Summary: Oregon's 1115 Medicaid Demonstration
Accountability Plan and Expenditure Trend Review

Agreement that establishes the methods, measurements and accountability for Oregon's Health System Transformation.

The Oregon Health Authority has reached a final agreement with the Centers for Medicare and Medicaid Services (CMS) as required by the Special Terms and Conditions (STCs) of Oregon's Section 1115 demonstration. The agreement outlines the methods, measurements and accountability for the state's plan to improve health and lower costs for people served by the Oregon Health Plan/Medicaid. The signed agreement supports Oregon's move toward a model of outcome-based, coordinated care. It also points the way to a health care system that is flexible, transparent and sustainable in the future.

Oregon's Accountability Plan describes how Oregon and Coordinated Care Organizations will be held accountable for reducing the growth in Medicaid expenditures while also improving health care quality and access. The document also describes CMS's commitments to Oregon, including a significant federal investment to support health system transformation.

The Accountability Plan is divided into two sections:

Section A:

- Part I: Quality Strategy
- Part II: Statewide Tests for Quality and Access
- Part III: Measurement Strategy

Section B: Draft Expenditure Review Plan

Section A, Part I: Quality Strategy

Traditionally, a Medicaid Quality Strategy is the document by which states identify their vision and strategy for quality, oversight and compliance with federal regulations for managed care. With the Accountability Plan, both Oregon and CMS are shifting toward a new model, encouraging a broad array of supports that focus on continuous learning, rapid cycle improvement and transformation. The Quality Strategy describes how CCOs will be held accountable for a new model of care within Medicaid that relies upon increased transparency, clear expectations, and incentives for improvement.

Highlights include:

- *Oregon's goals* in the areas of lower costs, improved quality of care, access to care, experience of care, and population health;
- *Improvement strategies* that include both stimuli (such as transparency and incentives) and supports (e.g., significant investment in measurement, analytics and evaluation)

Section A, Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluation

Statewide Quality and Access Test:

CMS requires that the state conduct a rigorous annual assessment of quality and access to ensure that the demonstration's cost control goal is not being achieved at the expense of quality. If quality and access diminish at the statewide level the state will face significant financial penalties. Part II of the Accountability Plan also includes overall monitoring and evaluation plans to support rapid feedback and continuous quality improvement .

Evaluation:

Quarterly reporting and public reporting of data and metrics will be aimed at providing timely and actionable feedback to CCOs, the state, and CMS on an ongoing basis.

There will also be more formal evaluations conducted by external, independent contractors that will employ sophisticated analytic methods in order to determine whether changes in quality and outcomes resulted from the state's transformation activities.

Section A, Part III: Measurement Strategy

The measurement of progress is a critical feature of the demonstration project. By tracking achievement on a variety of metrics, Oregon will be able to evaluate CCO performance, and CMS will be able to evaluate Oregon's progress. Part III describes measurement strategies to support both CCO-level quality activities as well as statewide quality activities.

The metrics evaluate performance in access to care, member satisfaction with care, and quality of care in seven focus areas: (1) Improving behavioral health/physical health coordination; (2) improving perinatal and maternity care; (3) reducing preventable rehospitalizations; (4) ensuring care is delivered in appropriate settings; (5) improving primary care; (6) deploying care teams to reduce unnecessary and costly utilization by super-utilizers; and (7) addressing population health issues. (See page 4 of this document for a complete list of the measures.)

Oregon's performance on health care quality and access will be evaluated by CMS using the metrics that follow at the end of this document. CCO quality pool payments will be determined by performance on the metrics set, "CCO Quality Pool Metrics."

Section B - Draft Expenditure Trend Review:

Under Oregon's approved waiver, the state agreed to reduce the Oregon Health Plan's per capita medical expenditure trend (i.e., the increase in capitation) by 2 percentage points over the final three years of the demonstration.

The 2 percentage point reduction will be evaluated based on expenditures for:

- All services provided through CCOs over the course of the demonstration;
- Wrap-around payments to health centers for services provided through CCOs; and
- Incentives and shared savings payments to CCOs.

The 2 percentage point reduction in per capita spending growth will be measured from a 5.4 percent annual projected trend over the course of the waiver, as calculated by the Office of

Management and Budget (OMB). Calendar year 2011 will serve as the base year. To meet the 2 percent reduction, increases in per capita expenditures cannot exceed 4.4 percent in the second year of the demonstration (July 2013 – June 2014) and 3.4 percent in the third year of the demonstration (July 2014 – July 2015).

In addition, the document includes a return on investment methodology to compare the savings to the infusion of federal dollars provided through the designated state health programs (DSHP) for health care transformation. Oregon will provide quarterly reports to CMS to monitor progress toward the 2 percentage point reduction goal and the return on federal investment.

Oregon Measures

CCO Quality Pool Metrics

The state's Metrics and Scoring Committee is responsible for identifying and adopting metrics by which CCOs will be held accountable for improved outcomes . The committee identified an initial set of 17 metrics, which were incorporated with few modifications by CMS into the Accountability Plan. Full specifications for these metrics are included in the Plan; 16 of these 17 metrics are also included in the metrics by which CMS will hold the state accountable.

1) Alcohol or other substance misuse screening, brief intervention and referral to treatment (SBIRT)
2) Follow-up care for children on ADHD medication (NQF #0108)[1]
3) Follow-up after hospitalization for mental illness (NQF #0576)
4) Screening for clinical depression and follow-up plan (NQF #0418)
5) Mental and physical health assessment for children in DHS custody
6) Timeliness of pre-natal care (NQF #1517)
7) Elective delivery before 39 weeks
8) Developmental screening by 36 months (NQF #1448)
9) Adolescent well-care visits
10) Colorectal cancer screening
11) Controlling high blood pressure (NQF #0018)
12) Diabetes: HbA1c poor control (NQF #0059)
13) Total emergency department and ambulatory care utilization (visits/1,000 members)
14) Patient-Centered Primary Care Home (PCPCH) enrollment
15) Access to care (CAHPS[2] composite):
    a. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?" (Adult)
    b. "In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?" (Adult)
    c. "In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed?" (Child)

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[1]An NQF (National Quality Forum) designation indicates that the measure has been endorsed as meeting consensus standards for measuring and publicly reporting on performance.

[2] CAHPS – Consumer Assessment of Healthcare Providers and Systems survey

   d. "In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?" (Child)

16) Satisfaction with health plan customer service (CAHPS composite):
   a. "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" (Adult)
   b. "In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?" (Adult)
   c. "In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?" (Child)
   d. "In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?" (Child)

17) EHR adoption (Meaningful Use composite – three questions)

Oregon Accountability Metrics

The Accountability Plan also includes the 33 metrics by which CMS will hold Oregon accountable for financial penalties, which includes 16 of the CCO metrics:

1) Alcohol or other substance misuse screening, brief intervention and referral to treatment (SBIRT)
2) Follow-up care for children on ADHD medication (NQF #0108)
3) Follow-up after hospitalization for mental illness (NQF #0576)
4) Screening for clinical depression and follow-up plan (NQF #0418)
5) Timeliness of pre-natal care (NQF #1517)
6) Elective delivery before 39 weeks
7) Developmental screening by 36 months (NQF #1448)
8) Adolescent well-care visits
9) Colorectal cancer screening
10) Controlling high blood pressure (NQF #0018)
11) Diabetes: HbA1c poor control (NQF #0059)
12) Total emergency department and ambulatory care utilization (visits/1,000 members-2 rates)
13) Patient-Centered Primary Care Home (PCPCH) enrollment
14) Access to care (CAHPS[3] composite-adult/child)
15) Satisfaction with health plan customer service (CAHPS composite-adult/child)
16) EHR adoption (Meaningful Use composite – three questions)
17) All-cause readmissions (NQF #1789)
18) Breast cancer screening (NQF #0031)
19) Cervical cancer screening (NQF #0032)
20) Medical assistance with smoking and tobacco use cessation (NQF #0027)
21) PQI 01: diabetes, short-term complications admission rate (NQF #0272)
22) PQI 05: chronic obstructive pulmonary disease (COPD) admission rate (NQF #0275)
23) PQI 08: congestive heart failure admission rate (NQF #0277)

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[3] CAHPS – Consumer Assessment of Healthcare Providers and Systems survey

24) PQI 15: adult asthma admission rate (NQF #0283)
25) Chlamydia screening in women (NQF #0033)
26) Comprehensive diabetes care: LCL-C screening (NQF #0063)
27) Diabetes: Hemoglobin A1c testing (NQF #0057)
28) Childhood immunization status (NQF #0038)
29) Immunization for adolescents (NQF #1407)
30) Well-child visits in the first 15 months of life (NQF #1392)
31) Child and adolescent access to primary care practitioners
32) Appropriate testing for children with pharyngitis (NQF #0002)
33) Provider access questions from Oregon Physician Workforce Survey (3 questions)