHA purchases health care for approximately 640,000 people under Medicaid and CHIP and also helps pay for the health care of some 200,000 others, including state employees and public school teachers and Oregonians who would otherwise be uninsured, essentially touching one in four insured Oregonians. Almost 80% of all providers in Oregon see Medicaid patients, so initial support to the CCO's success through the SIM funded activities, particularly the learning environment created by the Transformation Center will have impact on the community and clinical level. The timing is right for incorporating the major elements of the coordinated care model for individuals who are dually eligible for Medicaid and Medicare and in the contracting procedures for state employees' health benefits. Our intent is ultimately to further leverage this purchasing power by asking qualified health plans joining Cover Oregon to align with this new care model as a high quality, low cost option for all Oregonians.

Many of the commercial health plans are already business partners with the state, offering coverage options for the Medicaid population or state employees. Furthermore, many have Medicare Advantage plans that serve dual eligible and regular Medicare enrollees, and have contracted with providers who also serve Medicare FFS. Finally, many of commercial plans who are invested as partners in CCOs are also offering qualified health plans on the exchange. Please

see Appendix G for a visual representation of the connections between markets in Oregon, in addition to the following examples:

- Providence Health Plan is both a partner in the HealthShare CCO in the Portland area and is the Public Employees Benefit Board (PEBB) contracted plan with the largest number of PEBB lives. They have a Medicare Advantage plan for the Portland area, and are partners in Southern Oregon (Jackson County) in another CCO. They have started primary care home enhanced payments across their overall statewide network in PEBB, in addition to their HMO-like PEBB plan and these same providers are also serving Medicaid/CHIP clients in the Portland area under the new Healthshare CCO. In addition they have initiated some shared savings programs with some targeted specialty care providers in high spend areas such as orthopedics, cardiology and gastroenterology who serve both populations.

- PacificSource, another large commercial plan and also a Medicare Advantage plan, is an invested partner in a large CCO in the Central Oregon region of Bend, after having worked with that community for what was actually a prototype of a CCO for the past several years. They also are an invested partner in a smaller CCO along the Oregon-Washington border area of Hood River. In both regions, the provider network has been supported by PacificSource for their commercial, Medicaid/CHIP and Medicare Advantage populations including enhancing primary care, clinic and hospital grants on changing the culture of care to new innovative models for the last several years and innovative payments to specialty care providers. They work closely with the provider community in both regions, and also have contracted Idaho and Washington State providers to serve these regions. Innovative value-based payments by PacificSource will touch more than just Oregon Medicaid/CHIP providers.

- ODS is an invested partner in a CCO responsible for a 12-county rural/frontier region of Oregon. ODS is committed to innovative changes towards transformation in its partnership in the CCO has enlisted a medical director to work with small rural practices in partnership with local critical access hospitals to gain patient-centered primary care home certification and initiate enhanced payments. Additionally, ODS serves other populations in this same area and other parts of Oregon, including employees with coverage under the state's Oregon Educators Benefit Board (school districts). Its work with providers in the CCO region are the same providers serving commercial lines of business and allow for increased spread of alternative payment arrangements and innovations.

We envision that there will be a tipping point for transformation of Oregon's health care system when the coordinated care model's delivery system and payment innovations spread beyond Medicaid beneficiaries and state employees to more of the Medicare and commercial populations to create a truly transformed system. This spread of transformation will help to ensure that Oregon's delivery system and health care workforce is ready for the new expansions of Medicaid and Cover Oregon, and will help ensure costs remain sustainable over time. The Transformation Center is instrumental in building on our existing multi-payer efforts and in creating learning systems to accelerate innovation and the spread of the model across all payers. Advancing the date of that tipping point will ensure real and sustainable improvements in health status, enhanced patient experience and lower per capita cost trends

Forthcoming RFPs for state employee coverage and for qualified health plans within Cover Oregon will incorporate key elements of the coordinated care model. Successful respondents for these commercial contracts will demonstrate increasing adoption of model features such as value-based payment, care coordination and integration, and accountability for outcomes. In addition, the Oregon Health Authority and the Oregon Insurance Division are now exploring how the rate review process and other mechanisms might be leveraged to encourage carriers that do not participate in Cover Oregon to adopt elements of the coordinated care model. See Appendix D for a high-level timeline showing Oregon's vision for evolution of the coordinated care model across sectors.

A key strategy of the Oregon Health Authority is acting as a strong purchaser to spread the coordinated care model beyond Medicaid to public employees, to Medicare beneficiaries served by plans and providers who also contract with the state, and qualified health plans in Cover Oregon. The state will also employ other levers to encourage alignment between public and commercial payers and providers, as described below. It is relevant to note here that the majority of Oregon's providers and health systems participate in multiple markets, perhaps to a greater degree than seen in other states. For example, 74% of Oregon's physicians currently see Medicaid patients and 85% are open to new patients. Four of Oregon's seven largest individual market insurers already are involved in one or more CCOs, as noted in a response above. This degree of interconnection will help Oregon spread the coordinated care model rapidly to achieve health care transformation.

As CCOs and elements of the coordinated care model take root and begin to spread in Oregon, many of the same policy-making and stakeholder bodies that contributed to the model development will continue to provide oversight and feedback. The Oregon Legislature has explicitly requested quarterly reports on the implementation of health systems transformation through 2017. The first quarterly performance metrics report for Medicaid CCOs was published in May 2013, and the second report was published in August. Please see Appendix Z for both reports. The OHPB, Medicaid Advisory Committee, PEBB, OEBB and other existing bodies will track implementation and provide input. Targeted stakeholder and expert work groups, such as the legislatively-mandated Metrics & Scoring Committee, the CCO contractors, and the "Medi-Medi" advisory group consisting of CCOs and their affiliated Medicare Advantage plans and other key stakeholder groups will provide input on policies to further model implementation across payers, providers and populations.

Levers to enable action
Identifying and assessing the state policy and regulatory levers that are available, actionable, and consistent across the state provides an analytic perspective on the implementation and advancement of the coordinated care model.

1. Financial levers
Using penalties and incentives to drive behavior is one of the methods being employed in Oregon to support SIM efforts. The coordinated care model is being implemented statewide in Oregon's Medicaid and CHIP program through Coordinated Care Organizations. CCOs are in part defined by a new payment model that holds them accountable for the total cost of care

(behavioral, physical and dental health care) for enrolled members through a global budget. Between August and December 2012, 15 CCOs contracted with the state to provide comprehensive Medicaid/CHIP services. The state has made significant progress in transitioning to this new model of care, with 90% of Oregon's Medicaid and CHIP populations enrolled into a CCO as of January 2013.

The state is applying a form of a shared savings model that provides conditional rewards with one-sided (upside) risk using an incentive pool. The rewards are based on performance, not on growth of services, and are conditional to improving quality. Under the Oregon Health Authority's final agreement with CMS as required by the Special Terms and Conditions (STCs) of Oregon's Section 1115 demonstration, the state has committed to reducing the growth in Medicaid expenditures by 2 percentage points. It is achieving these savings through the multiple levers and the Triple Aim objectives outlined in the proposal. OHA has established a new financial pool ("quality pool") for CCOs. Initially funded at 2% of the total budget, the quality pool is viewed as a bridge strategy to move the state from a capitated payment system to one that increasingly rewards CCOs for value and outcomes, rather than utilization of services. This lever is one of several health system transformation mechanisms for achieving Oregon's vision for better health, better care, and lower costs.

The two primary payment models, the global budget and the enhanced, tiered payments for patient-centered primary care homes will be in effect for the entire grant period. The global budget currently impacts an estimated 576,000 Medicaid beneficiaries (90% of total). The goal is to have PCPCH payments in place by 2016 for approximately 75% of the Medicaid and duals population, 60% of public employees, and at least 10% of the commercially insured. While some of the payers have other new alternative payment models in place, many CCOs have not yet finalized which additional alternative payment methodologies they will choose to use with their contracted providers, nor is it possible to estimate the number of patients or volume of services covered by those alternative payments.

However, CCO contracts require that they create similar mechanisms to reward providers for improved quality and outcomes. They are being asked to initiate and broaden efforts to move away from FFS to value-based payments with their individual provider networks. Oregon's model emphasizes community flexibility, so the specific alternative payment methodology (APM) is not prescribed, and it is likely that there may be several different APMs that emerge depending on the characteristics of the regional delivery system. Each of the CCOs has recently submitted a contractually required Transformation Plan outlining several key areas of needed innovation and transformation, including specific APMs. The state will be finalizing amendments to CCO contracts that set specific benchmarks and milestones for 2014 and 2015 for implementing their APMs.

A majority of the CCOs are proceeding with enhanced patient-centered primary care home payments but a variety of additional efforts are under way or being considered for other providers and hospitals. Some of the CCOs are working to expand the mental health capitated payments to include substance abuse providers and services as well.

Finally, to further align with the goals of the coordinated care model, the Oregon Association of Hospitals and Health Systems (OAHHS) has proposed a 1% quality incentive pool in Medicaid for DRG hospitals in the state. Funds in the proposed incentive pool would be awarded according to achievement of outcomes/metrics designed to align with the coordinated care model. This initiative requires an amendment to Oregon's Medicaid 1115 demonstration waiver, which has been submitted.

PEBB members will have increased PCPCH options starting in 2013, as the largest PEBB PPO plan members who seek care from a recognized PCPCH will see a decrease in their cost sharing from 15% to 10% and the providers will receive incentive payments if they fulfill the standards for a higher level PCPCH. Moving to the future, any successful bid for the upcoming 2015 RFP will be required to demonstrate incentives to further spread the PCPCH model, including alternative payment methodologies. By aligning standards and payment incentives between Medicaid and PEBB, primary care providers and payers will have a common set of expectations across provider networks serving 25% of the Oregon insured population. CCOs can also bid on the 2015 PEBB RFP and, if successful, be offered as a plan choice for PEBB members. In addition, the Legislature built limits on PEBB spending tied to similar trend rates as in our Medicaid 1115 waiver agreement when approving their new budget. These will be critical in our negotiation with potential vendors to share in decreasing costs while maintaining quality and improving the health of state employees.

2. Legal and regulatory levers
Oregon's commitment to the coordinated care model as outlined in our Health Care Innovation Plan (see Appendix P) submitted in September 2012 is demonstrated through an intentional coordinated and strategic multi-year planning and implementation process that included extensive public discussion across the state and active engagement by the Governor, the Legislature and the Oregon Health Authority (OHA), and in partnership with the Oregon Insurance Division and Oregon's new health insurance exchange, Cover Oregon. This high level of coordination in planning and implementation continues today, now supported by the SIM grant, to extend the coordinated care model across the delivery system in Oregon.

As Oregon's health insurance exchange, Cover Oregon, prepares to begin operations in October 2013, Governor Kitzhaber has been working closely with its Governor-appointed board members to ensure that the 2015 qualified health plan RFP include attributes of the coordinated care model. The timing is right for incorporating the major elements of the coordinated care model for individuals who are dually eligible for Medicaid and Medicare and purchasing for state employees' health benefits. The intent is to further leverage this purchasing power by requiring qualified health plans in Cover Oregon to align with this new care model as a high quality, low-cost option for all Oregonians. The model will not be new to parts of the commercial market, as many of the commercial health plans are current business partners with the state, offering coverage options for the Medicaid population or state employees.

On June 3, 2013, the Governor delivered a letter to the Oregon Health Policy Board asking them to make recommendations by the end of the year to his office and the legislature about potential legislative or regulatory changes that may be needed to further align PEBB, OEBB and Cover Oregon around the coordinated care model (see Appendix B). One of the Governor's health

advisors is the current chair of the PEBB board, and is working closely with board members, the unions, and PEBB staff to include the coordinated care model in the state employee plan's upcoming RFP.

The Oregon Health Policy Board, in partnership with the Oregon Insurance Division, will be setting the framework for incorporating the coordinated care model into the rate review process. The Cover Oregon Board, with the Oregon Insurance Division will play a strong regulatory role in the products offered as well. Other regulatory efforts that support dissemination of the coordinated care model include administrative rules updates to strengthen Oregon's PCPCH standards and administrative simplification efforts that would increase efficiencies for public and private plans alike.

As outlined in the innovation plan (see Appendix P) and noted previously, Oregon's health system transformation is the result of an intentional multi-year planning and implementation process. Oregon's Legislature was actively involved at every step, crafting and passing key pieces of legislation including HB 2009 (2009), HB 3650 (2011), and SB 1580 (2012). These transformational pieces of legislation passed with broad bipartisan support (Senate 22–7 and House 59–1 for HB 3650; Senate 18–2 and House 53–7 for SB 1580). Oregon fully expects that the Legislature will continue to be a key player in accelerating and spreading health system transformation, including into the commercial market.

3. Structural levers
The three main health care-related agencies in Oregon, the Oregon Health Authority, the Oregon Insurance Division and Cover Oregon are aligning at multiple levels to ensure the coordinated care model is entrenched in current work to prepare for the 2014 expansions. Executive leadership of all three agencies meet on a weekly basis with the Governor's Office and the group also includes an experienced executive, whose role is to work with legislators and stakeholders to increase alignment with the coordinated care model objectives.

Governor Kitzhaber has been the primary driver of the coordinated care model, initiating the policy design discussion stakeholders and the Legislature, resulting in the enabling legislation in 2012. The Governor also was at the table in negotiation of the 1115 Medicaid demonstration waiver. Additionally, Governor Kitzhaber has been working closely with the Governor-appointed board members for Oregon's Health Insurance Exchange (Cover Oregon) regarding inclusion of coordinated care model elements in the next RFP for Qualified Health Plans. He has already started to meet with health plan executives about his desire to see the coordinated care model achieve both savings and improved quality in all commercial products.

Another structural component being implemented is the Oregon Transformation Center, which is envisioned as the state's hub, or integrator, for innovation and improvement, and is a key mechanism for implementing the coordinated care model successfully and rapidly across all markets. The Transformation Center will be initially focused on aiding the CCOs and their provider networks in moving to alternative payments and new delivery system models and is critical for setting up a learning environment that can spread innovation to achieve the metrics and goals the OHA has set for the CCOs and CMS has set for Oregon in our quality strategy.

One of the key elements of Oregon's SIM plan, the Innovator Agents, is coordinated through the Transformation Center. At its core, the role of Innovator Agents is to assist CCOs and their communities, provider entities, and OHA identify and implement innovations and best practices that support the coordinated care model and health transformation's three-part aim of better health, better care and lower cost.

There are two types of Innovator Agents: CCO Innovator Agents, as noted above, who will act as a single point of contact between the CCO and OHA, and to help champion and share innovation ideas; and long-term care (LTC) Innovator Agents, who will support shared accountability for the Triple Aim between CCOs and long-term care agencies and providers. It is important to clarify that Oregon's SIM grant provides financial support for four LTC Innovator Agents; the state budgeted for an additional three LTC Innovator agents and has and has committed to funding CCO Innovator Agents through other means.

Oregon SIM funds are invested in the Transformation Center to support the rate of adoption of innovation in Oregon's Coordinated Care Organizations (CCOs) and the spread of the Coordinated Care Model (CCM) to other payers.

The Transformation Center serves as a hub to help good ideas travel faster. It is doing this through a set of strategies designed to support the success of the Coordinated Care Organizations (CCOs) as the lead vehicle for system transformation in Oregon. As the CCOs gain momentum and experience success in adopting innovation, those lessons will be spread across other populations and payers. Because roughly 80% of Oregon's providers see Medicaid patients, efforts aimed at supporting changes in the delivery of care through CCO provider networks will also promote the spread of these innovations across multiple populations and payers. The Transformation Center will also actively seek input and participation from payers outside Medicaid in its learning network activities, including learning collaboratives and conferences. If SIM funds were not available, Oregon would not be able to develop a robust Transformation Center and activities would be limited to the Innovator Agents and one statewide learning collaborative of the CCOs. SIM funds allow Oregon to provide a rich offering of tools and resources to support innovation and the development of a culture of innovation, outside of the Innovator Agents and the otherwise modest support through various existing arms of OHA.

Transformation Center strategies supported by SIM:

- **Transformation Center Management Team**
  SIM funds support the positions of the lean management team responsible for guiding the work of the Center. SIM funds support the Transformation Center Director, Director of Systems Innovation, Director of Clinical Innovation and the Director of Operations.

- **Learning Collaboratives**
  SIM funds are used to support the Learning Collaboratives Manager and Coordinator positions, as well as the outside expertise and consultants needed to support the learning collaboratives. The Transformation Center has established three learning collaboratives in the SIM Implementation Period. Planning for a fourth learning collaborative focused on complex care is underway with the first meeting scheduled for November 5. Please see Appendix T

for detailed information about our learning collaborative activities to date. Current collaboratives include:

- o CCO Medical Directors and Quality Improvement Managers, focusing on the seventeen incentive metrics, one for each monthly session.
- o Community Advisory Council (CACs) chairs and members, focusing on developing the capacity and capabilities of the CACs to develop the community health assessments and community health improvement plans required by Oregon statues. These committees are required to be majority consumer members and need extensive technical assistance to achieve their goals.
- o Innovator Agents, focusing on supporting transformation efforts, sharing best practices, the Science of Improvement techniques, and the people side of change. The SIM-funded LTC Innovator agents will be included as they come on board to broaden this collaboration amidst the agents. While not funding the original Innovator Agents salaries, The SIM grant fuels their training particularly through providing investment for the state to work with the Institute for Healthcare Improvement to help the agents be successful.
- o The pre-work needed to stand up a learning collaborative focused on the care for high cost, high utilizers, with plans for this collaborative to formally launch in November.
- o More collaboratives will be developed as the audiences and content needs are identified. One already under development is focused on high utilizers and this collaborative is expected to be launched in the next two months.
- o SIM funds also provide support to Oregon's Patient-Centered Primary Care Institute (PCPCI), which works in collaboration with the Transformation Center PCPCI offers a Learning Collaborative that incorporates multiple learning methods to maximize opportunities for 26 practices to learn from each other and from technical experts in topic areas aligned with Oregon Health Authority's Patient-Centered Primary Care Home (PCPCH) program standards. Collaboratives include face-to-face training sessions, work between sessions via phone and web and individualized practice coaching.

- **Provider Engagement**

The Transformation Center, through the efforts of the Director of Clinical Systems, and a Transformation Analyst, the Center will develop a Council of Clinical Innovators, a cadre of 10-12 providers who will serve as champions of change and support the implementation of the Coordinated Care Model through provider-to-provider conversations. The initial meeting and training of this group of clinical innovators is anticipated to be in the first quarter of the first Demonstration Period. This "Transformation Academy" will translate into the spread and adoption of the coordinated care model principals across many practices areas as the champion's carryout their in-service commitments across the state in multiple practice settings and specialties to share knowledge and proven practices.

- **Coordinate Transformation Communications**

SIM funds support the Transformation Center, Director of Communications and a Communications Analyst position. These positions will develop a master communications plan; coordinate communications efforts and strategies across the Oregon Health Authority

with consumers, providers, stakeholders and the public. The Transformation Center's initial webpage is currently functioning as a central point of information dissemination about transformation. SIM funds will also be used to overhaul the OHA web presence and more effectively communicate OHA's triple aim goals across all areas of the Health Authority. This will help internally for all units of the Authority to understand and engage in their roles in transformation. SIM funding will support strategic outreach and align communication efforts with community partners and stakeholders, particularly around the multi-payer efforts underway and over the test years.

- **Technical Assistance**

SIM funds provide support for world class technical assistance in the area of health transformation. The Transformation Center has contracted with the Institute for Healthcare Improvement to provide training on the Science of Improvement to the Innovator Agents, CCO Account Representatives, Quality Improvement Coordinators and Transformation Center and OHA leadership. Additional support will be provided by IHI in the demonstration periods to continue to advance OHA capacity building in transformation and systems innovation. We will continue to engage other experts to support our work in alternative payment methodologies; clinical innovation, and the people side of change.

- **Transformation Analysts**

SIM funds support a group of four high level operations and policy analysts that will conduct research on policy and systems issues and requests. Policy and systems areas include: clinical standards and supports to CCOs, support for the Council of Clinical Innovators (described above); researching and resolving systems and policy issues brought to the Center by Innovator Agents; researching resources, best or emerging practices, and subject matter experts for issues that the Center will support and promote including: Physical health, mental health, addiction recovery, and dental health integration; Patient-centered Primary Care Home; Alternative Payment methodologies; Community Needs Assessments and Community Health Improvement Plans; Electronic Health Records and Health Information Exchange; Health equity issues, including cultural competency and health literacy, workforce diversity including traditional health workers, and addressing health disparities; Patient engagement and patient responsibility; Incentive Measures; Public health; Social determinants of health; and early childhood and the connection to Early Learning Hubs; This SIM investment allows for focused attention to gather what the delivery system needs to spread innovation, on the ground practical experience rather than just policy design and theory. It will allow the Transformation Center to make connections, peer to peer to those in the CCOs, health plans, health systems, hospitals and clinical providers and the community to drive transformational change.

4. Cooperative levers

In June 2013, Governor Kitzhaber directed the Oregon Health Policy Board to take action to align health transformation implementation activities. His directive includes: development of recommendations for possible additional statutory and regulatory changes necessary to ensure the Triple Aim goals are met. These may include, but are not limited to:

- Strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- Opportunities to enhance the Oregon Insurance Division's rate review process;
- Alignment of care model attributes with PEBB and OEBB contracts;
- Alignment of care model attributes with Cover Oregon's qualified health plans.

The Oregon Health Authority and the Oregon Insurance Division are now exploring how the rate review process and other mechanisms might be leveraged to encourage commercial carriers to adopt elements of the coordinated care model (e.g., affordability standards that align with aspects of the coordinated care model). The Governor and executive agency leads are working to encourage carriers to adopt CCM elements. Similarly, there has been ongoing dialogue and work with long-term care and Medicare stakeholders, particularly around the dually eligible population, with respect to how to align efforts to encourage collaboration and alignment with the coordinated care model.

As part of the work being done by the OHPB to address the Governor's letter, the Coordinated Care Model Alignment workgroup has been meeting monthly through the fall of 2013. The work group consists of two board members each from PEBB, OEBB, and Cover Oregon. Their work has been focused on understanding current alignment with the coordinated care model across the organizations, recognizing opportunities for future alignment and proposing ideas that will ensure continued collaboration. Current efforts towards alignment, as evidenced in contract language or in Request For Proposals (RFPs), has been mapped as a baseline. A final report with recommendations will be presented to the OHPB at the November 2013 board meeting. Please see Appendix II for the current alignment document, meeting agendas and summaries from this work group.

These latest cooperative efforts follow several years of efforts by the Governor, OHA, and other bodies to align all health care stakeholders in the state around the goals of transformation. Evidence of frequency and visibility of the Governor's efforts to encourage transformation across markets can be found in the media coverage highlighted in Appendix A and in the revised stakeholder engagement plan (Appendix E). Cooperative levers and voluntary alignment can be particularly powerful in a small state such as Oregon, where the health care stakeholders are strongly interconnected. See Appendix G for a visual representation of the connection between different stakeholder organizations and health care transformation initiatives in Oregon.

Mechanisms to engage CCOs in the innovation culture and practice
Contracts between each CCO and the state require each CCO develop a transformation plan. The purpose of the transformation plans is to encourage continuous quality improvement; foster transparency and accountability for achieving health systems transformation within the context of local control. OHA published initial guidance on the transformation plans in November 2012 and January 2013, all CCOs submitted plans that included a self-assessment and self-identified improvement goals across eight key areas:
- Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions (must specifically address the needs of individuals with severe and persistent mental illness).
- Continuing implementation and development of patient-centered primary care homes.

- Implementing consistent alternative payment methodologies that align payment with health outcomes.
- Preparing a strategy for developing a community health assessment and an annual community health improvement plan for the CCO service area.
- Developing electronic health records; health information exchange and meaningful use.
- Ensuring communications, outreach member engagement and services are tailored to cultural, health literacy and linguistic needs.
- Ensuring provider network and staff ability to meet the diverse cultural needs of the community (cultural competency training, provider composition reflects member diversity, nontraditional health care workers composition reflects member diversity).
- Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experiences of care and outcomes.

OHA trained a cadre of reviewers to evaluate the transformation plans and provided feedback and requested changes as necessary to achieve reasonable goals. OHA finalized approval of all CCO plans in March 2013, CMS approved the proposed contract amendments and the CCO contracts will be amended to include the commitments outlined in the CCO transformation plans. The amendments will become effective in July 2013. A key function of the Innovator Agents and the Transformation Center is to support CCO progress on transformation plan goals by fostering a culture of innovation and disseminating the evidence-based tools of innovation, including change management, providing technical assistance, access to national experts, establishing learning collaboratives and other supports as necessary.

Additionally, the Transformation Center's Council of Clinical Innovators (along with the medical directors of each CCO and other health plans) will act as champions for key innovations in the delivery and coordination of care with their colleagues and with Oregon's physician, specialty and other provider associations. With 74% of physicians in Oregon seeing Medicaid patients, the initial work with the Medicaid population and CCOs creates a strong foundation in the delivery system for innovation and transformation.

Mechanisms to engage government stakeholders
Integration with the public health system in Oregon has been ongoing and includes partnership with local public health authorities (LPHAs) and the Council of Local Health Officials (CLHO), and the OHA Public Health Division (PHD) in order to build infrastructure that supports health system transformation in Oregon. PHD staff have participated in the review of CCO applications and led the CCO Transformation Plan review for the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) component. Many LPHAs have been involved in the development of CCOs. Several local health officials serve on boards and/or advisory committees of CCOs. In May 2013, CLHO held the first meeting of the Health System Transformation subcommittee comprised of local health administrators and other LPHA staff that are working to partner with CCOs on community health initiatives. The primary focus of this committee is to support LPHAs operating as a system and aligning around strategic directions, priorities, and broad operational approaches related to Oregon's health system transformation and to develop system improvement recommendations to CLHO and OHA. Working to implement primary and secondary prevention strategies recommended by the U.S. Preventive Health Services Task Force Guides to Community and Clinical Preventive Services,

OHA plans to facilitate CCO partnerships with local public health authorities and other local organizations to reduce the leading causes of disease, injury, and death while also driving down the leading drivers of health care costs in their communities. These collaborations will use evidence-based clinical as well as community preventive strategies to address a specific health need, using a "flood-the-zone approach." The goal is for communities to make lasting changes in practice and/or policy to support prevention. This will impact PEBB members and dually eligible individuals in these communities, but also spread to other Oregonians as community efforts align with the clinical delivery system around the Triple Aim.

Other authorities and levers of state government are already part of OHA's overall portfolio. For example, the Office of Equity and Inclusion has established three regional equity coalitions currently operating as advisors to CACs and community partners on culturally relevant and specific strategies to reduce health disparities and how agencies and community leaders can act as change agents to improve equity and the representation of the interests of marginalized communities in health transformation efforts. This is a key strategy aimed at improving the social determinants of health. SIM resources will provide operational support for three additional regional coalitions as well as conducting training for three more cohorts of participants in the DELTA training program and certifying 150 new health care interpreters over the course of the SIM project period.

Oregon has a strong school-based health center program, with 63 centers. Many are pursuing recognition as patient-centered primary care homes and are participating in CCO delivery networks. The opportunity to align health and education system reform in Oregon can dramatically contribute to short- and long-term improvements in health outcomes for children. The goal of universal kindergarten readiness among Oregon children depends on both health and education system innovations and processes. Oregon's Early Learning Council recently adopted a statewide Kindergarten Readiness Assessment that will be broadly implemented in fall 2013. The CMMI grant provides the opportunity to test systems and supports that contribute to kindergarten readiness and to disseminate effective strategies.

OHA, via the Transformation Center, will partner with the Early Learning Council (ELC) to test innovative delivery models and shared incentives that result in improved kindergarten readiness. Effective strategies will be disseminated jointly by OHA and the ELC via learning collaboratives, technical assistance, and the Innovator Agents. For example the Transformation Center, in partnership with the ELC, will fund that test innovative strategies for improving kindergarten readiness, such as coordination of services across CCOs and "Early Learning Hubs" and shared measurement strategies.

OHA and the Oregon Department of Human Services (DHS) are sister agencies, sharing a common history and administrative services. In partnership with DHS, OHA is developing strategies to align financial incentives for CCOs and LTSS to coordinate care and achieve desired outcomes for individuals they serve in common. Oregon's Legislature excluded LTSS from CCO budgets, but Oregon has worked closely with stakeholders to develop strategies to share accountability and coordinate between CCOs and the LTSS system, including financial strategies. One promising coordination approach is the Congregate Housing with Services Model, such as the one used in Vermont, where partnerships between health plans, housing

providers, and LTSS providers can achieve positive health outcomes, address social determinants of health, increase member engagement, reduce health disparities, and save costs in communities or in Section 8 housing that serves mostly low-income, aged, and people with disabilities.

Another example of how the state has engaged other governmental agencies can be seen in two legislatively funded reports; one on the mental health system and one on the addictions system (summarized in this [report to the legislature](#)). These reports identified the complicated structure of the mental health and addiction systems in Oregon. Both reports recommended changing the system to an integrated funding and service model that will:

- Provide consistent service throughout the state;
- Consolidate funding;
- Regionalize;
- Make the system more transparent;
- Gain efficiencies in utilization of resources.

At the direction of the Joint Committee on Ways and Means, Subcommittee on Human Services, the OHA Addictions and Mental Health Division (AMH) is moving forward with the establishment of two or three demonstration projects that will integrate addictions, mental health, and physical health services in Oregon. The system change also will focus on an integrated service management and payment system. These two changes will result in a simpler system making more efficient use of state, federal and local resources and providing better services to those in need.

AMH will be using a website as its primary vehicle for communicating about the demonstration projects, which includes an automatic notification system that sends out emails as the site is updated. The demonstration projects will be guided by the following principles:

- The goal of treatment and recovery is to provide services and opportunities for individuals to become self-sufficient.
- The array of treatment and recovery services must address the therapeutic needs of people in a holistic fashion. To the extent possible services need to be delivered in a seamless and integrated manner. Services include a continuum of core health, mental health and addiction services, as well as wraparound services for housing and employment/education assistance.
- The service delivery system must be managed in the most cost-effective and individually focused manner. Funding for services should follow the shortest line from the state to community provider. The management structure used will consolidate all available funds, Medicaid and non-Medicaid funds, to pay for the array of core and wraparound services being provided with state funds.
- The service payment process will focus on achievement of measurable outcomes wherever possible.

Core mental health and addictions services aim to be geographically located to encourage access as close to home as possible. To avoid management and program duplication, services will be provided in a regional manner where possible.

Mechanisms to engage community and patient stakeholders

Local control and accountability
A key component of the coordinated care model is community-driven accountability. Within Medicaid, CCOs are organized to encourage local flexibility and accountability. CCOs are community-driven entities with requirements for provider, community and consumer involvement in governance and in active Community Advisory Councils (CACs). A core requirement is that CCOs collaborate with local hospitals, public health agencies, social services organizations and others. CACs are required have 51% consumer representation and are responsible for developing the CCO's community health assessments and annual community health improvement plans. This level of community involvement is intended to ensure that CCOs are responsive to local needs; they will also be held accountable through clear performance expectations, payment for outcomes and transparency in public reporting.

As the model is spread, PEBB and other purchasers will be looking at how potential vendors will encourage local flexibility and accountability as they incorporate elements of the coordinated care model into their review and contracting processes. CCOs may bid for the PEBB contract but any and all potential contractors will be assessed for their interactions with the local community and delivery system and efforts to ensure that individuals and their families are the focus of efforts to deliver benefits and services.

Stakeholder engagement
Consistent with Oregon's reputation as a leader in the public process for health policy development, Oregon committed itself to obtaining a wide range of input and feedback throughout the process of planning for health systems transformation, and the initial phase of CCO implementation and this will continue as the coordinated care model is spread. Section A of this Operational Plan and our previously submitted State Innovation Plan (please see Appendix P) has additional detail, but these efforts to date have included: (1) Oregon Health Policy Board (OHPB) meetings, work groups, and public comment; (2) the OHPB's targeted expert and stakeholder work groups (more than 130 participants); (3) OHA's Health System Transformation Community Meetings (more than 1,000 participants, eight cities); (4) tribal consultations with the nine federally recognized tribes in Oregon; (5) PCPCH development stakeholder groups; and (6) individual staff engagement with advisory councils, committees and other stakeholders to gain input and feedback throughout the process. There were more than 76 public meetings in total leading up to the development of the overall CCO implementation proposal and almost 350 key stakeholders and experts gave hours of their time to help build and refine the coordinated care model. Further details were provided in our stakeholder engagement plan provided in May, which has been revised. Please see Appendix E.

The PCPCH Program provides one clear example of how OHA has engaged payers, providers, governmental agencies, the community and other stakeholders throughout the development and implementation process in a variety of ways:
- Participates in the CMMI Comprehensive Primary Care Initiative as a public payer, convener, and collaborative partner in this multi-payer federal initiative.

- Established a multi-stakeholder implementation task force in partnership with the Northwest Health Foundation, to provide recommendations on resources needed for broad-scale adoption of patient-centered primary care.
- Established the PCPCH Standards Advisory Committee, a multi-stakeholder group providing policy direction and technical expertise for the patient-centered primary care home model. Representation from across government agencies includes county health departments, public and mental health authorities, public university medical centers, and private and public health plans, community-based stakeholder organizations, patient advocates, and local professional societies all participate on the committee.
- Established the Expert Oversight Panel for the Patient-Centered Primary Care Institute, which is composed of multiple public and private stakeholders that guide the institute's key decisions and strategic direction for technical assistance resources — representation includes the state School-based Health Centers Program, local foundations, community-based organizations, and patient advocates.
- Participated in the recently concluded multi-payer strategy consensus meetings on primary care payment with all the major public and private payers and provider groups, facilitated by SIM grant funding. The program was asked to develop a set of measurements for the payers to evaluate their investment in primary care homes and will actively imbed the payers and provider input into the ongoing Standards program; particularly as it builds up its site visit function with SIM funding (please see Appendix BB for meeting agendas, minutes and the draft straw proposal).

Ongoing support from key stakeholders is evident in the number and range of letters of support included in our original SIM application. They include letters from key policy-making and advisory groups to the OHA such as the Oregon Health Policy Board (OHPB), Medicaid Advisory Commission (MAC), and Oregon's Public Employees' Benefit Board (PEBB); CCOs including HealthShare in the Portland metro area and Trillium in Lane County; key delivery system partners and academic medical center partners such as Oregon Health & Science University, the Oregon Association of Hospitals and Health Systems, Oregon Health Care Association, Oregon Association of Area Agencies on Aging, and the Office of Rural Health; commercial payers represented by Providence Health Systems and the Oregon Business Council, philanthropic organizations, such as the Northwest Health Foundation, and consumer advocacy organizations such as AARP. These and other entities and stakeholder groups will be engaged throughout the SIM years as Oregon spreads the coordinated care model.

OHA will continue its strong commitment to outreach, inviting input through various methods including stakeholder presentations and webinars, annual regional listening sessions, a robust open public process of public meetings, transparent and public reporting of CCO performance and of progress toward health systems transformation goals, and ongoing direct work with key stakeholder groups (See Appendix E for Oregon's revised Stakeholder Engagement Plan and Appendix J Revised for a high-level timeline and overview of Oregon's health system transformation activities).

Alignment with federal positions and stated direction
The goals and strategies of Oregon's health system transformation initiatives align with several federal initiatives. Oregon's health reform bill, HB 2009, mirrors the Affordable Care Act,

passed nine months before the federal legislation was passed. In addition, Oregon's efforts align with Healthy People 2020, National Prevention Strategy and Aging and Disability Resource Center initiatives. In 2012, the Public Health Division (PHD) drafted its five-year strategic plan consisting of priority areas to make Oregon one of the healthiest states in the nation. These PHD strategic priority areas overlap with the aforementioned national initiatives as follows. In addition, Oregon is in the process of building its network of Aging and Disability Resource Centers (ADRCs). An active ADRC advisory group includes representatives from several OHA and Department of Human Services programs.

Further, Governor Kitzhaber's commitment extends beyond Oregon. He has agreed to join Governor Haslam of Tennessee as co-chairs of the Health Care Sustainability Task Force for the National Governor's Association (NGA). The stated purpose of the task force is to "… focus on state innovations that require the redesign of health care delivery and payment systems with the objectives of improving quality and controlling costs. Through the sharing of state experiences and best practices, the Task Force will work to identify areas where federal legislative or regulatory action is necessary to reduce barriers and further support state initiatives." (See NGA press release). On July 1, the Governor sent a letter to Secretary Sebelius and Marilyn Tavenner to Setting his goal to work closely with the Centers for Medicare and Medicaid and other governors to develop a multi-payer strategy and a common set of core principles that focus on fiscal sustainability and changing the way healthcare is organized (see Appendix O). He identifies that SIM is a key player in Oregon's and other states' success.

Please see Appendix K, Revised for the Oregon SIM project management plan and timeline.

Section H	**Participant Retention Process**

Oregon's SIM project is primarily focused on innovations in delivery *systems* and payment reform. Oregon's Medicaid 1115 demonstration waiver establishes obligations of the state to the federal funding agency for administering the Oregon Health Plan to beneficiaries via the coordinated care model using CCOs as the initial delivery vehicle. CCOs are partnerships that include both payers and providers. Included in the OHA contracts with CCOs, is the requirement to implement the coordinated care model and to participate in the duration of the contract period through the five-year period of the waiver ending in 2017.

Shared accountability of OHA and CCOs to achieve the goals of health transformation is reflected in the extensive set of CMS approved performance metrics developed as part of the Medicaid 1115 demonstration waiver. This includes 33 performance measures shared by the state and CCOs, of which 17 are quality incentive metrics that will link to a quality pool beginning in 2014 based on data collected during 2013 (See Appendix L for a list of the performance and quality incentive measures).

Commitment to align and spread the model to other populations
In June 2013, Governor Kitzhaber directed the Oregon Health Policy Board to take action to align health transformation implementation activities. His directive includes: development of

recommendations for possible additional statutory and regulatory changes necessary to ensure the Triple Aim goals are met. These may include but not limited to:

- Strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- Opportunities to enhance the Oregon Insurance Division's rate review process;
- Alignment of care model attributes within PEBB and OEBB contracts;
- Alignment of care model attributes within Cover Oregon's qualified health plans.

The Public Employees' Benefit Board (PEBB) represents an early next opportunity to translate the coordinated care model to the commercial market. The PEBB Board is adopting the coordinated care model in its current and future contracting and plan design elements, focusing on the value gained through creating incentives and accountability for improved health outcomes with its partner plans. Oregon and CMMI are engaged in technical assistance to prepare for the release of the PEBB RFP in fall 2013 for the 2015 plan year. Metrics for accountability will be aligned with those required for CCOs, and the RFP offers opportunities for financial arrangements and other key elements to align the coordinated care model. Similar actions will be undertaken to develop the OEBB RFP to begin to offer the model to Oregon educators for benefit year 2015.

As part of the work being done by the OHPB to address the Governor's letter, the Coordinated Care Model Alignment workgroup has been meeting monthly through the fall of 2013. The work group consists of two board members each from PEBB, OEBB, and Cover Oregon. Their work has been focused on understanding current alignment with the coordinated care model across the organizations, recognizing opportunities for future alignment and proposing ideas that will ensure continued collaboration. Current efforts towards alignment, as evidenced in contract language or in Request for Proposals (RFPs), has been mapped as a baseline. A final report with recommendations will be presented to the OHPB at the November 2013 board meeting. Please see Appendix II for current alignment document, meeting agendas and summaries from this work group.

Spread to the state employee and educator populations and the commercial market will be enhanced because many of the same delivery systems in Oregon are part of the new CCO networks, and several CCOs have commercial health plan partners as part of their governance. Additionally, PEBB and its health plan partners were involved as key stakeholders in the development of the coordinated care model. Seventy-four percent of Oregon's providers see Medicaid patients, most of whom also serve state employees, so alignment of contracting expectations will support delivery system transformation so the new CCOs will be contracting with many of the same provider networks as the commercial plans, and share similar metrics for performance. Finally, the PEBB Board has encouraged patient-centered primary care for many years as part of its contracts, but with the overall statewide acceleration there will be increased incentive to move to the new team-based model.

PEBB members will have increased PCPCH options starting in 2013, as the largest PEBB PPO plan members who seek care from a recognized PCPCH will see a decrease in their cost sharing from 15% to 10% and providers will receive incentive payments if they fulfill the standards for a

higher level PCPCH. Moving to the future, any successful bid for the upcoming 2015 RFP will be required to demonstrate incentives to further spread the PCPCH model, including alternative payment methodologies. By aligning standards and payment incentives between Medicaid and PEBB, primary care providers and payers will have a common set of expectations across provider networks serving 25% of the Oregon insured population. CCOs can also bid on the 2015 PEBB RFP and, if successful, be offered as a plan choice for PEBB members.

Additionally, the investment in the Transformation Center will provide the needed resources to bring national and local expertise in payment methodologies, analytics and evidence-based practices and tools across both public and private plans to accelerate the spread of the model into the commercial market. Oregon's commercial plans and the health systems and providers that work with them have been at the table in designing the model, but investment in moving the model to fit the different purchasing worlds and learning from each other's success is vital for the transformation of Oregon's overall health care delivery system.

The Oregon Transformation Center is envisioned as the state's hub, or integrator, for innovation and improvement, and is a key mechanism for implementing the coordinated care model successfully and rapidly across all markets. The Transformation Center will be focused on aiding the CCOs and their provider networks in moving to alternative payments and new delivery system models and is critical for setting up a learning environment that can spread innovation to achieve the metrics and goals we have set for the CCOs and CMS has set for us in our quality strategy. Private commercial payers will be included in this effort, many of which also are invested partners in CCOs in many regions of our state, have Medicare Advantage plans, and have contracted with providers who also serve Medicare FFS.[7]

Below are examples of how the support of Medicaid CCOs and the initial spread in PEBB has had a ripple effect across the delivery systems in Oregon:

- Providence Health Plan is a partner in the HealthShare CCO in the Portland area while also being a Public Employees' Benefit Board (PEBB) contracted plan with the largest number of PEBB lives. They have a Medicare Advantage plan for the Portland area, and are partners in Southern Oregon (Jackson County) in another CCO. They have started primary care home enhanced payments across their overall statewide network in PEBB, in addition to their HMO-like PEBB plan and these same providers are also serving Medicaid/CHIP clients in the Portland area under the new HealthShare CCO. In addition they have initiated some shared savings programs with some targeted specialty care providers in high-spend areas such as orthopedics, cardiology and gastroenterology that serve both populations. Providence is also offering a qualified health plan on Cover Oregon, the Oregon Health Insurance Exchange.
- PacificSource, another large commercial plan and also a Medicare Advantage plan is an invested partner in a large CCO in the Central Oregon region of Bend, after having worked with that community for what was actually a prototype of a CCO for the past several years. They also are an invested partner in a smaller CCO along the Oregon-Washington border area of Hood River. In both regions, the provider network has been

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[7] www.oregon.gov/oha/OHPB/Documents/special-terms-conditionsaccountability-plan.pdf

supported by PacificSource for their commercial, Medicaid/CHIP and Medicare Advantage populations including enhancing primary care, clinic and hospital grants on changing the culture of care to new innovative models for the last several years and innovative payments to specialty care providers. They work closely with the provider community in both regions, and also have contracted Idaho and Washington state providers to serve these regions. Innovative value-based payments by PacificSource will touch more than just Oregon Medicaid/CHIP providers. PacificSource is also offering a qualified health plan on Cover Oregon.

- MODA Health is committed to innovative changes towards transformation in its partnership in the Eastern Oregon CCO and has enlisted a medical director to work with small rural practices in partnership with local critical access hospitals to gain patient-centered primary care home certification and initiate enhanced payments. Additionally, MODA Health serves other populations in this same area and other parts of Oregon, including employees with coverage under the state's Oregon Educators Benefit Board (school districts). Its work with providers in the CCO region are the same providers serving commercial lines of business and allow for increased spread of alternative payment arrangements and innovations. MODA also is offering a qualified health plan on Cover Oregon.

Oregon's Patient-Centered Primary Care Home Program (PCPCH) standards also serve as a core around which many of the coordinated care model elements are built. With support from OHA's statewide program, PCPCHs are being formed and recognized across Oregon and are providing a new standard of coordinated care to all their patients, both inside and outside CCOs. More than 450 PCPCHs have been recognized to date. In Oregon there is growing participation in alternative payments for primary care homes by both public (e.g., Medicaid, PEBB) and private purchasers. Oregon's goal is that 75% of the state's population will have access to a recognized PCPCH by 2016.

Through Oregon's participation in the Comprehensive Primary Care Initiative (CPCI), all payers agreed to and adopted contract language requiring participating primary care practices to adopt the PCPCH model of care and become recognized as primary care homes in the first year of the initiative. Through CPCI, 68 primary care practices in Oregon are required to become recognized as primary care homes within the first year of the initiative. Oregon's PCPCH Program has already recognized more than 450 primary care practices across Oregon, representing more than 2,300 providers that have adopted the primary care home model of care. The 450 recognized practices are approximately half of the potentially eligible clinics.

In Oregon, we have a concentrated but competitive insurance marketplace, with seven major commercial domestic carriers accounting for 90% of the total commercial market.[8] Four of these are already engaged in the coordinated care model and its spread from Medicaid/CHIP, to PEBB and Medicare Advantage. Additionally, we anticipate these same plans will be offering products on our health insurance exchange, Cover Oregon. The synergy of these close linkages between payers of our target populations will be enhanced by the efforts of the Transformation Center to bring these Medicaid/CHIP participating plans and other commercial plans together with Oregon's clinical providers and health systems to move payment reform at the clinical level. At

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[8] See: www.cbs.state.or.us/ins/health_report/3458-health_report-2012.pdf

the same time, the state as a major purchaser (OHA purchases for an estimated 33% of the non-Medicare market) continues to move payment reform by tying global payments to specific quality and accountability metrics with the CCOs. At both the CCO and provider levels, Oregon is optimistic that it can shift 50% of the market from an FFS to a value-based system during the testing period, and an even greater proportion thereafter. [9]

HB 2118 (2013) requires Cover Oregon to establish a health plan quality metrics work group, with representation from the Oregon Health Authority and PEBB, among other organizations, to make recommendations on appropriate health outcomes and quality measures for QHPs by May 2014. In addition to the 2118 group, Cover Oregon is establishing an Evaluation Technical Advisory Group to provide advice and feedback about Cover Oregon's evaluation efforts and health plan quality rating system and has asked the OHA accountability director to participate.

Governor Kitzhaber recently asked the Oregon Health Policy Board for recommendations about statutory and regulatory changes needed to ensure alignment of coordinated care model attributes with PEBB and OEBB (Oregon Educators Benefit Board) contracts, and with contracts for Cover Oregon's qualified health plans. In the future, successful bids for these contracts will demonstrate increasing adoption of model features, such as value-based payment, care coordination and integration, and accountability for outcomes. The Governor's letter also asked OHPB to explore how cost transparency and accountability and the Oregon Insurance Division's rate review process might be leveraged to encourage carriers who do not participate in the exchange to adopt elements of the coordinated care model. See Appendix B for a copy of the Governor's letter.

Section I	Quality, Financial and Health Goals and Performance Measurement Plan

SIM performance goals
As described in Oregon's initial grant application, Oregon's quality, financial, and health goals for health systems transformation are centered on Oregon's version of the Triple Aim[10]:
- Improve the lifelong health of all Oregonians.
- Increase the quality, reliability and availability of care for all Oregonians.
- Lower or contain the cost of care so it is affordable for everyone.

Specific financial goals under the SIM grant are to:
- Reduce Medicaid PMPM cost growth 1 percentage point in FY 2014 (from a 2011 baseline) and by 2 percentage points in subsequent years.
- Reduce PMPM cost growth for the state's public employee coverage (PEBB) by 1 percentage point in FY 2015 and 2 percentage points FY 2016. Oregon expects to see cost containment in PEBB via reductions in ambulatory-care sensitive hospital admissions and potentially avoidable emergency department visits achieved through

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[9] www.cbs.state.or.us/ins/health_report/3458-health_report-2012.pdf
[10] Adapted from Institute for Healthcare Improvement, The Triple Aim, <http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm>, accessed November 22, 2010.

increased use of primary care homes and application of other key elements of the coordinated care model (CCM).

- Reduce Medicare dually eligible cost trend in Oregon by 1 percentage point in FY 2016, also through increased use of primary care homes and "spillover" effects of other key elements of the CCM.

Oregon aims to achieve this cost containment while at least maintaining — if not improving — quality of care. Because SIM funds are being used to amplify and accelerate existing plans for health systems transformation in Oregon, Oregon intends to align its SIM metrics with those measures already identified for monitoring and evaluating Medicaid transformation efforts, rather than specifically establishing a new set of performance measures for SIM. Alignment of these measures with the CMMI core set and with Oregon's SIM driver diagram (see Appendix I Revised) is addressed below.

Background on Oregon's measurement strategy

Performance measurement in Medicaid
Just as Oregon's coordinated care model was first implemented in Medicaid and will spread from there, the state's SIM performance measurement plan builds on the measurement strategy designed for Oregon's landmark Medicaid waiver in 2012. That strategy contains the following key elements:

- Seventeen CCO incentive measures, almost all of which are NQF-endorsed measures such as depression screening and follow up, hypertension control, and CAHPS patient experience measures. A few measures are specific to Oregon, such as use of Patient-Centered Primary Care Homes. CCOs are eligible to receive bonus payments annually based on their performance on these 17 quality metrics and the proportion of CCO payment that is at risk based on performance will increase over time.
- An additional 16 measures which, when combined with the 17 CCO incentive measures, will be used by CMS to hold Oregon's Medicaid program as a whole accountable for its performance. (CMS and Oregon have referred to this set of 33 measures as "quality and access test" measures.) As articulated above and in the SIM driver diagram (see Appendix I Revised), Oregon aims to reduce PMPM cost trend while improving or at least maintaining quality. In the context of Oregon's Medicaid waiver, CMS will use the 33 quality and access test measures to ensure that costs are not controlled by sacrificing quality: If Oregon achieves its Medicaid cost containment goals, but quality and access (as measured by an aggregate of the 33 measures) decline, the state faces significant financial penalties.
- Finally, the state will report annually to CMS on 17 "core" waiver performance measures. The core measures overlap in part with the CCO incentive and quality and access test measures but also contain a number of health improvement indicators, such as tobacco use, obesity rate, effective contraceptive use, low birth weight, and self-reported health status. The various population health datasets described in Section D will be key resources for tracking performance on these core measures and for monitoring population health overall.

- Oregon also has committed to testing and reporting the CMS Adult Medicaid Quality measures and the Children's Health Insurance Program Reauthorization Act (CHIPRA) measures as part of CMS grant projects previously awarded to the state.

With respect to the CCO incentive measures described above, the methodology used to determine whether a CCO will qualify for a bonus payment incorporates both uniform benchmarks and the CCO's baseline performance. The portion of available quality pool funds that a CCO will receive is based on the number of measures on which it achieves either an absolute benchmark or demonstrates improvement from its own baseline. Common benchmarks were set for each of the 17 incentive measures, typically at the 90th or 75th percentile for Medicaid plans nationally. A CCO that does not achieve the absolute benchmark must demonstrate at least a least a 10 percent reduction in the gap between its baseline status and the benchmark to qualify for incentive payments in a given year. (The improvement targets are based on the Minnesota Department of Health's Quality Incentive Payment System.) The CCO quality pool methodology is described in detail in Appendix DD and more information is available here: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

Measure alignment across initiatives and payers
The 17 CCO incentive metrics and the larger set of 33 quality and access measures were selected in close consultation with CMS. A majority are nationally endorsed measures also used at the federal and state levels in one or more initiatives (see Appendix L). As Oregon expands its transformation efforts, a key area of focus will be aligning these measures with those used by PEBB, the Oregon Educators Benefit Board, and by Cover Oregon. The Governor's June 2013 letter to the Oregon Health Policy Board, referenced in several sections of this operational plan, asks the board to make recommendations for care model alignment between Medicaid, PEBB, OEBB, and exchange QHPs; quality measurement will almost certainly be a featured element of those recommendations (see Appendix B). A great deal of alignment already exists or is in progress:
- PEBB has for several years measured and reported plan performance on a range of standard HEDIS quality and utilization measures, as well as patient experience. Work is currently under way to develop the competitive RFP for the 2015 plan year and PEBB's RFP performance subcommittee has stated its intention to align with the CCO performance measures to the greatest extent possible.
- Cover Oregon has identified 13 quality measures that will be used to provide consumers with quality ratings (1–4 stars) at the carrier level when open enrollment begins in October 2013. (As actual exchange performance data become available, the measures will be reviewed and possibly adjusted, and quality ratings will be created for each qualified health plan.) Alignment with CCO measures was one of the selection criteria and nine of the 13 Cover Oregon measures overlap with the Medicaid performance measures described above. Furthermore, HB 2118 (2013) requires Cover Oregon to establish a health plan quality metrics work group with representation from the Oregon Health Authority, PEBB, and OEBB, (among other organizations), to make recommendations on appropriate health outcomes and quality measures by May 2014. In addition to the HB 2118 work group, Cover Oregon is establishing an Evaluation Technical Advisory Group to get advice and feedback about their evaluation efforts and

health plan quality rating system and has asked the OHA accountability director to participate.

- As part of participation in the Comprehensive Primary Care Initiative (CPCI) in Oregon, Medicaid, Medicare, and four commercial plans have agreed on a set of quality, utilization, patient experience and cost metrics to track and support practice transformation. The quality and patient experience measures, in particular, overlap heavily with the set of 33 measures described above and many can also be used to help practices qualify for recognition as a patient-centered primary care home under Oregon's standards.

- [HB 2216](#) (2013) directs the Oregon Health Authority to establish a hospital performance metrics committee, with representation from hospitals, CCOs, other health plans and performance measurement experts. The group will recommend 3–5 quality measures and related benchmarks to be used to reward hospitals for their performance. Operationally, the hospital quality pool will have similarities to the CCO quality pool and the inclusion of two CCO representatives on this hospital performance metrics committee will help ensure good conceptual alignment between the hospital and CCO metrics.

- [HB 2013](#) (2013) specifies that OHA and Oregon's Early Learning Council shall work collaboratively with CCOs to develop performance metrics for prenatal care, delivery and infant care that align with early learning outcomes.

Measure alignment for Oregon's transformation is facilitated by the Oregon Health Care Quality Corporation (QCorp), an RWJF Aligning Forces for Quality grantee that publically reports primary care quality metrics across payers in Oregon. Since 2008, QCorp has aggregated claims data from multiple payers to produce quality and utilization reports for consumers, providers, health plans, policymakers and employers. QCorp's measurement experts have advised OHA, Cover Oregon, and many of the entities mentioned above on metric selection, and calculation, supporting alignment across the state. Via a business associate relationship with the state and a SIM-supported contract, QCorp will validate performance data for the CCO quality pool and will assist with the production of the multi-payer dashboard described below and in Section D.

Appendix M contains a crosswalk of many of the measure sets described above, showing areas of alignment. Measure sets listed include: the CCO incentive measures; the 33 Medicaid "quality and access test" measures; the core performance measures listed in Oregon's 1115 waiver; PEBB and OEBB's 2013 measures; and the 13 measures that Cover Oregon will use in 2014; along with four federal measure sets: the CHIPRA and Medicaid Adult quality measures, the CPCI measures, and CMMI's core set.

Stakeholder engagement in measure selection
Oregon's statutorily created Metrics and Scoring Committee consulted extensively with payers, providers, and consumers in selecting its Medicaid incentive and performance measures and will continue to involve stakeholders as it strengthens measure alignment between payers.

- Building on the work of two predecessor groups, the OHA nine-member Metrics and Scoring Committee is responsible for identifying outcome and quality measures, including measures of for ambulatory care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCOs. The group also establishes and updates performance benchmarks for the 17 measures that determine

CCOs' eligibility for quality bonus payments. The membership includes three CCO representatives, three measurement experts, and three at-large members and meetings are always open to the public.

- As described above, several new stakeholder groups are forming to provide input on the selection of specific measures:
  - [HB 2118](2013) requires Cover Oregon to establish a health plan quality metrics work group, with representation from the Oregon Health Authority, PEBB, and OEBB (among other organizations) to make recommendations on appropriate health outcomes and quality measures for QHPs by May 2014.
  - [HB 2216](2016) creates a hospital performance metrics work group, with representation from hospitals, CCOs, and performance measurement experts.
  - [HB 2013](2013) calls for OHA and the Early Learning Council to collaborate on metrics relevant to early childhood.
  - [The OHA's Metrics and Scoring Committee](link) has convened a short-term dental quality metrics work group to identify a small number of measures that can be used to monitor quality of services when oral health is folded into CCO global budgets in 2014.

SIM performance measures

As explained above, Oregon intends to align its SIM metrics with those measures already identified for monitoring and evaluating Medicaid transformation efforts, rather than establishing a new set of performance measures for SIM specifically. A partial list of those measures that will be most relevant for monitoring Oregon's innovation model is given below, organized by the aims and drivers from Oregon's SIM driver diagram but more specifics are provided in Section R. (Please refer to Appendix I - Revised for the driver diagram.)

Driver diagram (see Appendix I Revised)	Relevant performance measures
Aim 1: Spread key elements of the coordinated care model to state employees, dually eligible individuals and other Medicare beneficiaries, and Oregonians with coverage through the exchange by the end of the SIM grant period.	• Degree and pace of spread of CCM key elements (e.g., plan and provider contractual language reflecting CCM; further spread and use of PCPCHs, range of participation in alternative payment arrangements, etc.)
Aim 2: Reduce PMPM cost trend (specified by target population) while improving or at least maintaining quality.	• PMPM cost trend, overall and by category (inpatient, Rx, primary care, specialty care, etc.) • Rates of ambulatory care sensitive admissions • Potentially avoidable ER use • ED and ambulatory care utilization • Patient experience measures
Driver 1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)	• Adoption of PCPCHs • Rates of ambulatory care sensitive admissions • Potentially avoidable ED use • Readmissions

Driver 2: Implementing alternative payment methodologies (APMs) to focus on value and pay for improved outcomes	• Proportion of total payment from CCOs to providers made under an APM • Variation among CCOs and hospitals in amount of quality pool awards • Multi-payer participation in APM pilots or learning collaboratives • Ratio of primary to specialty care payment
Driver 3: Integrating physical, behavioral, and oral health care with community health improvement	• Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) • Follow up on hospitalization for mental illness
Driver 4: Standards and accountability for safe, accessible, and effective care	• Number and scope of Oregon evidence-based care guidelines • Use of evidence-based care guidelines • Contractual and other mechanisms enforcing accountability for delivery system performance
Driver 5: Testing, acceleration, and spread of effective delivery system and payment innovations	• Rate of adoption of best practices identified and disseminated by the Transformation Center • Multi-payer participation in TC initiatives and learning collaboratives

Oregon understands that CMMI is interested in having SIM testing states use a yet-to-be determined number of performance metrics from its core measures list (v. 9, March 2013) for SIM reporting. As the crosswalk in Appendix M shows, there is a good deal of conceptual alignment and a fair degree of actual overlap between the CMMI core measure and Oregon's key measure sets described above. Given Oregon's transformation goals, the most relevant measures from CMMI's core list are those that reflect system-level change: integration of care across silos, care coordination, prevention, and patient experience. Some of the more clinical, population- or disease-specific measures are less pertinent.

Self-monitoring and reporting
With respect to reporting on progress toward its transformation goals, Oregon has made a strong commitment to accountability and transparency. Starting with the fourth quarter of 2013 (Q1 of the first SIM testing year) Oregon intends to publish a quarterly, statewide multi-payer performance report with quality measures, utilization statistics, and expenditure trends by major payer category. After the first publication, future editions will show changes over time.

The multi-payer report will build on one already created to monitor performance and progress among Oregon's CCOs and for the Medicaid program in aggregate. The first of these quarterly reports was published in May 2013 and included baseline data from 2011 for 11 of the 17 CCO incentive metrics and all 16 of the additional measures that make up the set of 33 statewide quality and access measures, described above. For each incentive measure, the report shows CCO-specific baselines, the statewide average, and the benchmark set by the Metrics and

Scoring Committee, which is typically based on national data for high-achieving Medicaid programs. Benchmarks also are being developed for the financial and utilization data, using vendor specifications for a "well-managed" population. The second report was published in August. Please see Appendix Z for both reports.

The Transformation Center will be the main vehicle for rapid cycle learning in Oregon. Building on the performance reporting mechanisms described in Section I, the center will support continuous improvement through multiple methods including learning collaboratives, technical assistance and coaching, as well as Innovator Agents to disseminate reforms and innovations. Key Transformation Center and OHA staff and the Innovator Agents have received extensive training from Institute for Healthcare Improvement staff on improvement methods. The Transformation Center will engage clinicians, CCO and other health plans along with health systems staff, and others to understand what new processes and new innovations are being implemented. Practices that have been successful in one setting will be collected and shared by the Transformation Center with other CCOs, as well as with external health systems and payers. Other stakeholders will be included to ensure broad community engagement. In addition, the center will provide data and research on external innovations by recruiting expertise and input from around Oregon, regionally and nationally on the best evidence-based practices and innovations in quality and payment that will facilitate improvement on problems that have been identified.

Please also see sections D and R of the operational plan for data collection and performance monitoring and evaluation information.

Section J	**Appropriate Consideration for Privacy and Confidentiality**

Contracts with the Oregon Health Authority and the Department of Human Services involving financial assistance provided under the Health Insurance Portability and Accountability Act or the federal regulations implementing the act (collectively referred to as HIPAA), require the contractors and all subcontractors to comply with HIPAA. These requirements cover the following conditions: diagnoses related to behavioral health, HIV/AIDS, and sexually transmitted diseases; confidentiality for minors; genetic information and treatment in correctional settings.

The terms provided in each contract are as follows:
1. *Privacy and Security of Individually Identifiable Health Information.* Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between Contractor and Agency for purposes directly related to the provision of services to Clients which are funded in whole or in part under this Contract. However, Contractor shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate Agency Privacy Rules, OAR 410-014-0000 et. seq., or Agency Notice of Privacy Practices, if done by Agency. A copy of the most recent Agency Notice of Privacy Practices is posted on the Agency web site at http://www.dhs.state.or.us/policy/admin/infosecuritylist.htm, or may be obtained from Agency.

2. *Data Transactions Systems*. If Contractor intends to exchange electronic data transactions with Agency in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transaction, Contractor shall execute an EDI Trading Partner Agreement with Agency and shall comply with the Agency EDI Rules.

3. *Consultation and Testing*. If Contractor reasonably believes that the Contractor's or the Agency data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Contractor shall promptly consult the Agency HIPAA officer. Contractor or Agency may initiate a request for testing of HIPAA transaction requirements, subject to available resources and the Agency testing schedule.

The Transformation Center is working with CCOs to track requests for assistance, data, or improvements to streamline service delivery, administration or other points of potential improvement in a secure, online database. The center has developed a policy statement that directs users to not include personally identifiable health information of any type in the issue tracker system. Please see Appendix EE for this policy statement.

Challenges
Oregon will achieve the three-part aim of better health, better health care and lower costs, first with public payers but later with private payers, by implementing the coordinated care model across most payers. Within Medicaid, the model of care is being implemented through Coordinated Care Organizations (CCOs). CCOs are the single point of accountability for health quality and outcomes in the population they serve. They are responsible to provide behavioral health services to their clients — including substance abuse screening, intervention and treatment. Each of Oregon's 15 CCOs is structured differently; however, they all operate within global budgets and manage care through networks of local providers. They are governed by partnerships of providers and community members.

To coordinate care most effectively, the CCOs need to understand and gain access to clients' substance abuse treatment history. However, the CCOs are concerned that 42 CFR Part 2, *Confidentiality of Alcohol and Drug Abuse Patient Records*, (Part 2) may prevent the sharing of these records. Specifically, the CCOs would like to know whether written client consent must be obtained before Part 2 records can be shared. Oregon is interested in working with SAMSHA, CMMI and CMS to eliminate any unnecessary barriers to the effective coordination of physical and behavioral health services.

Substance abuse treatment providers may share protected information without client consent with Qualified Service Organizations (QSOs) with written QSO Agreements (QSOA). A QSO "Provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services …" Disclosure is limited to information that is "necessary for the QSO to perform its duties." QSOs may not re-disclose protected information. CCO representatives would like to confirm that they properly serve in the role of QSOs and what the implications of QSO status are.

Roles and responsibilities

SIM-specific job descriptions have been developed for all the positions in the initial hiring plan. Additionally, there are SIM specific position description templates available to assist managers across the Oregon Health Authority to quickly develop position descriptions for the additional staff slated to be hired in the next two to four months.

Recruitment and hiring

Oregon has made several key health transformation hires recently. Cathy Kaufmann, M.S.W., has been appointed as the Transformation Center Director. Ron Stock, MD, MA has been hired as a consultant to serve as the Director of Clinical Innovation. Chris DeMars, MPH has been hired as the Director of Systems Innovation. Beth Crane, EMPA serves as the Director Operations for the Transformation Center and as the SIM Project Director. Alissa Robbins serves as the Communications Director for the Transformation Center. Eight Innovator Agents have been hired with expertise from public health, mental health and addictions, health policy advocacy, senior services, and health information management systems, with an additional .5 FTE Innovator Agent position posted for the newly certified CCO in Klamath County. This part time Innovator Agent position is scheduled to be filled by the end of November. Additionally the Learning Collaboratives manager and the Learning Collaboratives coordinator have been hired. The executive assistant to the Transformation Center director has been hired and the Transformation Center administrative assistant position has been filled The Transformation Analyst positions have been posted, initial interviews have been completed and final round interviews are scheduled be concluded and final selections made by the last week of October.

Under the management of the SIM project director, the SIM grant management group coordinates the administrative functions that support the SIM cooperative agreement. The SIM project director facilitates a biweekly operations meeting attended by members of the SIM leadership group and SIM project area leads to facilitate cross-agency communication, coordinate project activities and identify and resolve barriers to progress. Oregon has hired two SIM business managers who will work with SIM project area leads to provide budget to expense reporting, budget development and refinement, and contract payment support. These positions also will provide position and contract payment tracking, coordinate financial and program progress reporting and integrate these activities into the existing Office of Health Policy and Research operations as well as the Oregon Health Authority fiscal management structure. The grants management administrative assistant will be responsible for document management, scheduling meetings and conference calls, developing meeting agendas and minutes and providing overall administrative functions for the grants management group.

Additionally, in coordination with the shared services group of OHA and DHS, 1.5 FTE contracts and procurement staff have been brought on board that are embedded in the SIM grants management group. These technical staff track contracts from request to execution, review statements of work and develop Request for Proposals, amendments for existing contracts, special procurements and other purchasing required to support SIM activities.

Oregon has engaged additional human resources staff to assist in broad recruitment efforts to attract the best and most accomplished staff to support our transformation efforts. In addition to standard recruitment strategies, Oregon has been recruiting on professional job websites, such as the American Public Health Association Careermart, the Oregon Public Health Association, Oregon Health Research and Evaluation Collaborative, Oregon Health &Science University, Portland State University Masters in Public Health and Public Administration programs, Mac's List, CNRGY list serves and through OHA's list-serve designed to communicate OHA employment opportunities to diverse audiences.

The health transformation coordinator position with the OHA Public Health Division has been filled. This position will serve as a liaison between the Transformation Center staff and the SIM community health initiatives.

The long term care policy analyst position and the administrative position shared between long term care and health information technology has been filled. The long-term care Innovator Agents position descriptions have been developed and the recruitment has been posted. Interviews are planned for November with positions scheduled to be filled by December 1.

Please see Appendix S for a SIM position description template and more information on our staff recruitment process.

Staff training and support
Oregon has contracted with the Institute for Healthcare Improvement (IHI) to provide staff development and training opportunities. Throughout the initial start-up period, IHI has conducted a series of coaching calls to assist OHA and its Innovator Agents. To further prepare Innovator Agents and other key OHA staff, IHI conducted a three-day Science of Improvement (SOI) Program for 26 OHA staff aimed to develop a culture of innovation and cultivate consistent, advanced practice skills. Components of the training included methods such as how to manage teams effectively, how to effectively measure and use data for improvement and decision-making, and the human side of change. Please see Appendix Y for the IHI training agenda.

Other IHI-conducted plans for development and evaluation include:
- A Training and Professional Development Plan that would continue to advance and support key OHA staff, Innovator Agents and CCO leaders' capacity and skills to drive forward health system innovation;
- In September IHI collaborated with OHA in a strategy and visioning meeting focused on providing a clear understanding of the existing landscape and the capabilities across the emerging CCOs. This work has led to a proposal for additional support IHI can offer to assist OHA in building a culture of quality improvement, support CCO transformation projects and support our learning collaboratives.

Based on the information gathered during the site visit and subsequent coaching and communications, IHI has developed a written assessment of the macro-environment of Oregon's efforts that summarizes the current state of transformation and makes recommendations for next steps and suggests areas for additional strategic guidance for continued innovation and systems change.

The Transformation Center has launched three learning collaboratives with a fourth in development. Please see Appendix T, for detailed information on rapid cycle learning projects to advance quality improvement initiatives.

In addition, OHA is preparing and planning continued information and education to the agency staff regarding the ongoing CCO implementation and spread of the coordinated care model. Cross-agency discussions to complete the Governor's recent directive to the Oregon Health Policy Board also will enhance sharing and learning across the agencies and necessary implementation steps.

Section L	Workforce Capacity and Monitoring

Oregon's health care workforce is a vital engine for transformation. Ultimately, it is providers who will make the practice changes that lead to better care, lower costs, and improved health, and none of Oregon's transformation plans can succeed if there are not enough providers to meet the demand for care. The state has a number of workforce capacity development and monitoring initiatives under way that will help ensure that Oregon has the health care workforce needed to support transformation. SIM funding will provide key support for a few specific workforce development projects.

Workforce development
Health care workforce development planning in Oregon is coordinated and guided by the Oregon Health Policy Board's Healthcare Workforce Committee. Established by HB 2009, the same legislation that created the Oregon Health Authority and set many of Oregon's market reforms in motion, the committee's charge is to coordinate Oregon efforts to educate, recruit, and retain a quality healthcare workforce to meet the demand created by the expansion in health care coverage, system transformation and an increasingly diverse population. Committee membership incorporates a range of health care providers, educators, and workforce policy or development bodies, including the Governor's Workforce Policy Advisor, and the committee consults with the Oregon Employment Department as needed. The membership also includes representatives from the Oregon Health and Sciences University—the state's only academic medical center—and from Western University, a California-based institution that recently opened a medical school offering Doctor of Osteopathy degrees in Lebanon, Oregon. It should also be noted that both the President of OHSU and the immediate past president of the Oregon Medical Association sit on the Health Policy Board and help to provide direction to the Healthcare Workforce Committee's activities. Over the past three years, the workforce committee has analyzed workforce needs and capacity and has made policy recommendations on a variety of topics including standards and training requirements for non-traditional health workers and professional competencies that must be emphasized in training to prepare providers to succeed with new models of care delivery. Please see Appendix FF for examples of this work.

Oregon's transformation goals demand a robust primary care workforce and a new cadre of flexible, trusted, community-based practitioners who can bridge the community-medical system divide, such as community health workers, peer wellness specialists, and personal health navigators, and doulas (collectively known in Oregon as non-traditional health workers,

NTHWs). The following programs have been developed (or will be developed and/or expanded under SIM) to develop the workforce required for Oregon's innovation model:

- *Medicaid primary care provider loan repayment*: As part of its 2012 Medicaid waiver, Oregon committed to providing $2 million annually in educational loan repayment to primary care providers willing to serve Medicaid clients (and others) in underserved areas of the state for the 2013–2015 biennium. A bill establishing the program was enacted in May 2013 and OHA recently established the necessary administrative rules. The goal is to open for applications by Dec 2013. The loan repayment incentive will be available to a range of primary care provider types, with priority given to providers who are counted by HRSA for purposes of Health Professional Shortage Area (HPSA) designations.

- *NTHW workforce development*: First under the auspices of the Oregon Healthcare Workforce Committee and now guided by a 15-member NTHW Steering Committee of culturally and professionally diverse stakeholders, Oregon has developed standards for training and certification of NTHWs. Temporary rules currently detail the standards and the process for individual worker certification as well as training program approval (permanent rulemaking will begin after the close of the 2013 Legislative Session). Oregon has committed to certifying 300 new community health workers by December 2015, with the Department of Community Colleges and Workforce Development providing more than $600,000 in the 2013–2015 biennium for curriculum development and training. These workers will promote health and support care provision in a range of settings across the state.

- *Health care interpreters*: Ensuring linguistically and culturally accessible care is a key component of health care transformation. Oregon's Medicaid Coordinated Care Organizations (CCOs) are taking a lead role in this area by developing transformation plans to ensure that communications, outreach, member engagement, and service delivery strategies are tailored to cultural, health literacy, and linguistic needs. To help CCOs and others deliver coordinated services using qualified and certified health care interpreters, Oregon has committed to establishing the infrastructure needed to accelerate certification of health care interpreters. With SIM funding, the state will certify 150 interpreters by June 2016.

- *Support for practice change*: Due to SIM support, Oregon's Patient-Centered Primary Care Institute (PCPCI) and the new Transformation Center are providing resources and assistance to help Oregon's current and incoming workforce make practice changes in support of Transformation. The PCPCH Institute is working with 25 practices in a focused learning collaborative involving peer-to-peer education and consultation with technical experts. Technical assistance webinars are available to a statewide audience have covered topics such as: best practices for coordinated care planning; shared decision making and strategies to increase adherence to care plans; and involving patients and families as practice advisors. Templates and other practical tools are also available to all providers through the institute's comprehensive website.

- *The OHA Transformation Center will be the hub for technical assistance* on practice transformation across Oregon, connecting with innovators in state and outside experts to provide tool and resources around improvement science and on specific topics of interest to the provider community. The center is working with stakeholders and a newly hired

Director for Clinical Innovation and launched its first learning collaborative in summer 2013, focused on how to improve performance in the domains of care represented in Oregon's 17 incentive measures for CCOs. A learning collaborative on complex care coordination will launch in November. The Director for Clinical Innovation also will convene a Council of Clinical Innovators, who, along with the medical directors of the CCOs and the commercial health plans, will serve as advisors and champions for the implementation of key innovations in the delivery and coordination of care. In the meantime, the Transformation Center's Innovator Agents are working with CCOs to implement their transformation plans in a variety of areas.

- *Projecting future primary care workforce demand*: It is widely anticipated that ACA implementation in 2014 will increase the demand for care. It is much more difficult to predict how many primary care providers will be needed to meet that demand in the context of a rapidly evolving care model. Team-based care, greater use of non-physician providers, patient engagement and community-based prevention, and increasing adoption of HIT all change the level of provider demand. Oregon has contracted with workforce and economic modeling experts to help produce a range of Oregon-specific projections of primary care workforce need, adjusted for the likely effects of new models of care, during the next 10 years. The results of this analysis are expected by the end of 2013.

Monitoring workforce capacity

In addition to its workforce development efforts, Oregon has several mechanisms in place for monitoring general workforce capacity and level of provider participation in key transformation efforts:

Oregon Healthcare Workforce Database: Thanks to the foresight of Oregon's Legislature and the cooperative efforts of many of the state's health professional licensing boards, Oregon has a statewide workforce database that includes demographic and practice characteristic information from 10 boards representing 21 major health care professions in the state:

- Dentists
- Dental hygienists
- Dietitians
- Registered nurses
- Nurse practitioners
- Certified registered nurse anesthetists
- Clinical nurse specialists
- Licensed practical nurses
- Licensed professional counselors and therapists
- Certified nursing assistants
- Occupational therapists
- Occupational therapy assistants
- Pharmacists
- Pharmacy technicians
- Physical therapists
- Physical therapist assistants
- Physicians
- Physician assistants
- Podiatrists
- Psychologists
- Social workers

The database has been in place since 2010 and is managed by the Oregon Health Authority. Because the data are collected as part of the license renewal process, participation is close to 100% for many licensed professions. Data elements include practitioner demographics, languages spoken, education, employment status, work setting, specialty, practice location, and

anticipated changes in practice. Some professionals — physicians, physician assistants, nurse practitioners, and dentists — also provide or will soon provide information on the payer mix for their current patients. The workforce database will be a valuable data source for ongoing tracking of health care workforce size, distribution, and capacity during the SIM period.

The most recent analysis and report from the Workforce Database is [included among the evidence accompanying this Operational Plan](). Comparing 2009/10 and 2011/12 licensing data, the majority of the health care professions listed above experienced an increase in Oregon licensees, including physician assistance, RNs, pharmacists, and physical and occupational therapists. However, the number of licensed dentists practicing in Oregon dropped by 8% and the number of physicians practicing in Oregon declined by 3%. There was a 2.9% net reduction in primary care practitioners (MDs/DOs, PAs, and NPs) identifying an Oregon practice address. The OHPB Healthcare Workforce Committee described above is focusing its efforts on strengthening the primary care workforce.

Oregon Physician Workforce Survey: The Oregon Health Authority has conducted a dedicated physician (M.D. and D.O.) workforce survey every two to three years since the early 2000s. The survey generates important information about physician attitudes and opinions, as well as demographics and practice characteristics. It has been a key data source for monitoring physician acceptance of Medicaid, Medicare, and commercial payment and, perhaps more importantly, reasons for non-acceptance when that is the case. For the 2012 survey, Oregon added a small number of questions regarding physicians' awareness of and participation in health care reform efforts, with the intent of using the 2012 data as a baseline to assess future changes. The question included items about work in multidisciplinary teams, care coordination, and ability to access non-medical supports and services for patients, as well as participation in patient-centered primary care homes and CCOs. The Oregon Health Authority currently is making plans for future rounds of the Physician Workforce Survey.

Non-traditional health worker and Health Care Interpreter Registries: In conjunction with the certification process for NTHWs described above, Oregon is creating a statewide registry of certified non-traditional health workers. (To qualify for Medicaid reimbursement, NTHWs must be certified by OHA through successful completion of an approved training program and enrolled in the registry.) The registry is currently in development with an anticipated launch date in fall 2013.

The Health Care Interpreter (HCI) Registry is a database of working health care interpreters in Oregon. The registry includes three types of interpreters:
- Those who have met only the requirements for registration;
- Qualified health care interpreters (who have demonstrated proficiency in both English and a second language, and have met formal HCI training and work experience requirements);
- Certified health care interpreters (those who have established their interpreting skills and medical knowledge as well as language proficiency via oral and written examination, along with formal training and experience).

Not all active interpreters choose to register but the HCI registry will enable the state to track the number of registered interpreters throughout the SIM period.

Documentation of training capacity: In 2010 and 2012, the Oregon Healthcare Workforce Institute produced an [inventory of Oregon health professions training programs](#) for the OHPB's Healthcare Workforce Committee. The latest version is included among the evidence Appendix GG for this Operational Plan.

Data regarding the provider community's level of engagement in SIM activities and Oregon's health care transformation will more broadly come from a variety of sources:
- Oregon's Patient-Centered Primary Care Home (PCPCH) Program records can provide timely data on which clinics or practices across the state have been recognized as PCPCHs and at which tier level (or level of development). Information on practices' geographic location and other characteristics are also available.
- As described above, the Oregon Physician Workforce Survey now includes items regarding physicians' awareness of and participation in health care reform efforts, including practice changes working in multidisciplinary teams and formal affiliation with a PCPCH or CCO. The survey data can be run by provider specialty and geography and compared to the 2012 baseline.
- As part of its own tracking, the OHA Transformation Center will maintain records of health care provider participation in the many different learning communities, trainings, and technical assistance events that the center provides. The center's Council of Clinical Innovators (along with the medical directors of each CCO and other health plans) will act as champions for key innovations in the delivery and coordination of care with their colleagues and with Oregon's physician, specialty and other provider associations.

Apart from direct workforce capacity monitoring, Oregon will track a number of access-to-care metrics as part of its SIM performance measurement plan. Depending on the population, measures are likely to include survey-based measures of beneficiaries' satisfaction with their ability to access care (e.g., CAHPS items or similar), claims-based measures of ambulatory and ED utilization or timely prenatal care, or others. See section (I) for more details.

Section M	**Care Transformation Plans**

Oregon is committed to developing transformative practices across the health delivery system. With SIM funding, there is work underway with multi-payer stakeholders to share best and promising practices across the delivery system through the Transformation Centers rapid cycle learning system; foster innovation in primary care clinics across the state through the PCPC Institute; and a multitude of other SIM-fueled activities. Coupled with new funding via Oregon's legislature through the transformation fund grants focused on enhancing care coordination, Oregon is set to launch Test Year 1 to demonstrate its multi-pronged approach to achieving the Triple Aim. The state is partnering with the Oregon's healthcare and business leaders with the Oregon Health Leadership Council cultivating opportunities to collaborate on multi-payer initiatives on payment reform and transparency. As we spread the coordinated care model, we are collaborating with the Oregon Association of Hospitals and Healthcare Systems to work with

hospitals, especially the smaller ones, as they work with their communities to transform care. Below we describe the transformation work supported and leveraged by SIM funding to further spread innovation across the delivery system.

CCO transformation plans
Another function of the Transformation Center is to develop, launch and evaluate rapid cycle learning. Oregon has adopted the Breakthrough Learning Model developed by the Institute for Health Care Improvement as the basis for design and implementation of our learning collaboratives. We will continue to engage IHI in offering the Transformation Center staff coaching, technical assistance and to act as faculty for Oregon's learning collaboratives. The Transformation Center's is currently offering three learning collaboratives with a fourth scheduled to be added in the Oct-Dec 2013 quarter. Please see Appendix T, Learning Collaboratives Initiatives for a list of the learning collaboratives underway and planned as well as meeting agendas and minutes. Additionally we are working closely with CCOs and other providers to coordinate training opportunities that spread innovation. Please see Appendix CC for an announcement for the Screening, Brief Intervention Referral to Treatment (SBIRT) training sponsored by Providence Health Plan, MODA Health, and HealthShare; that was broadly disseminated by Innovator Agents, health systems, CCOs and through other channels. Funded through Oregon's HRSA State Health Access Planning (SHAP) that is just ending, OHA launched the Patient-Centered Primary Care Institute in September 2012. It is the centralized, "front door" for primary care provider-level quality improvement training and technical assistance. The institute conducts the PCPCH Learning Collaborative with 25 practices from across Oregon, which includes in-person and virtual training, and practice facilitation services. The institute also conducts monthly webinars on core transformation and quality improvement topics, which are recorded and available to all providers at no cost. Furthermore, the institute website provides free, downloadable tools and resources related to quality improvement topics and adopting the PCPCH model of care. In summer 2013, the institute is conducting a "Technical Assistance Learning Network" and train-the-trainer program to increase the capacity and quality of technical assistance (TA) experts to support primary care transformation throughout the state. Recently, the Center for Health Care Strategies wrote an article featuring Oregon's provider-level TA supports. The Patient-Centered Primary Care Institute works with various stakeholder community-based organizations to leverage existing expertise via the Expert Oversight Panel, a multitude of technical assistance subcontractors, and the "Technical Assistance Learning Network," all designed to bring together TA experts, academic medical centers, independent physician associations, and other learning networks to identify resources gaps and strategically deploy needed provider-level supports.

Long-term care services (LTSS) and support systems alignment
Innovator Agents, specializing in innovation within the long-term care system will be joining Transformation Center Innovator Agents to coordinate, amplify and accelerate change related to long-term supports and services. The LTC Innovator Agents will focus on the promising mechanisms identified to achieve system-wide alignment between CCOs and the LTSS system including: sharing and educating about CCO and LTSS systems, increasing communication and coordination, especially around the needs of high cost utilizers, interdisciplinary care teams; shared-care plans; sharing client level data between CCOs and LTSS systems; and bringing health services to individuals in their homes or community-based care facilities. OHA and the

Oregon Department of Human Services (DHS) are in the process of implementing a shared accountability system with four components:

- Specific, contractual requirements for coordination between the two systems were implemented in 2012 for CCOs and LTSS local offices;
- All CCOs are required to have jointly developed memoranda of understanding (MOUs) with the local LTSS field offices in their area that describe clearly defined roles and responsibilities;
- Reporting and transparency of performance metrics related to better coordination between the two systems; and
- Incentives and/or penalties linked to performance metrics applied to the CCO and the LTSS system.

This sets the stage for building links from LTSS to other sectors of Oregon's health care delivery system, as we spread the coordinated care model. Smooth transitions and enhanced quality of care to and from the LTSS is essential for an individual and family-centered care model. Please see Appendix W for a template MOU between CCOs and LTSS field offices.

Clinical standards, supports and patient engagement
Oregon's Health Evidence Review Commission (HERC), building on decades of work on the Prioritized List of Health Services is developing evidence-based decision tools that are grounded in extensive research and expertise on treatment effectiveness in achieving meaningful clinical outcomes. Disseminated through the Transformation Center, these tools along with others such as the "Choosing Wisely" multi-specialty effort to get the right care at the right time will provide guidance to providers, CCO clinical advisory panels and others across into the private sector in delivering clinically- and cost-effective care. These resources also will provide the PEBB Board, other health plans, providers and health systems the best available evidence for benefit design and APMs. Oregon also will support payers and providers with evidence-based approaches and tools for patient activation and informed decision-making. Expanding availability of clinical guidelines as well as evidence-based patient engagement and shared decision-making tools directly engages providers and patients in health systems transformation efforts. Efforts through the Transformation Center will include training for providers in the use of these tools as well as education for individuals and their families.

Reducing health inequities is a key support to achieving the three-part aim. SIM support will build on regional health equity coalitions, efforts to expand health care interpreters and other efforts in Oregon to enhance communication and education across all populations and reduce the barriers that limit some from accessing the necessary benefits and services that can improve and maintain their health.

Modernized information systems
Oregon has long recognized the potential for improved data systems to contribute toward better health, and has initiated efforts to modernize information systems that support health care and other programs. In addition, Oregon will ensure streamlined access to Cover Oregon and interaction with Medicaid information systems to develop capacity for robust analytics. In the special terms and conditions of Oregon's recent Medicaid 1115 demonstration waiver approval,

Oregon committed to accomplish quality improvement activities and payment reforms that are heavily reliant on clear, reliable and timely data collection and analysis.

All health information technology-related (HIT) efforts are coordinated within and outside OHA. For internal coordination, OHA has created an HIT Policy and Program Steering Committee in which agency leaders address alignment of HIT efforts across program areas, including HIE, the EHR incentive program, analytics, accountability, behavioral health, and public health. OHA closely coordinates with other statewide HIT initiatives, such as O-HITEC, Oregon's Regional Extension Center, which is responsible for direct technical assistance to providers and clinics in launching certified EHR technology and helping providers meet meaningful use requirements. OHA also coordinates with the Oregon Health Network (OHN), Oregon's FCC Rural Health Care Pilot Program grantee, which focuses on extending broadband connectivity to all areas of the state.

Community health support
Integration with the public health system in Oregon has been ongoing and includes partnership with local public health authorities (LPHAs) and the Council of Local Health Officials (CLHO), and the OHA Public Health Division (PHD) in order to build infrastructure that supports health system transformation in Oregon. PHD staff have participated in the review of CCO applications and led the CCO Transformation Plan review for the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) component. Many LPHAs have been involved in the development of CCOs. Several local health officials serve on boards and/or advisory committees of CCOs. In May 2013, CLHO held the first meeting of the Health System Transformation subcommittee comprised of local health administrators and other LPHA staff who are working to partner with CCOs on community health initiatives. The primary focus of this committee is to support LPHAs operating as a system and aligning around strategic directions, priorities, and broad operational approaches related to Oregon's health system transformation and to develop system improvement recommendations to CLHO and OHA. Working to implement primary and secondary prevention strategies recommended by the U.S. Preventive Health Services Task Force Guides to Community and Clinical Preventive Services, OHA plans to facilitate CCOs' partnerships with local public health authorities and other local organizations to reduce the leading causes of disease, injury, and death while also driving down the leading drivers of health care costs in their communities. These collaborations will use evidence-based clinical as well as community preventive strategies to address a specific health need, using a "flood-the-zone approach." The goal is for communities to make lasting changes in practice and/or policy to support prevention. This will impact PEBB members and dually eligible individuals in these communities, but also spread to other Oregonians as community efforts align with the clinical delivery system around the Triple Aim.

Section N	**Sustainability Plans**

Sustainability through flexible growth and replication
Because the coordinated care model allows for local flexibility, it is an ideal platform for further innovation and for replication to other payers and populations and projects sustainability after the three-year testing phase. Oregon has invested the necessary time and resources to lay the foundational groundwork to advance the model first in Medicaid by working with key

stakeholders at the state level (including legislators, beneficiaries, health plans, providers, and advocacy organizations) and CMS (through its 1115 waiver and ACA 2703 Health Homes SPA). The 1115 demonstration waiver is under way and projections are that the coordinated care model will generate both federal and state Medicaid savings, a crucial element of long-term sustainability. Support from the SIM funding opportunity will provide the upfront investment and framework that Oregon will be able to support and continue well beyond the three-year testing phase by reinvesting a portion of the projected savings.

OHA currently purchases health care for almost 850,000 people, or about one in four insured Oregonians, and this will increase by an estimated 240,000 people with the 2014 Medicaid expansion. By spreading this model to those who are dually eligible for Medicare and Medicaid, to state employees, and to the Health Insurance Exchange we will create a "tipping point" for transformation of Oregon's entire health care delivery system. This transformation can ensure real and sustainable improvements in health status, enhanced patient experience of care and lower costs. Oregon expects to save a total of $372 million over the three-year SIM demonstration period from these efforts, but these efforts set the stage for continued savings across the system.

Sustainability plan and goals
As the Transformation Center only recently launched (April 1, 2013), a detailed sustainability plan has not yet been developed. However, by the end of the first year, the Transformation Center will begin to prove its value in accelerating and spreading transformation and the OHA Director and OHA agency leadership will begin working with the OTC Steering Committee and other health system leaders to establish a sustainability plan. A sustainability plan for the center will be completed by Sept. 1, 2014.

Oregon will sustain the investments made by CMMI in several ways: many of the staff, consultants and contractors will initiate activities but will ramp down or be eliminated over time. Some ongoing costs, including the Transformation Center, will eventually be funded in whole or in part by the savings generated out of the model. Over time, the center may transition to a public-private collaborative supported in part by fees from participating health sector entities and/or foundation grants.

Sustainability with contractors, consultants, and the Transformation Center
The long-term sustainability of Oregon's program after the grant period ends involves intense contractor and consultant support during the startup and initiation stages, with phase out as the program gains traction. In describing the challenge of health care transformation, Governor Kitzhaber often makes an analogy to a ropes course. He describes the moment when, in order to reach the rope that will swing you to the "new" platform, you have to let go of the "old" rope. In Oregon's SIM proposal, contractors and/or consultants will be used strategically to help providers, plans and OHA let go of that "old" rope and grasp the "new" rope that will move the state toward the Triple Aim. For this reason, contactor and consultant support is budgeted most heavily during startup and the first phases of project implementation, and will ramp down or be eliminated as critical functions become fully operational.

Oregon also is contributing a real investment, beyond SIM funding, in state staff in the Transformation Center and elsewhere to support the critical functions of health care transformation on an ongoing basis. Key positions include the Transformation Center director and CCO Innovator Agents. Through collaborative working relationships with consultants and contractors, these staff and others will gain expertise and Oregon will build internal capacity that can be carried forward beyond the grant period. Barriers to in-sourcing some activities at the outset of the grant period include the pace of transformation to which Oregon has committed itself and the perennial state restraints of government pay scales and limited appetite for new positions at the state Legislature.

Section O	**Administrative Systems and Reporting**

Programmatic and financial oversight
Oregon's SIM grant project is managed within the Office for Oregon Health Policy and Research (OHPR), with a dedicated project manager, Beth Crane, and with OHA Chief Medical Officer and OHPR Administrator Jeanene Smith, M.D., as the principal investigator and single point of accountability to CMMI for the SIM project. Dr. Smith has extensive experience managing complex projects and grants, and will be responsible for ensuring that the project is meeting the scope, budget, and timelines agreed to with CMMI, and will report to the Director of OHA and the OHA chief of policy on project progress and/or issues. Ms. Crane also has extensive experience with complex grant management and operations will report directly to Dr. Smith, and will manage all aspects of the project, ensuring that OHA cooperates with CMMI monitoring plans and that reports, data and other information requested by CMMI are submitted in a timely manner to allow for the evaluation of the project results.

Grant management activities will be conducted by the fiscal and administrative staff supported by the SIM grant. This includes business managers who report to Crane, and who will serve as fiscal and administrative support to SIM program area managers, providing monthly expense to budget reporting at both the SIM program area level and at the total grant level, tracking contract status and payments across the project, and assembling the required quarterly fiscal reports. The business managers also will be the coordinators for assembling and consolidating the quarterly SIM program area reports. The accounting codes for each program area have been set up and will allow for detailed reporting as well as macro rollup at the grant level across all project areas. The contracts specialists will support the SIM program area managers to develop sound contracting instruments in a timely manner and serve as the point of contact between the program and the Department of Justice to review contracts for legal sufficiency. As the load of contracts decreases, the FTE also will be reduced, based on program need. The administrative support positions will provide general support to ensure timely communications, developing meeting agendas and recording meeting minutes, posting documents on the appropriate websites and managing scheduling for coordination meetings. The SIM grant management staff will integrate SIM activities into the operations of the Office of Health Policy and Research and the other program areas within the Oregon Health Authority with SIM activities including: Office of Health Analytics, The Division of Medical Assistance Programs, the Public Health Division, and with our sister agency, the Aging and People with Disabilities Program within the Department of Human Services.

The SIM project manager facilitates a biweekly SIM operations meeting attended by members of the SIM leadership team as well as the SIM project area leads. This meeting focuses on coordinating activities, facilitating cross-agency communication, and identifying and resolving barriers. Leadership team members will raise issues and concerns to OHA and other necessary agency heads and/or the Governor's Office rapidly if necessary to ensure success of the SIM activities.

All SIM quarterly reports are reviewed and approved by the SIM principal investigator and the SIM Steering Committee prior to submission. Please see Appendix R for our first SIM Quarterly report which describes our progress in the first two periods of the implementation period. Subsequent reporting on the second half of the implementation period will be provided in the final report on the implementation period due December 30, 2013.

Please see the SIM governance model diagram in Appendix C, and the SIM organizational chart in Appendix Q for more information.

Section P	Implementation Timeline for Achieving Participation and Metrics

A detailed SIM project management plan with milestones can be found in Appendix K Revised. Please also see Appendix J Revised for a high-level visual timeline of Oregon's innovation and health care transformation plans and Appendix D Revised for Oregon's vision of the evolution of coordinated care models.

Section Q	Communications Management Plans

Stakeholder engagement
The state has been working with stakeholders on reforming health and health care since 2007, when the Oregon Health Fund Board began its work. Regular communication with stakeholders was essential after the passage of legislation that moved the coordinated care model forward for Medicaid participants in 2011 and 2012. These extensive, inclusive efforts will continue as part of the extension of the coordinated model of care to all payers.

Consistent with Oregon's reputation as a leader in the public process for health policy development, Oregon committed itself to obtaining a wide range of input and feedback throughout the process of planning for health systems transformation, CCO implementation, and this proposal. These efforts have included: (1) Oregon Health Policy Board (OHPB) meetings, work groups, and public comment; (2) the OHPB's targeted expert and stakeholder work groups (more than 130 participants); (3) OHA's Health System Transformation Community Meetings (more than 1,000 participants, eight cities); (4) tribal consultations with the nine federally recognized tribes in Oregon; (5) PCPCH development stakeholder groups; and (6) individual staff engagement with advisory councils, committees and other stakeholders to gain input and feedback throughout the process. There were more than 76 public meetings in total leading up to

the development of the overall CCO implementation proposal and almost 350 key stakeholders and experts gave hours of their time to help build and refine the coordinated care model.

Other governmental stakeholders engaged in this process have included: the Oregon Health Policy Board; Healthcare Workforce Committee, Early Learning Council, Metrics and Scoring Committee; Health Evidence Review Commission; Health Information Technology Oversight Council, and the Medicaid Advisory Committee.

Recent Transformation Center efforts include meeting regularly with Coordinated Care Organization leadership; coordinated care CEOs; CCO Quality Improvement and Health Outcomes Committee; CCO Community Advisory Councils; ongoing efforts will also include meeting with community organizations, provider including specialty associations and stakeholders, including those in the private sector. The Transformation Center will establish its steering committee at the start of year 1, with broad representation.

Stakeholders inclusive of public and private payers have been essential partners. The state has been working closely with the Public Employees' Benefit Board and will also coordinate and work closely with the Oregon Educators Benefit Board. State leadership, including the Governor's Office and the Director of OHA, consult frequently with the Health Leadership Council (OHLC), which is a private collaborative of health plans, hospitals and physicians working to develop practical solutions that reduce the rate of increase in health care costs and premiums. (The OHA Director is an OHLC member.) Additionally, OHA works closely with Cover Oregon, Oregon's Health Insurance Exchange; the OHA Director has a statutory seat on the Cover Oregon Board and meets regularly with the executive director of Cover Oregon.

Providers and caregivers have been key stakeholders have been essential partners and will remain essential. The Oregon Association of Hospitals and Health Systems (OAHHS), the Oregon Medical Association (OMA), the Oregon Academy of Family Practice (OAFP) and the Oregon Health Care Association (OHCA) as well as representatives of individual hospitals and clinics were all participants in the extensive planning process that led to the coordinated care legislation. Another example of the type of outreach extended to these partners was the long-term care listening tour, where the state engaged stakeholders around the future of long-term services and supports in Oregon.

The public health stakeholders, who are essential in integrating health care and public health, will continue to be a part of the transformation process. Some include the Conference of Local Health Officials; local health departments; the Public Health Advisory Board; the Oregon Sovereign Tribes; Regional Equity Coalitions; the Department of Education; the Oregon Healthy Teens and BRFSS Advisory Groups.

Social services, including medical transportation and education groups such as the Early Learning Council, housing authorities, and partners at the Department of Human Services are stakeholders that the state consistently communicates with often. Patients and their families have been included in numerous and essential ways including roles on boards and committees, as well being participants in public meetings.

See Appendix G for a visual representation of relationships between OHA and key health system transformation stakeholders and initiatives.

Multimodal techniques and external communications with each group of relevant stakeholders

Techniques to reach each of the audiences have been and will continue to be tailored to each specific stakeholder's needs and preferred communications and engagement methods. Public or in-person meetings have been a primary method of engagement for many stakeholder groups and will continue to be, including Oregon Health Policy Board meetings. Public meetings include public testimony, which commonly includes testimony from patients and their families. Smaller committee meetings have also been held, as the state worked to design and implement the coordinated model of care for Medicaid participants; this approach to involve stakeholders via face-to-face meetings supplemented with electronic option such as webinars continues to be a preferred mode for many stakeholder groups. Most meetings include a public call-in, live video stream or webinar option. Documents such as meeting agendas are also posted to websites available to the public.

Communications with external stakeholder groups began as early as 2007 with the work of the Health Fund Board (the Oregon Health Policy Board's predecessor). Working closely with these groups has remained critical as Oregon works to improve health and health care, including spreading the elements of the coordinated care model. Communicating with stakeholders was essential as the work of the Health Policy Board took off in 2009. The extensive committee work that took place in 2010 under the board's leadership helped form Oregon's Action Plan for Health, released in early 2011. This plan and the work of stakeholders' communications remained essential as everyone worked together to develop plans for the coordinated model of care, Health System Transformation, in 2011 and 2012 with the passage of state legislation. Relationships with these groups have continued and will continue as this work moves forward.

A variety of techniques were used to communicate with stakeholders, including public meetings with remote options; public forums and listening tours across the state; regular meetings with a variety of community and stakeholder groups; regular in-person meetings; and communication by telephone. External communications also have continued electronically, by way of emails to stakeholder group distribution lists and more direct electronic communication with key groups to supplement in-person meetings and communications by phone. Mass media have also been employed at key times, as well as social media to reach stakeholder groups, including patients and their families. As the CCO model moved forward, direct mail was used to reach patients, their families and caregivers. Direct mail will continue to be used as needed to reach patient, families, caregivers, providers and other stakeholders.

Other specific examples of external communications include:
- OHA's Public Employees' Benefit Board (PEBB) seeks to engage public employees in their health and encourages them to seek care in recognized primary care homes by offering a reduction in cost-sharing. PEBB conducts communication and outreach to public employees about what the PCPCH model of care means, and why they should select high-quality primary care services.

- A number of "Success Stories" are published on the OHA website and highlight how Oregon's health system transformation, including improved care coordination and patient-centered primary care homes, directly impacts patients and families' health and health care
- The PCPCH Program conducts outreach and engagement activities for patients and families via a consumer-friendly website, educational video, interactive map of recognized primary care homes, posters, window decals, and patient brochures available in seven languages. These brochures are used throughout the state by recognized primary care homes to explain the model of care and engage patients in their health.

See our revised Stakeholder Engagement Plan (Appendix E) for detailed information about stakeholders and the rationale for their involvement; the engagement method; stakeholder roles and responsibilities and timeframe. This appendix was revised for the October submission to reflect stakeholder categories suggested by CMMI.

The Oregon Health Authority Office of Communications and the Transformation Center director will oversee and execute all components of the communications plan during the grant period. A Transformation Center communications director will be appointed as the responsible party to carry out health transformation communication activities.

Section R	Evaluation Plan

Oregon has a long history of health services research and evaluation of its policy and implementation of the Oregon Health Plan. The State has actively partnered with local and national researchers over the years to optimally understand the impacts of the state's efforts to expand coverage and other health care policies. We have worked diligently during our 1115 Waiver negotiations to consider how best to evaluate the coordinated care model in Medicaid, but with SIM funding, we now can fully actualize the evaluation of the impact of the coordinated care model on Oregon's delivery system overall, in addition to the factors related to specific activities under SIM such as the Transformation Center. The various state levers Oregon is using to spread the model and work towards the Triple Aim will not only inform Oregon's next steps, but also other states undertaking transformation.

We understand that CMMI has contracted with Research Triangle Institute (RTI) and various subcontractors to plan and conduct a national evaluation for SIM and to provide technical assistance to states. As more information about those evaluation plans and requirements becomes available, Oregon will work with CMMI and its contractors to develop plans for data provision and participation in the national evaluation. This section describes Oregon's own plans for tracking and monitoring progress of SIM implementation and for assessing the impact of the coordinated care model (CCM) in the state.

Evaluation objectives
As described in Oregon's SIM application, Oregon has three primary evaluation objectives for its SIM project:

1. Assess the success of the overall model (CCM) in Medicaid, as outlined in the state's landmark 1115 waiver:
   - Research question: Is the state achieving targeted PMPM cost trend reductions in Medicaid while at least maintaining, if not improving, quality and access?
2. Test the spread of the CCM to other payers and populations, particularly public employees and Medicare:
   - Research questions: What is the degree and pace of spread of CCM key elements (e.g., patient-centered primary care homes, care coordination and management, accountable payment methods, etc.) to non-Medicaid payers? Are other payers or populations experiencing cost trend reductions and improvements in quality?
3. Assess some of the model's key payment, delivery system, and support elements individually to determine to what extent these elements contribute to overall success:
   - Research questions: Which of the key elements, or which combination of key elements, are most strongly associated with success for Triple Aim outcomes? Is there any evidence regarding whether and how community setting, payer, or other contextual differences affect which model elements or combination of elements are most predictive of success?

Evaluation plans
Operationally, Oregon's SIM evaluation will have two main components: (1) a self-evaluation that will track Oregon's progress on its cost and quality goals and provide timely information for course adjustments or improvements processes; and (2) a multifaceted outcome assessment to evaluate the spread and impact of the CCM, conducted with the help of independent researchers with expertise in evaluation and health systems research. Oregon does not intend to contract with just one entity for evaluation of its SIM efforts. Instead, the state will let contracts for particular elements of data collection, analysis, and evaluation as needed and will make strategic investments in internal capacity for data analysis and reporting in support of transformation. Existing contracts are described under the 'Contracts' heading later in this section.

The key self-evaluation and outcome assessment activities that Oregon has planned for each objective and research question are shown in the table below. Plans are still being discussed and refined and the outcome assessment components in particular should be read here as not yet completely finalized, but as providing a strong direction as we launch into Test Year 1.

Oregon SIM Evaluation Plan Outline

Research question	Targets	Self-Evaluation Measures	Frequency	Outcome Assessment
Objective 1: Assess the success of the overall model (CCM) in Medicaid, as outlined in the state's July 2012 1115 waiver				
Is the state achieving targeted PMPM cost trend reductions in Medicaid while at least maintaining, if not improving, quality and access?	• 1 percentage point trend reduction in Medicaid per-member per-month (PMPM) expenditures by FY 2014, from 2011 baseline; • 2 percentage point by FY 2015 • Maintenance or improvement in an aggregate score of approximately 30 quality and access performance measures	Please see Appendix L and M for Medicaid quality and access performance measures. Expenditure trend tracking methods are outlined in Section B (page 325) of the Medicaid waiver Accountability Plan at: www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf#page=161 . Data source is primarily Medicaid claims data but also includes survey data sources (e.g. for patient experience of care measures), EMR data (e.g. for clinical measures such as hypertension control) and programmatic data (e.g. Patient-Centered Primary Care Home enrollment).	Expenditures and most performance measures assessed quarterly, except where data source is updated less frequently. Please see Appendix Z for an example quarterly report.	Independent contract for a rigorous analysis of the association between state transformation activities for Medicaid and changes in Medicaid access and quality, controlling for external forces at two time points: • Once at the midpoint of Oregon's current 1115 waiver to enhance learning for state and federal stakeholders (results anticipated in early 2015); • Once at the end of the waiver period (July 2017) for a summative assessment.
Test the spread of the CCM to other payers and populations				
What is the degree and pace of spread of Coordinated Care Model (CCM) key elements beyond Medicaid?	• Coverage for PEBB enrollees aligns with CCM starting Jan. 2015 • Coverage for QHP and OEBB enrollees aligns with CCM starting Jan. & Sept. 2016, respectively • Key elements of CCM reflected in coverage for dual eligibles and other Medicaid beneficiaries by Jan. 2016	**Overall measures:** ■ Assess coverage provisions and plan designs for PEBB, OEBB, Exchange-based coverage, and duals to ascertain whether they include CCM elements ■ Number of lives in above lines of coverage ■ Physician awareness of and participation in Coordinated Care Organizations (CCOs) and Patient Centered Primary Care Homes (PCPCHs) (source: OR Physician Workforce Survey) **Measures specific to CCM key elements:** *Care coordination, especially through PCPCHs* ■ Number of recognized PCPCHs statewide and payer mix for those clinics	Oregon intends to track these measures quarterly where the data source permits and at least annually for all. Programmatic information is the primary data source for this tracking (e.g., information from the PCPCH Program on number of primary care homes statewide; data from OHA's Transformation Center on multi-payer	Potential contract with independent entity or entities to use APAC data to assess whether utilization, referral or expenditure patterns observed within Medicaid population before and after CCO implementation are reflected in PEBB, OEBB, commercial coverage, or other populations as model elements spread.

Research question	Targets	Self-Evaluation Measures	Frequency	Outcome Assessment
		• Number (and # covered lives) of non-Medicaid plans paying PCPCHs differently • Number and range of participants in Transformation Center complex care learning collaborative • Measures of investment in primary care across payers (TBD – related recommendation currently being considered by the Oregon Health Policy Board) *Alternative payment mechanisms* • Number (and # covered lives) of non-Medicaid plans paying PCPCHs differently • Proportion of PEBB & OEBB plan payments to providers that are "value-based" / not FFS • Number and range of participants in Transformation Center future alternative payment methods learning collaborative(s) *Integration of care* • Integration of care provisions in PEBB, OEBB, Exchange-based coverage, and duals plans • Selected measures of shared accountability between Medicaid CCOs and long-term care services and supports (in development and to be finalized in 2014) • Number of traditional health workers certified and employed in Oregon • Number and range of CCO-local public health collaboration projects • Number and range of CCO-Early Learning hub collaborations *Standards and accountability for safe, effective care* • Rate of EMR adoption among eligible providers and hospitals statewide, and among CCOs and recognized PCPCHs • Rate of participation in Oregon clinical data	participation in learning collaboratives or improvement initiatives).	

Research question	Targets	Self-Evaluation Measures	Frequency	Outcome Assessment
		registries ▪ Number and range of dissemination for clinical guidelines produced by the OR Health Evidence Review Commission *Testing, acceleration & spread of best practices* ▪ Number and range of multi-payer convening opportunities offered by the Transformation Center ▪ Number of clinicians involved in Council of Clinical Innovators ▪ Participant assessments from Transformation Center learning collaboratives and other events		
Are other payers or populations experiencing cost trend reductions and improvements in quality or access?	• 2 percentage point trend reduction in PEBB per-member per-month (PMPM) expenditures by FY 2016, from 2011 baseline; • 1 percentage point trend reduction in PMPM expenditures for dual eligibles by FY 2016, from 2011 baseline • Maintenance or improvement in select quality and access measures; see columns at right	For PEBB, OEBB, Medicare and – over time – individuals with Exchange-based coverage: • PMPM expenditures total and by category (inpatient, Rx, primary care, specialty care, etc.) • Rates of select ambulatory care sensitive admissions • Potentially avoidable ER use • Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) • Follow-up after hospitalization for mental illness • Patient experience of care and self-reported health status measures (CAHPS or similar)	Starting with the fourth quarter of 2013 (Q1 of the first SIM testing year) Oregon intends to publish a quarterly, statewide multi-payer performance report with cost data, utilization statistics, and quality and access measures, by major payer category. Most measures will be reported quarterly, except where the data source is updated less frequently. Oregon's All-Payer All-Claims (APAC) database is the primary data source for this tracking.	Potential contract with independent entity or entities to explore the relationship between level of exposure to the CCM and changes over time in quality of care, utilization, health status, and other measures.
Objective 3: Assess some of the Coordinated Care Model's key elements individually to determine to what extent they contribute to overall success				
Which of the key elements seem to be most	Not applicable.	The measures and tracking plans described above will provide data to address this evaluation objective but it is primarily an analytic question.	See objectives 1 and 2 for information on frequency of	Potential contract with independent entity or entities to explore the relationship between

Research question	Targets	Self-Evaluation Measures	Frequency	Outcome Assessment
important for achieving Triple Aim outcomes? How do community setting, payer, or other contextual differences influence which model elements are most predictive of success?			assessment for underlying data elements. The analysis necessary to address this evaluation objective is likely to take place during years 2 and 3 of the SIM grant, to allow time for the CCM to spread before assessing the impact of individual elements.	level of exposure to the CCM and changes over time in self-reported utilization, health status, and other measures.

In addition to these overall evaluation plans, several specific initiatives under Oregon's SIM grant include focused evaluation activities:

- The congregate housing pilot project will be thoroughly studied by experts from Portland State University. Their plans include: a process evaluation that involves attending meetings with cooperative partners, interviews with partners, and review of documents created for the pilot project; surveys and other data collection to assess resident satisfaction and health outcomes over time; and measurement to assess changes in utilization of hospital, ED, and long-term care services and supports. See Appendix X for an overview of the scope of work for this evaluation.

- A rolling process evaluation will be conducted over the project period for the Regional Equity Coalitions. Additionally an outcome evaluation will be conducted with baseline data collected in the first quarter of the demonstration period, with second-wave data collection in the eighth through 11th quarters following completion of each coalition's strategic plan due in Q7. Data analysis and an outcome evaluation report will be produced in the final quarter of the SIM project period.

Contracts for data collection, analysis and reporting processes

As noted above and described in Oregon's SIM application, the Oregon Health Authority Office of Health Analytics, in cooperation with the Transformation Center, will be responsible for much of the ongoing data collection and tracking for Oregon's SIM self-evaluation. As a statewide aggregator of health care data and statistics, the Office of Health Analytics provides unique and valuable resources to drive change across the health care system. The office leverages: all key health-related datasets containing claims/encounters; LTSS and other services and supports outside of CCOs; surveys including CAHPS and BRFSS; and integrated datasets such as the All-Payer All-Claims (APAC) database, and the Client Process Monitoring System (CPMS), which contains clinical data for mental health/chemical dependency treatment services. Sections D and I of this operational plan describe the data collection infrastructure and the performance measurement strategies that the Office of Health Analytics will develop and use in support of Oregon's SIM testing.

In addition to in-house capacity, Oregon has established or will establish contracts with several key entities for data collection, analysis, and reporting:

- **Milliman** serves a primary role in the collection and administration of Oregon's All-Payer All-Claims (APAC) database. Milliman collects claims and enrollment data from more than 40 mandatory reporters, analyzes content and quality of key elements, assesses data volume trends over time, tests referential quality (a key component that assesses data consistency over time), and benchmarks reasonableness for key CPT codes. Upon successful submission, Milliman loads each data submission into a secure data warehouse and its MedInsight Analytic Platform. In addition to warehousing the data, Milliman provides a number of analytic tools to enable greater use and understanding of Oregon's health care system. These include risk adjusters, groupers, benchmarks, and member identifiers that enable an understanding of individuals' health care utilization over time even as their plans, employers or even names change. Finally, Milliman produces public use data files and limited use data files that OHA can make available to interested parties and researchers for further analysis.

- The **Oregon Health Care Quality Corporation** (Q Corp) is an independent, nonprofit, multi-payer health care quality organization in Oregon, an AHRQ Chartered Value Exchange and an RWJF Aligning Forces for Quality grantee. Q Corp will provide strategic consulting and external validation for OHA's Medicaid performance measurement and will assist with multi-payer performance measurement using both APAC data (under a business associate agreement with OHA) and their own administrative claims database, which includes 75% of the state's commercial insured population, 71% of the Medicaid population and more than 38% of the Medicare population. Q Corp recently was selected as one of the first three Qualified Entities in the country to receive Medicare fee-for-service data and estimates that they soon will have data for approximately 96% of Medicare enrollees in Oregon.

- **Social Science Research Solutions** (SSRS) will manage survey planning, fielding, and data cleaning for a third round of the Oregon Health Insurance Survey, which is a key data source for monitoring health coverage, utilization, and health status in Oregon. SSRS was the contractor for the first two cycles of this survey.

- DataStat will manage annual collection and reporting of patient experience data (via AHRQ's CAHPS survey tools) as a key component of Oregon's performance measurement and self-monitoring plans.

In addition to these data collection and analysis contracts, Oregon plans to contract with independent evaluators to investigate the dissemination and impact of the Coordinated Care Model in different populations, as described in the "outcomes assessment" column of the table above. A contract relevant to Objective 1 of the evaluation—a rigorous analysis of the association between state transformation activities for Medicaid and changes in Medicaid access and quality, controlling for external forces—was recently out for bid and will be awarded shortly. CMMI staff and SIM technical assistance contractors provided input on the RFP.

Oregon is lucky to have an active and engaged health services research community with a history of sophisticated, policy-relevant health systems research including the landmark Oregon Health Study. The Oregon Health Research & Evaluation Collaborative (OHREC) serves as a point of collaboration and connection between state staff and researchers from a variety of organizations in Oregon and across the nation. A number of OHREC-affiliated projects—led by researchers at Oregon Health & Sciences University, Providence's Center for Health Outcomes Research & Education and Portland State University—have already received funding from the NIH, the Robert Wood Johnson Foundation, and private philanthropy to examine aspects of Oregon's Medicaid transformation efforts. (See www.ohrec.org for a full listing of OHREC-affiliated health policy research.) This local capacity and experience should facilitate Oregon's ability to find highly qualified contractors for SIM evaluation work.

Ensuring that performance feedback drives improvement
The Transformation Center will be the main vehicle for rapid cycle learning in Oregon. Building on the performance reporting mechanisms described in Section I, the center will support continuous improvement through multiple methods, including learning collaboratives, technical assistance and coaching, as well as Innovator Agents to disseminate reforms and innovations. Key Transformation Center and OHA staff and the Innovator Agents have received extensive

training from Institute for Healthcare Improvement staff on improvement methods. The Transformation Center will engage clinicians, CCO and other health systems staff, and others to understand what new processes and new innovations are being implemented. Practices that have been successful in one setting will be collected and shared by the Transformation Center with other CCOs, as well as with external health systems and payers. Other stakeholders will be included to ensure broad community engagement. In addition, the center will provide data and research on external innovations by recruiting expertise and input from around Oregon, regionally and nationally on evidence-based practices and innovations in quality and payment that will facilitate improvement on problems that have been identified.

Section S	**Fraud and Abuse Prevention, Detection and Correction**

Oregon's coordinated care model incorporates protections and builds in requirements to address potential fraud and abuse. Our focus is a three-pronged approach: prevention, operational detection and recovery. This model has been operationalized in the Medicaid CCO contracts and we will use a similar framework in our spread of the coordinated care model as we develop additional contractual and regulatory vehicles. SIM funding is integral to the success of spreading the model, and state processes and procedures will insure the grant expenditures will also be regularly monitored and tracked to ensure they are used to their intended intent.

Prevention, operational detection, and recovery in Medicaid
The prevention effort is largely accomplished by following the expanded provider screening requirements stipulated by section 6401 of the Patient Protection and Affordable Care Act of 2010 (ACA). All providers are now held to this higher screening standard, which tries to make sure that providers, facility owners and managers who may seek to enter the Medicaid system for fraudulent purposes are identified and prohibited from doing so. These screening requirements also are applied to those providers who serve our clients in a managed care setting. If an applicant is matched to an excluded individual, their application is denied. Lastly, the full provider file in the MMIS is scrubbed though an automated monthly process that also looks for excluded individuals. If an excluded person is matched to a provider in our MMIS, their active status is immediately ended.

The operational detection occurs in the robust series of edits and audits within our Medicaid Management Information System (MMIS). The MMIS is used to process both claims and managed care encounters for goods and services provided to our Medicaid clients. Any claim or encounter that hits an editor audit is either pended for manual review or denied, dependent upon the programmed actions for that specific edit. Further, applying data analytics to the claims and encounter data generated by the MMIS also aids in fraud and abuse detection. Finally, auditors from the Office of Payment Accuracy and Recovery (OPAR) add a post-payment identification component through their regular audit investigation process.

Once an overpayment is identified, the MMIS is designed to recover funds by reprocessing the claim and recouping the overpayment. Larger recoveries are typically completed by OPAR's Overpayment Recovery Unit, which possesses the tools and training necessary for recoveries with higher levels of complexity.

Prevention, operational detection and recovery as the model is spread
The PEBB and OEBB benefits contracts will contain language to prevent and detect fraud and contract language to recover funds if fraud is found, similar to the protections found in the CCO contracts supported by Medicaid funds. Please see Appendix U for the PEBB RFP and our requirements for fraud protection contract language for the PEBB vendors. Similar protections will be in place in contracts OEBB and for qualified health plans under Cover Oregon.

Section T	Risk Mitigation Strategy

Oregon's model for health transformation has been under development for several years and during that process has undergone intensive examination by stakeholders, including the Oregon legislature, federal funders, business partners, the provider community, technical experts and the general community. This has provided a rich environment to refine and adjust the model to meet multiple stakeholder interests and as a result, the Oregon coordinated care model is a mature proposal for large scale health care systems change as reflected in our State Innovation Model project Operational Plan.

Oregon's SIM project is a systems change model, leveraging every opportunity to align actions, outcomes and timelines to maximize impact and amplify and accelerate success across all payers and populations. As an ambitious and complex undertaking, forward thinking and planning is necessary to identify potential risks and mitigation strategies to maintain forward momentum towards achieving the triple aim.

Our risk mitigation plan described below is based upon the major components described in our SIM Operational Plan. Building off a model developed by Minnesota, Oregon has adapted a Risk Probability/Risk Impact matrix that evaluates and assigns a risk priority value to the major areas of the Oregon SIM project.

		Risk Impact		
		High	Medium	Low
Risk Probability	*High*	*High/*High	*High/*Medium	*High/*Low
	Medium	*Medium/*High	*Medium/Medium*	*Medium/*Low
	Low	*Low/*High	*Low/*Medium	*Low/*Low

Overall Risk Mitigation Priority	High	Med	Low

Guiding Principles for Risk Mitigation

Systems Change: Oregon's SIM goals involve widespread systems change at every level of health care delivery. That requires a broad commitment to reflection on efficacy and effectiveness and the potential for change at every point of contact in every institutional setting including state government, coordinated care organizations and health plans, clinical delivery, workforce development, payer institutions and at the patient level of engagement.

Quality Improvement Principles and Practices: OHA has made extensive investments in quality improvement training and has a strong commitment to use QI principles and practices to improve internal process and procedures and to build quality improvement capacity across the health delivery system to support systems change at every level and in every setting. SIM resources will be used to extend Oregon's investment in QI across the system, with the Transformation Center acting as the vehicle to connect the various levels of the delivery system with expertise, training and opportunities to share best practices.

Strong project management: Oregon has a strong project management team with seasoned staff with experience in leading complex, high stakes projects. We have the tools to develop solid project planning and management systems, track and communicate progress and early identification of issues and barriers and work proactively towards effective solutions. For SIM activities, Oregon will use the biweekly meeting of the SIM Operations Team as the platform for early identification of emerging risks and signal implementation of necessary mitigation strategies.

Consistent communications: With SIM support, we have a strong communication team dedicated to health transformation that supports our need for consistent, reliable communications internally and with our stakeholders. Regular communications with CMMI and Oregon's project leads will continue to identify any emerging risks and discuss any assistance for mitigation early.

Involvement of stakeholders at every level: As reflected in our SIM Operations Plan, Oregon has a long history of stakeholder involvement in our health transformation efforts. This continues as we implement our model, seeking feedback and opportunities to improve quality and access and reduce costs at every level. From the Governor to each level of the Oregon Health Authority and its sister agency, the Dept. of Human Services and in partnership with Cover Oregon, Oregon's Health Insurance Exchange and our Oregon Dept. of Insurance, outreach and engagement of stakeholders is integral to the spread of the coordinated care model. The delivery system leaders, systems, hospitals, clinicians and other providers have multiple avenues to participate and provide input in the spread of the model, along with focused efforts to engage individuals, their families and their communities as well.

Commitment to equity: OHA has a deep commitment to increasing health equity and reducing health disparities. We do this through our active partnering with communities to develop positive, proactive solutions to overcome barriers to equitable health for all Oregonians. Impact on health equity goals will be considered when alternatives or changes in strategy, focus, resource allocation or other aspects of our model are examined or implemented. Explicit efforts are built into Oregon's SIM activities such as the Regional Health Equity Coalitions and

increasing training of health care interpreters, as well as contract language with the CCOs and other health plans partnering in care purchased by the State. Data and analytics focused on equity will continue to be monitored to ensure these efforts are successful and assess additional areas of intervention.

Responsive to local needs: Oregon is a diverse state in geography, population composition and distribution, infrastructure, and culture. Our coordinated care model is specifically designed to take into account the health needs of the population at the local level and to adjust systems and delivery methods to ensure the best outcomes across the state. In Medicaid, the structure of the CCOs is built upon community advisory councils with representation at the CCO Governance Board level. PEBB continues to seek input around the state as it crafts how to best incorporate the coordinated care model into its 2015 benefit offerings, acknowledging the community variability across the state. Providers and health systems' unique challenges and concerns are being incorporated in the efforts of the Transformation Center and the Patient-Centered Primary Care Home Institute to spread and share best practices, peer to peer.

Transparency: Oregon will use the Transformation Center's website and the redesign of the OHA web presence to facilitate transparency in our health transformation efforts with all stakeholders including the public. Quarterly scorecards are in place already for the Medicaid CCOs and will be expanded to include the entire delivery system in 2014 to openly share performance across the state with everyone. Ongoing evaluation efforts are designed to ensure transparency in the spread of the coordinated care model and as Oregon proceeds to implement the Affordable Care Act.

Data-driven decision making: With SIM investments, Oregon will be able to provide detailed reporting on health outcomes at multiple levels and reflect upon the strengths and weaknesses of the system to identify successes and focus needed improvements. Strong data and analytics will support the success of the health transformation efforts. Efforts to modernize information systems in Medicaid, linking with our All-Payer All Claims data base, interacting with Cover Oregon, Oregon's Health Insurance exchange, and eventual full Medicare data is critical to see the influence of the spread of the model on all Oregonians.

Implementation of evidence-based best practices: Oregon has a long history of promoting evidence-based decision making for over the past 20 years, starting in the early days of the Oregon Health Plan and its Prioritized List. SIM investments in the Transformation Center and other SIM project areas will facilitate our ability to broaden our efforts across the delivery system. This support will allow Oregon to identify evidence-based practices and scale or adapt them for implementation in the Oregon environment.

Commitment to public stewardship: Oregon maintains the highest standards for public stewardship in all our actions. We are fortunate to be able to attract the most qualified and experienced staff from across the nation to conduct our programs and projects. We engage in contracting and procurement activities to secure the greatest value for the public investment. We maintain high standards for professional conduct and accountability to ensure public confidence in the integrity of efforts for health transformation.

Evaluating Probability, Impact and Risk Priority

Oregon's coordinated care model requires overall systems change and is therefore coordinated across all levels and agencies within the Oregon Health Authority and in collaboration with our sister agency on Aging and People with Disabilities within the Department of Human Services. We have established the SIM Operations Team to coordinate project activities. Each area has at least two identified project area leads responsible for communicating and coordinating activities. We meet biweekly for updates and share progress, identify barriers and develop solutions. Issues requiring escalation for resolution are directed to the SIM Steering Committee. Below we discuss our risk probability, impact and overall priority matrix across the major areas of our SIM project and our proposed mitigation strategies.

Governance, management structure and decision making authority

Risk Identification	Risk Probability	Impact	Overall Priority
1. Lack of clarity on roles, responsibilities and lines of communication and decision making authority across SIM areas	L	M	M

Mitigation Strategies
- Develop a SIM Operational Team charter that delineates roles, responsibilities and lines of communication and process to escalate issues for resolution if necessary
- Bring issues requiring resource allocation or with policy implications to the SIM Steering Committee for resolution
- Use the SIM Operational Team as a platform to coordinate activities and communicate about success and issues as they arise
- Use team building processes and activities to build shared understanding of project goals and outcomes

Risk Identification	Risk Probability	Impact	Overall Priority
2. Staff resources inadequate to achieve milestones or deliverables on time	M	H	M

Mitigation Strategies
- Scale projects to staffing available
- Seek additional funding or leverage existing resources to meet goals on time and budget

Coordination with other CMS, HHS and federal or local initiatives

Risk Identification	Risk Probability	Impact	Overall Priority
3. Changes in federal rules or guidance that conflict with planned activities	M	H	M

Mitigation Strategies
- Negotiate with federal agencies to achieve agreement on actions necessary at all levels to implement health care reform within the scope and scale of Oregon's approved model test.
- Monitor activities of federal agencies developing rules and participate in/comment on proposed rules that impact Oregon efforts.
- Develop or revise project plans to adapt to federal or state regulatory requirements

Model intervention, implementation and delivery

Risk Identification	Risk Probability	Impact	Overall Priority
4. Changes in CMMI rules or guidance that conflict with planned activities	H	H	H

Mitigation Strategies
- Negotiate with CMMI project officer and leadership, if necessary, to achieve agreement on actions necessary at all levels to implement IM activities within the scope and scale of Oregon's approved model test.
- Develop or revise project plans to adapt or rescale to CMMI revised requirements

Risk Identification	Risk Probability	Impact	Overall Priority
5. Stakeholders have financial disincentives to work with state or conflicts of interest related to SIM goals	M	H	H

Mitigation Strategies
- Conduct rigorous engagement activities to understand the stakeholder environment
- Conduct broad environmental scan to identify similar issues and solutions developed in other states
- Identify areas of possible common interests and develop shared goals
- Engage state leadership for identifying potential shared solutions to minimize financial disincentives

Risk Identification	Risk Probability	Impact	Overall Priority
6. Critical needs identified that are outside of project scope	L	M	L

Mitigation Strategies

- Track issues and identify potential resources for future project seek additional resources or reallocate existing resources if necessary

Risk Identification	Risk Probability	Impact	Overall Priority
7. Recommendations developed under project lack force of law; payers/providers not required to comply without statutory/regulatory change	L	M	M

Mitigation Strategies
- Engage state leadership for identifying potential shared solutions to participate
- Develop recommendations for policy changes necessary to implement required compliance for appropriate legislative or administrative action

Risk Identification	Risk Probability	Impact	Overall Priority
8. Sharing of information may be impeded by lack of clarity regarding federal regulation 42 CFR	H	H	H

Mitigation Strategies:
- Conduct strong advocacy and partnership with CMMI to assist with timely data acquisition.

Risk Identification	Risk Probability	Impact	Overall Priority
9. Barriers to acquiring Medicare FFS data to align with our data in our APAC database to ensure we are seeing across the entire landscape as the model is implemented	M	H	H

Mitigation Strategies:
- Conduct strong advocacy and partnership with CMMI to assist with timely data acquisition.

Risk Identification	Risk Probability	Impact	Overall Priority
10. Lack of progress in providing support for transformation	L	H	M

Mitigation Strategies
- Ensure the high performance of the Transformation Center through:
  - Establishing a multi-payer stakeholder advisory council
  - Hiring highly qualified staff to provide technical assistance
  - Establishing strategic priorities;

- o Coordinating timely and effective communications
- o Operating a robust learning management system
- o Capturing and sharing lessons learned
- o Applying quality improvement practices internally
- o Building quality improvement capacity externally
- o Access state leadership, if needed , for gaining additional support or resources needed to accomplish strategic goals and objectives
- o Develop a Transformation Center sustainability plan during the first SIM demonstration period
- Ensure data driven decision making
- o Acquire data analytic capacity through hiring highly qualified staff and purchasing software tools needed for complex analyses
- o Request assistance from CMMI or other federal agency, if needed, to fully utilize Oregon's All Payers All Claims database for robust analytics and transparency
- o Publish and disseminate quarterly metrics reports
- o Robust evaluation and monitoring of activities

Risk Identification	Risk Probability	Impact	Overall Priority
11. Lack of progress in SIM projects improving the delivery of care	L	M	M

Mitigation Strategies
- Strong project management using clear targets for deliverables and timelines
- Strong communications on project status
- Early identification and resolution of issues and barriers
- Publish quarterly metrics reports
- Strong stakeholder engagement in all areas, particularly in HIT planning and implementation, PCPCH spread, and multi-payer alternative payment approaches.
- Development of an HIT sustainable financing plan to ensure health information exchange efforts sustainable over time.
- Engagement of leadership as needed to resolve systems or resource issues
- Engagement with CMMI for technical assistance to resolve issues or barriers

Risk Identification	Risk Probability	Impact	Overall Priority
12. Lack of progress in reforming payment in designated timeline	M	H	H

Mitigation Strategies
- Strong, early and sustained stakeholder engagement
- Establish shared vision, goals and actions

- Provide strong, high level state leadership to support success
- Utilize all necessary levers to ensure success
- Engagement with CMMI for technical assistance as necessary

Risk Identification	Risk Probability	Impact	Overall Priority
13. Clarification of the definition of "flexible services" for CCOs. If "flexible services" counts as a medical expense rather than an administrative expense, it can work against plans for spreading the model to the commercial market. Yet if "flexible services" counts as an administrative expense, it can raise issues as well. The intention is to get the individual the necessary care and prevent expensive care in emergency departments and hospitals.	H	H	H

Mitigation Strategies
- Conduct strong advocacy and partnership with CMMI to assist with clarifying the definition of flexible services

Quality, Financial and Health Goals, Performance Measurement

Risk Identification	Risk Probability	Impact	Overall Priority
14. Lack of progress in improving quality of care and health outcomes	L	H	M

Mitigation Strategies
- Publish quarterly metrics
- Provide early identification and problem solving
- Build quality improvement capacity at all levels of the system
- Provide technical assistance where needed for improvement
- Engage contract compliance mechanisms when necessary

Risk Identification	Risk Probability	Impact	Overall Priority
15. Moving the system from "payment for volume" to "payment for outcomes." Oregon is starting with a 2% withhold for CCOs, to move payment towards outcomes. Current volume payments are also tied to actuarial soundness, a concept that may not fit best in a world of payment for outcomes, as it assumes	H	H	H

no efforts to contain costs, improve health or quality of health care.			

Mitigation Strategies:
- Strong advocacy and partnership with CMS to discuss how to move from the old world of payment to a real new world that fits with the Triple Aim.

Risk Identification	Risk Probability	Impact	Overall Priority
16. Overall model not financially sustainable	L	H	H

Mitigation Strategies
- Examine aspects of the model that challenge sustainability and make appropriate adjustments
- Rescale the model as necessary to sustain the greatest benefits and offset the most important detractions from sustainability

Likelihood of success
The coordinated care model has broad support from stakeholders, executive leadership, the Oregon Legislature, and CMS. In 2011 and 2012, the Governor and legislative leadership enacted legislation to establish and implement the coordinated care model statewide for Oregon Health Plan (OHP) members through Coordinated Care Organizations, including individuals eligible for both Medicare and Medicaid (if they choose to enroll). House Bill 3650 and Senate Bill 1580 passed the state Legislature with broad support; in fact, in March 2012, SB 1580 passed an evenly divided House by 53–7. CCOs also have CMS support in the form of approval for Oregon's Medicaid 1115 waiver amendment in July 2012. Oregon gained buy-in for the coordinated care model from key stakeholders across the state through a series of stakeholder committees, boards, councils and work groups convened from 2007 through 2012, with more than 76 public meetings in the year preceding the passage of our health system transformation-enabling legislation alone. More than 300 Oregonians representing health plans, providers, beneficiaries, consumer advocacy groups and other key stakeholder groups participated in the strategic planning and development of Oregon's health system transformation agenda. As stated earlier, there was strong support for adopting the coordinated care model — Oregon has completed a $1 billion procurement for its Medicaid program for the 16 organizations successfully certified as CCOs (See Appendix E for Oregon's revised stakeholder engagement plan).

Oregon continues to engage stakeholders as the coordinated care model is rolled out and implemented. As evidenced by the number of CCOs already certified and PCPCHs already recognized, the model has widespread engagement across Oregon and has passed the first set of hurdles associated with bringing a concept to implementation. The proposed Transformation Center will be a critical factor to the success of the model as implementation continues, since it will provide CCOs, providers, consumers, and communities with the examples and technical assistance they need to make reforms work and the information necessary for rapid-cycle improvement.

Additional risk mitigation considerations

Strong data and analytics will support the success of the health transformation efforts. Oregon has long recognized the potential for improved data systems to contribute toward better health, and has initiated efforts to modernize information systems that support health care and other programs. In addition, Oregon will ensure streamlined access to Cover Oregon and interaction with Medicaid information systems to develop capacity for robust analytics. Oregon intends to work closely with its Federal partners on ensuring the ability to fully integrate behavioral, physical and dental health information for individuals and their families in order to maximize coordination of care, striving to ensure 42 CFR doesn't impede that effort and maintain the silos the CCO structure was designed to correct. Medicare data is also critical to see the influence on the Medicare lives, as the balance is tipped with both Medicaid and private payers working on the coordinated care model, while the state works on streamlining administrative functions.

Oregon is committed to accomplish quality improvement activities and payment reforms that are heavily reliant on clear, reliable and timely data collection and analysis. Change and innovation at this scale are never without risks and capacity for transformation is an important one. Oregon's vision for health systems transformation calls for significant changes on an accelerated timeline. Providers, plans, consumers, and the state must all adopt new business models or shed outdated paradigms. Strong governance with a committed Governor and engaged Legislature, and continued active stakeholder engagement mitigate the risks. The Transformation Center will mitigate the risk inherent in the transformation of complex systems by providing a structured path for sharing of best practices and robust data to support mid-course corrections and rapid cycle improvement strategies.

Oregon believes that the coordinated care model is likely to be successful as we spread the model to other populations. For example, it is likely to be successful for state employees within Oregon's Public Employees' Benefit Board (PEBB) because of the steps already taken to incorporate key elements of the model and because PEBB and its health plan partners were involved as key stakeholders in the development of the model.

In addition, as is often true in a policy environment, there are multiple initiatives being implemented at the same time in the state — some state-sponsored, some health system-sponsored and some federally sponsored. It will be critical to our success that Oregon continues to track and collaborate with these multiple efforts where possible in order to best reach shared policy goals.

The risks that OHA will face are considerable but well understood. The transformation activities under way in Oregon create a dynamic environment, and OHA will continually monitor the impact of different reforms to make quick adjustments and corrections as well as build on experience.