

Oregon Metrics and Scoring Committee

AGENDA

August 22, 2012

8:30 a.m. to 11:30 a.m.

Clackamas Community College, Rm. 112

29353 SW Town Center Loop E

Wilsonville, OR 97070

Public call-in number (listen only line): Dial: 1-877-455-8688; participant code: 915042

#	Time	Item	Presenter	Action Item
1	8:30	Welcome and introductions	Tina Edlund	
2	8:40	Committee charter and overview	Tina Edlund	
3	9:00	Incentive program framework	Michael Bailit Tina Edlund	
4	10:00	Waiver requirements	Tina Edlund	
5	10:20	Core measures	Carole Romm	
6	10:50	Next meeting agenda	Carole Romm	
7	11:00	Public testimony		

Next Meeting:

Sept. 11, 2012

8:30-noon

Location: TBD

Metrics and Scoring Committee

Roster

Committee members:

Maggie Bennington-Davis
Cascadia BHC
Portland, OR

Gloria Coronado
Kaiser Permanente Center for Health
Research
Portland, OR

Robert Dannenhoffer
Umpqua Health Alliance
Roseburg, OR

Robert Gillespie
Oregon Pediatric Improvement
Project
Portland, OR

Phil Greenhill
Western Oregon Advanced Health
Coos Bay, OR

Bob Joondeph
Disability Rights Oregon
Portland, OR

David Labby
HealthShare of Oregon
Portland, OR

Jeff Luck
Oregon State University
Corvallis, OR

Jeanine Rodriguez
SEIU
Portland, OR

Staff:

Carole Romm
Oregon Health Authority

Sarah Bartelmann
Oregon Health Authority

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Oregon Metrics and Scoring Committee CHARTER

In 2012, Oregon Senate Bill 1580, Section 21, established the nine-member metrics and scoring committee appointed by the Director of the Oregon Health Authority.

Committee Membership

The members of the committee serve two-year terms and must include:

- Three members at large;
- Three individuals with expertise in health outcome measures; and
- Three representatives of coordinated care organizations.

Committee Purpose

The committee shall use a public process to identify objective outcome and quality measures [and benchmarks], including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations.

Committee Responsibility

The committee must adopt outcome and quality measures annually and adjust the measures to reflect:

- The amount of the global budget for a coordinated care organization;
- Change in the membership of the organization;
- The organization's costs for implementing outcome and quality measures;
- The community health assessment and the costs of the community health assessment.

Measures may include health status, experience of care and patient activation, and key demographic variables including race and ethnicity.

These measures must be consistent with existing state and national quality measures and will be used by the Oregon Health Authority to hold coordinated care organizations accountable for performance and customer satisfaction requirements.

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The Evidence Supporting Quality-Based Incentive Programs

Presentation to the Oregon Metrics and Scoring Committee

Michael Bailit

August 22, 2012

bailit
health
INTEGRATED HEALTHCARE

Agenda

The Challenge of Misaligned Incentives

Creating Incentives for Quality

Evidence for Quality-Based Incentive Programs

Recommendations and Conclusions

The Challenge of Misaligned Incentives

- Tens of thousands of Americans die each year from medical errors¹
- Hundreds of thousands suffer nonfatal injuries that a high-quality health care system would largely prevent¹
- Traditionally few incentives for quality beyond intrinsic motivation
 - Current marketplace does not reward high quality health plans with more enrollees or higher reimbursement

Agenda

The Challenge of Misaligned Incentives

Creating Incentives for Quality

Evidence for Quality-Based Incentive Programs

Recommendations and Conclusions

Proposed Solution: Creating Incentives for Quality

- Quality-based incentives are strategies used by purchasers of health insurance and health care services to make some aspect of plan or provider payment or policy contingent on performance on specified quality measures.

Agenda

The Challenge of Misaligned Incentives

Creating Incentives for Quality

Evidence for Quality-Based Incentive Programs

Recommendations and Conclusions

Limited Evidence of Effectiveness

- Despite the broad application of Quality-Based Incentive programs across commercial insurance, Medicaid and Medicare programs, there is **limited evidence of clinical effectiveness.**
- Problems due to research limitations:
 - Very few controlled studies exist
 - Studies plagued by confounding variables (multiple variables that influence provider performance)
- Problems due to poor design and/or implementation

Few Evaluations of State-Managed Incentive Programs with Health Plans

- Like all Quality-Based Incentive programs, state-run Quality-Based Incentive programs have not been sufficiently evaluated.
 - Limited state resources
 - Absence of a control group
 - Multiple programmatic changes at one time (confounding)
 - Insufficient data
- A survey of state Medicaid directors found that they *believe* that the quality-based incentives are effective¹

Positive Results from New York's P4P Program

- Since 2002, NY's Medicaid program has offered quality-based bonuses and auto-assignment incentives to health plans
- Over the first four years of the program, NY paid approximately \$71.5 million in bonuses
- The state has seen an increase in enrollment in plans that the state identifies are "high quality"
- A Commonwealth Fund study after the incentives were implemented reported that appropriate postpartum care rose from 49% to 68%¹

Evaluations of Employer-based Programs with Health Plans

- Very few formal evaluations
- Anecdotal evidence suggests positive results
- Example: General Motors
 - GM implemented a program that linked the size of the employee contribution to premiums to health plan quality
 - Observed health plans improved quality over time in response to the incentives
 - Experience showed that better performing plans improve faster
 - Low performing plans sometimes did improve but “break-through” improvements often required internal health plan changes (leadership, cultural, etc.)²

Evidence for Physician-Level Programs

- Very limited evidence available
- The results of studies that do exist are mixed
- In 2006, Meredith Rosenthal and Richard Frank reviewed evaluations of pay-for-performance programs and concluded:
 - “...the empirical foundations of pay-for-performance in health care are **rather weak.**”
 - “Among the health care studies that we reviewed, many of those with the strongest research designs **yielded null results with only two positive findings.**”

Some Positive Evaluations

- Some reviews of the literature have found that Quality-Based Incentive programs targeting providers have a positive impact on quality
 - In 2008, a team from the University of Minnesota reviewed nine physician pay-for-performance programs. While the reviewing authors expressed reservations about the design of the studies reviewed due to potential for bias, confounding or lack of appropriate comparison group, they found that **every evaluation** included in the review **found significant improvement** on at least one quality measure.¹
 - A 2006 review published in the *Annals of Internal Medicine*, studied 6 physician-level programs and found that **five of the six studies** had positive or partially positive results with a modest effect size.²

1:Christianson JB, Leatherman S, and Sutherland K. "Lessons from Evaluations of Purchaser Pay-for-Performance: A Review of the Evidence" *Medical Care Research and Review*, December 2008;65(6) supplement:5S-35S. www.ncbi.nlm.nih.gov/pubmed/19015377.

2: Petersen LA, Woodard LD, Urech T, Daw C and Sookanan S. "Does Pay-for-Performance Improve the Quality of Health Care?" *Annals of Internal Medicine*, August 15, 2006;145(4):265-272. www.annals.org/content/145/4/265.abstract.

Other Studies Show Little to No Improvements in Quality

- A seven-year evaluation of the United Kingdom's pay-for-performance program, the largest of its kind which offered generous bonuses, failed to demonstrate a meaningful improvement in quality.³

Very Limited Research on Cost- Reduction

- There has been limited research linking P4P plans with a reduction in spending.
- One study did find an average net savings of \$2.4 million per year associated with reduced hospitalization, physician costs, pharmacy and outpatient spending due to improvements in diabetes care. ¹

Modestly Positive Provider Group-Level Studies

- A 2009 evaluation of the California Integrated Healthcare Association's (IHA) pay for performance program targeting 182 physician organizations in California found that after three years of participation, the physician organizations had made changes in response to the financial incentives.
- However, there were no “breakthrough improvements in quality” and there were still significant gaps in performance when top performing physician organizations were compared to the lowest performing.¹

1: Damberg, C. L., Raube, K., Teleki, S., dela Cruz., E. “Taking Stock Of Pay-For-Performance: A Candid Assessment From The Front Lines.” *Health Affairs*. April 2009. Vol. 28. No. 2. 517-525. doi: 10.1377/hlthaff.28.2.517

Global Budgets May Slow Growth in Medical Spending and Improve Quality of Care

In 2009, BCBS of MA implemented a global payment model called the Alternative Quality Contract (AQC)

- Includes specific quality benchmarks for providers that they must meet to achieve rewards
- Places provider groups at financial risk for failure to meet budget targets

■ After two years, AQC provider groups showed **lower spending and improved quality** compared to a control group.

- Participating providers improved quality and saved more money in year 2 than year 1
- Participation in the contract led to overall savings of 2.8% over the two years (1.9% in year one and 3.3% in year two)
- Reductions in outpatient facility spending on procedures, imaging, and testing accounted for most of the savings.

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The Challenge of Misaligned Incentives

Creating Incentives for Quality

Evidence for Quality-Based Incentive Programs

Recommendations and Conclusions

Recommendations

- While there has been limited research evaluating the Quality-Based Incentive programs with health plans, there has been significant experience with such programs.
- The recommendations that follow are informed by literature and our own research and experience.
- The recommendations are organized as follows:
 - Program design
 - Performance measures
 - Financing
 - Implementation

Program Design Recommendations

- Provide incentives for excellence *and* for performance improvement over time (as specified with CMS)
- Incentivize performance improvement within areas that the CCOs can control
- Engage CCOs in the design process and give them a meaningful role in program design
- Ensure that performance measurement and payment methodology is clear and transparent
- Recognize that incentives will cause CCOs to prioritize
- Consider the impact of underlying payment methodology

Performance Measure Recommendations

- Use measures that adequately capture the relevant and highest priority dimensions of CCO behavior and/or patient outcomes
- Use valid and reliable performance measures, ideally from national measure sets
- Quality measures should focus on outcomes to the extent possible
- Exclude measures that would be expected to be heavily influenced by patient case mix
- Control for the effects of random variation
 - Measure type
 - Denominator size

Financing Recommendations

- Implement budget neutral pay-for-performance programs
- Fund incentives at a level sufficient to motivate CCOs and achieve meaningful improvements in quality
 - For clinicians, a general rule of thumb is that an incentive in the range of 10% is effective¹
- **Dedicate adequate resources to program administration** to avoid measurement error, erroneous algorithm calculations, payment delays or inaccurate payments, all of which could irreparably harm the credibility of the program.

Implementation Recommendations

- Apply incentives where you want to see performance improve (aspirations), and penalties where you want to make sure performance does not decline (basic expectations)
- Make incentives large enough for CCOs to care.
- Conduct thorough education of CCOs prior to implementation
- Introduce models or model elements incrementally where no historical precedent
- Offer technical support to those CCOs being offered incentive opportunities
- Include a process for CCOs to request review of their performance results and correct inaccurate results

Implementation Recommendations

- Regularly update and refine quality incentive strategies
 - changes in plan performance
 - changes in standardized measures (including development of new ones)
 - changes in state quality improvement priorities
- But...
 - don't make changes so often that CCOs don't have time to realize gains
 - Require holding of gains with “retired” measures

Evaluation Recommendations

- Routinely evaluate the program for effectiveness and unintended consequences.
- Recognize that not everything will go as planned and adjustments in design and execution, informed by data, will be necessary.

Conclusion

- Quality-based incentive programs cannot eliminate all of the barriers and perverse incentives that exist in the current payment system
- Quality-based incentive programs can help align state objectives for high quality and efficient evidence-based care with CCO economic incentives.
- CCO quality and efficiency incentives will need to be aligned with the incentives of the CCO providers for state performance objectives to be realized.

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**Oregon Health Policy Board
Oregon 1115 Demonstration Waiver**

On July 5, 2012 the Centers for Medicare & Medicaid Services (CMS) approved Oregon's 1115 Medicaid Demonstration Waiver that was necessary to implement health system transformation. Waivers of this size and scope usually take years to negotiate. The ability to finish so rapidly is a testament to both the importance of this waiver and to an effective federal and state partnership. A brief summary of the key issues follow:

1. **Establishment of Coordinated Care Organizations:** Establishes CCO's as the delivery system for Medicaid. Language in the waiver that describes CCO's mirrors that in our legislation.
2. **Flexibility in use of federal funds:** State has ability to use Medicaid dollars for flexible services e.g. non-traditional health care workers. All flexible services will have to be used for health-related care however the CCO will have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health.

Flexible services will be accounted for in what is paid to CCO's and utilization assumptions for use of these services will be applied. The state and CMS have 120 days to develop the appropriate methodology for accounting for flexible services and their utilization.

3. **Federal Investment:** Calls for federal investment of ~\$1.9 billion over 5 years (Year 1: \$620 million, Year 2: \$620 million, Year 3: \$290 million, Year 4: \$183 million, Year 5: \$183 million). This funding comes through expenditures in the Designated State Health Programs (DSHP). Penalties apply as noted below.
4. **Savings:** State agrees to reduce per capita medical trend by 2 percentage points by the end of the second year of the waiver. There is a ramp up to achieve this. During this year, there is no reduction. Second year must average a 1 percentage point reduction, but again the state must be at a 2 percentage point reduction by the end of the second year. The reduction is from an assumed trend of 5.4% as calculated by OMB and based on the President's budget. Base expenditure is calendar year 2011.

Reporting: Waiver lays out basic parameters, but state has 120 days to develop many details: services, annual pmpm for the baseline period, etc.

Penalties: Penalties for not achieving these savings are significant. Ranging from \$145 million for not achieving the second year goal, to \$183 million in Years 4 and 5.

Earning back: If we subsequently meet the savings goal, or "catch up", we can earn 40% of the penalty back by meeting the goal and not degrading quality; 50% if we meet the goal and IMPROVE quality.

5. **Quality:** There are strong criteria around quality. CMS wants to assure that cost savings are not realized by either withholding needed care, degrading quality or by cutting payment rates. As such there is a requirement that CCO's meet a number of quality metrics and that there is a financial incentive for achieving performance benchmarks. The state and CMS have 120 days to work with national experts on creating the appropriate metrics and incentives. There is a requirement by CMS for a 1% withhold beginning in Year 2 for timely and accurate data submission. A bonus incentive pool is also required in Years 2 and beyond.

Required Core Measures for Years 1 and 2 (all to be reported by race and ethnicity):

- Member satisfaction/experience of care
- Health status
- Rate of tobacco use among CCO enrollees
- Obesity rate among CCO enrollees
- Outpatient and ED utilization
- Potentially avoidable ED
- Ambulatory care sensitive avoidable hospitalizations
- Medication reconciliation post discharge
- All cause readmissions
- Alcohol misuse screening; brief intervention and referral for treatment
- Initiation and engagement in alcohol and drug treatment
- Mental health assessment for children in DHS custody
- Follow up after hospitalization for mental illness
- Effective contraceptive use among women who do not desire pregnancy
- Low birth weight
- Developmental screening by 36 months

In addition, state and CMS will identify additional access measures and measures of cost reduction.

Bonus Pool: Incentives paid will be tied to each CCO's performance on the above quality, cost and access measures as well as EHR adoption. Incentives will be designed to reward both absolute and comparative improvement. CCOs must ensure that incentives are included in CCO-provider agreements to ensure that incentives are passed through to providers.

Quality Improvement Focus Areas: CCOs must commit to improving care in at least 4 of the following 7 focus areas (3 of these may count as a CCO's Performance Improvement Projects (PIP))

- Reducing preventable rehospitalizations
- Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs, etc.
- Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by "super-utilizers".
- Integrating primary care and behavioral health
- Ensuring appropriate care is delivered in appropriate settings
- Improving perinatal and maternity care

- Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care throughout the CCO network

Reporting: State has 120 days to develop both the quarterly report format and the annual report format:

- Quarterly reports in meeting the statewide spending growth reduction AND improvement of statewide quality and access to care. Due 60 days at the end of each quarter, beginning in the second quarter of the first year.
- Annual report of same elements

Penalties to the State for late submission are significant:

0.2% of quarterly administration budget for being 15-30 days late

0.4% of quarterly administration budget for being 31 to 40 days late

0.8% of quarterly administration budget for being 41-50 days late

1% of quarterly administration budget for being 51 or more days late

DRAFT

- 6. Transparency:** CMS requires that must assure that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by Coordinated Care Organization (CCO) by publishing performance data, by CCO, on its website.
- 7. Workforce:**
- To support the new model of care within CCO's will require changes in the health care workforce. As such Oregon will establish a loan repayment program for primary care providers who agree to serve Medicaid populations in rural or underserved communities in Oregon.
 - Failure to establish an annual funding level of \$2,000,000 (for 2-3rd years) will result in a reduction in states DSHP funding associated with workforce development. Reduction will be 25% of the difference between the \$2,000,000 and the amount the state is able to reinstate in the following year.
 - Training for 300 community health workers by December 2015.
 - Capacity: state must track the number of Medicaid primary care providers. Must submit first report within 180 days of approval. Must track where the graduates of Oregon's health profession training programs (in community colleges, OUS, and OHSU) are working and whether they accept Medicaid.
- 8. OHP Medical Benefits:** Current OHP medical benefits will be maintained (there will be no reduction to lines covered on the Prioritized List).

Metrics Principles, Domains and Example CCO Accountability Metrics

OHPB Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics

Potential CCO Performance Measures

At a minimum, any selected performance measure selected should meet standard scientific criteria for reliability and face validity. Potential measures should also be evaluated against the principles below, with the goal of establishing a set of CCO performance measures that reasonably balances the various criteria. OHA should re-examine selected measures on a regular basis to ensure that they continue to meet criteria.

Principle	Selection criteria	Change criteria
Transformative potential	<ul style="list-style-type: none"> ○ Measure would help drive system change 	<ul style="list-style-type: none"> ○ Measure reinforces the status quo rather than prompting change
Consumer engagement	<ul style="list-style-type: none"> ○ Measure successfully communicates to consumers what is expected of CCOs 	<ul style="list-style-type: none"> ○ Measure is not understandable or not meaningful to consumers
Relevance	<ul style="list-style-type: none"> ○ Condition or practice being measured has a significant impact on issues of concern or focus* ○ Measure aligns with evidence-based or promising practices 	<ul style="list-style-type: none"> ○ Lack of currency - measure no longer addresses issues of concern or focus*
Consistency with existing state and national quality measures, with room for innovation when needed	<ul style="list-style-type: none"> ○ Measure is nationally validated (e.g. NQF endorsed) ○ Measure is a required reporting element in other health care quality or purchasing initiative(s) ○ National or other benchmarks exist for performance on this measure 	<ul style="list-style-type: none"> ○ Measure loses national endorsement ○ Measure is unique to OHA when similar standard measures are available
Attainability	<ul style="list-style-type: none"> ○ It is reasonable to expect improved performance on this measure (can move the meter) 	<ul style="list-style-type: none"> ○ CCO or entity performance is “topped out” ○ Measure is too ambitious
Accuracy	<ul style="list-style-type: none"> ○ Changes in CCO performance will be visible in the measure ○ Measure usefully distinguishes between different levels of CCO performance 	<ul style="list-style-type: none"> ○ Measure is not sensitive enough to capture improved performance ○ Measure is not sensitive enough to reflect variation between CCOs
Feasibility of measurement	<ul style="list-style-type: none"> ○ Measure allows CCOs and OHA to capitalize on existing data flows (e.g. state All Payer All Claims reporting program or other established quality reporting systems) ○ Data collection for measure will be supported by upcoming HIT and HIE developments 	<ul style="list-style-type: none"> ○ Burden of data collection and reporting outweighs the measure’s value

Reasonable accountability	<ul style="list-style-type: none"> ○ CCO has some degree of control over the health practice or outcome captured in the measure 	<ul style="list-style-type: none"> ○ Measure reflects an area of practice or a health outcome over which CCO has little influence
Range/diversity of measures	<ul style="list-style-type: none"> ○ Collectively, the set of CCO performance measures covers the range of topics, health services, operations and outcomes, and populations of interest 	<ul style="list-style-type: none"> ○ There is a surplus of measures for a given service area or topic ○ Measure is duplicative ○ Measure is too specialized

* These issues include, but are not limited to: health status, health disparities, health care costs and cost-effectiveness, access, quality of care, delivery system functioning, prevention, patient experience/engagement, and social determinants of health.

Domains of Measurement

OHA should assess CCO performance in these domains:

- Accountability for system performance in all service areas for which the CCO is responsible:
 - Adult mental health
 - Children’s mental health
 - Addictions
 - Outpatient physical
 - Inpatient physical
 - Women’s health
 - Dental
 - Prevention
 - End-of-life care
- Accountability for transformation:
 - Care coordination and integration
 - Patient experience and activation
 - Access
 - Equity
 - Efficiency and cost control
 - Community orientation

37. **Structure.** Capitation rates and incentives for the Coordinated Care Organizations (CCOs) for each demonstration year (DY) will be structured as follows:

a. Demonstration Year 11:

- i. Capitation rates. There will be no major changes in the currently approved rate-setting methodology for DY11.
- ii. Incentives and Withholds. There will be no incentive payments made to CCOs or amount withheld from the CCOs.
- iii. Special performance Standards. The State will apply special performance standards of timely and accurate data reporting in the first year.

b. Demonstration Years 12 through 15:

- i. Capitation Rate Withhold. The first quarter of DY 12 will include a 1-percent capitation rate withhold that will be returned to CCOs successful in DY 11 performance metrics which reward timely and accurate data reporting. A CCO that successfully meets the performance metrics of timely and accurate data reporting in DY 11 will receive the full capitation rate in this quarter. A CCO that does not meet the DY 11 performance metrics will not have the withhold restored, resulting in a 1-percent rate reduction. The state will determine the parameters for the special performance standards of timely and accurate data reporting within 120 days of this agreement.
- ii. The State will have an additional 120 days after the agreement is in effect to address the details of DYs 12-15 so long as it is within the following parameters and subject to CMS approval:
 1. Bonus Incentive Pool. The State will establish a separate bonus/incentive pool outside of the capitation rates (i.e., in addition to any capitation rate withholds). Incentives must be designed to reduce costs and improve health care outcomes. When developing the bonus pool, the State will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing.

- a. The State will alert the CCOs that the bonus incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole bonus incentive pool amount will be at risk. The State will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark, and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance. Within 120 days of the Demonstration approval, the State will submit and CMS will approve the specific requirements. The State will amend its CCO contracts to incorporate the changes immediately following the 120-day period.
2. CCO Provider Agreements. Incentives must be correlatively reflected in the CCO/provider agreements to insure that the incentives are passed through to providers to reflect the arrangement with the State-CCO contract.
- iii. Each subsequent DY rates and incentives will be set in the DY preceding the implementation in order to apply program experience as the program matures (e.g., DY 13 rates and incentives will be set in DY 12). The State will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.

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

38. **Overview.** Improving access and quality is a key component of the State health system transformation and measurement is necessary to determine whether the demonstration's goal of advancing the triple aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required.
39. **Metrics and Scoring Committee.** The State's strategy for a robust measurement includes the newly established Metrics and Scoring Committee. The Committee will review data and the relevant literature, determine which measures will be included in the CCO incentive program, and establish the performance benchmarks and targets to be used in this incentive program. The Committee will endorse/develop specifications for each measure. In future years, the Committee will review earlier decisions and make adjustments as needed. A transitional Metrics and Scoring Committee recommended a set of metrics for the first

program year, which were described in CCO RFA contracts. Going forward, the permanent Metrics and Scoring Committee will recommend metrics that will be used to determine financial incentives for CCOs.

40. **Additional Quality Measures and Reporting at the CCO Level.** CMS developed an additional list of requirements for the Metrics and Scoring Committee that should be incorporated into the measurement planning and financial incentive determinations. This should not supplant the work of this committee, but rather provide some strategic direction to reach the two goals of this Demonstration. The CCOs will be required to collect and validate data and report to the State on the metrics listed in this section, which may be revised or added to over time as the demonstration matures, but these metrics will remain constant for the first 2 years of the demonstration. CMS also encourages the CCOs to report on the core set of performance measures for children and adults in Medicaid and CHIP.

a. **Metrics to track quality improvement focus areas:** Pursuant to paragraph 25.b.i), the State and CMS will ensure the collection and validation of measures to track progress in the quality improvement focus areas. (See Attachment E)

b. **Core set of quality improvement measures.** The initial core measures will track the following:

- i. Member/patient experience of care (CAHPS tool or similar);
- ii. Health and functional status among CCO enrollees;
- iii. Rate of tobacco use among CCO enrollees;
- iv. Obesity rate among CCO enrollees
- v. Outpatient and emergency department utilization;
- vi. Potentially avoidable emergency department visits;
- vii. Ambulatory care sensitive hospital admissions;
- viii. Medication reconciliation post discharge;
- ix. All-cause readmissions;
- x. Alcohol misuse-screening, brief intervention, and referral for treatment;
- xi. Initiation & engagement in alcohol and drug treatment;
- xii. Mental health assessment for children in DHS custody;
- xiii. Follow-up after hospitalization for mental illness;
- xiv. Effective contraceptive use among women who do not desire pregnancy;
- xv. Low birth weight;
- xvi. Developmental screening by 36 months; and
- xvii. Difference in these metrics between race and ethnicity categories;

- c. **Access improvement measures based on CCO data.** The State and CMS will identify and agree to additional access measures by 120 days after the approval of this demonstration planning period. CCOs will ensure the collection and validation of the measures of access such as those listed below. These measures may be based on claims and encounter data, survey data, or other sources, and may be revised over time as the demonstration matures.
- i. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
 - ii. Percentage of adults with any outpatient visit.
 - iii. Percentage of adults with a chronic disease w/any outpatients visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
 - iv. Percentage of adults with a chronic disease in the prior year, w/any outpatient visit this year.
 - v. Percentage of children with at least one dental visit.
 - vi. Fraction of physicians (by specialty) ‘participating’ in the Medicaid program.
 - vii. Change in the number of physicians (by specialty) participating in Medicaid
 - viii. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
 - ix. Percentage of CCO enrollees with access to a PCPCH.
- d. **Access improvement measures based on state survey data.** The State will identify and CMS will approve additional access measures, particularly measures based on survey data, by 120 days after the approval of this demonstration planning period. Additional survey-based measures could include:
- i. Percent of beneficiaries with a usual source of care.
 - ii. Percent of beneficiaries with a preventive visit in past year.
 - iii. Percent of beneficiaries with a dental visit in past year.
 - iv. Percent of beneficiaries with any unmet needs.
 - v. Percent of beneficiaries delaying/deferring care due to cost.
 - vi. Percent of beneficiaries delaying/deferring care due to lack of available provider.
 - vii. Percent of beneficiaries delaying/deferring care due to provider office being closed at time of illness.
 - viii. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

41. **Utilization of new services.** The State and CCOs must track discrete services whether it is a State Plan service or other service paid for with Medicaid funds under the capitation rate and report this as encounter or other data, as appropriate. This is a joint state-CCO reporting requirement.
42. **Quality and Access Data Reporting from the State to CMS.** In accordance with paragraph 7864, ~~Monitoring to Assure Progress in Meeting Demonstration Goals,~~” the State will submit quarterly reports to CMS including a summary of the three types of data, aggregated at the state level: metrics on the quality improvement focus areas, core quality metrics on the overall Medicaid program, and access metrics. Additionally, the State will develop commensurate metrics tooled for fee-for-service populations, targeted to measure quality and access improvements for fee-for-service populations and services outside the CCOs. Within 120 days of the Demonstration approval, the State will submit and CMS will approve a reporting format.
43. **Consequences to CCOs for Failing to Fulfill Requirements or Meet Performance Standards.**
- a. **Statewide quality, access, and expenditure monitoring and analysis.** The State, working with the CCO Innovator agents, shall monitor statewide CCO performance, trends, and emerging issues within and among CCOs on a monthly basis, and provide reports to CMS quarterly. The State must report to CMS any CCO issues impacting the CCO’s ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights
 - b. **Intervention to improve quality, access and expenditures.** Upon identification of performance issues, indications that quality, access, or expenditure management goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the State shall intervene promptly within 30 days of identifying a concern, with CMS’ technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified. Interventions may include but are not limited to focused learning collaboratives and/or innovator agents, targeting underlying issues affecting outcomes, performance, access and cost.
 - c. **Additional actions taken if goals are not achieved.** If the interventions undertaken pursuant to paragraph 43.b do not result in improved performance in identified areas of

concern within 90 days, the state should consider requiring the CCO to intensify the rapid cycle improvement process. CMS technical assistance will be available to support that process. Subsequent action can include the State placing the CCO on a corrective action plan. The State must inform CMS when a CCO is placed on a corrective action plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the learning collaboratives and peer-support to the extent practicable.

44. **EQRO.** The State is required to meet all requirements found in 42 CFR 438, subpart E. The State will need to amend its current EQRO contract to require the reporting of outcomes information in the annual technical report related to performance measures and performance improvement projects. The State should generally have available its final EQR Technical Reports to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)]. In the first year of the transition to the CCO system and to a modified EQRO contract, CMS will use the quality and access data from the quarterly reports as identified in paragraph 42 to satisfy regulatory requirements.
45. **State Quality Strategy.** In accordance with CMS regulations, the State is required to submit a written strategy for assessing and improving the quality of managed care service offered by all managed care entities. This written strategy (also referred to as the “quality strategy”) must meet all of the requirements found in 42 CFR 438, subpart D. Before implementing a final, approved quality strategy, the State is required to submit a draft quality strategy to CMS for approval within 120 days of the approval date of the Demonstration. The State will submit a revised strategy to CMS within 60 days, whenever significant changes are made. The State will submit annual reports to CMS on the implementation and success of the strategy, by means of the annual EQRO technical report or a separate annual report that assesses the implementation and effectiveness of the quality strategy.

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

This section establishes the parameters by which the State and CMS will annually measure the impact of Health Systems Transformation on expenditures, quality, and access, including specific targets for expenditure growth reduction and parameters for quality and access measurement, and financial consequences that occur if these expenditure targets and associated quality measurements are not achieved. Data specified in this section shall be reported on a quarterly and annual basis as specified in paragraph 64.

Oregon Metrics and Scoring Committee PERFORMANCE MEASURES

Core performance metrics

1. Member/patient experience of care (CAHPS tool or similar);
2. Health and functional status among CCO enrollees;
3. Rate of tobacco use among CCO enrollees;
4. Obesity rate among CCO enrollees
5. Outpatient and emergency department utilization;
6. Potentially avoidable emergency department visits;
7. Ambulatory care sensitive hospital admissions;
8. Medication reconciliation post discharge;
9. All-cause readmissions;
10. Alcohol misuse-screening, brief intervention, and referral for treatment;
11. Initiation & engagement in alcohol and drug treatment;
12. Mental health assessment for children in DHS custody;
13. Follow-up after hospitalization for mental illness;
14. Effective contraceptive use among women who do not desire pregnancy;
15. Low birth weight;
16. Developmental screening by 36 months; and
17. Reduction of disparities: differences in these metrics among race and ethnicity categories

Additional Year 1 Measures

18. Planning for end-of-life care
19. Screening for clinical depression and follow-up plan
20. Timely transmission of transition record
21. Care plan for members with long-term care benefits

Access Measures

1. Based on CCO data (examples):
 - a. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
 - b. Percentage of adults with any outpatient visit.
 - c. Percentage of adults with a chronic disease w/any outpatient visits in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
 - d. Percentage of adults with a chronic disease in the prior year, w/any outpatient visits this year.
 - e. Percentage of children with at least one dental visit.
 - f. Fraction of physicians (by specialty) participating in the Medicaid program.
 - g. Change in the number of physicians (by specialty) participating in Medicaid
 - h. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
 - i. Percentage of CCO enrollees with access to a PCPCH.

2. Based on state survey data (examples):
 - a. Percent of beneficiaries with a usual source of care.
 - b. Percent of beneficiaries with a preventive visit in past year.
 - c. Percent of beneficiaries with a dental visit in past year.
 - d. Percent of beneficiaries with any unmet needs.
 - e. Percent of beneficiaries delaying/deferring care due to cost.
 - f. Percent of beneficiaries delaying/deferring care due to lack of available provider.
 - g. Percent of beneficiaries delaying/deferring care due to provider office being closed at time of illness.
 - h. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

Quality Improvement Focus Areas (PIPs)

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

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Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
1	<p>Member Experience of Care*^ (Key items/domain scores TBD from member experience survey (version TBD and may alternate by year))</p> <p>HEDIS CAHPS 4.0 <i>Also part of:</i> Medicaid Adult Core, CHIPRA Core, Medicare ACOs, Medicare Part C, OR PCPCH, others</p> <p><i>NQF #/Steward TBD</i></p>	<ul style="list-style-type: none"> Improving patient experience is one of the three parts of the Triple Aim Key topic identified by stakeholder workgroup Required by Medicaid Adult and CHIPRA Core sets Meets stakeholder measure selection criteria of relevance, consumer engagement, consistency with state or national measures, attainability, accuracy, feasibility, and reasonable accountability. 	<p>2011 CAHPS:</p> <p>Adult composites:</p> <ul style="list-style-type: none"> Getting Care 45% Getting Care Quickly 51% How well doctor communicates 66% Health Plan Information and Customer Service 53% <p>Adult Ratings:</p> <ul style="list-style-type: none"> Personal Doctor 60% Specialist 62% Overall Health Care 43% Overall Health Plan 42% <p>Child Composites:</p> <ul style="list-style-type: none"> Getting Care 50% Getting Care Quickly 67% How well doctor communicates 73% Health Plan info & Customer Service 58% <p>Child Ratings:</p> <ul style="list-style-type: none"> Personal Doctor 68% Specialist 63% Overall health: 55% Overall Health Plan 56% <p>Mental Health: <i>Adults</i></p> <ul style="list-style-type: none"> Access 74% Treatment participation 56% Outcomes 54% Social connectedness 59% 	<p>Adult composites:</p> <ul style="list-style-type: none"> 51% 56% 70% 53% <p>Adult Ratings:</p> <ul style="list-style-type: none"> 63% 62% 49% 54% <p>Child Composites:</p> <ul style="list-style-type: none"> 55% 71% 75% 60% <p>Child Ratings:</p> <ul style="list-style-type: none"> 70% 66% 61% 64% <p>Mental Health: <i>Adults</i></p> <ul style="list-style-type: none"> 85% 87% 87% 71%

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
			<ul style="list-style-type: none"> • General satisfaction 79% • Quality and appropriateness 78% <p><i>Children</i></p> <ul style="list-style-type: none"> • Access 72% • Treatment participation 79% • Outcomes 54% • Social connectedness 85% • General satisfaction 69% • Cultural sensitivity 89% 	<ul style="list-style-type: none"> • 88% • 88% <p><i>Children</i></p> <ul style="list-style-type: none"> • 83% • 87% • 71% • 85% • 83% • 93%
2	<p>Member health status CAHPS Functional status*[^]</p> <p><i>CAHPS Health Plans and Systems 4.0 Adult Medicaid Core, CHIPRA core, NCQA Accreditation</i></p>	<ul style="list-style-type: none"> • Improving health is one of the three parts of the Triple Aim • Summary outcome measure from client perspective (in whole or in part) • Meets stakeholder measure selection criteria of relevance, consumer engagement, accuracy, feasibility, and reasonable accountability. 	<p>Adult</p> <p style="padding-left: 20px;">Excellent 7%</p> <p style="padding-left: 20px;">Very Good 16%</p> <p style="padding-left: 20px;">Good 33%</p> <p style="padding-left: 20px;">Fair 29%</p> <p style="padding-left: 20px;">Poor 14%</p> <p>Child</p> <p style="padding-left: 20px;">Excellent 37%</p> <p style="padding-left: 20px;">Very Good 36%</p> <p style="padding-left: 20px;">Good 20%</p> <p style="padding-left: 20px;">Fair 6 %</p> <p style="padding-left: 20px;">Poor 0%</p> <p>Of those who accessed Mental Health services:</p> <p>Adults 56%</p> <p>Children 59%</p>	<p>Adult</p> <p style="padding-left: 20px;">Excellent 11%</p> <p style="padding-left: 20px;">Very Good 22%</p> <p style="padding-left: 20px;">Good 32%</p> <p style="padding-left: 20px;">Fair 24%</p> <p style="padding-left: 20px;">Poor 10%</p> <p>Child</p> <p style="padding-left: 20px;">Excellent 37%</p> <p style="padding-left: 20px;">Very Good 36%</p> <p style="padding-left: 20px;">Good 21%</p> <p style="padding-left: 20px;">Fair 5%</p> <p style="padding-left: 20px;">Poor 1%</p> <p>Mental Health:</p> <p>Adults 71%</p> <p>Children 62%</p>

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
3	<p>Rate of tobacco use among CCO enrollees*^ (% members who use tobacco products)</p> <p>CAHPS Also part of: Nat'l Quality Strategy NQF #/Steward: Unknown</p>	<ul style="list-style-type: none"> Tobacco use is disproportionately high among Medicaid population and a driver of high costs and poor health Outcome measure relevant to key topics of prevention and cost control Meets stakeholder measure selection criteria of relevance, transformative potential, consumer engagement, attainability, accuracy, feasibility, and reasonable accountability. 	31%	37%
4	<p>Obesity rate*^ (BMI outside parameters) among CCOs enrollees</p> <p>HEDIS, Medical Home Core, Part C, NCQA</p>	<ul style="list-style-type: none"> Obesity associated with numerous chronic conditions and poor health status Outcome measure relevant to key topics of prevention and cost control Meets stakeholder measure selection criteria of relevance, transformative potential, consumer engagement, feasibility (via survey or member report of height and weight) and reasonable accountability. 	TBD	
5	<p>Access to Care, primary care and ED *^</p> <p>HEDIS- CHIPRA Technical Specification CHIPRA Core, NCQA HEDIS NQF #/Steward: NCQA/HEDIS</p>	<ul style="list-style-type: none"> Relevant to key topics of access and cost control Meets stakeholder measure selection criteria of relevance, consistency with state or national measures, attainability, accuracy, feasibility and reasonable accountability. 	<p>ED utilization for children 0-20 Years: 41.6/1000 member months in 2010</p> <p>Access to Care (one or more ambulatory visit)</p> <p>25 months – 6 85.54%</p> <p>7 -11 86.5%</p> <p>12 -19 86.8%</p> <p>20-44 84.2%</p> <p>45-64 90.1%</p> <p>65+ 85.4%</p>	<p>ED utilization for children 0-20 years: 62/1000 member months</p> <p>Age 20-44: 77.1%</p> <p>Age 45-64: 82.8%</p>

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
6	<p>Potentially avoidable ED visits*^</p> <p><i>Specific metric to be determined</i></p>	<ul style="list-style-type: none"> • Relevant to key topics of access and cost control • Meets stakeholder measure selection criteria of relevance, transformative potential, consumer engagement, attainability, and reasonable accountability. 	Establish baseline in year 1	
7	<p>Primary-care sensitive hospital admissions*^ (Prevention Quality Indicator, PQIs)</p> <p>AHRQ ,using member months</p> <p><i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p><i>NQF #/Steward: 0272-0285, 0638/ AHRQ</i></p>	<ul style="list-style-type: none"> • Transformation should incent primary care over tertiary • Relevant to key topics of access, prevention, cost control • Required by Medicaid Adult core set • Meets stakeholder measure selection criteria of relevance, transformative potential, consumer engagement, consistency with state or national measures, attainability, accuracy, feasibility and reasonable accountability. 	2011 rate = 6.4/ per 10,000 Member Months	
8	<p>Medication reconciliation post-discharge (% patients discharged from acute or non-acute inpatient facility who had discharge meds reconciled with current med list in the medical record within 30 days).</p> <p><i>Also part of: Medicare ACO set</i></p> <p><i>NQF #/Steward: 0097</i></p>	<ul style="list-style-type: none"> • Lack of communication between patients and physicians and the burden of taking multiple medications can result in drug interactions, adverse drug events, drug overuse and drug underuse; adverse drug events are a leading cause of morbidity and mortality. • Relevant to key topic of care coordination • Meets stakeholder measure selection criteria of relevance, transformative potential, consumer engagement, consistency with state or national measures, attainability, accuracy, feasibility and reasonable accountability. 	Establish baseline in year 1	None

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
9	<p>All-cause readmissions*^ - %</p> <p><i>NQF # 1768, Adult Core Measure, Medical Home Core stays followed by a readmission for any reason within 30 days; (also report separately for psychiatric)</i></p>	<ul style="list-style-type: none"> • Widespread state and national interest in reducing readmissions • Relevant to key topics of care coordination, cost control, and patient experience • Required by Medicaid Adult core set • Meets stakeholder measure selection criteria of relevance, transformative potential, consistency with state or national measures, attainability, feasibility and reasonable accountability. 	<p>Establish baseline Year 1</p> <p>Mental health (psych readmits): 10%</p>	<p>Mental health (psych readmits) 14%</p>
10	<p>Alcohol or other substance misuse - Screening, brief intervention, referral for treatment (SBIRT)^ (% members 18+ with routine visit in the measurement year screened for alcohol or other substance misuse, and referred as necessary)</p> <p><i>Also part of: OR PCPCH NQF #/Steward: n/a – RAND measure</i></p>	<ul style="list-style-type: none"> • Stakeholder workgroup emphasized importance of screening and follow-up for behavioral health issues given CCO emphasis on integration & coordination and relevance of behavioral health issues as cost drivers • Relevant to key topics of addictions, and care coordination and integration • Meets stakeholder measure selection criteria of relevance, consistency with state or national measures, attainability, accuracy, feasibility and reasonable accountability. 	<p>Establish a baseline in year 1</p>	<p>None</p>

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
11	<p>Initiation & engagement in alcohol and drug treatment[^] (% members with new episode of alcohol or drug dependence who have initial encounter w/in 14 days of diagnosis and 2+ services with 30 days of initial visit)</p> <p><i>Also part of: Medicaid Adult Core, HEDIS, Meaningful Use, OR PCPCH</i> <i>NQF #/Steward: 0004</i></p>	<ul style="list-style-type: none"> • Stakeholder workgroup emphasized importance of screening and follow-up for behavioral health issues given CCO emphasis on integration & coordination and relevance of behavioral health issues as cost drivers • Relevant to key topics of addictions, access, and patient experience/engagement • Meets stakeholder measure selection criteria of relevance, consistency with state or national measures, attainability, accuracy, feasibility and reasonable accountability. 	Establish baseline in year 1	None
12	<p>Mental health assessment for children in DHS custody (% Children who receive a mental health assessment within 30 days of DHS custody)</p> <p><i>Also part of: Current MHO performance measure (DHS/OHA wraparound initiative)</i> <i>NQF #/Steward: Unknown</i></p>	<ul style="list-style-type: none"> • Stakeholder workgroup emphasized importance of screening and follow-up for behavioral health issues given CCO emphasis on integration & coordination and relevance of behavioral health issues as cost drivers • Measure emphasizes cross-system coordination (medical and social services) • Relevant to key topics of care coordination, mental health, and access • Meets stakeholder measure selection criteria of relevance, consistency with state or national measures (is currently used as an MHO performance measure), attainability, accuracy, feasibility and reasonable accountability. 	58%	N/A

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
13	<p>Follow-up after hospitalization for mental illness*^ (% of members with follow-up visit within 7 days after hospitalization for mental illness)</p> <p><i>HEDIS; CHIPRA Technical Specifications</i> <i>Also part of: Adult Medicaid Core, NCQA/NQF# 0576, Health Home Core</i></p>	<ul style="list-style-type: none"> Stakeholder workgroup emphasized importance of screening and follow-up for behavioral health issues given CCO emphasis on integration & coordination and relevance of behavioral health issues as cost drivers Required by Medicaid Adult core set Relevant to key topics of care coordination, mental health Meets stakeholder measure selection criteria of relevance, consistency with state or national measures, attainability, accuracy, feasibility and reasonable accountability. 	<p>Adults 52%</p> <p>Children 39%</p>	<p>Overall 44.6% (NCQA, Medicaid HMO avg. 2009)</p>
14	<p>Effective contraceptive use (% reproductive age women who do not desire pregnancy using an effective method of contraception)</p> <p><i>Also part of: HP 2020</i> <i>NQF #/Steward: Unknown</i></p>	<ul style="list-style-type: none"> Unintended pregnancy are highest among low-income women Relevant to key topic areas of prevention, women's health or maternal & child health, and access Meets stakeholder measure selection criteria of relevance, attainability, accuracy, feasibility and reasonable accountability. 	<p>In 2010, approximately 67% of women who would be income-eligible for Medicaid if pregnant reported using an effective method of contraception⁴</p>	
15	<p>Low birth weight (rate or % of births where infant weighs < 2,500 grams)</p> <p><i>HEDIS; CHIPRA Technical Specification</i> <i>NQF #/Steward: (0278)</i></p>	<ul style="list-style-type: none"> Outcome measure with population orientation Required in CHIPRA core set Relevant to key topic areas of prevention, women's health or maternal & child health Meets stakeholder measure selection criteria of relevance, consistency with state or national measures, accuracy, feasibility. and reasonable accountability 	<p>6.9% (vs. 6.3% statewide)</p>	<p>8.2% (overall national rate)</p>

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
16	Developmental screening by 36 months <i>CHIPRA Technical Specifications</i> <i>Also part of: NQF #1448</i>	<ul style="list-style-type: none"> • Developmental screening is a key interest for Governor’s Early Learning Council; measure supports cross-system coordination • Required in CHIPRA core set • Relevant to key topic areas of prevention, maternal & child health • Meets stakeholder measure selection criteria of relevance, transformative potential, consistency with state or national measures, attainability, accuracy, feasibility, and reasonable accountability. 	14.6%	
17	Reduction of Disparities - report all metrics by race and ethnicity	<ul style="list-style-type: none"> • Improving health equity is an important goal of health systems transformation • Key topic identified by stakeholder workgroup • Meets stakeholder measure selection criteria of relevance, consumer engagement, transformative potential, attainability, feasibility, and reasonable accountability. • Accuracy and completeness of data expected to improve with measurement requirement. 	Establish baseline in year 1	
18	Planning for end-of-life care <i>Specific metric to be determined</i>	<ul style="list-style-type: none"> • Relevant to key topic areas of end-of-life care, care coordination, patient experience, and cost control • Meets stakeholder measure selection criteria of relevance, transformative potential, consumer engagement, and reasonable accountability (and others, pending definition of specific measure). 	Establish baseline in year 1	

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
19	<p>Screening for clinical depression and follow-up plan[^] (% of members patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented)</p> <p><i>Also part of: Adult Medicaid Core, Medicare ACOs</i> <i>NQF #/Steward: 0418 (CMS - PQRS)</i></p>	<ul style="list-style-type: none"> • Stakeholder workgroup emphasized importance of screening and follow-up for behavioral health issues given CCO emphasis on integration & coordination and relevance of behavioral health issues as cost drivers • Required in Medicaid Adult core set • Relevant to key topics of mental health, care coordination and integration • Meets stakeholder measure selection criteria of relevance, consistency with state or national measures, attainability, accuracy, and reasonable accountability. 	Establish baseline in year 1	
20	<p>Timely transmission of transition record[^] (% of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours)</p> <p><i>Also part of: Adult Medicaid Core, Health Homes Core</i> <i>NQF No: 0648</i></p>	<ul style="list-style-type: none"> • A critical aspect of primary care home • Required in Medicaid Adult core set • Relevant to key topic of care coordination • Meets stakeholder measure selection criteria of relevance, consistency with state or national measures, attainability, accuracy, and reasonable accountability. 	Establish baseline in year 1	

Core Metrics for Oregon Healthcare Transformation

#	Measures	Why selected?	Baseline	National Average
21	<p>Care plan for members with long-term care benefits (% of members with a joint care plan in place)</p> <p><i>Specific metric to be determined</i></p>	<ul style="list-style-type: none"> • Coordinated care planning is a key expectation for CCOs; focus on those with long-term care benefit supports joint accountability with LTC system • Relevant to key topics of care coordination, patient experience and engagement • Meets stakeholder measure selection criteria of relevance, consumer engagement, attainability, and reasonable accountability (and others, pending definition of specific measure). 	Establish baseline in year 1	

* Report separately for members with severe and persistent mental illness

^ Report separately for individuals with Medicaid-funded Long-Term Care (LTC) – These measures may be used to promote shared accountability between CCO and LTC systems.

1. Oregon 2010 Statewide Health Improvement Plan, available at: <http://health.oregon.gov/OHA/action-plan/hip-report.pdf>. Data source: 2004 Oregon Medicaid BRFSS.
2. Oregon 2010 Statewide Health Improvement Plan, available at: <http://health.oregon.gov/OHA/action-plan/hip-report.pdf>. Data source: 2007 Medicaid plans CAHPS survey.
3. Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012, available at: http://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/Oregon_PANfactst_2012.pdf. Data source: 2009 Oregon BRFSS.
4. Oregon Public Health Division (program analysis). Data source: 2010 Oregon BRFSS data.
5. Oregon Vital Statistics Annual Report 2010 Volume 1, available at: <http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/10v1/Pages/Section2.aspx>