E-Appendix

Oregon's Medicaid Transformation: An Innovative Approach To Holding A Health System Accountable For Spending Growth

GLOBAL BUDGET - DETAILS

The state will compensate CCOs using a global budget that consists of two parts: (1) a capitated per member per month (PMPM) payment; and (2) a separate payment for services not included under the capitation rate. The capitated PMPM includes funding for all services now provided for physical health and behavioral health. By 2014, this capitated PMPM will also include funding for dental care. The second, separate payment covers programs and services currently provided outside of the CCO. These services include mental health drugs, long-term care, tribal targeted case management, and categorical public health grant funds. Some services (e.g., non-emergent transportation, case management for people with HIV/AIDS and those receiving nurse home visits) are not included initially in the global budget but will be considered for inclusion in the future.

ENROLLMENT EXCEPTIONS

American Indian tribal enrollees and those dually eligible for Medicaid and Medicare were allowed to opt out of the CCO plan and individuals with special health needs, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), and those receiving services for End Stage Renal Disease received individualized transition plans.

PRIMARY CARE HOMES – THE OREGON MODEL

Oregon has invested in the development of its own medical home model, known as Patient-Centered Primary Care Homes. Development of the guidelines for the PCPCH included public stakeholder groups who reviewed various approaches to medical homes including the National Committee for Quality Assurance (NCQA) standards, concluding that the NCQA standards did not go far enough to encourage improved health outcomes. The Oregon PCPCH includes six key attributes considered to be the core of the Oregon standards. They include access to care, accountability, Comprehensive, Whole-Person Care, Continuity, Coordination and Integration, and Person and Family-Centered Care. The Oregon PCPCH model has received national attention[1] and is considered crucial to the CCO transformation.

In addition to primary care homes, CCOs are expected to expand the use of non-traditional healthcare workers, including community health workers, peer wellness specialists, patient navigators, and doulas.

ACCESS AND QUALITY METRICS - DETAILS

CCO Accountability to the State. Seventeen "Incentive Measures" track the quality of CCO care and encompass preventive care, access and patient satisfaction, chronic illness management, behavioral health, maternal care, overuse, and electronic health record (EHR) adoption and use (see Table 1). The Oregon CCO Incentive Measures are part of the CCO incentive pool, which establishes a bonus pool of 2% of the aggregate value of the PMPM CCO budget, from which CCOs will be awarded for attaining performance targets or improving performance. Recognizing

the fixed costs associated with quality improvement, the incentive payments also include a floor such that, regardless of enrollment, each CCO can earn at least $1 million for maximal performance. Furthermore, while CCOs may be eligible for bonuses of up to 2% of the aggregate value of the PMPM budget, the overall spending reduction achieved by the State must be inclusive of any bonuses paid out to CCOs. Table 1 also identifies current baseline (average) quality scores across the majority of these measures, as well as the benchmark (target) metrics that CCOs will be expected to achieve in order to receive incentive payments. CCOs receive incentive payments by either (a) achieving the benchmark metric or (b) improving performance by reducing the relative gap between its baseline and the state's benchmark metric by 10%, while requiring a floor of 1% to 3% in absolute improvement to insure that improvements are of significant size.[2] The amount of the incentive payment that a CCO receives is based on the number of incentive measures that the CCO either achieves its improvement target or meets the benchmark measure. The full incentive payment can be achieved by meeting benchmark or the improvement target on at least 75 percent of the incentive measures as well as meeting the benchmark or improvement target for the Electronic Health Record (EHR) measure. As a CCO meets fewer benchmarks or improvement targets, it receives a lower payment.[3] The percent of the global budget assigned to the quality pool is intended to increase gradually over time, continuing to reward CCOs for value and outcomes, rather than utilization of services

State Accountability to CMS. The Oregon Quality and Access Test Measure metrics includes 33 measures: 16 of the 17 CCO Incentive Measures, as well as an additional 17 drawn from three previously identified metric groups, each with a considerable amount of overlap: (1) the Social Security Act section 1115 Demonstration Core Performance Measures; (2) the CMS Adult Core Set for Medicaid; and (3) the CMS Child Core Set for Medicaid and the Children's Health Insurance Program (See Table 1). The additional measures include several to assess ambulatory care sensitive admissions (e.g., hospital admissions for asthma for adults, who presumably could be cared for in a preventive way with access to high quality outpatient care), appropriate screening, clinical quality, and access.

These components will be measured for each CCO and aggregated across all CCOs to construct a single composite score, similar to the composite score used for the Alternative Quality Contract of Massachusetts Blue Cross Blue Shield.[4] Each measure includes a "baseline" level of performance, established based on calendar year 2011 data, and a "target" level of performance, reflecting the best possible performance that could be achieved. During the evaluation period each measure is scored according to the percentage improvement between baseline and target levels, with best performance receiving a score of 100%. It is also possible to receive negative scores if quality diminishes. The composite measure averages the unweighted scores across all 33 metrics and rounds to the nearest tenth of a percentage. Oregon will pass the CMS quality and access test if the aggregate measure is greater than or equal to zero (in subsequent years, 2014 and 2015, Oregon will pass only if the score is strictly greater than zero). A failure to pass this test triggers a second test that is more complex, but likely to be more robust in adjusting for external or secular effects unrelated to Oregon's policy. A failure to pass the second test would result in significant financial penalties for Oregon, ranging from $145 million for not achieving the second year goal to $183 million in Years 4 and 5.

COMMUNITY HEALTH ASSESSMENTS - DETAILS

CCOs are required to establish a Community Advisory Council, which is responsible for conducting the Community Health Assessments. A general framework for the Assessments has

been established, but the Assessments are not standardized across CCOs. The State has identified 6 phases in the Community Health Assessment process:

1. Community Engagement
2. Visioning
3. Assessment
4. Analysis
5. Community Health Improvement Plan
6. Continuing Assessment and Quality Improvement

The Assessment (Phase 3) is intended to provide a comprehensive picture of the community and may draw on multiple data sources, including public health accreditation documents, community health needs assessments that are required to be conducted by all hospitals, and other sources of qualitative and quantitative data By including Community Health Assessments as an accountability measure for CCOs, the State provides an incentive for CCOs to use a portion of their global budgets on “upstream” public health initiatives as part of efforts to reduce costs and improve population health. As an example, the Trillium Community Health Plan offers cash incentives to pregnant women who stop smoking. The ways in which these Community Health Assessments shape care delivery are likely to be revealed in more detail over the next two to three years.

E-APPENDIX REFERENCES

1. Stenger RJ, Smith J, McMullan JB, et al. Defining the Medical Home: The Oregon Experience. *J. Am. Board Fam. Med.* 2012;25(6):869–877. doi:10.3122/jabfm.2012.06.120026.
2. Oregon Health Authority. Oregon Health Authority CCO Incentive Measures Methodology. 2013. Available at: http://www.oregon.gov/oha/CCOData/CCO%20Incentive%20Measures%20Methodology.pdf. Accessed May 15, 2013.
3. Oregon Health Authority. Oregon Health Authority Quality Pool. 2013. Available at: http://www.oregon.gov/oha/CCOData/Quality%20Pool%20Methodology.pdf. Accessed May 15, 2013.
4. Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-Payer Innovation In Massachusetts: The “Alternative Quality Contract.” *Health Aff. (Millwood)*. 2011;30(1):51–61. doi:10.1377/hlthaff.2010.0980.

Table 1. Oregon Measures Matrix: Measures included in the test for quality and access

Measure	CCO Quality Pool Metrics (17)	Oregon Account-ability Metrics (33)	2011 Baseline	Benchmark
Behavioral health measures				
Alcohol or other substance misuse screening, brief intervention and referral to treatment (SBIRT)	x	x	0.1%	TBD
Follow-up after hospitalization for mental illness (NQF 0576)	x	x	57.6%	68.0%
Screening for clinical depression and follow up plan (NQF 0418)	x	x	*	*
Mental and physical health assessment within 60 days for children in DHS custody (state measure)				
Mental health assessment within 60 days for children in DHS custody (state measure)	x		56.0%	90.0%
Physical health assessment within 60 days for children in DHS custody (state measure)			67.1%	90.0%
Follow up care for children prescribed ADHD medications (NQF 0108)	x	x	52.3%	51.0%
Medical assistance with smoking and tobacco cessation (NQF 0027)				
Component 1: Adult tobacco users advised to quit by their doctor			50.0%	81.4%
Component 2: Adult tobacco users whose doctor discussed or recommended medications to quit smoking		x	24.0%	50.7%
Component 3: Adult tobacco users whose doctor discussed or recommended strategies to quit smoking			22.0%	56.6%
Prenatal/maternity/postpartum care				
Timeliness of prenatal care (NQF 1517)	x	x	65.3%	69.4%
Elective delivery before 39 weeks	x	x	*	*
Developmental screening by 36 months (NQF 1448)	x	x	20.9%	50.0%
Well-child visits in the first 15 months of life (NQF 1392)		x	68.3%	77.3%
Utilization metrics				
Total emergency department and ambulatory care utilization (per 1000 member months)	x	x	61.0	44.4
All cause readmission (NQF 1789)		x	11.3%	10.5%
Diabetes short term complication admission rate (PQI 1)		x	192.9	62.7
Chronic obstructive pulmonary disease admission rate (PQI 5)		x	454.6	559.0
Congestive heart failure admission rate (PQI 8)		x	336.9	380.7
Adult asthma admission rate (PQI 15)		x	53.4	63.4

(Table 1 continued below)

Table 1 (continued) Oregon Measures Matrix: Measures included in the test for quality and access

Preventive measures				
Colorectal cancer screening	x	x	32.5%	54.6%
Cervical cancer screening (NQF 0032)		x	56.1%	74.0%
Breast cancer screening (NQF 0032)		x	*	*
Childhood immunization status (NQF 0038)		x	66.0%	82.0%
Immunization for adolescents (NQF 1407)		x	49.2%	70.8%
Chlamydia screening in women (NQF 0033)		x	59.9%	63.0%
Access measures				
Patient-Centered Primary Care Home (PCPCH) enrollment	x	x	51.7%	100%
Adolescent well-care visits	x	x	27.1%	53.2%
Access to care (CAHPS composite-adult/child) †	x	x	83.0%	87.0%
Child and adolescent access to primary care practitioners†				
Child and adolescent access to primary care practitioners - Overall (ages 12 months – 19 years)			88.5%	TBD
Child and adolescent access to primary care practitioners (ages 12 – 24 months)		x	97.4%	98.2%
Child and adolescent access to primary care practitioners (ages 25 months – 6 years)			86.2%	91.6%
Child and adolescent access to primary care practitioners (ages 7 – 11 years)			88.2%	93.0%
Child and adolescent access to primary care practitioners (ages 12 – 19 years)			88.9%	91.7%
Clinical quality				
Appropriate testing for children with pharyngitis (NQF 0002)		x	73.7%	76.0%
Controlling hypertension (NQF 0018)	x	x	*	*
Low density lipoprotein cholesterol (LDL-C) screening in diabetics (NQF 0063)		x	67.2%	80.0%
Hemoglobin A1c testing (NQF 0057)		x	78.5%	86.0%
Hemoglobin A1c poor control (NQF 0059)	x	x	*	*
Additional questions				
Provider access questions from Physician Workforce Survey		x	*	*
Electronic Health Records, Meaningful Use composite	x	x	*	*
Satisfaction with health plan customer service (CAHPS composite-adult/child)	x	x	78.0%	84.0%

ADHD = attention deficit hyperactivity disorder; CAHPS = Consumer Assessment of Healthcare Providers and Services; DHS = Oregon Department of Human Services; NQF = National Quality Forum; PQI = Prevention Quality Indicator

(Continued below)

(Continued from Table 1)
*Not yet available
TBD – Still to be determined by State and/or CMS
†Access to care (CAHPS): Percentage of patients (adults and children) who thought they received appointments and care when they needed them; Children and adolescent access to primary care practitioners - Percentage of children and adolescents who had a visit with a primary care provider in the last year