Oregon's Health System Transformation Quarterly Legislative Report

Q2 & Q3 2016






Published January 2017

Oregon Health Authority

About this report

Welcome to OHA's quarterly report to the Legislature on Oregon's Health System Transformation progress for Q2 and Q3 2016 (April—September). In order to provide the legislature with the most recent information and data and to catch up and better align with the calendar year, OHA is combining Q2 and Q3 where data is available.

This report was developed to address legislatively established reporting requirements for health system transformation and coordinated care organizations (CCOs).[1]

On a quarterly basis, this report will provide updates on the Oregon Health Plan population and CCOs' efforts to further the transformation of our health system.

For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority Director's Office at:

503-947-2340 or
OHA.DirectorsOffice@state.or.us

[2]Requirements include Senate Bill 1580 (2012), Oregon Revised Statutes 414.620 and 414.629, and House Bill 3650 (2011), which established Oregon's integrated and coordinated health care delivery system in which CCOs are used to improve health, quality, access, and outcomes.

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Director's Message

Across the nation there are many questions about the future of health care reform. While we don't know the extent of the impact on the state of the national health care debate, we do know that the progress we are making here in Oregon is real and measurable. The good news is Oregon recently received approval of our federal Medicaid waiver, allowing Oregon to continue its innovative model of health care for Oregon Health Plan (OHP) members and maintain the gains the state has made in the past five years to improve the integration, coordination, and quality of care. Oregon's uninsured rate has dropped from 15 percent to 5 percent in the past five years, leaving Oregon with the 19th lowest uninsurance rate in the country. Currently, 95 percent of Oregon adults and 98 percent of children have health coverage.

When the Centers for Medicare & Medicaid Services (CMS) acting administrator Andy Slavitt came to Oregon in October to personally take a look at our health system transformation, he was impressed with the great work of Oregon's coordinated care organizations (CCOs), which is showing results in improving health outcomes while reducing the rate of cost growth, while beginning to address social determinants of health. Administrator Slavitt's visit to Oregon was a testament to the hard work accomplished over the past five years.

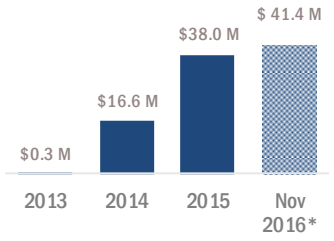
Oregon's progress in health system reform is reflected in this quarterly legislative report. I encourage you to review the report, draw your own conclusions and share your thoughts with us. In Oregon, health transformation is a team effort.

What is clear from this data is that Oregon's health system transformation is focused on improving the health outcomes for Oregon Health Plan (OHP) members. OHP provides needed health coverage to approximately 1 million people, or more than one in four Oregonians and more than one in three Oregonians in many rural counties. It is the largest health plan in the state and the engine for the health system transformation that has improved health outcomes and avoided state and federal costs of more than $1.4 billion since 2012.

Key features of this report include:

- A highlight on financial pressures facing Medicaid program and CCOs, including the **impact on the OHP budget of increasing pharmacy costs**. In 2015, pharmacy expenditures reached $674 million compared to $533 million in 2014. Hepatitis C drug expenditures continue to significantly rise, with $38.0 million spent on Hepatitis C drugs in 2015 compared to $16.6 million in 2014.
- Metrics related to emergency department utilization, and follow-up after hospitalization for mental illness all continue to improve across Oregon since pre-CCO baseline in 2011. Dental sealants for children has also improved remarkably since 2014, the year dental services were integrated into the CCO model.
- The Oregon Health Authority continues to focus on **addressing OHP member complaints and working with CCOs to quickly resolve issues**. In the third quarter of 2016, 99 percent of complaints were resolved within the first quarter.

Hepatitis C drug expenditures
Total since 2013: $95.7 million



*Claims received by OHA as of November 2016.
July-November are incomplete. Final CY 2016 will increase.

In Q3 2016, **99%** of complaints were resolved within the quarter

Director's Message

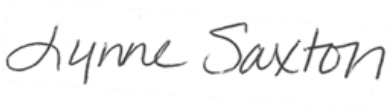
- An evaluation of the patient-centered primary care home (PCPCH) model that focuses on primary care and preventive measures. The report from Portland State University showed that for every $1 increase in primary care expenditures in the PCPCH program, there are $13 in savings. In the first three years, the PCPCH program has saved Oregon $240 million to Oregon's health system.
- A key focus on the recruitment and training of **traditional health care workers to deliver high-quality, culturally competent care** to achieve Oregon's triple aim and help address health disparity in Oregon. In 2016, OHA certified over 1,500 traditional health workers, mostly in the peer wellness field.

In 2016, OHA certified 1,506 traditional health workers.

Program:	# Certified
Community health workers	422
Personal health navigators	6
Peer wellness/support specialists	1,011
Other (doulas)	28
TOTAL	1,506

As we begin a new year, it is important to remember Oregon has a long history of bipartisan health care reform and we stand ready to make improvements to ensure all Oregonians have access to affordable, high-quality health care.

I look forward to working with Governor Brown and Oregon's leaders to make changes that move us forward, not backward.



Lynne Saxton, Director
Oregon Health Authority

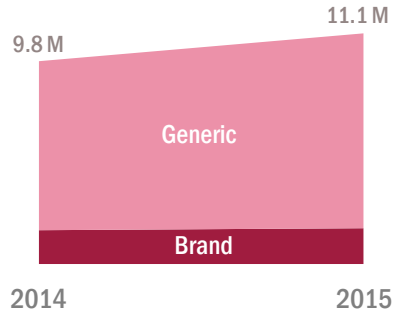
Hot Topics

Pharmacy expenditures and utilization are increasing.

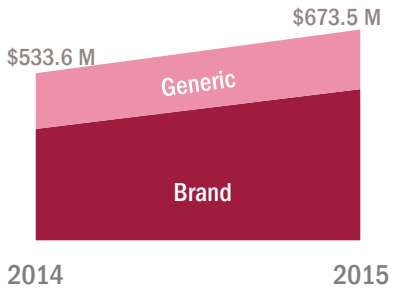
Over the last few years, pharmacy costs have continued to increase and have an impact on the Oregon Health Plan budget. During the 2017 rate development process, CCOs reported a significant increase in pharmacy expenditures from 2014 to 2015.

Brand drugs make up a much smaller share of prescriptions utilized...

(# of prescriptions)



...but a larger share of total expenditures.



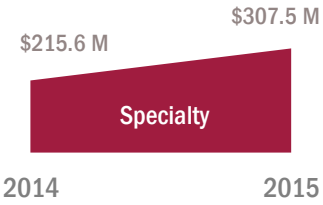
With limited levers to control costs and the capped growth of 3.4 percent annually, the Oregon Health Authority is exploring alternative options to contain these emerging pharmacy costs. Strategies to address the rising cost of prescription drugs in Oregon include:

- Partnering with 11 other states in the Sovereign State Drug Consortium to negotiate rebates;
- Participation in SMART-D multistate collaborative to develop alternative payment models for purchase of high cost specialty drugs;
- Developing use of Oregon Prescription Drug Program by CCOs to leverage group purchasing; and
- Working with all CCOs to align drug purchases, resulting in lower net costs.

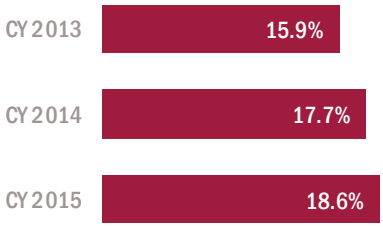
A short report highlighting pharmacy cost and utilization data was presented to the Oregon Health Policy Board in October and is available online at: http://www.oregon.gov/oha/hpa/csi/Documents/Pharmacy-Costs-Report.pdf.

Specialty drug expenditures have also increased.

(Specialty is define d as drugs that cost more than $600 per month. It is a subset of generic and brand)



Each year, prescriptions make up a larger share of CCO physical and mental health expenditures reported in the claims data.



Hot Topics

CCO Listening Sessions

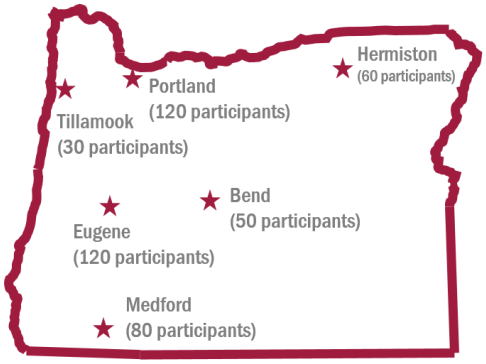
As the state nears the end of the first five year period with coordinated care organizations delivering care to almost 1 million Oregonians, the Oregon Health Policy Board (the Board, OHPB) was asked by the Governor and the House Healthcare Committee to review the vision for coordinated care and make recommendations to build on the promise and progress achieved by health system transformation and coordinated care organizations thus far.

To meet this charge the Board toured the state last fall to seek qualitative input from stakeholders. In addition to six listening sessions, the Board fielded an online survey with the same questions asked at listening sessions. The online survey was available for 45 days in Spanish and English and was distributed through electronic newsletters, social media and via community outreach.

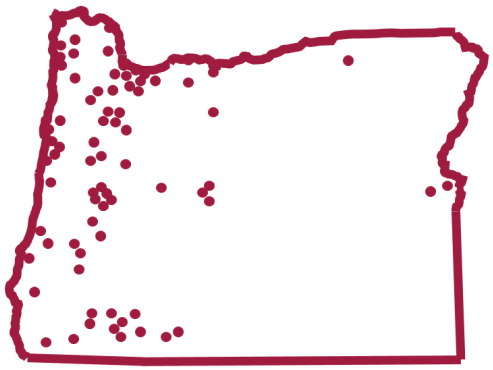
A wide range of themes was heard. The majority of responses fall into five broad policy areas and have been formed into the five broad DRAFT statements below based on analysis of listening session notes and survey responses:

1. **CCO coordination:** CCO community coordination to address the social determinants of health must be accelerated and strengthened to link Oregonians with the right kind of care at the right place at the right time.
2. **CCO integration**: The integration of physical, behavioral and oral healthcare services has improved but should be accelerated to realize the vision of an integrated delivery system.
3. **Health equity:** Health care delivery system disparities persist; strategies that address cultural competency, social stigmas, and equitable access should continue to be prioritized.
4. **Value-based payment:** Payment reform is in progress but needs more clarity, coordination and technical assistance to achieve critical mass.
5. **CCO governance and structure:** Governance structures should reflect local community and public needs, be transparent and accountable; CCOs should invest savings in community-needed services.

In-person listening sessions were held throughout the state...



... and online survey respondents represented a wide geographic range.



The Board will issue its final recommendations later this month.

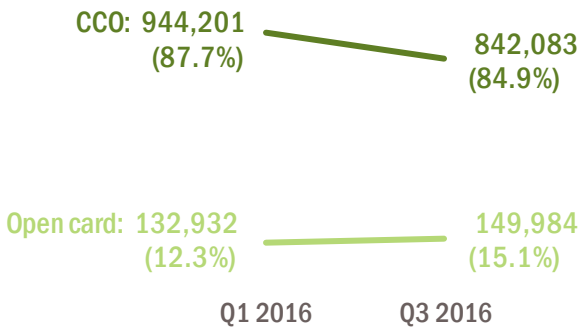
Current Board membership:

- Chair - Zeke Smith (Portland)
- Vice Chair – Carla McKelvey, MD, (Coos Bay)
- Oscar Arana (Portland)
- Felisa Hagins (Portland)
- Brenda Johnson (Medford)
- Karen Joplin (Hood River)
- Joe Robertson, MD (Portland)

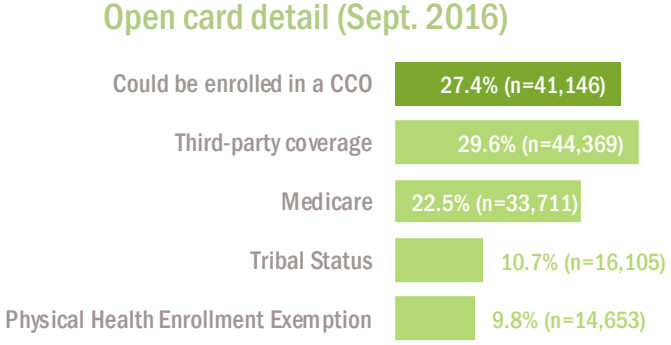
Oregon Health Plan Demographics (Q3)

Medicaid enrollment has increased almost 70 percent since the 2014 expansion, with total enrollment in September 2016 of 992,067. The majority of Medicaid members are enrolled in coordinated care organizations (CCOs).

Oregon Health Plan enrollment

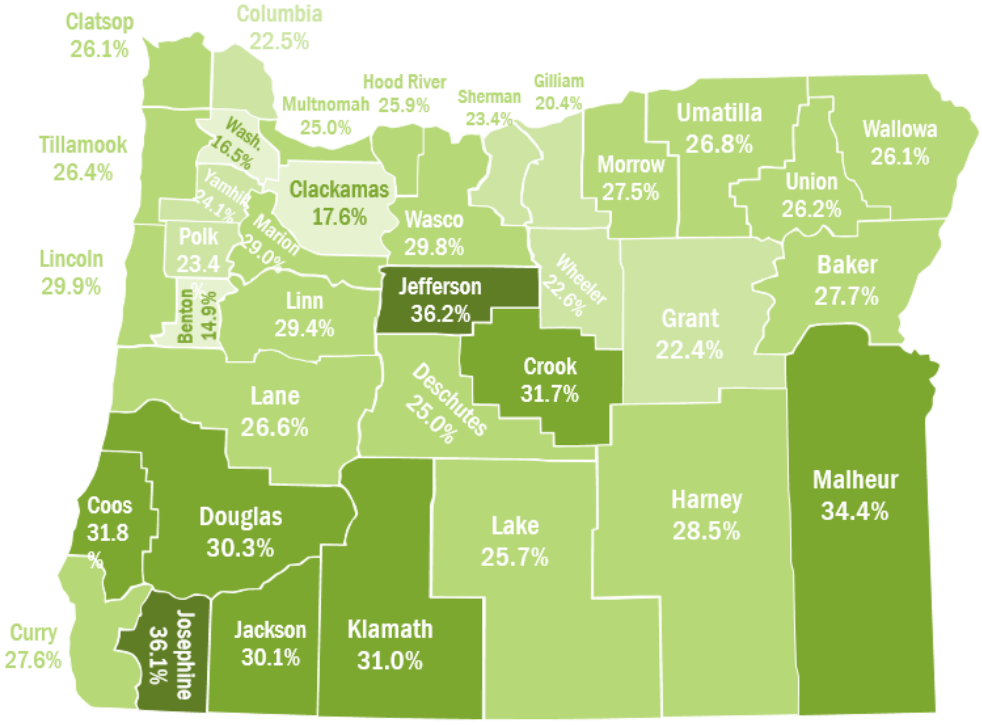


More than one quarter of open card members could be enrolled in a CCO.



As OHA worked to implement ONE, the new eligibility system, redeterminations for Medicaid eligibility were delayed for large portions of the OHP population. The redetermination began in earnest in March of 2016 and since then OHA has seen decreasing enrollment in OHP (see page 27 for more on Eligibility and Enrollment). Much of the decrease is associated with the MAGI (Modified Adjust Gross Income) populations who did not respond to redetermination requests. This has impacted the CCO enrolled populations to varying degrees. The fee for service (or open card) population has slightly increased. Where possible, OHA hopes to move this population to CCOs.

Percent of Oregon's population enrolled in OHP, by county
September 2016



Definitions:

Oregon Health Plan (OHP)
Oregonians who receive comprehensive Medicaid benefits. OHP covers services such as regular check-ups, prescriptions, mental health care, addiction treatment, and dental care.

Open Card
OHP members who are not enrolled in a CCO or other managed care organization. Sometimes referred to as "fee for service."

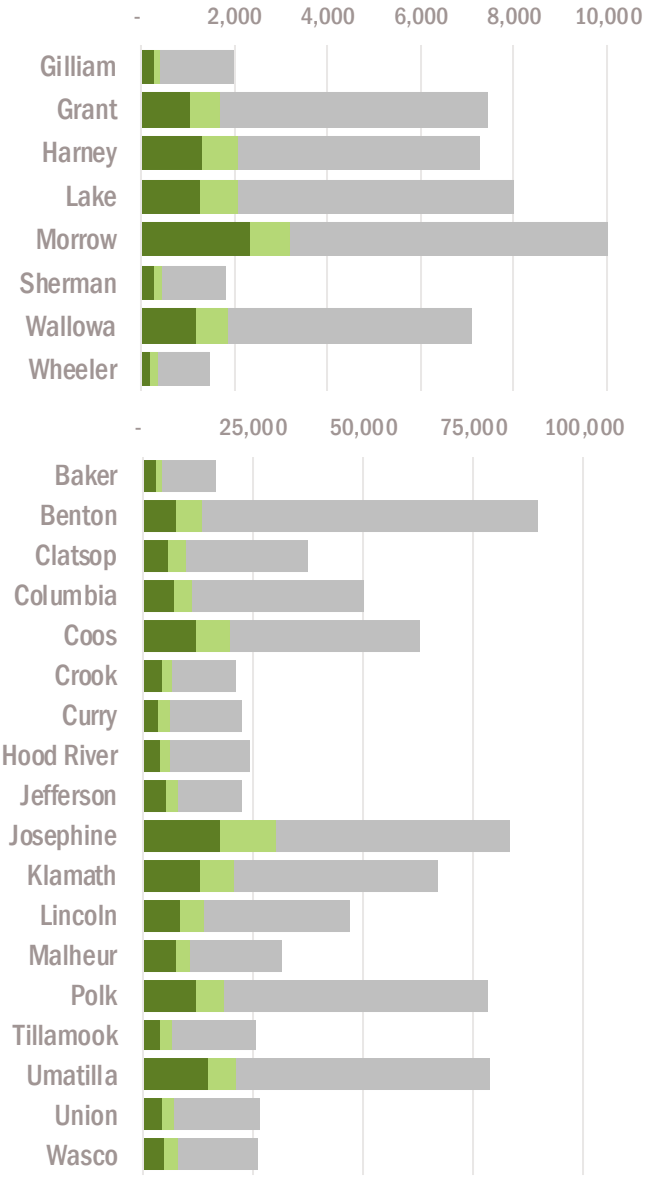
Map legend:	25-29%
14-19%	30-34%
20-24%	35-39%

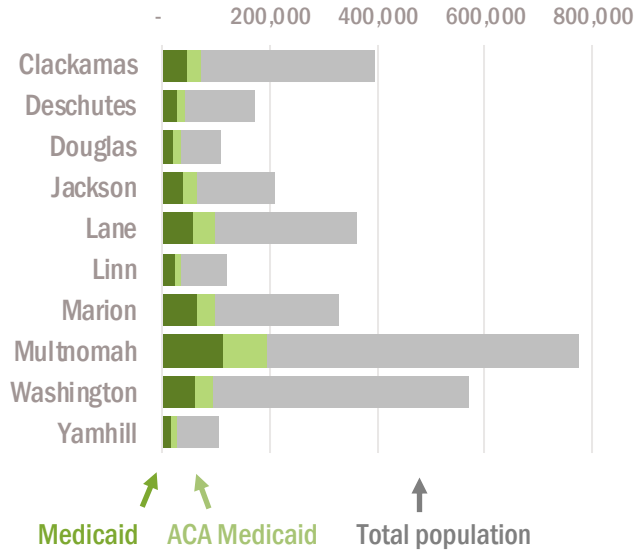
Oregon Health Plan Demographics (Q3)

In September 2016 more than 378,000 Oregonians and one in three Medicaid recipients were receiving Medicaid coverage through new income eligibility criteria allowed by the Affordable Care Act (ACA).

Numbers of Oregonians who receive Medicaid and receive Medicaid because of the ACA, as part of total population, by county.

Note that counties are plotted on different axes based on total population size. Data tables are available in Appendix A (page 30).



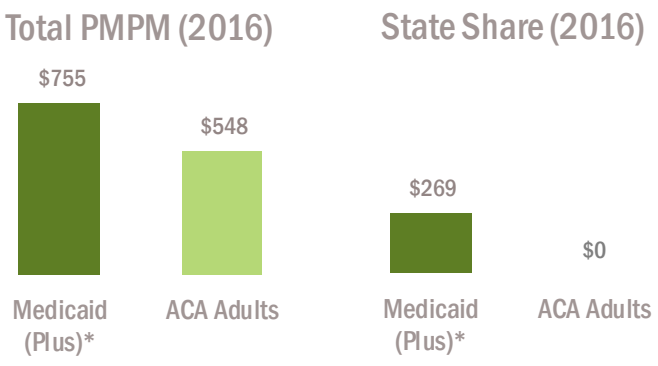


ACA adults cost less per member per month (PMPM) than Medicaid (plus) adults.

Adult Oregonians who receive Medicaid because of the ACA have lower PMPM costs than adults who receive Medicaid for other reasons (also known as "Medicaid (Plus)").

In CY 2016, the state paid 35.6% of costs for Medicaid (Plus) members, and 0.0% of costs for ACA adults.

During the 2017-2019 biennium, the state share increases to 36.7% for Medicaid (Plus) and 6.0% for ACA adults.

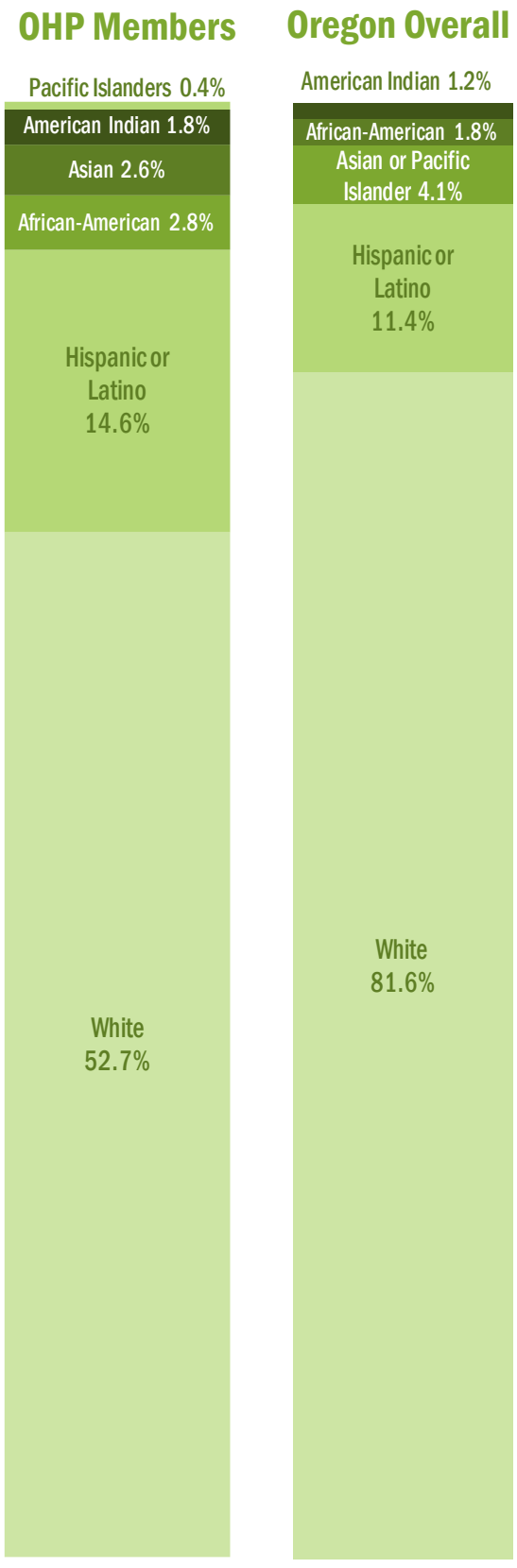


Statewide, **one in three** Medicaid recipients has coverage through the Medicaid expansion in the **Affordable Care Act**

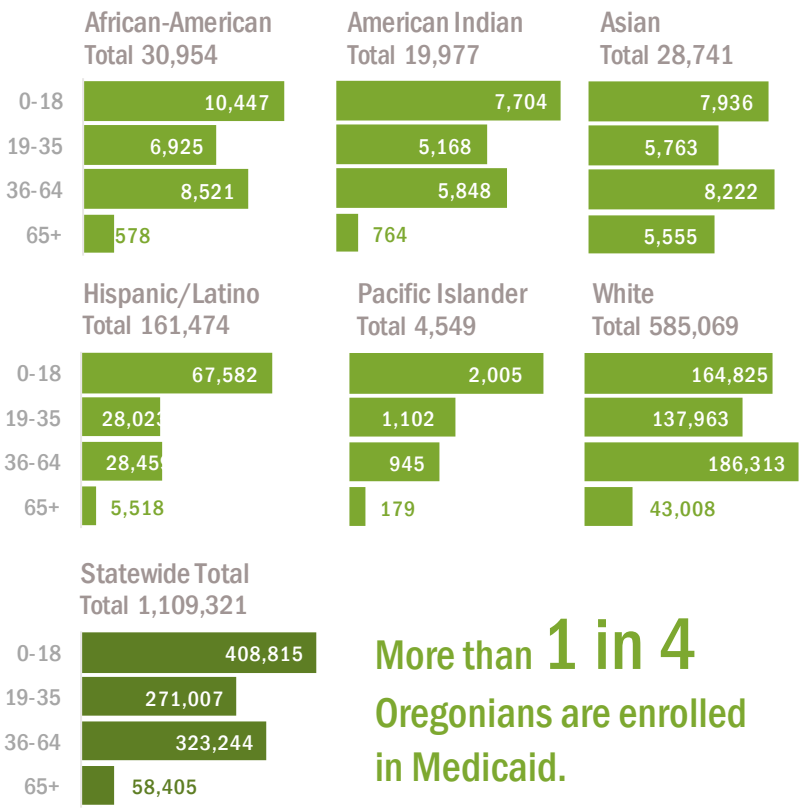
Oregon Health Plan Demographics (Q3)

OHP and Oregon populations, by race and ethnicity

The racial and ethnic makeup of the Oregon Health Plan population differs from Oregonians overall, but has remained fairly consistent despite the inclusion of new members following the Medicaid expansion in 2014.



OHP enrollment by race/ethnicity and age, September 2016



More than **1 in 4** Oregonians are enrolled in Medicaid.

- Data are missing for 7.9 percent of the population, and 17.2 percent are categorized "unknown other." Thus, percentages do not add to 100.
- Missing data are where the race/ethnicity fields are blank on the member's enrollment file; unknown/other is used when member information is provided, but is not clear or does not align with existing categories.
- Race and ethnicity are collected separately, but reported together here. For example, an individual who indicates they are both White (race) and Hispanic/Latino (ethnicity) is counted as Hispanic/Latino. An individual who indicates that they are Native American (race) and non-Hispanic (ethnicity) is counted as Native American.

Oregon Overall: Source, 2010 US Census

Oregon Health Plan Demographics (Q3)

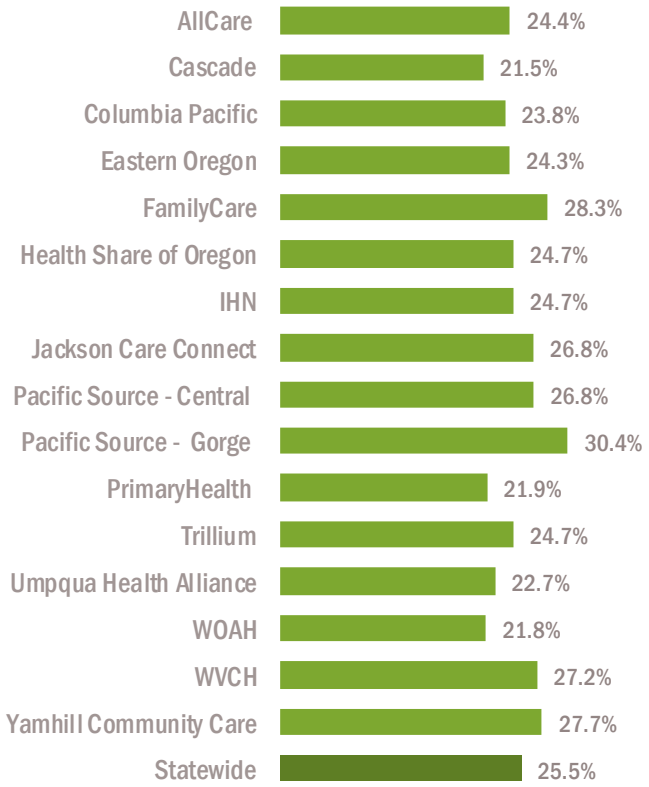
Oregon Health Plan eligibility

To qualify for the Oregon Health Plan, individuals and families must meet income and residency requirements. Oregonians may also qualify based on age and disability status.

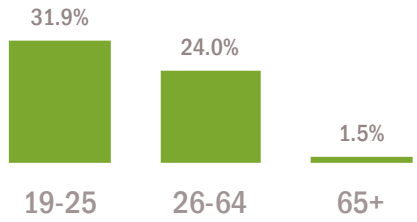
- **Adults**: OHP is available to adults who earn up to 138 percent of the Federal Poverty Level (FPL). That's about $16,300 a year for a single person, or $33,500 a year for a family of four.
- **Children:** OHP is available to children and adolescents (0-18) whose family earns up to 300 percent FPL. That's about $48,000 a year for a family of two, or $72,900 a year for a family of four.

Oregon Health Plan, by employment status

Percent of adult members ages 19-64 who work at least half time, by CCO.
September 2016



Percent working at least half time, statewide by age.
September 2016



Statewide, nearly 40% of CCO members ages 19-64 have some type of employment.

And 8% of adult CCO members are working more than full time.

Employment data published in the Q1 2016 issue of this report came from Kaiser Family Foundation survey data. The data shown here are from state Medicaid and employment data and are more reflective of Oregon's Medicaid population.

CCO Performance on Incentive Quality Metrics (Q2)

CCOs are in the middle of the fourth year in which the Oregon Health Authority will distribute bonus payments from a "quality pool" to CCOs that meet benchmarks or demonstrate certain improvements on a set of 18 measures. A mid-year progress report — covering the measurement period July 2015 through June 2016 — has been published simultaneously with this Legislative Report and is available online at: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx.

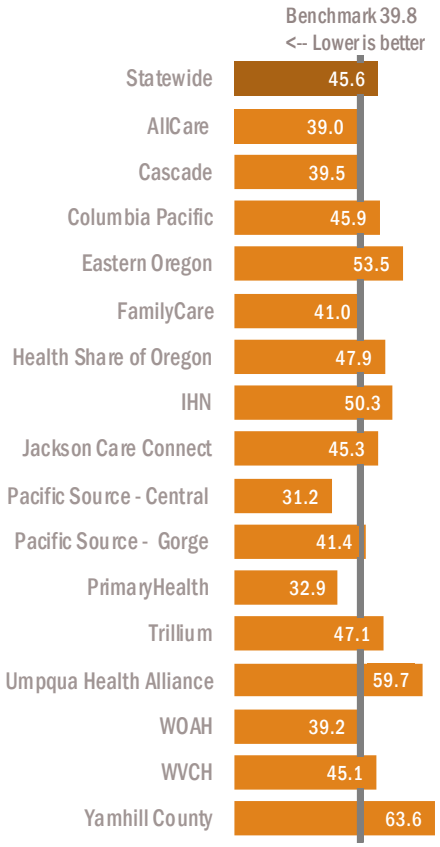
The report includes results for all measures over time (since 2011 baseline) reported at the state level, by CCO, and by race/ethnicity where available, as well as a subset of measures stratified by members with disability, mental health diagnoses, and severe and persistent mental illness (SPMI). The report shows progress on CCO incentive measures, as well as additional state and core performance and measures, such as avoidable emergency department utilization, diabetes short-term complication admission rates, and more.

The graphs below show progress through Q2 2016 on a selection of quality measures, statewide and by CCO compared against the benchmark. The next page shows these same measures stratified by various sub-populations. Since late 2014 CCOs have been receiving monthly "dashboards" that allow users to slice the data and view performance for specific populations. This helps CCOs understand and address disparities within the Oregon Health Plan population they serve.

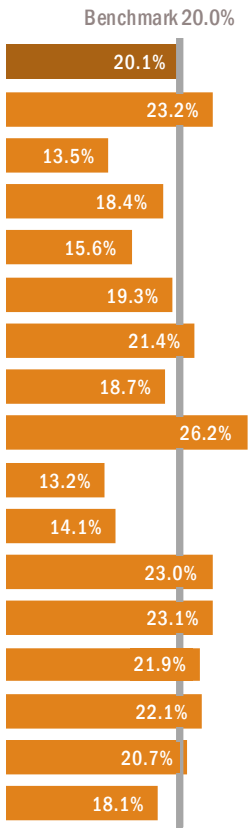
Measuring quality and access to care are key to moving health system transformation forward, to ensure high-quality care for Oregon Health Plan members.

Emergency Dept utilization, Q2 2016

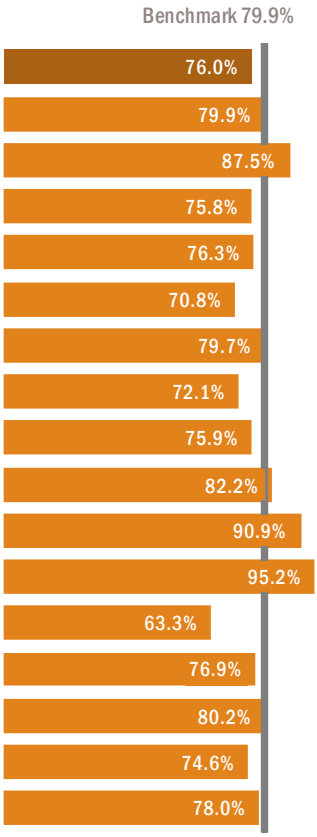
Lower is better. Per 1,000 member months.



Dental sealants for children, Q2 2016



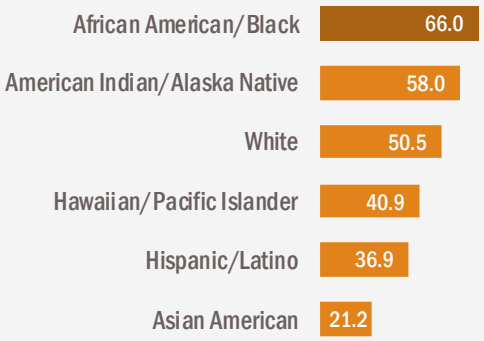
Follow-up after hospitalization for mental illness, Q2 2016



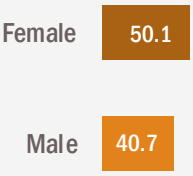
CCO Performance on Incentive Quality Metrics (Q2)

Emergency department utilization* was higher among...

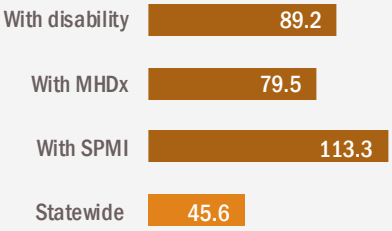
...African-American members,



...women,



...and members with disability, mental health diagnoses (MHDx), and severe and persistent mental illness (SPMI)



Emergency department utilization among

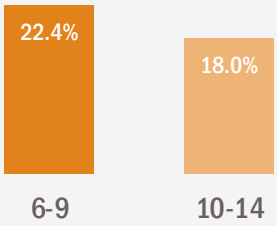
African-American women with SPMI: 154.9

Notes

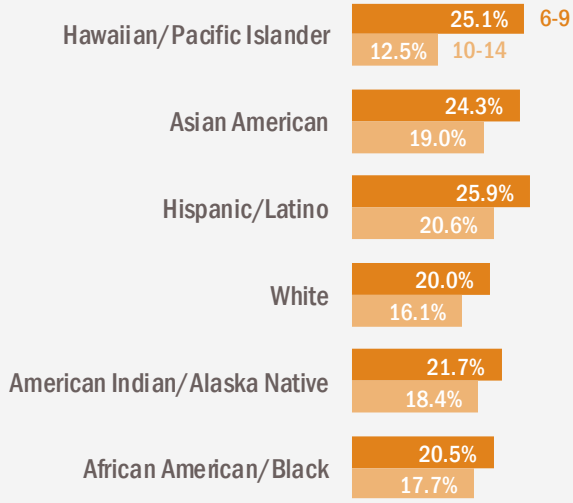
*ED utilization is reported per 1,000 member months. This means that in one month, XX visits occurred per 1,000 members. Lower is better.

^ Data for other racial groups suppressed due to small denominators (n<30) among rural populations

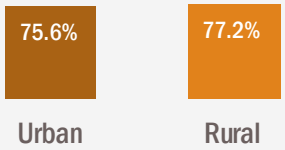
Dental sealants varied by age...



...and the disparity by age was especially large among Hawaiian/ Pacific Islander children.



Follow-up after hospitalization for mental illness was slightly higher in rural areas...



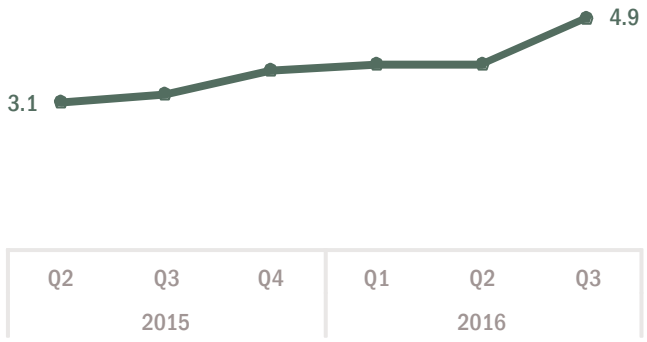
...but when stratified by race and ethnicity^, Hispanic members in rural areas had lower rates of follow-up.

Member Satisfaction (Q3)

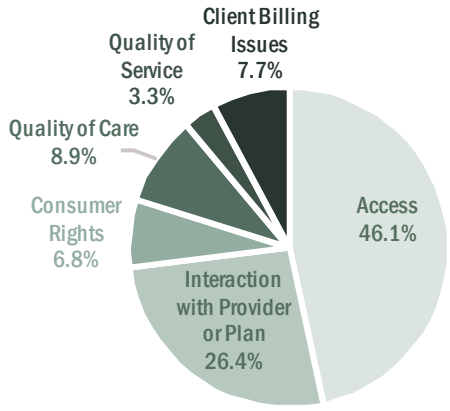
Complaint and Grievance Reporting

Oregon's 1115 Demonstration Waiver requires reporting on six categories of complaints and grievances: Access to Providers and Services, Interaction with Provider or Plan, Consumer Rights, Clinical Care, Quality of Services, and Client Billing Issues.

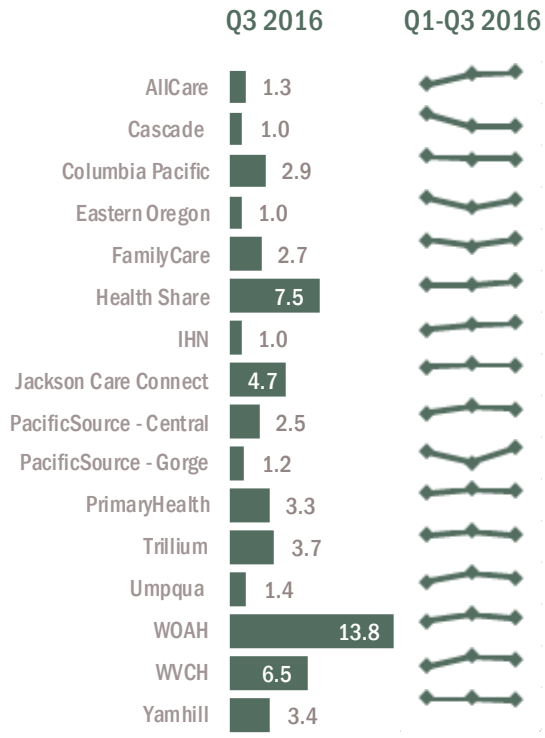
Complaints and grievances per 1,000 members



Most Q3 2016 complaints were about access to care or interaction with provider.



Complaints varied by CCO* per 1,000 members



In Q3 2016, 99% of complaints were resolved within the quarter

Due to changes in CCO reporting processes, the number of complaints reported have increased over the past few quarters. OHA is working directly with CCOs to address complaints and grievances in a timely manner and standardize the complaint and grievance processes across CCOs

Complaint and grievance information is reported individually by each CCO; complaints and grievances received directly by OHA from open card OHP members are tracked separately by OHA. Appeals of coverage denials, or notices of action (NOAs) are also captured and reported separately from complaint and grievance information. Summaries of complaint, grievance, appeal trends and interventions are included in the Oregon Health Plan Section 1115 Quarterly Report.

*CCOs define what constitutes a complaint or grievance and choose when and how to report complaints to OHA. Because the definition of complaint or grievance is not standard across CCOs, comparisons across CCOs should be made with caution.

Health Disparities (Q3)

Traditional Health Worker Program and Commission

Traditional health workers (THWs) include five primary worker types: community health workers, peer support specialists (e.g., addictions and mental health), peer wellness specialists, personal health navigators, and doulas. The utilization of traditional health workers assures delivery of high-quality, culturally competent care which is instrumental in achieving Oregon's triple aim. THWs provide critical services in mobilizing patients, managing and coordinating care, assisting in system navigation, and health promotion and coaching.

HB 3650 (2011) required Oregon to develop and establish criteria and descriptions of traditional health workers to be used by CCOs, and the education and training requirements for THWs. In 2016 OHA certified 1,506 thw's and approved 38 training programs.

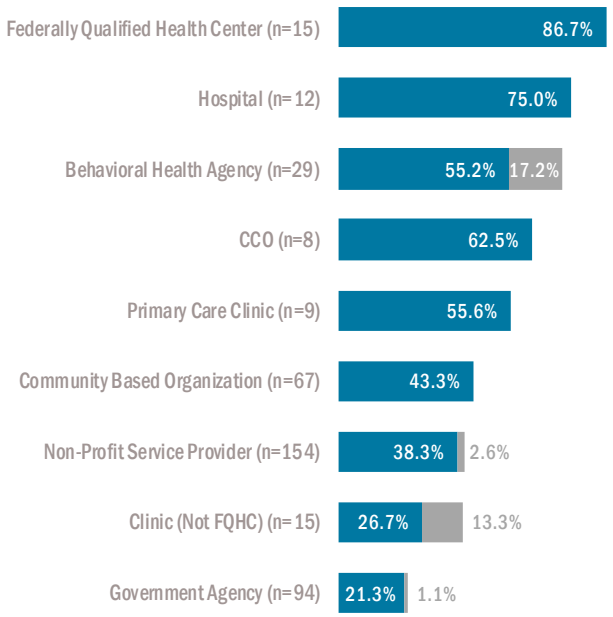
Key focal areas for THWs in Oregon include pursuing strategies to integrate with CCOs, advancing community engagement opportunities, and developing and implementing ongoing revisions to the THW scope in the context of health system transformation.

In 2016, OHA certified 1,506 traditional health workers.

Program:	# Certified
Community health workers	422
Personal health navigators	6
Peer wellness/support specialists	1,011
Other (doulas)	28
TOTAL	1,506

Percent of organizations surveyed that employ traditional health workers

Gray segments represent respondents that "plan to employ THWs"



THWs are being integrated across the health system, including among CCOs, the public health system, community-based organizations, and hospitals (see graph at left).

For example, Eastern Oregon Coordinated Care Organization (EOCCO) recently started utilizing and reimbursing state-certified community health workers with a new billing code who are employed and supervised by contracted EOCCO providers.

Multnomah County Health Department community health clinics have hired 15 community health workers and peers to be based in local clinics to address health disparities.

Both Yamhill and Clackamas counties' behavioral health departments have hired and contracted with peer, family, and youth support specialists to provide addiction and mental health services in those counties.

Finance (Q2)

The financial overview below provides highlights of CCO operating performance on a comparative basis, including operating and total margins, and a description of the member services ratio (MSR) and the medical loss ratio (MLR). Details are also provided for CCO capitalization focusing on net assets and liquidity. A critical factor for CCO success is the development of capitated rates paid for health services; a synopsis of the rate development process and a brief description of financial risks and pressures facing the agency and CCOs is provided.

Operating performance

OHA tracks two key metrics each quarter: the CCOs' operating margin and total margin (which includes the impact of non-operating income and expenses as well as income taxes). Operating margin is calculated by dividing operating income by total operating revenue, resulting in a percentage.

On a statewide basis, CCO operating margins have been trending downward from their peak in 2014. Much of the increase in margins during 2014 was the result of cost and utilization assumptions used to develop the rates for the new ACA population. By 2015, OHA had adequate emerging experience (claims information) to begin to quantify the true underlying cost of the ACA population. As such, the rates were aligned and generally lowered to reflect the costs and risks of the CCO's membership.

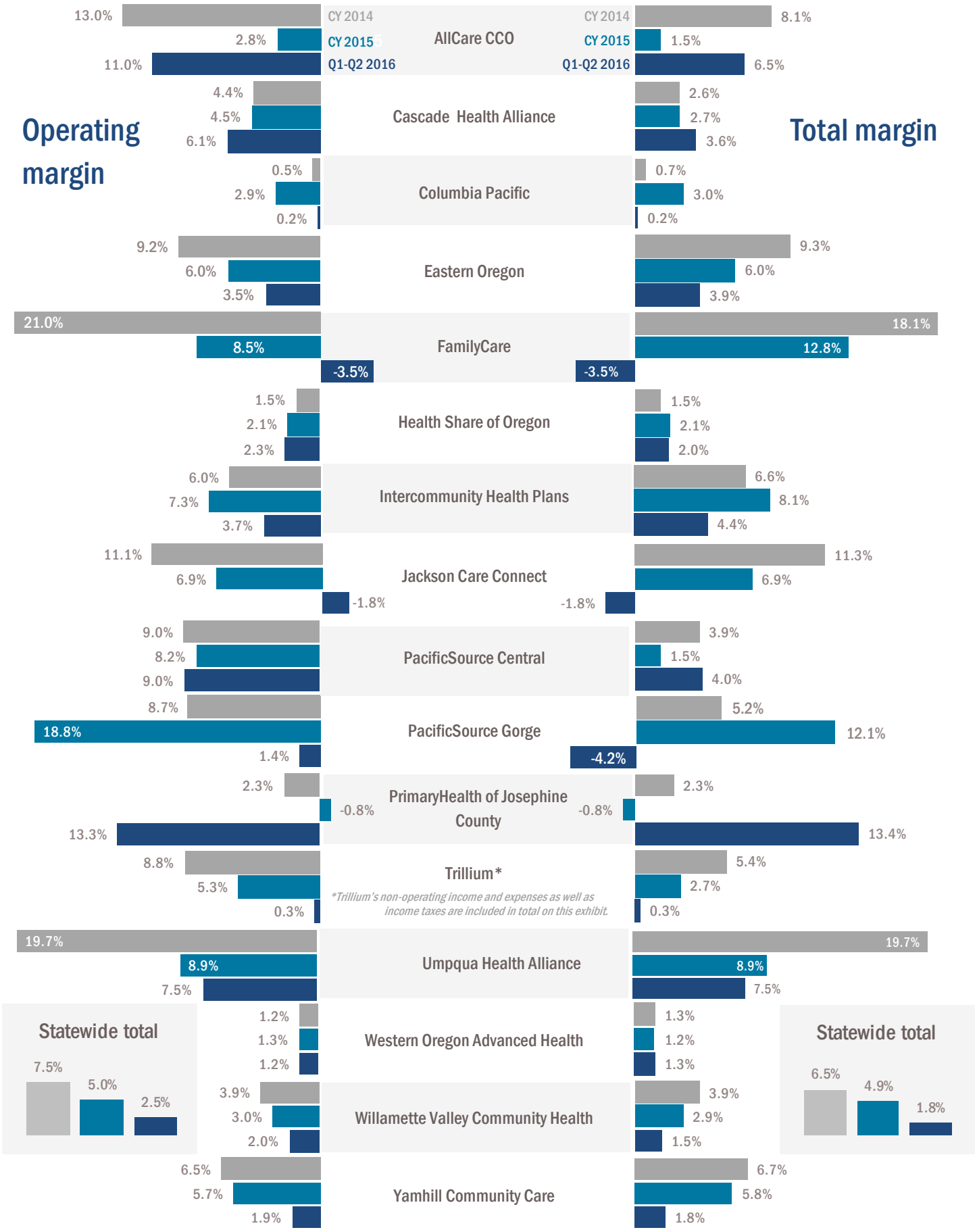
Below is a table that displays each CCO's operating margin and total margin for the past two complete years as well as the first six months of the current year:

	Operating margin $ millions			Total margin* $ millions		
	CY 2014	CY 2015	Q1-Q2 2016	CY 2014	CY 2015	Q1-Q2 2016
AllCare CCO, Inc.	$ 27.3	$ 6.3	$ 13.2	$ 17.0	$ 3.4	$ 7.8
Cascade Health Alliance	$ 2.1	$ 3.6	$ 2.6	$ 1.2	$ 2.1	$ 1.6
Columbia Pacific	$ 0.6	$ 4.4	$ 0.1	$ 0.8	$ 4.4	$ 0.1
Eastern Oregon CCO	$ 18.4	$ 15.6	$ 5.0	$ 18.5	$ 15.6	$ 5.6
FamilyCare	$ 85.5	$ 46.4	$ (8.9)	$ 73.5	$ 69.4	$ (8.9)
Health Share of Oregon	$ 14.5	$ 22.5	$ 13.0	$ 14.5	$ 22.6	$ 11.5
Intercommunity Health Plans, Inc.	$ 15.2	$ 20.5	$ 5.7	$ 16.8	$ 22.8	$ 6.6
Jackson Care Connect	$ 13.8	$ 9.9	$ (1.2)	$ 14.1	$ 9.9	$ (1.2)
PacificSource Comm. Solutions - Central	$ 19.6	$ 22.2	$ 12.1	$ 8.4	$ 4.1	$ 5.5
PacificSource Comm. Solutions - Gorge	$ 4.4	$ 12.3	$ 0.5	$ 2.6	$ 7.9	$ (1.4)
PrimaryHealth of Josephine County	$ 1.0	$ (0.4)	$ 3.7	$ 1.0	$ (0.4)	$ 3.7
Trillium Community Health Plan**	$ 36.4	$ 36.2	$ 0.7	$ 22.6	$ 22.4	$ 0.8
Umpqua Health Alliance	$ 23.0	$ 10.8	$ 5.0	$ 23.0	$ 10.8	$ 5.0
Western Oregon Advanced Health	$ 1.2	$ 1.4	$ 0.7	$ 1.2	$ 1.4	$ 0.8
Willamette Valley Community Health	$ 14.1	$ 13.4	$ 4.7	$ 14.1	$ 12.7	$ 3.7
Yamhill Community Care	$ 5.3	$ 6.1	$ 1.0	$ 5.5	$ 6.2	$ 1.0
Consolidated Total	$ 282.5	$ 231.2	$ 58.1	$ 235.1	$ 215.3	$ 42.1

* Total Margin includes the impact of non-operating income and expenses as well as income taxes.

** Trillium's non-operating income and expenses as well as income taxes are included in total for 2014 and 2015.

Finance: CCO operating and total margins (Q2) (operating income as percentage of revenue)



Finance (Q2)

Member services ratio / Medical loss ratio

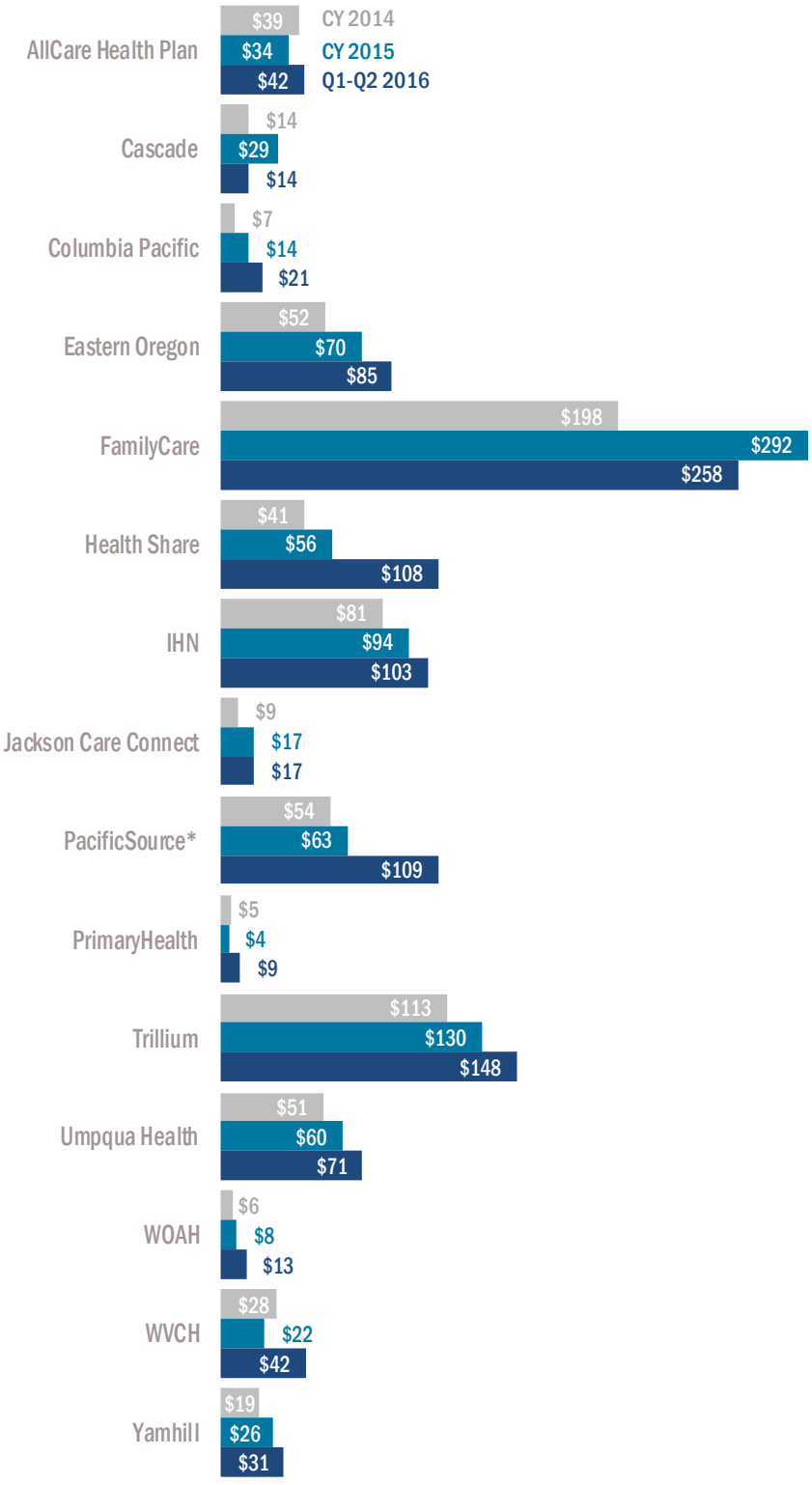
CCO member services ratio (MSR) is a key financial metric that calculates the costs of services a CCO provided to its members (both medical and non-medical such as flexible services) as a percentage of total revenue. Member service expenditures are reported to OHA on the CCOs' financial statements, submitted on a quarterly basis. Closely correlated to the MSR is the medical loss ratio (MLR), which is a term used within the insurance industry and by the Centers for Medicare & Medicaid Services (CMS). The MLR is calculated using the MSR as the starting point and then allows certain defined administrative services to be included in the calculation, such as health care quality improvement expenses, and starting in 2017, fraud prevention expenses. Under new CMS Rules for Medicaid managed care organizations, all CCOs must meet a minimum MLR of 85 percent in 2018. Oregon first adopted a minimum MLR requirement in 2014 with the ACA expansion and has developed a phased approach to achieve all of the CMS requirements for MLR in 2018.

The below graphs display each CCO's member services ratio for the past two complete years as well as the first six months of the current year:

Data Source: Data in this section are drawn from annual audited financial statements as prepared by an independent accounting firm. CCOs submit these annual statements after the close of the year. It is important to note that the financial statements follow generally accepted accounting principles, which could include accrued contingencies and reserves per each CCO's individual financial reporting and business model.

Finance: Capitalization (Q2)

Cash and investments, 2014—Q2 2016 ($ millions)



CCOs are paid monthly capitation payments, commonly referred to as per member per month (PMPM) payments, to manage and deliver health care for the CCO's membership. CCOs have flexibility in allocating the capitation revenues, determining how best to provide, purchase and coordinate their members' care.

The increased membership resulting from ACA expansion generally led to an increase in both the net asset and restricted reserve requirements. CCOs are currently required to maintain a net asset level of 5 percent of their average annual revenue (a rolling average of the past four quarters' adjusted revenue) as a minimum amount of operating capital. They are also required to maintain a restricted reserve account held in OHA's name as a safeguard against unanticipated losses.

See the table on the next page for CCOs' net assets in total compared to their required net assets. The display also includes net assets per member, which allows for normalization between large and small CCOs.

The increase in CCO membership and the higher margins during 2014 also contributed to an increase in their cash and investments. The graph at left reflects each CCO's cash and investments at the end of each of the past two years as well as the first six months of the current year.

**Note that while PacificSource has two contracts, one for Columbia Gorge and one for Central Oregon, only one corporate balance sheet is provided; financial data presented here represent PacificSource Community Solutions combined.*

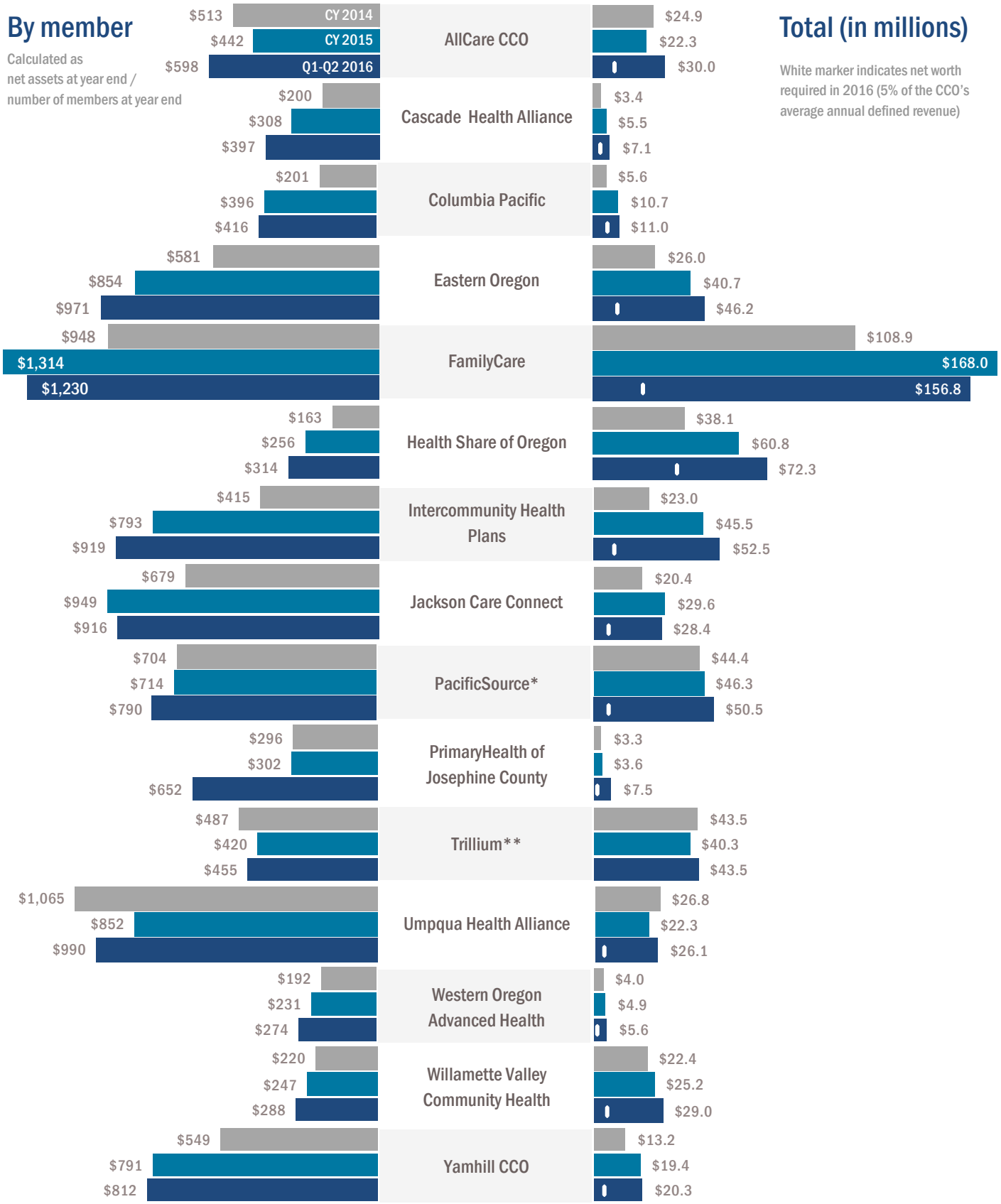
Finance: Net assets by CCO, 2014 to Q2 2016

By member

Calculated as net assets at year end / number of members at year end

Total (in millions)

White marker indicates net worth required in 2016 (5% of the CCO's average annual defined revenue)



* PacificSource has two contracts, one for Columbia Gorge and one for Central Oregon. Only one corporate balance sheet is provided; financial data presented here are combined.

**Trillium financial statements filed through Department of Consumer and Business Services with financial oversight based on NAIC oversight requirements.

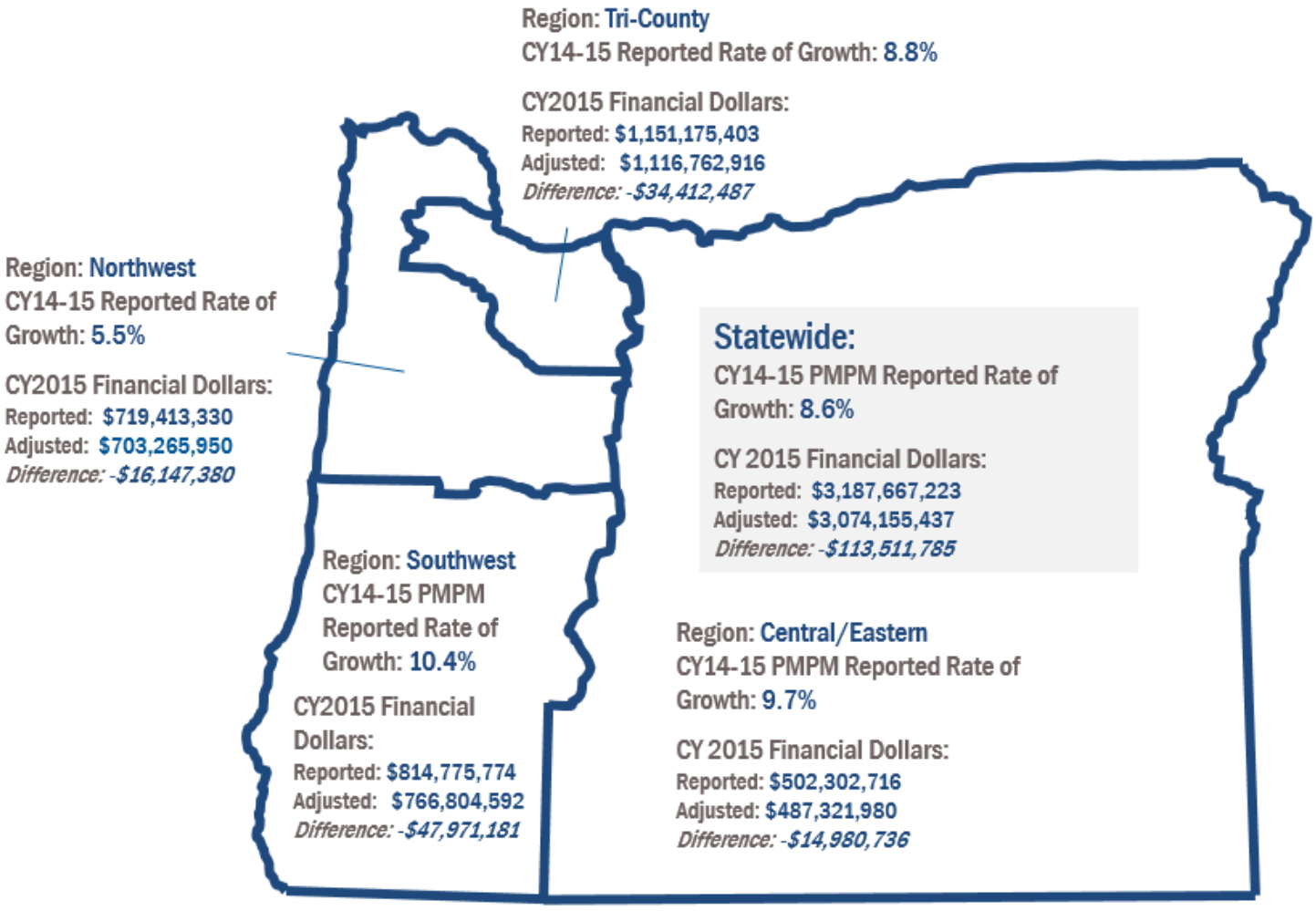
Finance: Rate development (Q2)

OHA has continued to engage Optumas, an external actuarial firm, to certify the 2017 CCO capitation payment rates. For the 2015 rates and going forward, OHA moved to a regional rate development methodology that matches payment to risk and meets applicable CMS and actuarial standards.

During the 2017 rate development process, OHA and Optumas observed that CCOs reported significant increases in per member spending from 2014 to 2015. Optumas reviewed the drivers of this growth and found in some cases it was due to increased reimbursement and payout of surpluses to providers as incentives.

In order to continue to contain costs to the capped 3.4 percent annual growth, OHA developed a policy to evaluate the high growth rate from 2014 to 2015 related to CCO business decisions. In summary, the policy makes no reimbursement adjustments for CCOs that are at a reasonable growth rate; however, for CCOs that were outliers above the sustainable rate of growth and had increased reimbursement from 2014 to 2015, adjustments were made to claim-level reimbursement and/or incentives for the purposes of normalizing payments within the rate process. This means the financial information that informs the rate process for 2015 was adjusted down after isolating the business decisions (see map below).

2017 CCO rate results: After making the adjustments below, actual rates were completed and amounted to a statewide increase of 3.2% in 2017 CCO rates over the 2016 rates.



Finance (Q2)

Risks and pressures

The Medicaid program and CCOs are facing a number of financial pressures. Cost sustainability is an important topic going forward, especially with a constrained state budget. This is an ongoing issue and will continue to be a risk to the CCOs and the Oregon Health Plan.

CCOs are also experiencing cost pressure in a variety of areas that affect their capitation rates. From a national perspective, pharmaceutical costs continue to rise rapidly and are affecting the Oregon program (see page 5). Although these increases are most notable in specialty drugs, the increase is affecting generic drug costs as well. In a recent review of cost reports, CCOs saw increases in overall drug costs between 15 and 25 percent from 2014 to 2015.

Similarly, the costs of new treatments and expanded benefits covered through the Oregon Health Plan adds financial pressure to CCOs. CCOs implemented new benefits as of July 2016 including: expanded dental benefits for adults, a change in guidance covering back pain through more alternative approaches and less reliance on opioid drugs, and the addition of Applied Behavioral Analysis (commonly referred to as "ABA") as a treatment for children with autism.

CCOs are also experiencing pressure in rising costs in the rural and critical access hospitals. Starting in 2016, some of these hospitals were moved to an alternative payment method that restricts annual reimbursement growth; however, many smaller and rural hospitals are still on cost-based reimbursement, which puts cost pressure on specific CCOs that serve rural and frontier areas. OHA continues to partner with CCOs to ensure there is a fiscally sustainable annual health care cost growth rate.

Hepatitis C

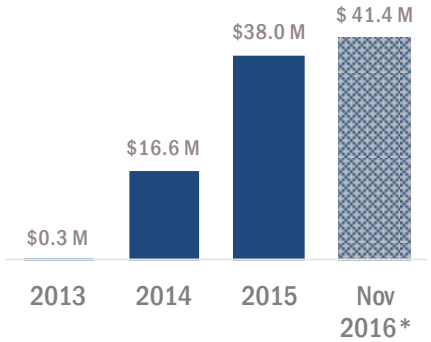
There has also been significant attention on the coverage of Hepatitis C treatment for OHP members in stage 3 and 4 with an emerging drug therapy, direct acting antivirals (DAA).

CCOs received a rate adjustment in 2015 and 2016 to cover these added costs; however, CCOs had varying levels of utilization in 2015 due to different prior authorization (PA) criteria. OHA has undergone a robust review process to align PA criteria for these drugs and ensure appropriate access in 2016.

In 2017, OHA has taken an additional step to contractually require CCOs to align with OHA's fee for service preferred drugs to allow for improved negotiating power with DAA drug manufactures for enhanced rebates by leveraging all utilization across OHP.

Hepatitis C drug expenditures

Total since 2013: $95.7 million



*Claims received by OHA as of November 2016. July-November are incomplete. Final CY 2016 will increase.

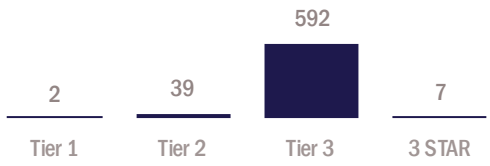
Patient-centered primary care homes (PCPCHs) (Q3)

PCPCHs across Oregon

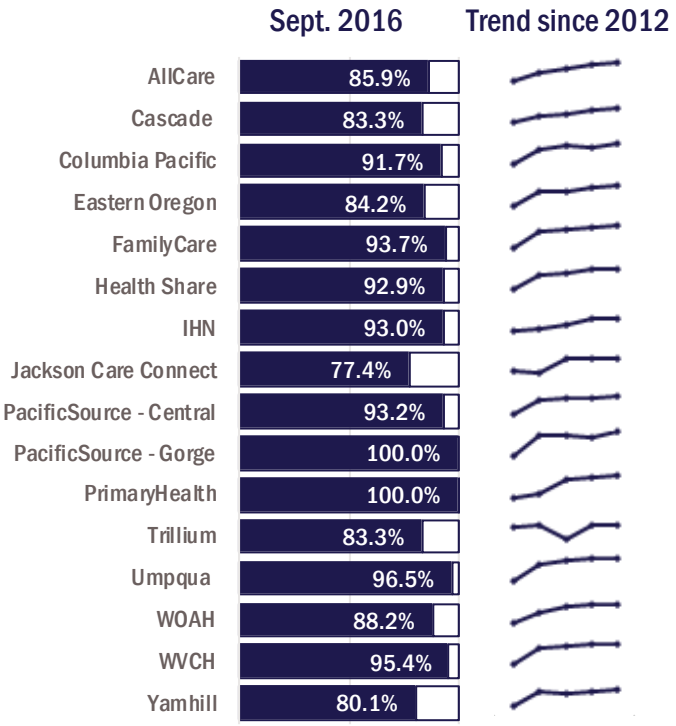
The adoption of PCPCHs is integral to transforming the health system, with their patient- and family-centered approach to all aspects of care, wellness, and prevention. Although the PCPCH program has been operational fewer than five years, about two-thirds of all primary care clinics in the state are recognized PCPCHs.

As of September 2016, 640 clinics had been recognized as PCPCHs, with the majority reaching Tier 3 recognition, the highest level possible. Seven practices have been awarded 3 STAR designation for implementing advanced PCPCH model measures that further health system transformation: Childhood Health Associates of Salem; Grants Pass Clinic; Winding Waters Clinic; and Metropolitan Pediatrics of Portland, Gresham, Westside, and Happy Valley.

Recognized PCPCHs by tier, Sept. 2016



Percent of CCO members enrolled in PCPCHs

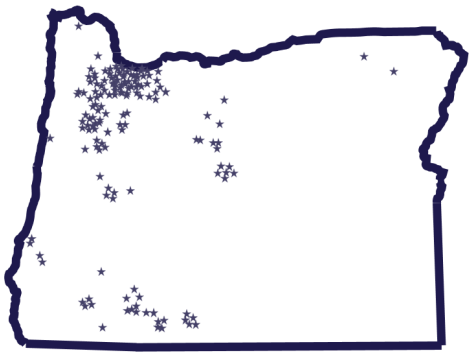


Comprehensive Primary Care Plus (CPC+)

CPC+ is a regionally based, multi-payer advanced medical home model offering an innovative payment structure to improve healthcare quality and delivery. It is a five-year federal program beginning in January 2017 that will bring significant Medicare dollars to Oregon.

The Centers for Medicare & Medicaid Services (CMS) opened the opportunity for CCOs and payers to submit applications. CMS has selected 20 payers and 159 practices in Oregon to participate in CPC+. The practices are diverse and vary by size, organizational structure, geographic location and practice type. Nearly 90 percent of the practices are recognized patient-centered primary care homes.

Practices participating in CPC+ are located throughout the state



CCOs participating in CPC+

- ✓ AllCare Health Plan
- ✓ Columbia Pacific
- ✓ Eastern Oregon CCO
- ✓ FamilyCare
- ✓ Health Share*
- ✓ Jackson Care Connect
- ✓ PacificSource—Central
- ✓ PacificSource—Gorge
- ✓ PrimaryHealth
- ✓ Umpqua
- ✓ WOAH
- ✓ WVCH
- ✓ Yamhill

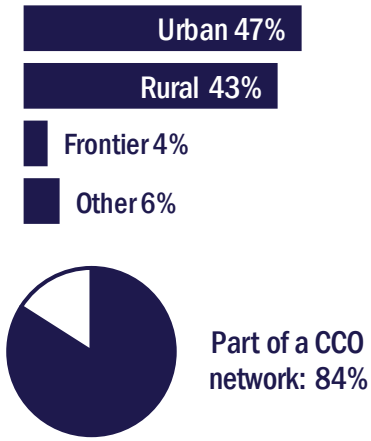
**Three of the four Health Share risk-accepting entities (CareOregon, Providence, and Tuality) were accepted.*

Primary Care Transformation (Q3)

Behavioral Health Workforce Survey

The Oregon Health Policy Board's Healthcare Workforce Committee's Behavioral Health Integration subcommittee distributed an online survey in April 2016 to gather feedback on activities related to behavioral health integration efforts in Oregon. The survey was voluntary and targeted to clinics that were familiar with or already attempting to move towards behavioral health integration; 189 surveys were returned. Approximately one-third of respondents reported having on-site access to some type of physical, mental and addiction services providers; and nearly two-thirds reported having on-site access to some type of physical and mental health providers (but no addiction service providers).

Survey respondents were:



Part of a CCO network: 84%

The most significant barriers to behavioral health integration were identified as:

1. **Network adequacy**, including space and time constraints;
2. **Communication and collaboration issues**, including provider education, IT challenges and cultural shifts;
3. **Billing and funding issues**, specifically related to the inability for providers to be compensated for integrated care, and the cost of adding a behavioral health provider.

Number of patients seen in January 2016 ranged from 20 to 35,000

The survey also captured the elements of integration that were being undertaken at clinics (e.g., co-location of services or chart-note integration). See Appendix C for link to full report.

Behavioral Health Collaborative

OHA Director Lynne Saxton convened the Behavioral Health Collaborative in July 2016 with the goal of charting a course for excellence and sustainability in behavioral health services across systems. With an emphasis on cross-system coordination and collaboration, the collaborative will produce recommendations defining policy, financing, and infrastructure needs to modernize and integrate Oregon's behavioral health system with individuals and families at the center and quality client outcomes as the goal.

Behavioral Health Collaborative membership was determined through an application process. Membership includes peers, consumers, tribal health care, behavioral health, prevention, education, corrections, public safety, housing, judicial, disability services, coordinated care organizations, and county mental health providers.

The Behavioral Health Collaborative has been meeting biweekly since July 14, 2016, and is scheduled to complete its work in January 2017. Three collaborative meetings were devoted to workgroups to develop recommendations specific to the following content areas: workforce, data, outcomes, scope of responsibility, waste/efficiencies, and payment reform/finance.

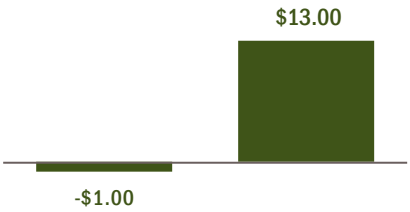
Evaluations (Q3)

Under the current Medicaid demonstration waiver, OHA has engaged external evaluators to assess OHA and CCOs' activities aimed at transforming Oregon's Medicaid delivery system. See Appendix for links to completed reports.

Patient-Centered Primary Care Home (PCPCH) Evaluation

In 2013 Portland State University evaluated whether utilization and expenditures changed for patients served in PCPCHs compared to non-PCPCH practices in the first year following PCPCH recognition. In fall 2016 researchers published a new report building on this project. Researchers found that PCPCH program implementation encouraged clinics to embrace team-based care and continuous improvement, and to adopt a "patient centered lens." Additional key findings included:

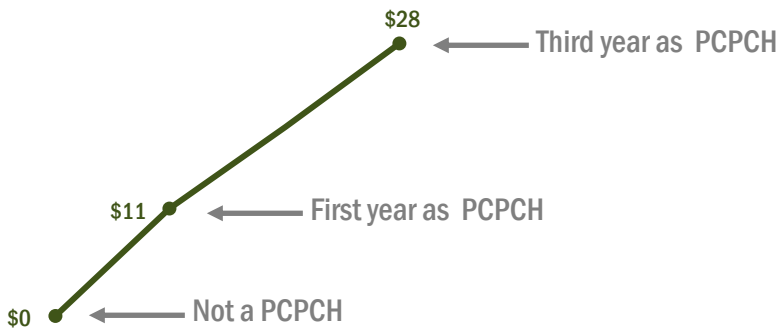
For every $1 increase in primary care expenditures related to the PCPCH program, there are $**13 in savings** in other services, such as specialty care, emergency department and inpatient care.



PCPCH program implementation has resulted in **$240 million in** savings to Oregon's health system over its **first three years**.

For a clinic that has been a PCPCH for three years, the total **cost of care per member, per month is lowered by $28**. This is more than double the overall average savings of $11 per member, per month for a PCPCH in the first year of recognition.

Savings per member per month:



Decreases in:

- Specialty care ↓ 11.1%
- Emergency department visits ↓ 19.2%
- Inpatient care ↓ 26.4%

contributed to the lowered expenditures.

Local Governance (Q3)

In November 2016 the Transformation Center surveyed CCOs about whether their community advisory councils (CACs) and CCO governing boards meet legislative requirements for representation and transparency. All of Oregon's 16 CCOs responded to this survey. There are 34 CACs across the 16 CCOs; the number of CACs per CCO varies. OHA will be working with CCOs in the coming year to ensure legislative requirements are met.

Community Advisory Councils

CAC legislative requirements (ORS 414.627)	# CCOs in compliance
CCOs include on its CAC representatives of the community and of each county government served by the CCO.	
Consumer representatives constitute a majority of the CAC membership.	
CAC has its membership selected by a committee composed of equal numbers of county representatives from each county served by the CCO and members of the governing body of the CCO.	
CAC meets at least once every three months.	
CAC posts a report of its meetings and discussions to the website of the CCO and other websites appropriate to keeping the community informed of the CAC's activities.	
CCO holds quarterly, public CAC meetings	
CCO posts to the organization's website contact information for, at a minimum, the chairperson, a member of the CAC, or a designated staff member of the organization.	
Addressed in legislation, but not a legislative requirement:	
Regular CAC meetings are open to the public and attended by the members	

* *Two of the three CCOs not meeting the majority of membership requirement note that they are very close to meeting the requirement.*

\+ *The CCO that answered "no" has multiple CACs and a Regional Advisory Council. Each CAC has a nominating committee and the full CAC votes to approve based on nominating committee recommendations. The Regional Advisory Council is composed of the Chair and Co-Chair of each local advisory council per CCO board direction.*

^ *Of those answering "no," one CCO's website is under construction and the rest of the CCOs post some items.*

\# *One CCO does not post the contact information to the website because the webiste under construction.*

How Community Advisory Councils are helping address the triple aim

"**Our CAC led decision-making for a portion of the Transformation Funds for the Gorge region** and has been consistently used as one source of patient input to help service providers better understand how to improve the experience of care for our members." **(PacificSource Columbia Gorge)**

Local Governance (Q3)

"**The CAC has been instrumental in educating our members to assist them in managing their health.** We have participated in various health and county fairs and farmer's market, to educate members on smoking cessation, prenatal care, adolescent well care, chronic disease self-management, as well as how they can actually get involved with the CAC to help improve healthcare for the wider community." **(Cascade Health Alliance)**

"**Both CACs are directly involved in the oversight of extremely ambitious community health improvement plans.** To date, those plans have been directly responsible for improving health (e.g., increasing the proportion of pregnant women who enter pre-natal care during the first trimester) and hold the potential for decreasing costs through substantial advocacy for improved lifestyle choices and healthy living." **(Western Oregon Advanced Health)**

"**The Health Share Council has been integral in several key areas that have assisted us in addressing the triple aim.** They include: Overseeing the development of our community health needs assessment; overseeing the development of our coordinated health partnership – how we invest in community health; and participation in several key committees to influence the delivery system and care developed including on issues of health equity/cultural competency, behavioral health and traditional health workers." **(Health Share)**

"**The CAC developed a Community Health Improvement Plan focused on a population, transition age youth.** FamilyCare completed an assessment of transition age youth to develop strategies to improve the health and patient experience of this population." **(FamilyCare)**

CCO Governing Boards (ORS 414.625)

All 16 CCOs indicated that they meet legislative requirements of ORS 414.625 regarding membership composition of their CCO governing boards. Specifically, all CCOs indicate their boards include:

- A majority of persons that share in the financial risk of the organization
- The major components of the health care delivery system
- At least two health care providers in active practice, including:
    - A physician licensed under ORS Chapter 677 or a nurse practitioner certified under ORS 678.375 whose area of practice is primary care
    - A mental health or chemical dependency treatment provider
- At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and
- At least one member of the CAC.

CCO Clinical Advisory Panels

While Clinical advisory panels (CAPs) are not required of CCOs, the Oregon Health Policy Board recommended CCOs create them, and many CCOs have. Twelve of 16 CCOs reported having an active CAP, while one said it convenes a clinical workgroup that aims to build alignment across its health plan providers. Ranging from nine to 15 members, CAPs commonly include primary care physicians, behavioral health providers and dental providers. Other members on CAPs include pharmacists, pediatricians, psychiatrists, nurses, physical therapists, and in one case, representatives from local social service organizations. Overall, CAPs provide direction around a range of CCO clinical activities, including evidence-based strategies for possible CCO adoption, selection of providers, patient experience of care, population health, and credentialing functions. Some CAP successes reported include developing strategies to help CCOs meet incentive metrics and address chronic pain and opioid utilization.

Administrative Rules: Changes related to CCOs

Rule Number and Name	Description	Effective Date	Rulemaking Action	Concerns?
410-141-0000 Definitions: Addition of Managed Care Entity (MCE)	In order to find a singular term representing all plan types in Medicaid rule language and in an effort to be compliant with the term Managed Care Entity (MCE), the Authority sought guidance from CMS, with particular consideration given to the newly revised Medicaid managed care rules. The response received from CMS: To your question: Managed Care Entity (MCE) is a definition that can be used to encompass multiple organizations, plans, etc., (in your/Oregon's case CCO, DCO, MHO). Managed Care Entity is currently defined at 42 CFR 457.10: Managed care entity (MCE) means an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers. Link to 42 CFR 457.10: http://www.ecfr.gov/cgi-bin/text-idx?SID=c5cba4e2e28a4c186d3c4a075f239285&mc=true&node=se42.4.457_110&rgn=div8. It is the Authority's intent to use the term "managed care entity (MCE)" starting with OAR 410-141-0000 to house the definition referenced above. There have also been two cross references directing the reader to OAR 410-120-0000 added for the terms "client" and "member."	7/1/16	Amendment	No
410-141-0520 - HERC Prioritized List,	The OHP program administrative rules govern the Division's payments for services provided to clients. The Authority needs to temporarily amend 410-141-0520. This change references the approved Health Evidence Review Commission (HERC) Prioritized List of Health Services, incorporating by reference, new modifications, effective July 1, 2016, to the Centers for Medicare and Medicaid Services' (CMS) approved biennial January 1, 2016–December 31, 2017 Prioritized List of condition treatment pairs funded through line 475, including interim modifications approved at the October 1, 2015, and November 12, 2015, HERC meetings. The July 1, 2016, Prioritized List includes previously delayed changes to the Prioritized List involving the treatments for conditions of the back and spine. (Implementation of these changes had been delayed from its original planned date of January 1, 2016.) In addition, several new interim modifications are included that were approved at the January 14, 2016, and May 19, 2016, HERC meetings, which represent conforming changes involving the pairing of treatments for conditions of the back and spine.	Effective July 1, 2016	Temporary rules –	No
410-141-3015, 3145, 3260, 3300 Amending Rules to Comply with Amended CFR's, Gender Identity and Provider Enrollee Communications	These temporary rules provide immediate direction and clarification to the coordinated care organizations and Prepaid Health Plans for compliance with the newly revised Code of Federal Regulations, effective within 60 days of publication, May 5, 2016. These amended rules reflect federal changes related to provider enrollee communications requirements and adding gender identity to the certification criteria.	7/6/16 to 1/1/17	Temporary rule of Federally mandated changes	No

Administrative Rules: Changes related to CCOs

Rule Number and Name	Description	Effective Date	Rulemaking Action	Concerns?
410-141-3070 Preferred Drug List Requirements	This rule amendment aligns CCO pharmacy prior authorization processes in 410-141-3070 and 410-141-3420. Also, the rule provides CCOs with framework for the Preferred Drug List requirements under OHP in the managed care environment. This rule will be revised again for January 1, 2018, to be compliant with the newly revised Medicaid managed care Code of Federal Regulations as they pertain to pharmacy prior authorization.	7/1/16	Amendment	No
410-141-3110 CCO Substance Use Disorder Provider, Treatment and Facility Certification and Licensure	This administrative rule addresses substance use disorder (SUD) provider, treatment, and facility certification and licensure as they fit into the coordinated care organizational framework.	7/1/16	Rewrite of existing rule	No
410-141-3262 Requirements for CCO Appeal	Grievance system rules, as required by 42 CR 438.420, provide framework and guidance for the CCOs with which to administer the appeals process within the managed care delivery system. Revision of this rule provides clarification in the language for a standard appeal. An oral appeal request must be followed up by a written request. We have also provided clarification language regarding what happens should a member fail to follow up a standard oral request for an appeal with a written request.	7/1/16	Amendment	No
410-141-3420 and Repeal of 141-0420 Managed Care Entity (MCE) Billing and Payment	The Division's rule requires that "Managed care entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to: managed care organizations, prepaid health plans, and primary care case managers, as defined in 410-120-0000 and 42 CFR 457.10: http://www.ecfr.gov/cgi-bin/text-idx?SID=c5cba4e2e28a4c186d3c4a075f239285&mc=true&node=se42.4.457_110&rgn=div8. MCE's are to demonstrate they are able to provide coordinated care services efficiently, effectively, and economically. This is the first OHP managed care rule to consolidate the MCE requirements for billing and payment into one administrative rule and to utilize the term (MCE) when making collective reference to those managed care plans providing the delivery system under the Oregon Health Plan. Revisions to language have been made in the following areas: • Clarifying the four-month billing requirement; • Specifying separate plan type requirements as applicable; • Aligning the pharmacy preauthorization timeline with 410-141-3070 Preferred Drug List Requirements; • Updating claim submission timeframes with CFR and the 2016 contracts; • Clarifying school-based health service considerations; and • Updating A and B Hospital payment methodology language in order to align with current practices.	7/1/16	Rewrite of existing rule	No

Appendix A: OHP Enrollment by County

County	Total population	Total Medicaid recipients	Receiving Medicaid due to ACA	% of total population receiving Medicaid	% of total population receiving Medicaid due to ACA	% of Medicaid population receiving Medicaid due to ACA
Baker	16,425	4,545	1,754	27.7%	10.7%	38.6%
Benton	90,005	13,389	5,881	14.9%	6.5%	43.9%
Clackamas	397,385	69,830	26,376	17.6%	6.6%	37.8%
Clatsop	37,750	9,861	4,083	26.1%	10.8%	41.4%
Columbia	50,390	11,356	4,315	22.5%	8.6%	38.0%
Coos	62,990	20,032	7,835	31.8%	12.4%	39.1%
Crook	21,085	6,683	2,531	31.7%	12.0%	37.9%
Curry	22,470	6,200	2,623	27.6%	11.7%	42.3%
Deschutes	170,740	42,603	17,595	25.0%	10.3%	41.3%
Douglas	109,910	33,281	13,223	30.3%	12.0%	39.7%
Gilliam	1,975	402	152	20.4%	7.7%	37.8%
Grant	7,430	1,665	624	22.4%	8.4%	37.5%
Harney	7,295	2,079	786	28.5%	10.8%	37.8%
Hood River	24,245	6,272	2,267	25.9%	9.4%	36.1%
Jackson	210,975	63,453	25,173	30.1%	11.9%	39.7%
Jefferson	22,445	8,128	2,787	36.2%	12.4%	34.3%
Josephine	83,720	30,208	12,465	36.1%	14.9%	41.3%
Klamath	67,110	20,798	7,799	31.0%	11.6%	37.5%
Lake	8,010	2,055	791	25.7%	9.9%	38.5%
Lane	362,150	96,371	39,366	26.6%	10.9%	40.8%
Lincoln	47,225	14,127	5,794	29.9%	12.3%	41.0%
Linn	120,860	35,574	12,461	29.4%	10.3%	35.0%
Malheur	31,480	10,842	3,131	34.4%	9.9%	28.9%
Marion	329,770	95,693	30,370	29.0%	9.2%	31.7%
Morrow	11,630	3,194	881	27.5%	7.6%	27.6%
Multnomah	777,490	194,678	82,245	25.0%	10.6%	42.2%
Polk	78,570	18,368	6,144	23.4%	7.8%	33.4%
Sherman	1,790	418	172	23.4%	9.6%	41.1%
Tillamook	25,690	6,793	2,679	26.4%	10.4%	39.4%
Umatilla	79,155	21,231	6,492	26.8%	8.2%	30.6%
Union	26,625	6,965	2,452	26.2%	9.2%	35.2%
Wallowa	7,100	1,851	700	26.1%	9.9%	37.8%
Wasco	26,370	7,857	2,826	29.8%	10.7%	36.0%
Washington	570,510	94,085	33,242	16.5%	5.8%	35.3%
Wheeler	1,445	326	150	22.6%	10.4%	46.0%
Yamhill	103,630	24,927	8,539	24.1%	8.2%	34.3%
Unknown		5,927	1,903			32.1%
Statewide	4,013,845	992,067	378,607	24.7%	9.4%	38.2%

Appendix B: CCO Profile

Although all of Oregon's 16 CCOs are community based in terms of local governance, there is a wide variety of legal and corporate structures under which they exist. All of the CCOs generally fit into one of the following corporate structures:

- Taxable Publicly Traded Corporation
- Taxable Private Corporation
- Tax-exempt Charitable Organization – 501(c)(3)
- Tax-exempt Non-Charitable Organization – 501(c)(4)
- Limited Liability Corporation – LLC

Within those general structures, there are also variations within each CCO. Below is a table which describes the corporate structure of each CCO:

CCO	Corporate Status	Parent / Owner
AllCare CCO	Private corporation single owner	Mid Rogue AllCare Health Assurance, Inc. (multiple shareholders)
Cascade Health Alliance	LLC single owner	Cascade Comprehensive Care, Inc. (multiple shareholders)
Columbia Pacific	LLC single owner	CareOregon 501(c)(3)
Eastern Oregon CCO	LLC multiple owners	Owners include both for-profit and not-for-profit organizations
FamilyCare	501(c)(4)	
Health Share of Oregon	501(c)(3)	
Intercommunity Health Plans	501(c)(4)	Samaritan Health Services, Inc. 501(c)(3)
Jackson County CCO	LLC single owner	CareOregon 501(c)(3)
PacificSource Community Solutions -Central	Private corporation single owner	PacificSource (not-for-profit holding company)
PacificSource Community Solutions -Gorge	Private corporation single owner	PacificSource (not-for-profit holding company)
PrimaryHealth of Josephine County	LLC single owner	Grants Pass Management Services (multiple shareholders)
Trillium Community Health Plan	Publicly traded corporation	Agate Resources, Inc./Centene Corp. (publicly traded on NYSE)*
Umpqua Health Alliance (DCIPA)	LLC single owner	Architrave Health, LLC (two owners)
Western Oregon Advanced Heatlh	LLC multiple owners	Owners include both for-profit and not-for-profit organizations
Willamette Valley Community Health	LLC multiple owners	Owners include both for-profit and not-for-profit organizations
Yamhill Community Care	501(c)(3)	

* Agate Resources, Inc. was acquired by Centene Corporation (a publicly held corporation traded on the NYSE) as of 9/1/2015.

Appendix C: Additional Transformation Reporting

This appendix summarizes OHA reports on health system transformation topics and provides links to full reports for additional information.

Oregon Health Plan Demographics

OHA publishes a suite of Oregon Health Plan demographic, enrollment, and eligibility reports every month: www.oregon.gov/oha/healthplan/pages/reports.aspx. Select by report type.

CCO Performance on Quality Metrics

CCO metrics are reported semi-annually, with quality pool payment reporting each June: www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

Member Satisfaction

- CAHPS survey data are published annually. Statewide and by CCO reports ("banner books") are available: www.oregon.gov/oha/analytics/Pages/CAHPS.aspx
- OHP member complaints and grievance data are reported quarterly; summaries of compliant, grievance, appeal trends and interventions are all included in OHA's quarterly waiver reports. Select by report type "quarterly" www.oregon.gov/oha/healthplan/pages/reports.aspx.

Health Disparities

- Traditional Health Worker Commission: www.oregon.gov/oha/oei/Pages/thw-commission.aspx
- Race, Ethnicity, Language and Disability (REAL-D) uniform standards for data collection, 2016 legislative update: www.oregon.gov/DHS/ABOUTDHS/DHSBUDGET/20152017%20Budget/realD-OEMS-Legis-presentation.pdf
- Oregon Regional Health Equity Coalitions Evaluation Report, 2016: www.oregon.gov/oha/oei/reports/RHEC%20Evaluation%202016.pdf
- The Transformation Center posts CCO transformation plans and reports for both 2013-2015, and 2015-2017: www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx

Finance

CCO annual audited financial statements and internal financial statements are available: https://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Financial-Information.aspx

Patient-Centered Primary Care Homes

- Behavioral Health Collaborative: www.oregon.gov/oha/amh/Pages/strategic.aspx
- The Senate Bill 231 (2015) Primary Care Spending in Oregon first legislative report was published in February 2016: www.oregon.gov/oha/pcpch/Documents/SB231_Primary-Care-Spending-in-Oregon-Report-to-the-Legislature.pdf

Appendix C: Additional Transformation Reporting

- Additional reports including the PCPCH Program Annual Report, and evaluation results are available: www.oregon.gov/oha/pcpch/Pages/reports-and-evaluations.aspx
- Oregon standards for certified community behavioral health clinics (CCBHCs), as directed by Senate Bill 832: www.oregon.gov/oha/bhp/CCBHC%20Documents/Oregon-Standards-for-CCBHCs.pdf

Evaluations

- A new webpage was launched in September to highlight evaluation reports related to health system transformation: www.oregon.gov/oha/analytics/Pages/Evaluation.aspx

Local Government

- Senate Bill 436 report on community health improvement plan (CHIP) development, 2014: www.oregon.gov/oha/Transformation-Center/Resources/SB436_FINAL_report-0107152.pdf
- OHA's Public Health Division publishes State Health Improvement Plan indicators by CCO: public.health.oregon.gov/About/Pages/HealthStatusIndicators.aspx

Eligibility and Enrollment

- OHA's processing and customer service performance charts are presented monthly: www.oregon.gov/oha/healthplan/pages/ohp-Update.aspx
- DCBS posts quarterly enrollment reports: www.oregon.gov/DCBS/insurance/insurers/other/Pages/quarterly-enrollment-reports.aspx

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