Table 1: Hospital - CCO Contracting Arrangements

Hospital Name	Contracting CCOs	Number of Discharges, Baseline Year
MCKENZIE WILLAMETTE MED CTR	ColumbiaPacific	58
	Jackson	109
	Trillium**	221
	Yamhill	27
MERCY MEDICAL CENTER INC	Umpqua	35
SHRINERS HOSPITALS FOR CHILDREN	IHN	55
	Pacific Source (both CCOs)	173
	Umpqua	35
SKY LAKES MEDICAL CENTER	Cascade	4
TUALITY COMMUNITY HOSPITAL	ColumbiaPacific	58
	HealthShare**	1118
	Jackson	109
	Yamhill	27
WILLAMETTE VLLY MED CNTR	ColumbiaPacific	58
	Jackson	109
	Yamhill**	27
KAISER SUNNYSIDE	HealthShare	1118
KAISER WESTSIDE	HealthShare	1118

****Primary relationship (risk accepting entity and/or CCO with which hospital works most closely)**

Table 2: Hospital-wide All-Cause Readmissions, Floor Options							1 percentage point floor/reduction		0.5 percentage point floor/reduction		3% floor/reduction	
	Numerator	Denominator	Rate	Standard Deviation	Confidence Interval *95% confidence level	CI range	# additional readmissions that must be prevented[1]	% change	# additional readmissions that must be prevented[1]	% change	# additional readmissions that must be prevented[1]	rate required
Adventist	1,606	12,177	13.2%	1.1%	0.6%	12.6% to 13.8%	-122	7.6%	-61	-3.8%	-48	12.8%
Asante Rogue Regional	1,681	15,331	11.0%	1.3%	0.7%	10.2% to 11.7%	-153	9.1%	-77	-4.6%	-50	10.6%
Asante Three Rivers	639	6,918	9.2%	1.3%	0.7%	8.5% to 10.0%	-69	10.8%	-35	-5.4%	-19	9.0%
Bay Area	695	6,005	11.6%	1.4%	0.8%	10.8% to 12.4%	-60	8.6%	-30	-4.3%	-21	11.2%
Good Samaritan Regional	948	9,401	10.1%	0.8%	0.4%	9.7% to 10.5%	-94	9.9%	-47	-5.0%	-28	9.8%
Kaiser Sunnyside	1,784	15,930	11.2%	1.6%	0.9%	10.3% to 12.1%	-159	8.9%	-80	-4.5%	-54	10.9%
Kaiser Westside	486	7,901	6.2%	1.3%	0.7%	5.4% to 6.9%	N/A	N/A	N/A	N/A	N/A	N/A
Legacy Emanuel	1,184	10,310	11.5%	1.0%	0.6%	10.9% to 12.1%	-103	8.7%	-52	-4.4%	-36	11.1%
Legacy Good Samaritan	1,255	10,407	12.1%	1.5%	0.8%	11.2% to 12.9%	-104	8.3%	-52	-4.1%	-38	11.7%
Legacy Meridian Park	857	8,902	9.6%	0.6%	0.3%	9.3% to 10.0%	-89	10.4%	-45	-5.2%	-26	9.3%
Legacy Mount Hood	551	6,187	8.9%	1.8%	1.0%	7.9% to 9.9%	-62	11.2%	-31	-5.6%	-17	8.6%
McKenzie-Willamette	675	6,519	10.4%	1.4%	0.8%	9.6% to 11.1%	-65	9.7%	-33	-4.8%	-20	10.0%
Mercy	776	7,133	10.9%	1.5%	0.8%	10.0% to 11.7%	-71	9.2%	-36	-4.6%	-23	10.6%
OHSU	3,661	20,886	17.5%	0.8%	0.4%	17.1% to 18.0%	-209	5.7%	-104	-2.9%	-110	17.0%
PeaceHealth RiverBend	2,544	24,668	10.3%	0.6%	0.3%	10.0% to 10.6%	-247	9.7%	-123	-4.8%	-76	10.0%
PeaceHealth University	282	2,379	11.9%	2.7%	1.5%	10.3% to 13.4%	-24	8.4%	-12	-4.2%	-8	11.5%
Providence Medford	773	6,523	11.9%	1.2%	0.7%	11.2% to 12.5%	-65	8.4%	-33	-4.2%	-23	11.5%
Providence Milwaukie	313	2,370	13.2%	2.8%	1.6%	11.6% to 14.8%	-24	7.6%	-12	-3.8%	-9	12.8%
Providence Portland	2,481	22,476	11.0%	1.2%	0.7%	10.4% to 11.7%	-225	9.1%	-112	-4.5%	-74	10.7%
Providence St. Vincent	2,977	29,102	10.2%	0.4%	0.2%	10.0% to 10.5%	-291	9.8%	-146	-4.9%	-89	9.9%
Providence Willamette Falls	463	5,738	8.1%	1.2%	0.7%	7.4% to 8.7%	-57	12.4%	-29	-6.2%	-14	7.8%
Salem	2,531	24,014	10.5%	0.7%	0.4%	10.1% to 11.0%	-240	9.5%	-120	-4.7%	-76	10.2%
Samaritan Albany General	300	3,430	8.7%	1.7%	0.9%	7.8% to 9.7%	-34	11.4%	-17	-5.7%	-9	8.5%
Shriners for Children	20	406	4.9%	4.4%	2.5%	2.4% to 7.4%	N/A	N/A	N/A	N/A	N/A	N/A
Sky Lakes	560	5,803	9.7%	1.6%	0.9%	8.7% to 10.6%	-58	10.4%	-29	-5.2%	-17	9.4%
St. Charles Bend	1,316	15,081	8.7%	0.7%	0.4%	8.3% to 9.1%	-151	11.5%	-75	-5.7%	-39	8.5%
Tuality Healthcare	397	5,015	7.9%	1.4%	0.8%	7.1% to 8.7%	-50	12.6%	-25	-6.3%	-12	7.7%
Willamette Valley	373	3,722	10.0%	1.5%	0.9%	9.2% to 10.9%	-37	10.0%	-19	-5.0%	-11	9.7%
Total	**32,128**	**294,734**	**10.9%**	**0.3%**	**0.2%**	**10.7% to 11.1%**	**-2,947**	**9.2%**	**-1474**	**-4.6%**	**-964**	**10.6%**
						min	-291	5.7%	-146	-6.3%	-110	7.7%
						max	-24	12.6%	-12	-2.9%	-8	17.0%

[1] Assumes the number of discharges (denominator) remains at baseline level

For the full report, see
https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf

NATIONAL ACADEMY
for STATE HEALTH POLICY®

State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools

Melanie Schoenberg, Felicia Heider, Jill Rosenthal, Claudine Schwartz and Neva Kaye

March 2015

Conducted on behalf of the Medicaid and CHIP Payment and Access Commission

EXECUTIVE SUMMARY

Since 2010, eight states (California, Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Texas), have negotiated with the federal government to implement Delivery System Reform Incentive Payment (DSRIP) or "DSRIP-like" programs. These programs are a component of Section 1115 demonstrations that incentivizes system transformation and quality improvements in hospitals and other providers serving high volumes of low-income patients. DSRIPs aim to meet strategic goals, based on the Triple Aim[1] principles of better care, improved health, and lower costs by incentivizing reforms that transition away from episodic treatment of disease toward prevention and management of health and wellness among patient populations. DSRIP programs restructure historic Medicaid supplemental payment funding that provides hospitals[2] with critical financial support to care for underserved patients into a pay-for-performance structure in which hospitals and other providers are rewarded for achieving specified delivery system reform metrics. DSRIP and DSRIP-like programs—worth up to a combined $3.6 billion in federal funds ($6.7 billion state and federal) in fiscal year 2015—provide states with a unique opportunity to redesign Medicaid delivery systems within the context of state-specific needs and goals.

This report provides an in-depth cross-state analysis of current DSRIP and DSRIP-like programs. It describes implementation experiences from the federal, state, and provider perspectives.

While DSRIPs are still in their infancy, this examination of DSRIP and DSRIP-like state programs has revealed several takeaways:

- DSRIP signals a shift in Medicaid financing toward greater accountability as supplemental payments originally intended to make up for Medicaid payment shortfalls shift to incentive-based payments. Although the Centers for Medicare & Medicaid Services (CMS) describes DSRIP as a tool intended to assist states in transforming their delivery systems to fundamentally improve care for beneficiaries, states have been candid that DSRIP programs have been pursued as a means to preserve supplemental funding. Key financing questions persist, including the use of DSRIP to make payments that exceed prior supplemental payments and states' ability to come up with the non-federal share of DSRIP incentive payments.
- Though each state program is intentionally unique, DSRIPs continue to evolve toward being more standardized, increasing accountability by incorporating more outcomes-based payments, and operating through community partnerships. While respecting local flexibility and innovation for projects to achieve improvements, DSRIPs must be able to demonstrate outcomes and ensure accountability for allocated funding.
- DSRIPs are being designed to support broader delivery system reforms, yet questions remain regarding DSRIP's lifespan and its linkage to other Medicaid financing strategies. According to CMS, while DSRIPs can provide critical support, they are not intended to be a long-term solution for Medicaid under-reimbursement, nor are they intended to be the sole funding source for system transformation over the long-term.
- While lacking comprehensive DSRIP evaluation data, there are multiple examples of quality improvement and care delivery redesign activities implemented as a result of DSRIP. States and providers note anecdotally that as they focus on driving innovation, not all improvements can be captured by DSRIP metrics (e.g. cultural transformation), yet CMS is increasingly focused on

standardizing metrics in areas where there is strong evidence.

- Providers, states, and the federal government must spend significant time to launch DSRIP programs; as a result, a five-year transformation project may in reality be only three to four years. Additionally, most DSRIPs require significant resources for administration and implementation.

New Jersey

General Program Information and Context

- DSRIP is part of the New Jersey Comprehensive Waiver, that seeks to provide comprehensive health care benefits to 1.3 million New Jersey citizens, including Medicaid beneficiaries and other specified populations. Through DSRIP, New Jersey aims to transition safety net hospital payments from the previous supplemental payment system (Hospital Relief Subsidy Fund) to an incentive-based model for all New Jersey hospitals where payment is contingent on achieving quality improvement goals.
- Each participating hospital submits a Hospital DSRIP Plan, which describes how it will carry out one project that is designed to improve quality of care, efficiency, or population health. Hospital projects are selected from a menu of focus areas that include: asthma, behavioral health, cardiac care, substance abuse, diabetes, HIV/AIDS, obesity, and pneumonia. Each project consists of a series of activities drawn from a predetermined menu of activities grouped according to four project stages. Hospitals may qualify to receive DSRIP payments for fully meeting performance metrics (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care. All acute care general hospitals in New Jersey are eligible to participate.

General Information	**Program Length**	5 years
	Stage of Implementation	Year 3
	Date Submitted to CMS	9/14/2011
	Date Approved by CMS	10/1/2012
	Date Expires	6/30/2017
Funding	**Maximum Potential Pool Funding (federal)**	$292,000,000
	Maximum Potential Pool Funding (all funds)	$583,000,000
	Current FMAP	50.00%
	Source Of Matching Funds (Non-Federal)	Provider tax
	Average Funding Available Per Year	Available DSRIP funding fluctuates per year but averages to about $146 million per year.[4]
	Relation of Total Funding to Prior Supplemental Payments	Same as prior supplemental payments (Hospital Relief Subsidy Fund)
	Total Distribution of Payments	In Year 1, 100 percent of DSRIP funding is provided as a transition payment. In Year 2, 50 percent of DSRIP funding is provided as a transition payment; 25 percent is paid to hospitals that develop a hospital specific plan; the remaining 25 percent is paid for progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period. Over time, funding gradually shifts from project improvements to quality improvements (first as pay-for-reporting and then to pay-for-performance).
Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	No. The waiver does, however, authorize transition payments in DY 1-DY2.
	Corresponding Designated State Health Program (DSHP)	No.

Providers	**Participating Providers**	All acute care hospitals are eligible to participate in DSRIP. Total of 63 eligible hospitals; 50 have approved DSRIP projects; 13 are not participating.
Projects Being Funded	**DSRIP Project Domains**	Each hospital must select one project from a menu of focus areas that include: behavioral health, HIV/AIDS, chemical addiction/substance abuse, cardiac care, asthma, diabetes, obesity, pneumonia, or another medical condition that is unique to a specific hospital, if approved by CMS. There are then four stages of activities: Stage 1: Infrastructure Development: Stage 2: Chronic Medical Condition Redesign and Management Stage 3: Quality Improvements Stage 4: Population Focused Improvements
	Project Funding Per Year	Average project funding per year is $3.26 million.
	Number of Approved Projects	50
	Minimum Number of Projects Required	Each participating hospital has selected one project from a menu of focus areas.
	Additional Funded Program Elements	New Jersey has a Universal Performance Pool (UPP) which is made up of the following funds: • For DY2, Hospital DSRIP Target Funds from hospitals that elected not to participate or where CMS did not approve the hospital's submitted plan. There will be no carve out allocation amount for DY2. • For DY3-5, Hospital DSRIP Target Funds from hospitals that elected to not participate, the percentage of the total DSRIP funds set aside for the UPP, known as the carve out allocation amount, and Target Funds that are forfeited from hospitals that do not achieve project milestones/metrics, less any prior year appealed forfeited funds where the appeal was settled in the current demonstration year in favor of the hospital. Hospitals are also required to participate in learning collaboratives as part of the stage 2 metrics.
Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	For DY4 and DY5, over half of quality improvement metrics will be pay-for-performance.
	Metrics and Benchmarked Improvement Targets	Incentive payment during the pay-for-performance demonstration years is based on hospitals making a measurable improvement in a core set of the hospital's quality improvement performance measures. For measures with a national or publicly available benchmark, a measurable improvement is a minimum of a 10 percent reduction in the difference between the hospitals baseline performance and improvement target goal. For hospitals working with project partners, this gap is reduced from 10 percent to 8 eight percent. For measures without a national or publically available benchmark, a measureable improvement is a 10 percent rate of improvement over the hospital's baseline performance (per year).
	Denominator for Improvement	Performance measurement for both Stage 3 and 4 metrics will measure improvement for specified population groups, including the charity care, Medicaid and CHIP populations, collectively referred to as the low income population. An attribution model to link the low-income population with DSRIP hospitals and project partners for Stage 3 and 4 performance measurement has been developed by the Department with the input and support by the hospital industry.
	Statewide Accountability Test	N/A

Reporting & Monitoring	**Provider Reporting**	DY2: Hospitals are required to submit the DSRIP plan (covers 50% of DY2 Target Funding amount), and submit the DY2 Progress Report (covers the other 50% of DY2 Target Funding) DY3-DY5: Hospitals are required to submit an annual DSRIP application renewal for DY3-5 and quarterly DSRIP Progress Reports for DY3-5 that are based on stage-specific activities/milestones and metrics achieved during the reporting period.
	State Reporting	The Department and CMS will use a portion of the Monthly Monitoring Calls for March, June, September, and December of each year for an update and discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.
	Mid-Point Assessment Process	A mid-point assessment of DSRIP will be completed by June 2015 by the independent DSRIP evaluator to provide broader learning both within the state and within the national landscape. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.
	Program Evaluation	• The Rutgers Center for State Health Policy is conducting the evaluation of New Jersey's waiver. The quantitative portion of the evaluation consists of analysis of Medicaid claims data and payer data in addition to hospital reported measures. The qualitative portion consists of a survey and key informant interviews with hospitals. • Interim Evaluation Report: The state must submit a draft interim evaluation report by July 1, 2016, or in conjunction with the state's application for renewal of the demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report. • Final Evaluation Report: The state shall submit to CMS a draft of the final evaluation report by July 1, 2017.
	External Audit/Review	• The Center for State Health Policy at Rutgers University is conducting both the mid-point assessment and final evaluation.

New York

General Program Information and Context

New York's Delivery System Reform Incentive Payment (DSRIP) program is part of the state's Partnership Plan 1115 demonstration waiver. As described in demonstration Amendment 13, the state plans to invest savings generated from reform under New York's Medicaid Redesign Team (MRT) into state health care reform efforts, including the DSRIP pool. Under DSRIP, Medicaid providers and community-based organizations are organized into ACO-like structures called Performing Provider Systems (PPSs) that collectively implement 5-11 quality improvement projects designed to create regional integrated delivery systems able to accept value-based payments for attributed populations.

New York's DSRIP program was created to incentivize provider collaboration at the community level to improve the care for Medicaid beneficiaries while lowering costs and improving health. Participating PPSs receive DSRIP funding for achieving specific project milestones, metrics and outcomes.

A specific goal of DSRIP is to reduce avoidable hospital use by 25 percent over five years within the state's Medicaid program. In addition, DSRIP focuses on: "(1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform."

General Information	**Program Length**	6 years
	Stage of Implementation	Year 1 (planning only)
	Date Submitted to CMS	8/6/2012
	Date Approved by CMS	4/14/2014
	Date Expires	12/31/2019 (assuming renewal of the Partnership 1115 demonstration 12/31/2014)
Funding	**Maximum Potential Pool Funding (federal)**	$6,919,000,000
	Maximum Potential Pool Funding (all funds)	$13,837,000,000
	Current FMAP	50.00%
	Source Of Matching Funds (Non-Federal)	Intergovernmental transfers (IGTs) from major public hospitals, supplemented by some state general revenue funded by DSHP.
	Average Funding Available Per Year	Available DSRIP funding fluctuates per year.
	Relation of Total Funding to Prior Supplemental Payments	No relation to prior supplemental funding; NY DSRIP funding comes from Medicaid Redesign Team (MRT) savings and no prior supplemental payments were rolled into DSRIP.
	Total Distribution of Payments	New York includes $140 million in funding for planning in Year 1/DY 0 and then has 5 years of DSRIP implementation activities. Funding for Domain 1, Project Program milestones, is highest (80% and 60% of total DSRIP funding,) in DY 1 and 2, respectively, and steadily declines to 0% in DY5. Funding for Domains 2 and 3 steadily increases throughout the program and reaches 55% and 40%, respectively, in DY 5. Domains 2 and 3 are a combination of P4P and P4R and in each case; more funding is based reporting in earlier years and on performance in later years. New York also has a population health domain, which remains consistently at 5% of total DSRIP funding every year.

Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	No (although the F-SHRP 1115 demonstration does include an indigent care pool for clinics that is not related to the DSRIP)
	Corresponding Designated State Health Program (DSHP)	Yes; $4 billion related to DSRIP (total, all funds); Additional DSHP had previously been approved as part of other initiatives
Providers	**Participating Providers**	Eligible providers form regional coalitions known as Performing Provider Systems (PPSs) led by major public hospitals or other eligible safety net providers; PPSs can include health care providers, health services, community-based organizations, and others. Twenty-five PPSs have been identified as of March 2015. Eligible hospitals are public hospitals, Critical Access Hospitals or Sole Community Hospitals, or hospitals that served a minimum number of Medicaid or uninsured patients. Eligible non-hospital based providers must also meet requirements for volume of Medicaid/uninsured patients. The state and CMS may also approve certain non-qualifying organizations for participation in a PPS.
Projects Being Funded	**DSRIP Project Domains**	1. Overall Project Progress 2. System Transformation and Financial Stability 3. Clinical Improvement 4. Population Health
	Project Funding Per Year	Average project funding per year is $900,000.
	Number of Approved Projects	258
	Minimum Number of Projects Required	PPSs must include a minimum of five projects and a maximum of 11 projects per DSRIP plan with specific criteria for each project category.
	Additional Funded Program Elements	$1 billion total computable in temporary, time limited, funding is available from an Interim Access Assurance Fund (IAAF) for payments to providers to protect against degradation of current access to key health care services in the near term. DSRIP Design Grants are available in CY2014 to support providers in developing DSRIP project plans. They amount to up to $200 million total computable. A high performance pool is available for PPSs that close the gap between baseline and benchmark by 20% and/or exceed the 90th performance percentile on a subset of metrics related to avoidable hospitalization, behavioral health and cardiovascular disease. Funding is composed of up to 10% of annual DSRIP project funds and any unclaimed project funding. The DSRIP budget includes $600 million total computable for state administration of the program over 6 years. As part of these duties, the state will lead learning collaboratives at the regional and state levels that are required for all PPSs.

Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	A standard set of metrics is required for each domain and project. Many of these measures are pay-for-reporting in earlier program years, and transition to being pay-for-performance in later years.
	Metrics and Benchmarked Improvement Targets	All quality improvement targets are closing the gap between the PPS' baseline and the state or national benchmark of the 90th percentile by 10% year-over-year.
	Denominator for Improvement	Population of attributed Medicaid beneficiaries (minimum of 5,000 Medicaid members in outpatient settings) for most projects. One project is for the uninsured and Medicaid non/low utilizing population, and uses that attributed population for the denominator for that project's metrics.
	Statewide Accountability Test	If the state fails to meet specified performance metrics, DSRIP funds will be reduced in Years 4-6 (DYs 3-5) by 5%, 10%, and 20% respectively. If penalties are applied, CMS requires the state to reduce funds in an equal distribution, across all DSRIP projects.
Reporting & Monitoring	**Provider Reporting**	PPSs must report twice a year for payment purposes though they may only be eligible for payment at the end of the year report. PPSs will also report quarterly to support New York's quarterly assessments.
	State Reporting	The state will publish project-by-project updates on a quarterly basis.
	Mid-Point Assessment Process	All plans initially approved by the state must be re-approved by the state in order to continue to receive funding in Years 5-6 (DYs 4 and 5). The state will submit draft mid-point assessment criteria and checklist to review plans to CMS, which will be modified in consideration of learning and new evidence.
	Program Evaluation	The state is currently developing its evaluation plan: it submitted an evaluation proposal and received public input. Will have an interim and final independent evaluation.
	External Audit/Review	New York is contracting with an independent assessor, Public Consulting Group (PCG), to serve as an external auditor and reviewer.

Oregon Hospital Performance Metrics Advisory Committee
By-Laws

ARTICLE I
The Committee and its Members

- The Hospital Performance Metrics Advisory Committee ("Committee") was established by Oregon's 2013 House Bill 2216, and the work of the committee extended in Oregon's 2015 House Bill 2395. The Committee's function is to recommend performance standards for hospitals that are designed to advance health system transformation, reduce hospital costs, and improve patient safety consistent with the Committee's Charter, and as further determined by the Oregon Health Authority.

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Director of the Oregon Health Authority in consultation with the Speaker of the House and the President of the Senate. Committee members will be appointed by the Director for an initial 2-year term. Committee members may be re-appointed at the discretion of the Director for 1-year terms, for a total of 4 years on the Committee.

- Members of the Committee who no longer represent the organization or role they were selected for can continue to serve on the Committee at the discretion of the Director of the Oregon Health Authority.

- Members of the Committee are not entitled to compensation for services but shall be reimbursed for actual and necessary travel expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair from among its members. The Chair will serve for 12 months from the date of their election.

- Duties of the Chair are:
  - Preside at all meetings of the Committee.
  - Coordinate meeting agendas after consultation with Committee staff.
  - Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
  - Be advised of all presentations or appearances before legislative committees that relate to the work of the Committee.
  - The Chair may designate other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

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- The Chair's term shall run from July 1 – June 30.

- The Committee shall select a Vice-Chair from among its members. The Vice-Chair shall become the Chair the year following their election as Vice-Chair ("chair elect"). The Vice-Chair will serve for 24 months from the date of their election: The first 12 months are as Vice-Chair (chair elect), and the second 12 months as Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Perform any other duties assigned by the chair.
  - Serve as the Chair in the year following their election as Vice-Chair.
  - The Vice-Chair's term shall run from July 1 – June 30.

ARTICLE III
Committee Meetings

- The Committee shall meet at least ~~quarterly~~ four (4) times per year, and more frequently at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws.

- The preliminary agenda will be available from the Committee staff and posted on the Committee website [*www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx*] at least two working days prior to the meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- As a general rule, the Committee will conduct its business through discussion and consensus. In cases where consensus cannot be achieved, a vote may be used. Use of a vote and its results will be recorded in the meeting minutes. Official action by the Committee requires the approval of a majority of a quorum of Members.

- When voting on motions, resolutions, or other matters, a voice or electronic vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other

and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair, Vice-Chair, or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

- The by-laws in this section apply to the full Committee and any subcommittees or designated workgroups.

ARTICLE IV

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Committee.

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