Oregon's Health System Transformation Quarterly Legislative Report

Q1 2016






Published September 1, 2016

Oregon Health Authority

About this Report

Welcome to the first quarterly report to the Legislature on Oregon's Health System Transformation progress in Q1 2016 (January—March).

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

We welcome your ideas for report improvements.

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[1]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, improve quality, access, and health outcomes.

Executive Summary

Director's Message

As Oregonians, we all want to see the results of our investment in Health System Transformation and Medicaid expansion, as well as our progress toward the triple aim of better health, better care, and lower costs. Key elements of Oregon's health system transformation include:

- Using best practices to manage and coordinate care
- Shared responsibility for health
- Transparency in price and quality
- Measuring performance
- Paying for outcomes and health
- A sustainable rate of growth

Each of these elements individually and collectively produces better health outcomes for Oregonians at lower prices.

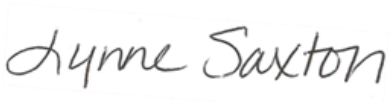
We have much to be proud of now that ninety-five percent of Oregonians have health insurance. Health coverage is a significant driver in providing preventive, appropriate, and timely access to health care, and Oregon has successfully taken on approximately 400,000 new Medicaid enrollees, while keeping the cost of health care within our 3.4 percent annual average growth rate. We have accomplished a tremendous amount in the past year.

Additionally, Oregon's approach to monitoring performance has been recognized nationally as a model for other states. Our CCO and hospital performance metrics effectively ensure system accountability for quality and outcomes, while rewarding and replicating success.

Next steps in what we call Health System Transformation 2.0 (HST 2.0) include:

- Focusing on accelerating quality and integration for our behavioral health system
- Integrating population health through public health modernization
- Continuing to move to value-based payments for incentivizing health outcomes
- Maintaining a financially sustainable model

Thank you for your role in Oregon's success. We welcome your comments on this report and your commitment to the work ahead in HST 2.0.



Lynne Saxton, Director
Oregon Health Authority

Executive Summary

Oregon Health Plan Demographics

Early estimates of Oregon's Medicaid expansion projected more than 240,000 newly eligible Oregonians, and 20,000 previously eligible Oregonians would enroll in the Oregon Health Plan.[2] In actuality:

- Medicaid enrollment increased by approximately 400,000 individuals since the Affordable Care Act expansion took effect January 2014, bringing enrollment to approximately 1.1 million Oregonians. This increase has changed the Oregon Health Plan population to include more adult members, with children ages 0-18 now representing 40 percent of OHP, in contrast to 60 percent in 2013. CCOs responded to the significant enrollment growth while also improving quality, as indicated by the annual performance metrics.

- Almost 90 percent of the Medicaid population eligible for enrollment in CCOs are enrolled. Of the remaining individuals not enrolled, many have exemptions such as dual enrollment in Medicare and other third party resources. OHA is exploring options for more of these individuals to be served by CCOs.

- 57,015 individuals are enrolled in Citizen Alien Waived Emergent Medical, or CAWEM, a benefit which provides emergency medical assistance and coverage for pregnant women that does not require proof of citizenship for Oregon residents who meet financial criteria.

CCO Performance on Quality Metrics

Oregon has demonstrated that when CCOs have a meaningful percentage of their payment at risk for performance, they achieve performance improvement and affect transformative change.

- OHA just completed the third year of its incentive payment program with CCOs to encourage performance improvements. For measurement year 2015, four percent ($168 million) of total capitation payments were distributed to CCOs based on quality measures performance. Fifteen of the 16 CCOs earned 100 percent of the possible funds.

- CCOs continue to reduce emergency department visits and preventable visits to hospitals, as well as maintaining and expanding member enrollment in patient-centered primary care homes. Avoidable emergency department visits have decreased by 50 percent since 2011. Further improvement is needed in measures for substance use disorders, and tobacco / smoking cessation.

Member Satisfaction

- OHA monitors member satisfaction through the standard Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and through complaints and grievances. 2015 survey results indicate CCOs are focused on improving health plan customer service; however, further improvement is necessary in making written or online information available to members about their health plans.

- In the first quarter of 2016, most complaints (43 percent) were related to access to care or interactions with providers or their health plan (31 percent). Ninety-seven percent of complaints received in Q1 were resolved.

[2] Estimated Financial Effects of Expanding Oregon's Medicaid Program under the Affordable Care Act (2014-2020), 2013 http://www.shadac.org/publications/estimated-financial-effects-expanding-oregons-medicaid-program-under-affordable-care

Executive Summary

Health Disparities

CCOs are contractually required to focus on how they will reduce health disparities and advance health equity for culturally and socially diverse communities.

- CCOs are fully engaged in improving health equity, with a focus on health literacy and cultural competency. CCO activities include financial support for health equity coalitions, engaging community advisory councils (CACs) in equity work, and reviewing data to identify disparities and develop equity strategies.

- Nine CCOs met their Transformation Plan benchmarks regarding health disparities in 2013-2015, and nine met benchmarks in cultural competency. OHA monitors Transformation Plans and provides technical assistance.

Finance

OHA pays CCOs a monthly capitation payment to manage and deliver health care for OHP members. Approximately 77 percent of OHP expenditures are distributed as capitation payments to CCOs—a total of $4.9 billion in CY 2015. Overall, CCOs are in good financial standing and exceed minimum net worth requirements.

In 2014, with the expansion of the Medicaid program, CCO membership increased more than 70 percent. At the time, this expansion population was largely unknown and assumed to have more health care concerns than the previous population; CCO payments were set assuming higher costs. However, this population was not as costly in 2014 as previously assumed; therefore, CCOs realized an increased operating margin in 2014.

The statewide composite operating margin was over 7 percent in 2014, with CCO increases fluctuating between less than 1 and 21 percent. In 2015, the composite CCO statewide operating margin was 5 percent, with CCO operating margins ranging from less than a 1 percent loss to over 18 percent. The statewide operating margin is closer to the national average of 4 to 5 percent. It should be noted that the state's sustainability threshold of 3.4 percent relates to the annual rate of growth in health care costs, not operating margins.

Patient-Centered Primary Care Homes

The adoption of patient-centered primary care homes is integral to transforming the health system, with their patient and family-centered approach to all aspects of care, wellness, and prevention. Oregon expects CCOs to work with their contracted providers to attain highest levels of PCPCH certification.

- Today, about two-thirds of all primary care clinics in the state are recognized PCPCHs. As of December 2015, all CCOs had at least 70 percent of their members enrolled in PCPCHs.
- Senate Bill 231, passed in 2015, requires OHA and the Department of Consumer and Business Services (DCBS) to report on the percentage of medical spending allocated to primary care for CCOs and select commercial plans. In 2014 CCOs allocated 13 percent of their total medical spending to primary care on average. Two-thirds of primary care spending by CCOs was non-claims based. These are payments to providers intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity. This was the first year of reporting; comparative data will be available in future years.
- A Multi-Payer Primary Care Payment Reform collaborative is working to sustain and improve primary care statewide with expected recommendations to the Oregon Health Policy Board.

Executive Summary

Evaluations

Early findings from Oregon's State Innovation Model (SIM) grant evaluation show that CCOs and other payers initially focused on integration and care coordination as part of health system transformation. They were less focused on alternate payment methodologies, health information technology, and the health care workforce.

The Hospital Transformation Performance Program (HTPP) evaluation found that the first two years of the hospital incentive metrics program has increased collaboration between hospitals and CCOs, and has helped most hospitals with their quality improvement efforts.

Local Governance

Each Coordinated Care Organization's Community Advisory Council(s) advise and make recommendations on the strategic direction of their organization. Community Advisory Councils (CACs) are comprised of local community members and the majority is to be made up of Oregon Health Plan members.

- CCOs are required to have at least one CAC which helps ensure the CCO is addressing the health needs of CCO members and the community. CAC strengths include helping break down silos to address social factors that influence health and improving diversity within community-CCO partnerships.

- CACs struggle to achieve majority consumer membership and diverse representation.

More information on CACs is available online at https://www.oregon.gov/oha/OHPB/Pages/cac.aspx.

Eligibility and Enrollment

For OHA Member Services, the first quarter of this year marked the launch of a new eligibility system, a restart to the coverage renewal process, and a focus on reducing the application backlog. For the first time, using the new Medicaid system OregONEligibility (ONE), call center staff were able to process an application and tell a member they had benefits before the call ended. ONE has improved efficiency for members and will continue to improve our member services response.

OHA also resumed renewals (that is, members renewing their Oregon Health Plan eligibility for continued enrollment) in February; renewals had previously been paused while OHA transitioned to the ONE system. Of the more than 116,000 memberships up for renewal, 59 percent of members renewed their applications within the 60-day timeline.

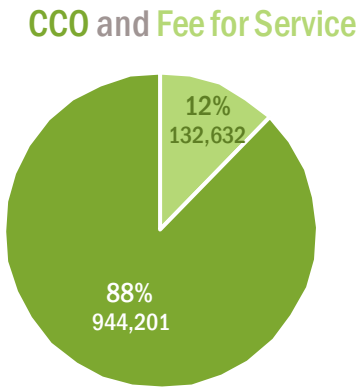
Administrative Rules

This section of the report summarizes five new administrative rules and eight amendments to existing rules related to CCOs. Of these rule changes, six were challenging and generated debate as evidenced by public comment, including rules related to prescription prior authorizations, enrollment criteria for children in foster care, enrollment criteria for non-hospital births, and the rules process for flexible services.

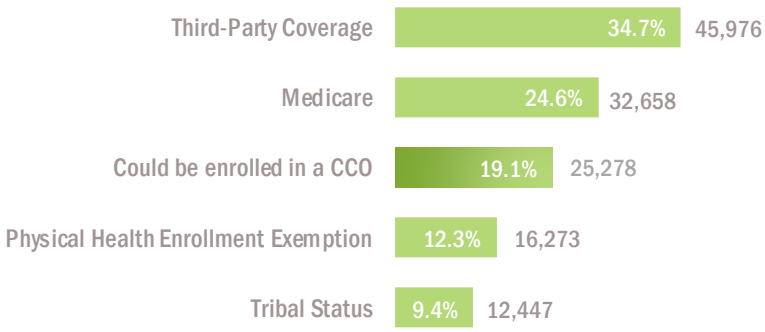
Oregon Health Plan Demographics

Medicaid enrollment has continued to grow since the 2014 Expansion, with total enrollment reaching just over 1.1 million members in early 2016. The majority of Medicaid members are enrolled in coordinated care organizations (CCOs).

Oregon Health Plan Enrollment (March 2016)
Non-OHP Enrollment is 80,730

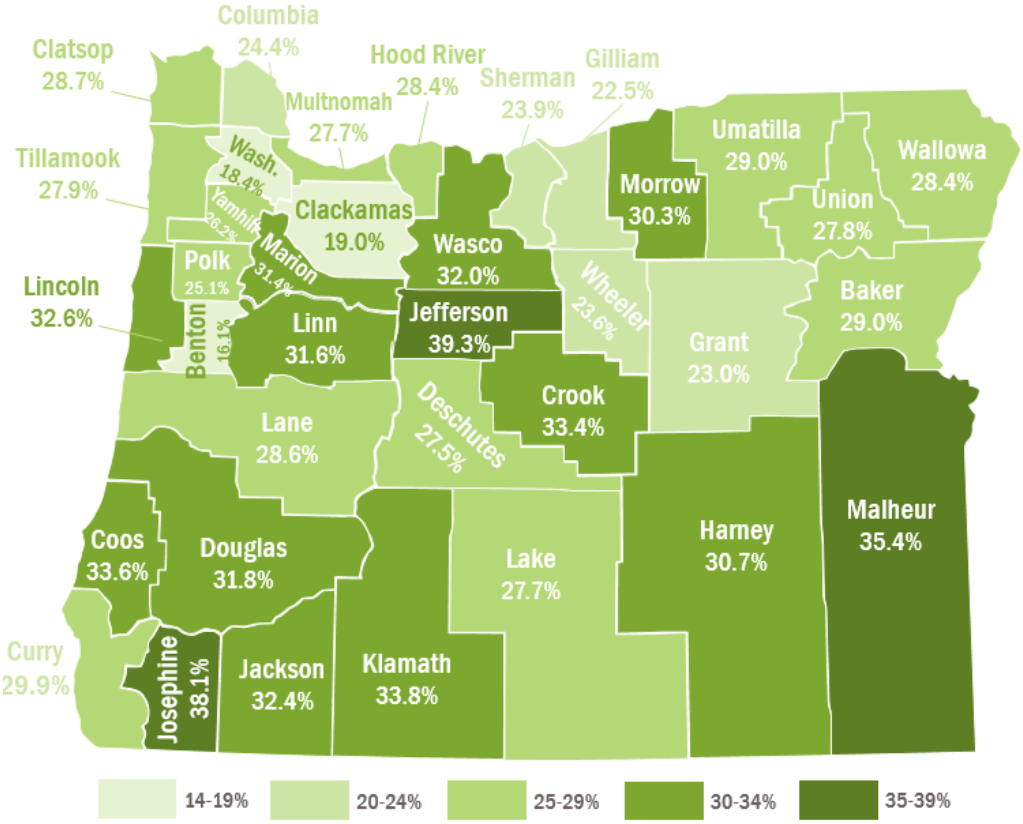


Fee For Service Detail (March 2016)
Clients with:



CCO counts include members enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Non-OHP includes 57,015 individuals who are enrolled in Citizen Alien Waived Emergent Medical (CAWEM), a benefit that provides emergency medical assistance and pregnancy coverage that does not require proof of citizenship for Oregon residents who meet financial eligibility criteria, and Medicare premium program groups.

Percentage of Oregon's population enrolled in OHP, by county
March 2016



Definitions:

Oregon Health Plan (OHP)
Oregonians who receive comprehensive Medicaid benefits.

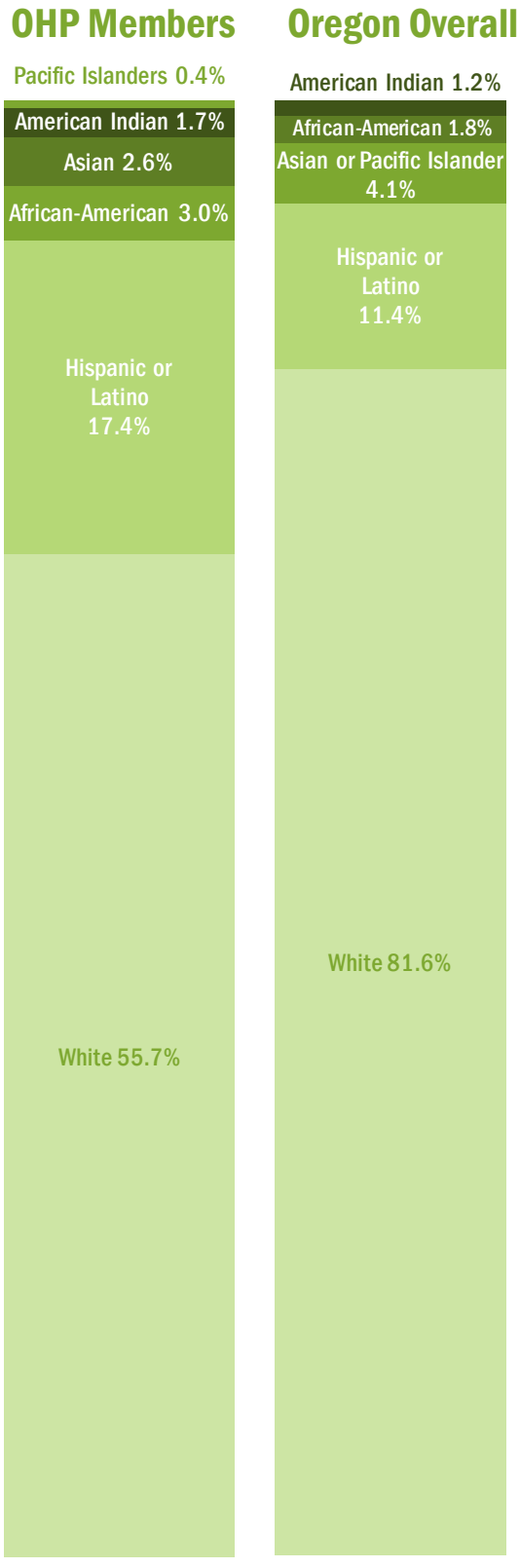
Non-OHP
Oregonians who receive Medicaid benefits, but are not eligible to receive the comprehensive OHP benefits package. This may include clients who receive CAWEM, senior drug plan, or members who also receive Medicare (dual eligible).

Fee For Service
OHP members who are not enrolled in a CCO or other managed care organization. Sometimes referred to as "Open Card"

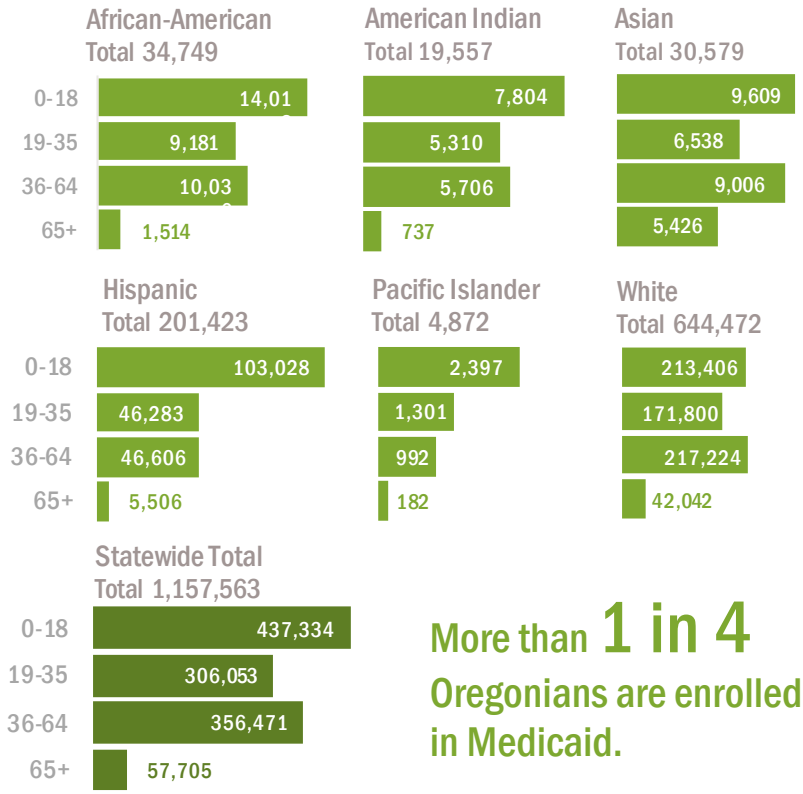
Oregon Health Plan Demographics

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, March 2016



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

- Data are missing are for 9.1 percent of the population, and 10.0 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

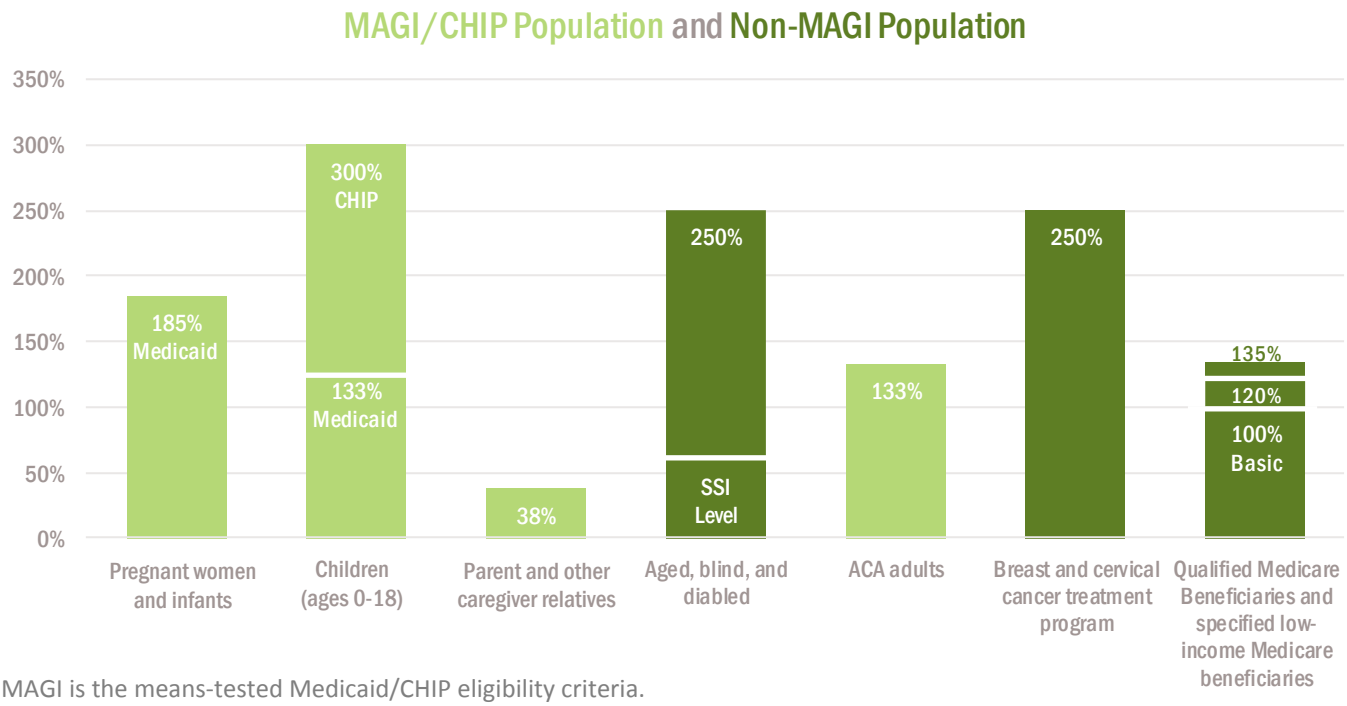
Oregon Health Plan, by Eligibility Group

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.

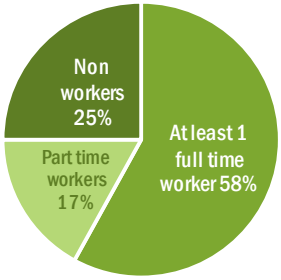
Approximate Federal Poverty Level (FPL) for Medicaid eligibility groups in 2015



MAGI is the means-tested Medicaid/CHIP eligibility criteria.
Non-MAGI has other eligibility criteria in addition to the means test.

Oregon Health Plan, by Employment Status

According to a 2015 analysis from the Kaiser Commission on Medicaid and the Uninsured, three-quarters of non-elderly Oregon Health Plan population are employed either full time or part time.* This is similar to the national average.



*http://kff.org/medicaid/state-indicator/distribution-by-employment-status-4/

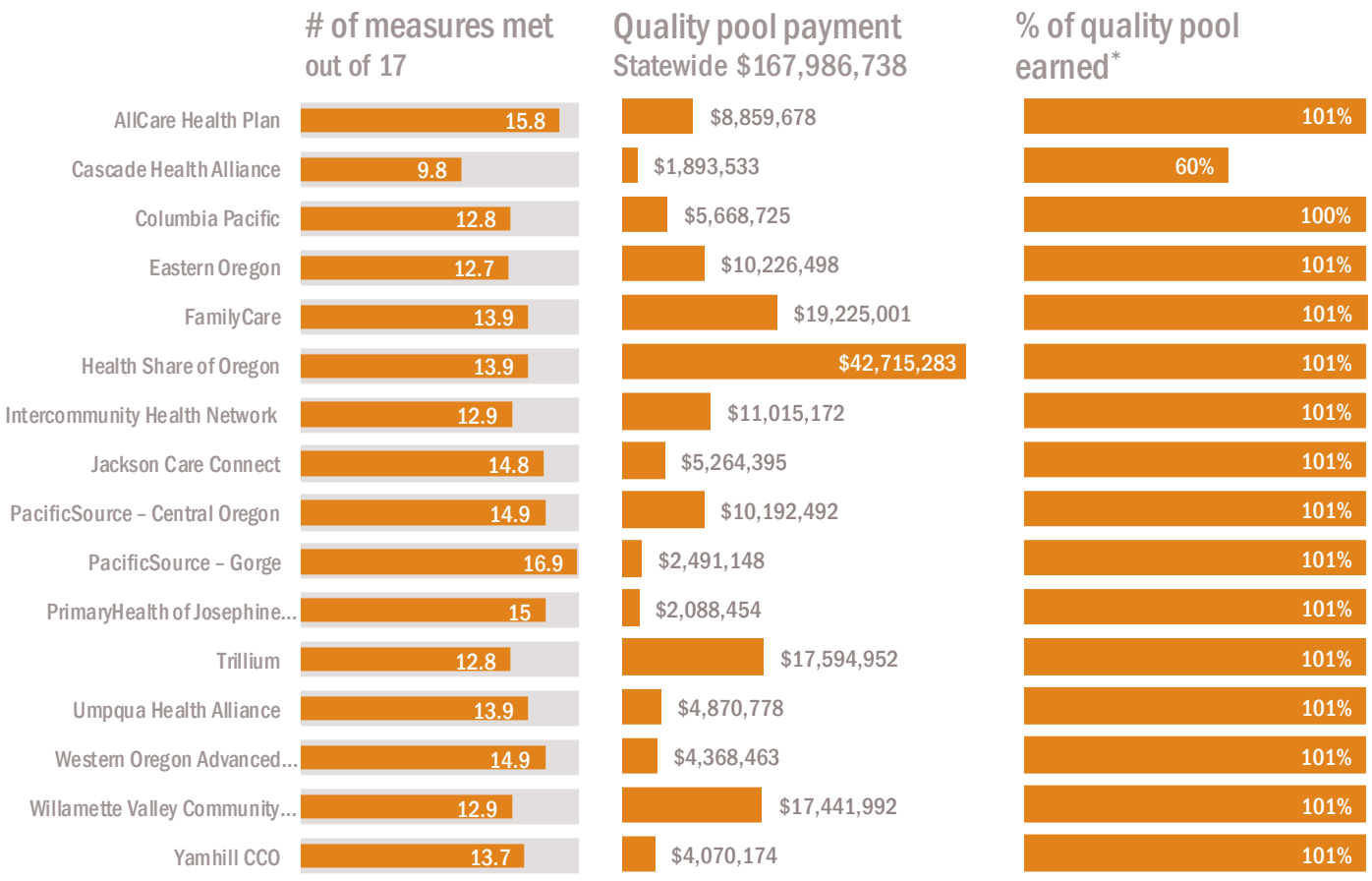
CCO Performance on Quality Metrics

2015 is the third year in which the Oregon Health Authority distributed bonus payments from a 'quality pool' to CCOs that met benchmarks or demonstrated certain improvements on a set of 17 measures. The 2015 quality pool was four percent of monthly payments to CCOs, totaling $168 million.

Quality pool dollars are distributed based on the number of measures met and CCO size (number of members). In 2015, 15 of the 16 CCOs earned 100 percent of the quality pool funds they were eligible for by meeting 12 of 16 measures, and having at least 60 percent of their members enrolled in a patient-centered primary care home (the 17th measure). The remaining CCO met eight of the measures and had at least 60 percent of their members enrolled in a PCPCH and earned 60 percent of the quality pool funds for which they were eligible. CCOs are contractually required to distribute their quality pool funds to the provider networks, and many run their own incentive programs.

Oregon's coordinated care model, which CCOs are implementing, continues to demonstrate improvements in a number of areas, such as reductions in emergency department visits, and increases in dental sealants and alcohol and drug screening. These improvements help support Oregon's achievement of the Triple Aim: better health, better care, and lower costs.

CCO Performance and Payments, CY 2015

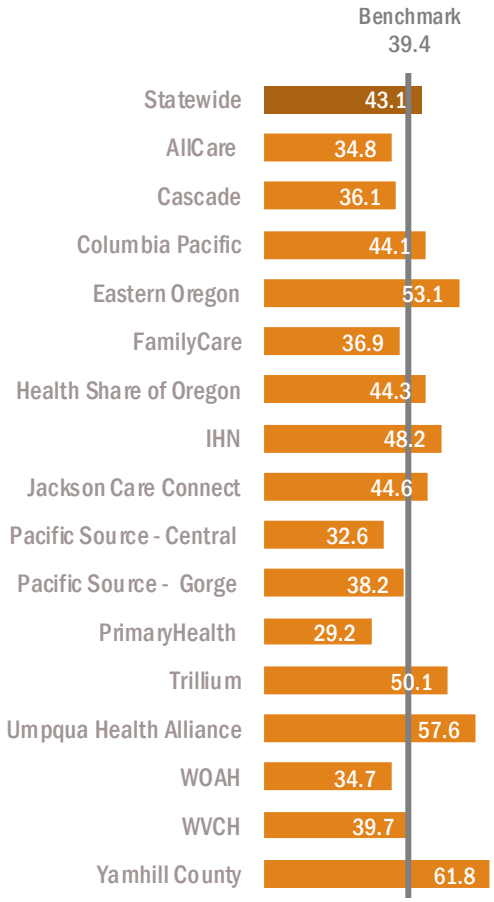


*Funds from CCOs not earning 100% were redistributed based on CCO performance on four selected measures, resulting in CCOs earning more than 100% of their own quality pool totals. See Appendix for link to the full 2015 CCO Metrics report.

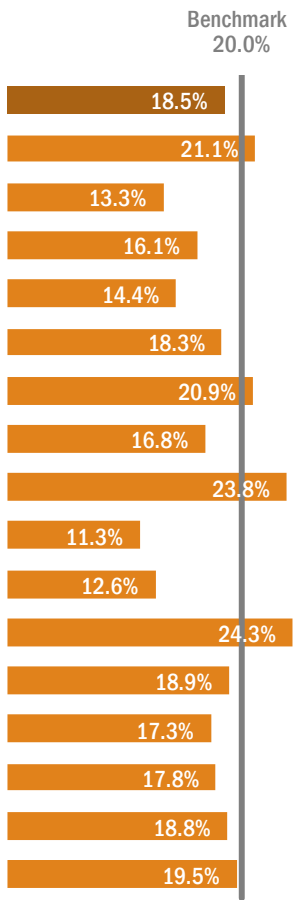
CCO Performance on Quality Metrics

The graphs below show a selection of quality measures, statewide and by CCO compared against the benchmark, for calendar year 2015. The full CY 2015 CCO Metrics report includes results for all measures reported at the state level, by CCO, and by race/ethnicity where available. http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

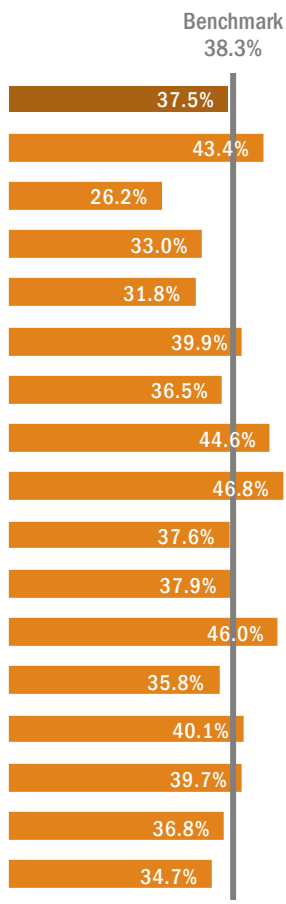
Emergency Dept. utilization, 2015
Lower is better. Per 1,000 member months.



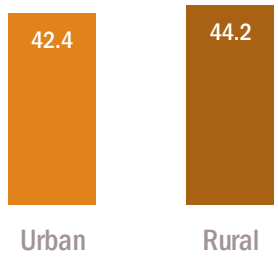
Dental sealants, 2015
Ages 6-9. Higher score is better.



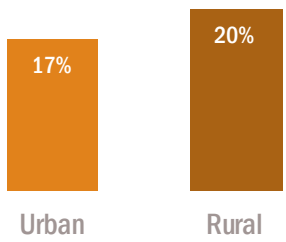
Initiation of alcohol or drug treatment, 2015
Higher score is better.



ED utilization, statewide



Dental sealants, statewide



While we see improvement in reducing emergency department utilization since 2011 baseline, there are still areas in need of attention, including initiation of treatment for those newly diagnosed with substance use disorders.

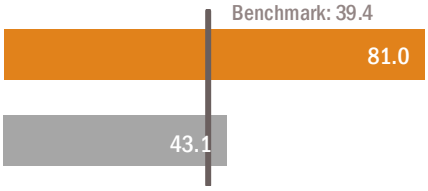
CCO Performance on Quality Metrics

The graphs below show a selection of 2015 quality measures for OHP members with disability, mental health diagnoses, and severe and persistent mental illness (SPMI) indicated in the orange bars compared to OHP members statewide (grey bars). The dark line indicates the benchmark for each measure. See Appendix for a link to the full 2015 metrics report.

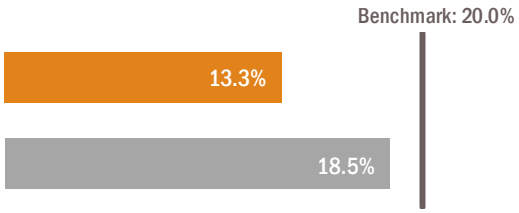
Members with disability, mental health diagnoses, and SPMI used the emergency department at much higher rates than the statewide average. Children with disability were less likely to receive dental sealants, and children in DHS custody who had mental health diagnoses were less likely to receive health assessments than other children. Effective contraceptive use among women at risk of unintended pregnancy was lower among women with disability, but higher among women with mental health diagnoses.

With disability

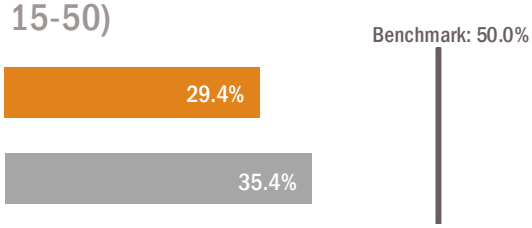
Emergency department utilization (per 1,000 member months)



Dental sealants (ages 6-14)

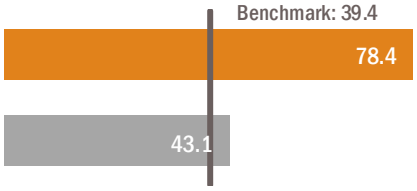


Effective contraceptive use (ages 15-50)

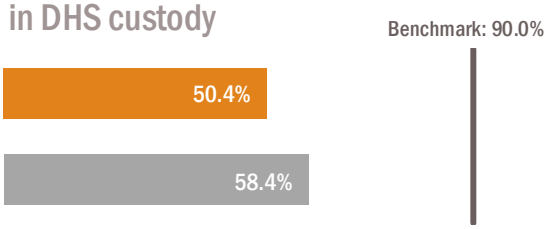


With mental health diagnoses

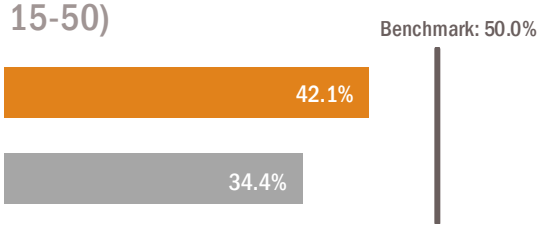
Emergency department utilization (per 1,000 member months)



Health assessments for children in DHS custody

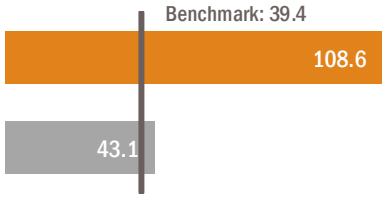


Effective contraceptive use (ages 15-50)

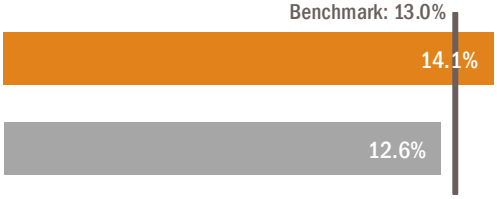


With severe and persistent mental illness

Emergency department utilization (per 1,000 member months)



Screening, brief invervention, and referral to treatment (ages 18+)



Member Satisfaction

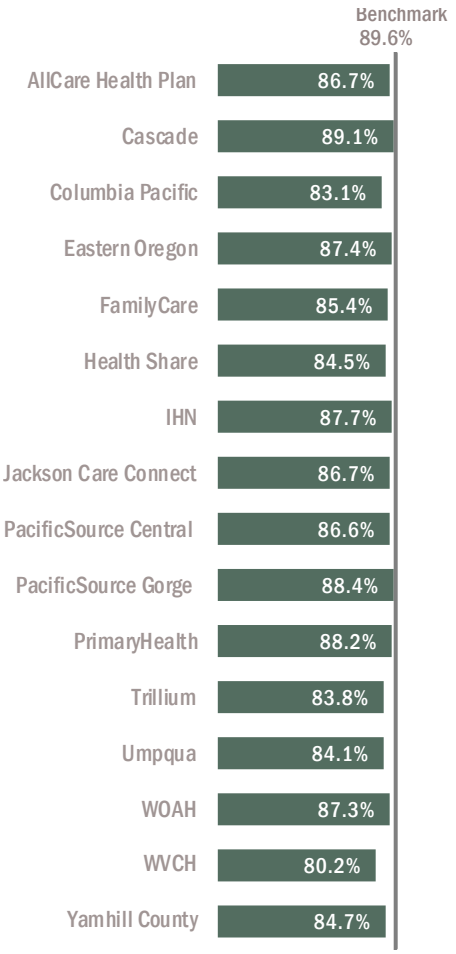
The Oregon Health Authority values Oregon Health Plan member experience as an essential measure of health system transformation success. Accordingly, OHA monitors and evaluates OHP member experience and satisfaction in a number of ways.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

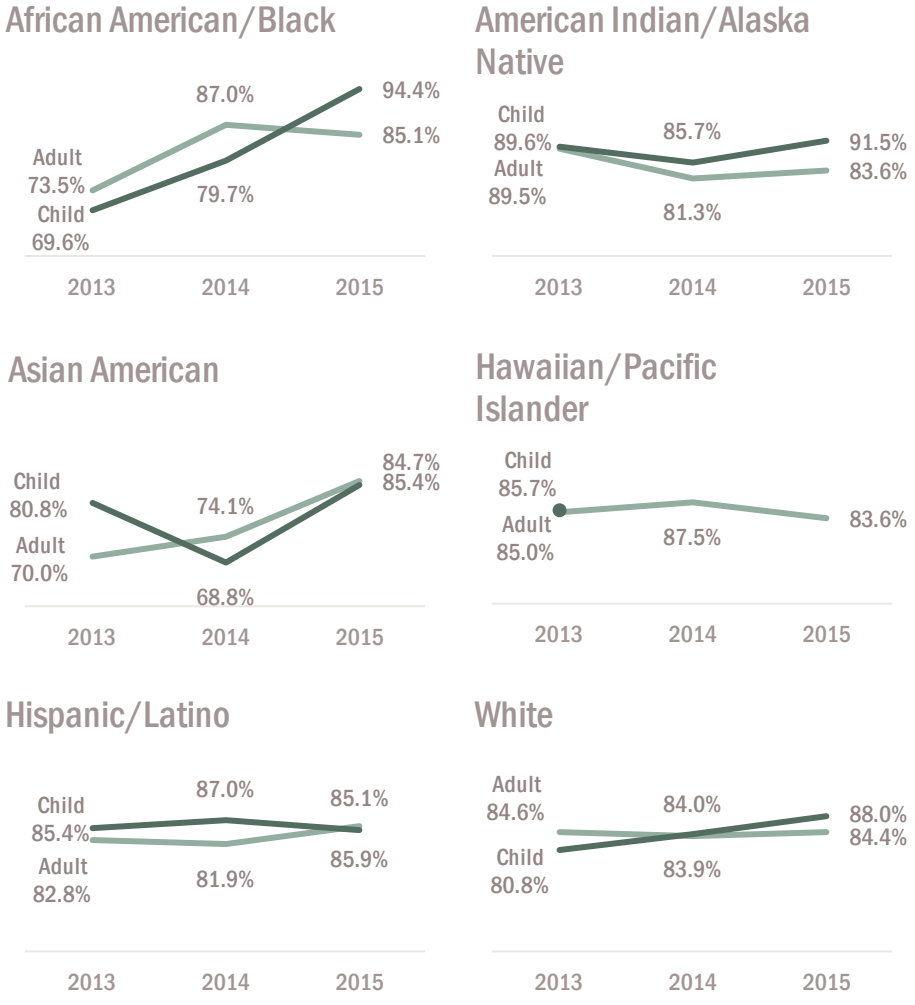
OHA administers the CAHPS survey every year. This survey covers topics that are important to OHP members and focuses on aspects of care that members are best qualified to assess. Results of the survey allow OHA and CCOs to evaluate how well they are meeting members' expectations, encourage accountability, and help inform action plans.

CAHPS data are used in the CCO incentive measure Satisfaction with Health Plan Customer Service composite, which is based on two questions: In the last six months, how often has your health plan's customer service 1) given you the information or help you needed? 2) treated you with courtesy and respect? Data are reported for "usually" and "always" responses.

2015 member satisfaction by CCO



Member satisfaction by race/ethnicity



Results for Hawaiian/Pacific Islander children not available in 2014-2015 due to small denominators (n<30)

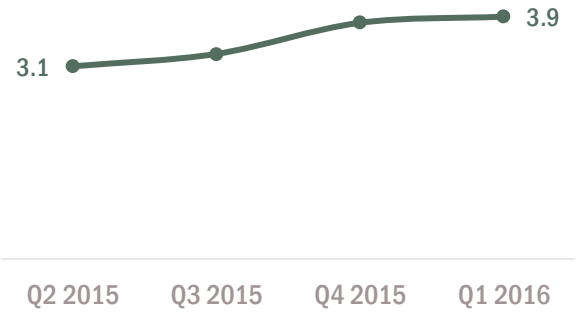
Satisfaction with Health Plan Customer Service is highly correlated with how members rate their health care, which is highly correlated with access to care, and how members rate their personal doctor.

Member Satisfaction

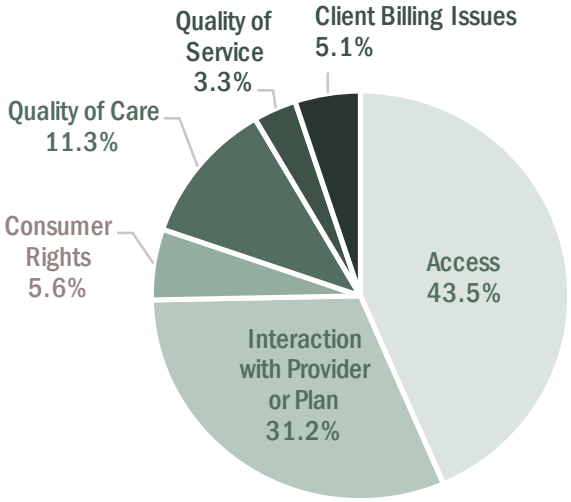
Complaint and Grievance Reporting

The CAHPS survey is a requirement of Oregon's 1115 Demonstration Waiver. In addition, the Waiver requires reporting on six categories of complaints and grievances: Access to Providers and Services, Interaction with Provider of Plan, Consumer Rights, Clinical Care, Quality of Services, and Client Billing Issues.

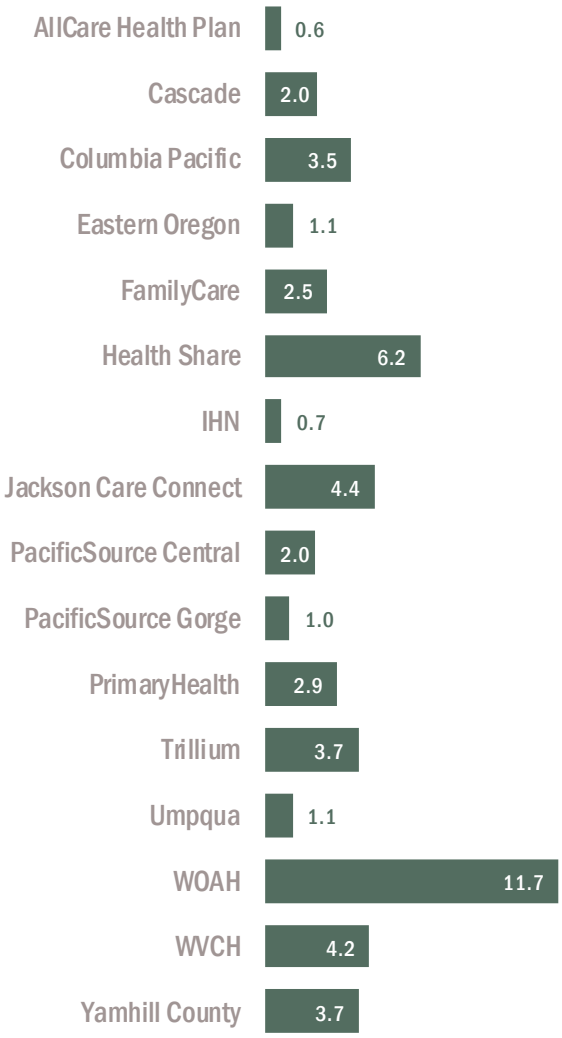
Complaints increased each quarter
per 1,000 members



Most Q1 2016 complaints were about access to care or interaction with provider.



Complaints varied by CCO, Q1 2016
per 1,000 members



In Q1 2016,
97.4%
of complaints were resolved.

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.

Health Disparities

Transformation Plans

CCO transformation plans, as required by contract, include eight transformational elements; three elements specifically require CCOs to address improving member engagement, cultural competency, and health disparities. CCOs identify their own objectives and set benchmarks for transformation plan elements; these are reviewed and approved by OHA. Each of the following activities is reflected in the transformation plans for at least half of the CCOs:

- Providing cultural competency, cultural diversity, and/or health equity trainings for their clinic and provider networks;
- Reviewing and revising member materials for appropriate health literacy; and
- Analyzing, reporting, and disseminating their quality performance measure data stratified by member demographics, such as race, ethnicity, language, age, gender, and disability.

OHA provided each CCO with suggested technical assistance available from the Transformation Center and the Office of Equity and Inclusion to help meet equity-related transformation plan goals.

CCOs meeting Transformation Plan Benchmarks in 2013-2015

	Member Engagement	Cultural Competency	Health Disparities
AllCare Health Plan	No	No	Yes
Columbia Pacific CCO	Yes	No	No
Eastern Oregon	Yes	No	Yes
FamilyCare	Yes	Yes	No
Health Share of Oregon	Yes	No	Yes
Intercommunity Health Network	Yes	No	Yes
Jackson Care Connect	Yes	Yes	No
PacificSource—Central	Yes	Yes	Yes
PacificSource—Gorge	Yes	Yes	Yes
PrimaryHealth of Josephine County	Yes	Yes	Yes
Trillium Community Health Plan	Yes	No	No
Umpqua Health Alliance	Yes	Yes	Yes
Western Oregon Advanced Health	Yes	Yes	No
Willamette Valley Community Health	Yes	Yes	Yes
Yamhill CCO	Yes	Yes	No

Cascade Health Alliance's Transformation Plan is excluded from this summary, as their Exhibit K report was not included in their CCO contract until October 2013.

Finance

CCO Profile

Although all of Oregon's 16 CCOs are community-based in terms of local governance, they exist under a wide variety of legal and corporate structures. 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. The table below 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.

Finance

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 for 2013 aggregated to approximately 3 percent with the highest margin being approximately 8 percent. With the expansion of the Medicaid program in 2014, CCO membership increased more than 70 percent. The 2014 rates developed for the new expansion population (referred to as ACA population) were calculated with little to no historical cost data. The general assumption was that the ACA population would consist of individuals who had more health care concerns than the current Medicaid population, as well as pent-up demand from uninsured individuals, and rates were paid based on these assumptions. In reality, the new ACA members who joined the CCOs were younger and healthier, which resulted in generally higher CCO operating margins for 2014.

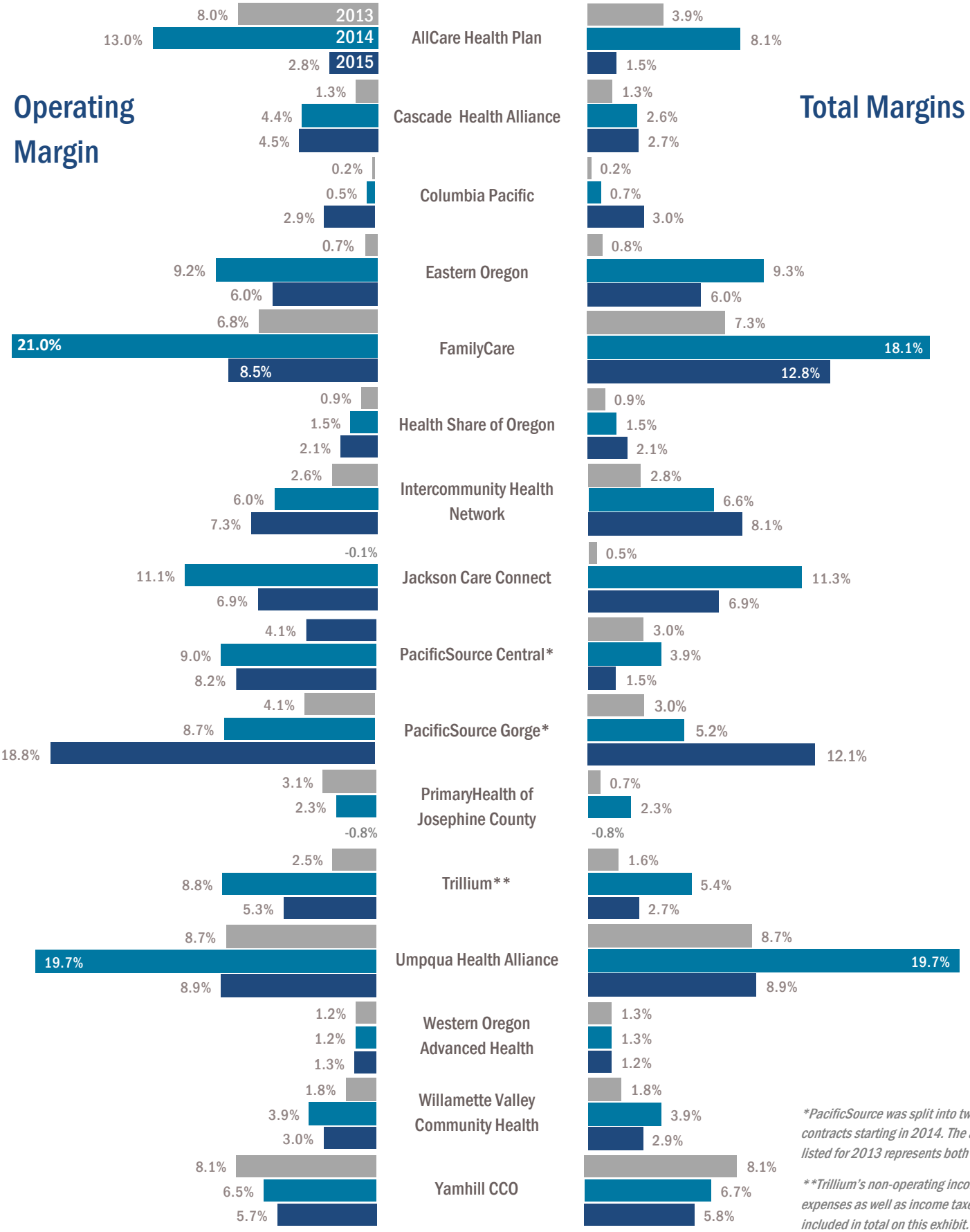
By early 2015, OHA had adequate emerging experience (claims information) to begin to quantify the true underlying cost of the ACA population. In cooperation with CMS, OHA retained an external actuarial firm (Optumas), redeveloped the 2015 rates, and changed the rate development methodology to better align the CCOs' population risk to their capitation rate. The redeveloped rates were retroactively applied to the CCOs' 2015 rates, which resulted in generally lower operating margins for the year.

CCO Operating and Total Margins

	Operating Margin $ millions			Total Margin** $ millions		
	2013	2014	2015	2013	2014	2015
Allcare Health Plan, Inc.	$ 8.8	$ 27.3	$ 6.3	$ 4.3	$ 17.0	$ 3.4
Cascade Health Alliance	$ 0.4	$ 2.1	$ 3.6	$ 0.4	$ 1.2	$ 2.1
Columbia Pacific	$ 0.1	$ 0.6	$ 4.4	$ 0.1	$ 0.8	$ 4.4
Eastern Oregon	$ 0.7	$ 18.4	$ 15.6	$ 0.8	$ 18.5	$ 15.6
FamilyCare	$ 11.3	$ 85.5	$ 46.4	$ 12.1	$ 73.5	$ 69.4
Health Share of Oregon	$ 4.8	$ 14.5	$ 22.5	$ 4.8	$ 14.5	$ 22.6
Intercommunity Health Network	$ 3.4	$ 15.2	$ 20.5	$ 3.5	$ 16.8	$ 22.8
Jackson Care Connect	$ -	$ 13.8	$ 9.9	$ 0.3	$ 14.1	$ 9.9
PacificSource Comm. Solutions - Central*	$ 5.6	$ 19.6	$ 22.2	$ 4.1	$ 8.4	$ 4.1
PacificSource Comm. Solutions - Gorge*	NA	$ 4.4	$ 12.3	NA	$ 2.6	$ 7.9
Primary Health Josephine Co	$ 0.7	$ 1.0	$ (0.4)	$ 0.2	$ 1.0	$ (0.4)
Trillium Comm. Health Plan***	$ 2.4	$ 36.4	$ 36.2	$ 0.3	$ 22.6	$ 22.4
Umpqua Health Alliance	$ 5.8	$ 23.0	$ 10.8	$ 5.8	$ 23.0	$ 10.8
Western Oregon Advanced Health	$ 0.6	$ 1.2	$ 1.4	$ 0.6	$ 1.2	$ 1.4
Willamette Valley Community Health	$ 3.5	$ 14.1	$ 13.4	$ 3.5	$ 14.1	$ 12.7
Yamhill County Care Organization	$ 3.7	$ 5.3	$ 6.1	$ 3.8	$ 5.5	$ 6.2
Consolidated Total	$ 51.8	$ 282.4	$ 231.2	$ 44.6	$ 234.8	$ 215.3

*PacificSource was split into two contracts starting in 2014. The amount listed for 2013 represents both CCOs. ** 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 on this exhibit.

CCO Operating and Total Margins (operating income as percentage of revenue)



**PacificSource was split into two contracts starting in 2014. The amount listed for 2013 represents both CCOs.*

***Trillium's non-operating income and expenses as well as income taxes are included in total on this exhibit.*

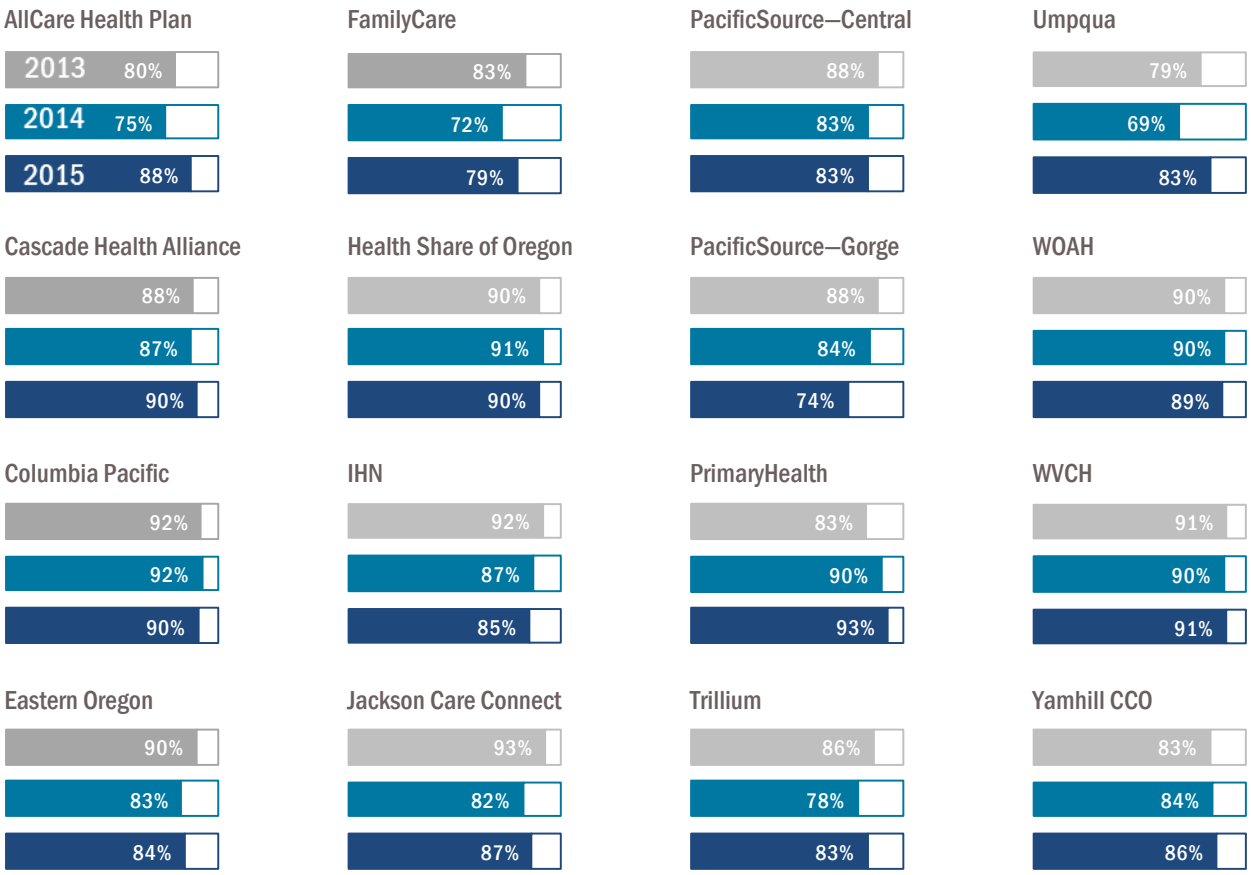
Finance

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.

Below is a table that displays each CCO's Member Services Ratio for the past three years:



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 (GAAP), which could include accrued contingencies and reserves per each CCO's individual financial reporting and business model.

Finance

Capitalization

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 purchase and coordinate their members care.

The increased membership resulting from ACA expansion in 2014 led to increased net worth and higher restricted reserve requirements. CCOs are currently required to maintain a net worth level of five percent of their average annual revenue (a rolling average of the past four quarters' revenue) as a minimum amount of operating capital.

See the table on the next page for CCOs' net assets in total compared to their required net worth, and reported by member. This allows for normalization between large and small CCOs.

Partially as a result of the increase in CCO enrollment with the expansion of Medicaid, CCOs built up operating capital and realized a sharp increase in cash and investments between 2013 and 2014. This increase continued between 2014 and 2015 (see table below).

In 2014, CCOs realized a sharp increase in cash and investments, primarily due to the increased investment from Medicaid expansion.

Cash and Investments (in millions)	2013	2014	2015	Trend
Allcare Health Plan, Inc.	$12.5	$39.1	$33.5	
Cascade Health Alliance	$6.2	$14.0	$28.8	
Columbia Pacific	$2.8	$7.1	$13.8	
Eastern Oregon	$16.6	$52.2	$69.8	
Family Care	$60.3	$197.8	$292.1	
Health Share of Oregon	$23.9	$41.2	$55.5	
Intercommunity Health Network	$32.2	$80.7	$94.0	
Jackson Care Connect	$4.3	$8.5	$16.8	
PacificSource Comm. Solutions*	$26.3	$54.5	$62.8	
Primary Health Josephine Co	$4.4	$4.8	$4.1	
Trillium Comm. Health Plan	$54.7	$112.7	$131.3	
Umpqua Health Alliance	$14.1	$51.5	$60.5	
Western Oregon Advanced Health	$2.8	$5.8	$8.1	
Willamette Valley Community Health	$8.9	$27.8	$22.0	
Yamhill County Care Organization	$9.1	$19.5	$25.9	
Consolidated Total	$279.1	$717.1	$919.1	

**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.*

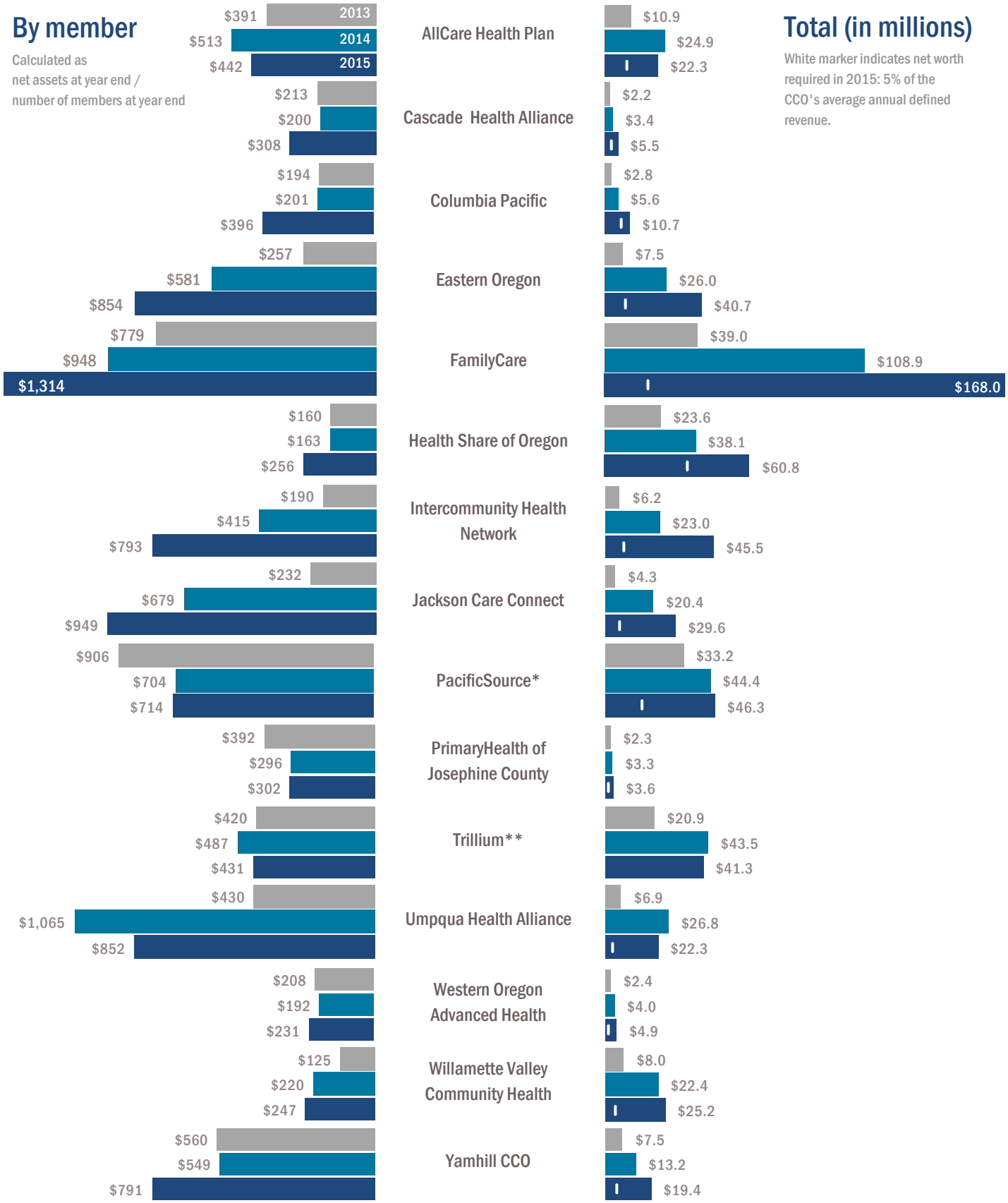
Finance: Net assets by CCO, 2013-2015

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 2015: 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 Community and Business Services with financial oversight based on NAIC oversight requirements.

Finance

Rate Development

In 2015, OHA engaged Optumas, an external actuarial firm, to re-examine the methodology for developing CCO capitation payment rates and subsequently re-developed the 2015 CCO rates. The updated regional methodology matches payment to risk and meets applicable CMS and Actuarial standards. The 2015 and 2016 CCO rates were developed using this updated rate methodology.

OHA is currently developing the 2017 CCO rates with the same rate methodology. During this process, some 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. Other factors included high pharmacy cost trends and increased small/rural hospital costs.

In order to continue to contain costs to 3.4% 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.

This means the financial information that informs the rate process is being adjusted. Actual rates have not been completed at the time this report was published. OHA is working closely with Optumas to finalize trend assumptions and complete the development of the 2017 rates.

Risks and Pressures

The Medicaid program and CCOs are facing a number of financial pressures. Nationally, pharmaceutical costs continue to rise rapidly. Although these increases are in specialty drugs and breakthrough therapies, the increase is impacting generic drug costs as well. In a recent review of cost reports, CCOs are seeing increases in drug costs of between 20 and 30 percent.

Similarly, the costs of new treatments and expanded benefits covered through the Oregon Health Plan (OHP) adds financial pressure to CCOs. There has been significant attention on the coverage of Hepatitis C treatment for OHP members in stage 3 and 4. 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.

CCOs have 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 some autistic children.

OHA continues to partner with CCOs to ensure our annual health care cost growth rate does not exceed 3.4 percent.

Patient-Centered Primary Care Homes (PCPCH)

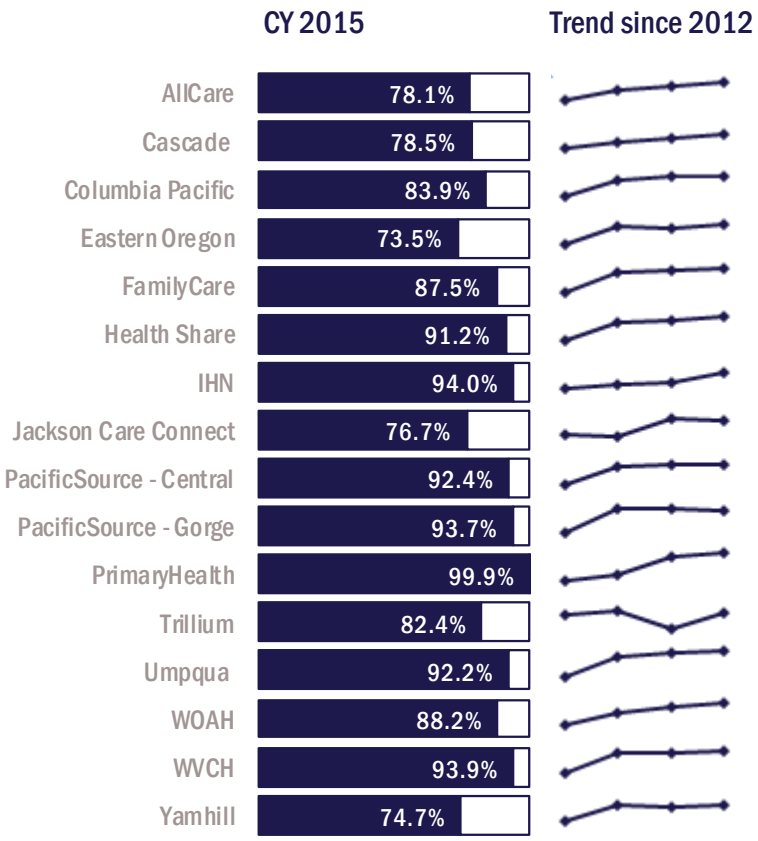
PCPCHs across Oregon

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 less than five years, about two-thirds of all primary care clinics in the state are recognized PCPCHs.

As of March 2016, more than 620 clinics had been recognized as a PCPCH, 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.

Recognized PCPCHs by tier, March 2016

Percent of CCO members enrolled in PCPCHs



2017 PCPCH standards: Accelerate integration, engagement, and quality

In January 2017, the PCPCH program will implement revised PCPCH standards based on the recommendations of the PCPCH Standards Advisory Committee. Notable changes include:

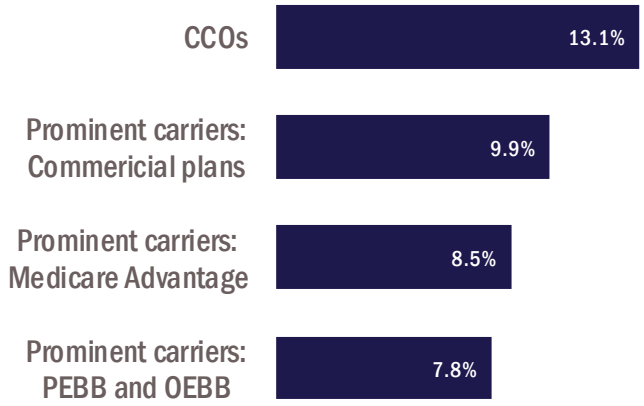
- An improved framework for behavioral and physical health care integration in a PCPCH. Mandated by SB 832, this work will help break down barriers to integrated care.
- Greater engagement with patients by requiring PCPCHs to survey their patient population at least once every two years about their experience of care.
- A greater emphasis on a PCPCH's use of data to identify areas of improvement and implement quality improvement processes.
- Two new levels of PCPCH recognition to encourage and support continued transformation for the most advanced practices.

Primary Care Transformation

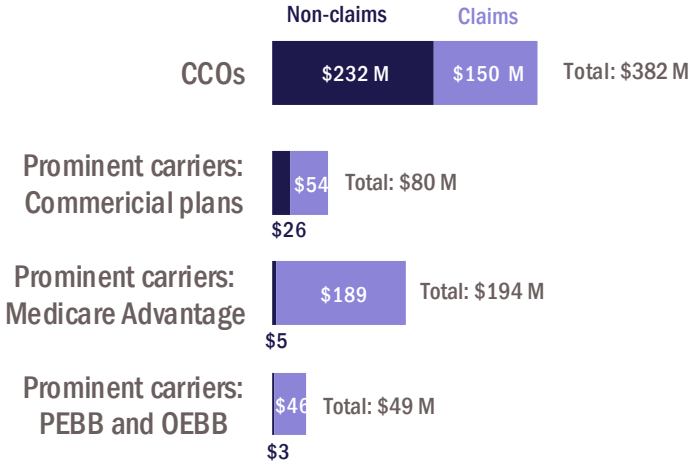
Primary Care Spending

Senate Bill 231 (2015) requires the Oregon Health Authority and the Department of Consumer and Business Services to report on the percentage of medical spending allocated to primary care for CCOs, health plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB), and prominent carriers (those health insurers with annual premium income of $200 million or more). See Appendix for a link to the full report from Feb2016.

In 2014, CCOs allocated 13% of total medical spending to primary care on average



In 2014, CCOs spent $232 million on primary care through non-claims based payments



Non-claims-based payments are payments to health care providers intended to incentivize efficient care delivery, reward achievement of quality or cost-saving goals, and build primary care infrastructure and capacity.

Comprehensive Primary Care Plus (CPC+)

CPC+ is a regionally based, multi-payer advanced primary care medical home model offering an innovative payment structure to improve healthcare quality and delivery. It is a five year federal program that will bring significant Medicare dollars to Oregon. CPC+ begins Jan 2017 in 20 regions across the country with up to 5,000 practices, 20,000 physicians, and 25 million patients.

Oregon has 65 practices that have been participating in the first Comprehensive Primary Care initiative, bringing Medicare enhanced payments into Oregon to support primary care. CPC brought in $12 million of additional funding paid directly to primary care practices.

CPC+ accepted payers (CCO only)

AllCare	ColumbiaPacific	EOCCO
FamilyCare	Health Share*	Jackson
PacificSource - Central	PacificSource - Gorge	Primary Health
Umpqua	WOAH	WVCH
Yamhill		

*Three of the four Health Share risk-accepting entities (RAEs) were accepted.

Oregon was just accepted as a CPC+ region, which brings enhanced Medicare dollars in state, increases the number of participating practices, and bolsters our efforts to move from fee-for-service to a system that pays for outcomes.

Evaluations

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 full reports.

Waiver Midpoint Evaluation

This evaluation, conducted by Mathematica Policy Research (MPR), assessed the extent to which OHA and CCOs supported and implemented activities to transform Medicaid, and provided insight into transformation areas where CCOs focused their efforts (based on CCO self-assessment).

Midpoint Evaluation Findings

- Significant changes appeared to be concentrated in primary care improvements.
- Start-up phase of CCOs did not reflect significant transformation findings.

MPR found few statistically significant changes associated with the introduction of CCOs, with significant changes concentrated in the area of improving primary care. Primary care is a foundational element of transformation, with a focus on prevention, case management, and care coordination delivered through team-based care.

The analysis included a limited timeframe (only the first 15 months of CCO experience) and did not have a comparison group. The evaluation may have only reflected where CCOs devoted their attention during their start-up phases.

Patient-Centered Primary Care Home (PCPCH) Evaluation

Key Findings

- PCPCHs showed significant increases in preventive procedures and decreases in specialty visits compared to non-PCPCHs.
- PCPCHs showed significant decreases in primary care visit and specialty office visit expenditures compared to non-PCPCHs.

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.

Findings are consistent with the expectation that PCPCHs should emphasize primary care utilization over specialty care when appropriate. Researchers are building on this project and a new report will be published in fall 2016.

Hospital Transformation Performance Program (HTPP) Evaluation

This evaluation estimated the impact of the HTPP on hospital performance, quality improvement activities, and collaboration with CCOs.

All CCO representatives interviewed reported that HTPP has increased collaboration between hospitals and CCOs and nearly all hospitals reported that HTPP has helped their quality improvement efforts and programs.

Key Findings

- Hospitals have increased outreach to primary care for emergency department (ED) use and alcohol and substance use screening in the ED.
- Hospitals that increased collaboration with CCOs experienced statistically significant improvement on select measures.

Local Governance

Community Advisory Councils

COOs are required to have at least one Community Advisory Council (CAC), which meets regularly to ensure the CCO is addressing the health needs of the CCO members and the community. Representation is made up of members of each community of each county served, must include a majority of consumers and representation from each county government in the service area.

CAC strengths include driving partnerships between CCOs and communities on diverse projects, including those that address social factors that influence health, and giving Medicaid members a voice in setting CCO priorities. CAC challenges include achieving majority consumer membership and more diverse representation, specifically from Hispanic/Latinos.

The Transformation Center is supporting CCOs in recruiting CAC members with a customizable public service announcement in English and Spanish, a toolkit for CAC member recruitment, and assistance with CCO marketing and outreach materials.

Community Health Improvement Plans

All 16 CCOs have completed a Community Health Improvement Plan (CHIP), a document that must be updated at least every five years. CACs play an integral part in developing these plans by providing a local community perspective to improving community health. A 2014 review of CHIP development found CCOs included a diverse range of stakeholders in the process, and over 80 percent of CCOs focused on (1) improving integration of services; (2) primary care, behavioral health, and oral health; and (3) addressing promotion of health, prevention, and early intervention in treatment.

Coordination with Local Public Health

CCOs are contractually required to collaborate with local public health authorities (LPHAs) in a number of areas, including health promotion and prevention, and addressing disparities, although they are not required to have a formal contract or memorandum of understanding. Most CCOs have a close working relationship with their LPHAs.

OHA also provides competitive grants to 10 CCO and 23 LPHAs to work collaboratively to improve community health. Recipients must demonstrate that a local consortium of at least one CCO and one LPHA exists. Not all CCOs applied.

Community Prevention Program grants support evidence-based population and clinical interventions that align with community priorities.

Health Share	Multnomah, Clackamas, Washington
IHN	Benton, Lincoln, Linn
AllCare, Jackson, and PrimaryHealth	Jackson, Josephine
Eastern Oregon	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler

Sustainable Relationships for Community Health grants build local systems to prevent and manage chronic diseases

FamilyCare	Clackamas
ColumbiaPacific	The Public Health Foundation of Columbia County
IHN	Benton, Lincoln, Linn
Cascade	Klamath
Trillium	Lane

Eligibility and Enrollment

OHA maintains a close working relationship with the Department of Consumer and Business Services (DCBS) to ensure cross-agency collaboration between Qualified Health Plan Marketplace and Medicaid operations.

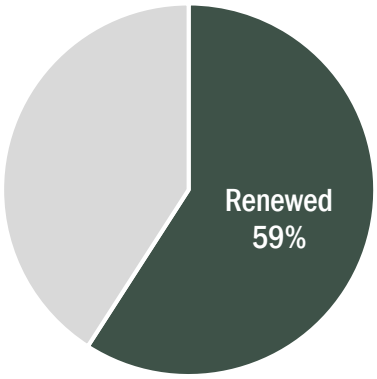
Areas of collaboration include coordination with HealthCare.gov to ensure that there is no "wrong door" for applications, and the implementation of OHA's new Medicaid eligibility and enrollment system, OregONEligibility (ONE), which began operations in December 2015. OHA's goal is to give Oregonians a better customer experience when they apply for coverage and benefits, through an easier, automated process.

Renewals and Closures

Members can renew their Oregon Health Plan eligibility by submitting an online PDF or paper application, or applying by phone. Members have approximately 60 days to respond to a renewal notice before their benefits are closed.

In 2015 OHA received approval from the Centers for Medicare and Medicaid Services to pause renewals for 90 days while OHA transitioned to the ONE eligibility system. Renewals resumed in February 2016. Starting in September, OHA is working to make renewals easier for members by sending a prepopulated renewal form.

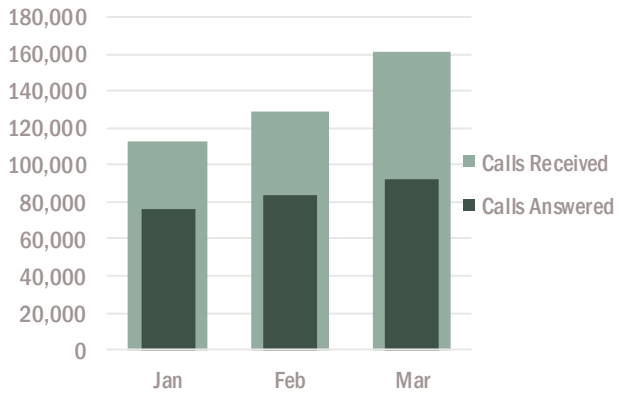
Of 116,660 memberships up for renewal, 59 percent of members renewed within 60 days.



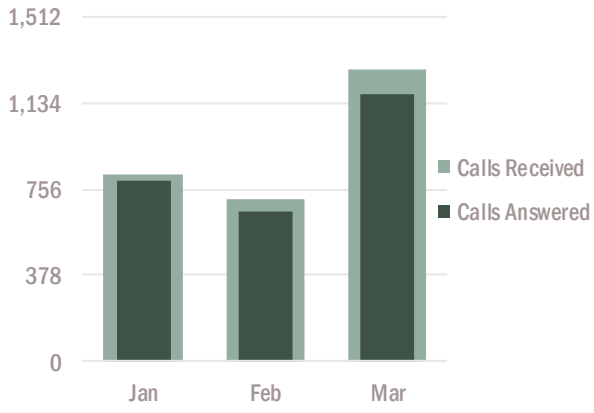
Outreach and Education

OHA and DCBS are currently coordinating their outreach and education efforts, including partnering to provide a network of community partner organizations with more than 800 enrollment assisters capable of helping and enrolling both qualified health plan and Medicaid eligible individuals, and coordinating call center operations and information.

Calls to OHA's Call Center have risen each month in Q1 2016



Calls to the Marketplace have also increased in Q1 2016



Administrative Rules: Changes related to CCOs

Rule Number and Name	Description	Effective Date	Rulemaking Action	Concerns?
OAR 410-141-3110 Substance Use Disorder Provider, Treatment and Facility Certification and Licensure	Rule addresses Substance Use Disorder (SUD) Provider, Treatment and Facility Certification and Licensure for the coordinated care organizational framework.	07/01/16	New Rule	No
OAR 410-141-3262 Requirements for CCO Appeal	Clarification has been provided in the Grievance System rule language for a standard appeal request for CCO members: a verbal appeal request must be followed by a written request.	07/01/16	Amendment	No
OAR 410-141-3070 Preferred Drug List Requirements	Rule language revisions clarify the pharmacy pre-authorization timelines and align prescription (Rx) prior authorization (PA) timeframes also stated in OAR 410-141-3420. *Concerns:* • Anticipated Rx PA language from CMS for 2017 • CCOs want to align language with Medicare Advantage requirements to align business practices *Resolution:* Avoid rework—CCOs and OHA agreed to follow CMS 2017 Rx PA requirements.	07/01/16	Amendment	Yes
OAR 410-141-3420 Billing and Payment — repeal of OAR 410-141-0420	Rule changes to provide guidance for CCOs, MHOs, and DCOs in single rule set: • Clarifies the 4-month billing requirement; • Specifies separate plan type requirements as applicable; • Aligns the pharmacy pre-authorization timeline with 410-141-3070 Preferred Drug Requirements—see above; • Updates claim submission timeframes with federal requirements and 2016 contracts; • Clarifies school-based health service considerations; and • Updates A and B hospital payment methodology language to align with current practices. *Concerns & Resolution:* See above re: OAR 410-141-3070. OAR 410-141-0240 was repealed as duplicate	07/01/16	Amendment and Repeal	Yes
OAR 410-141-3060 Enrollment; OAR 410-141-3080 Disenrollment	Rule changes were made as a result of public comment and OHA policy decisions re: consideration of non-hospital birth enrollment and disenrollment criteria, enrollment for children in DHS custody, and general housekeeping changes. *Concerns:* • CCOs and other contractors feel the enrollment of women not meeting non-hospital delivery criteria is adverse selection; they oppose CCO enrollment for these women. • Children are auto enrolled into dental and mental health CCOs, with manual enrollment for physical health. Requested auto-enrollment into physical health also. *Resolution:* No changes to current rule language made to address DHS custody auto enrollment; agency will review processes for all children in Child Welfare custody.	06/28/16	Amendment	Yes

Administrative Rules: Changes related to CCOs

Rule Number and Name	Description	Effective Date	Rulemaking Action	Concerns?
OAR 410-141- 3345 General Financial Reporting and Financial Solvency Matters; Transition	Expands the number of reports DCBS filers need to complete and submit to OHA so that they are filing reports with both agencies.	01/01/16	Amendment	No
OAR 410-141-3150 Flexible Services	Applying a new title, definition and rule structure *Concerns and resolution:* CCOs and other contractors felt OHA did not listen to public comment provided; advocates were interested in recourse for members through the complaints and grievance system. OHA sent a letter clarifying that all comments were held until completion of flexible services waiver discussion with CMS, then the rule will be re-opened / comments considered. Rule provides recourse for members.	01/01/16	New Rule	Yes
OAR 410-141-3267 CCO/OHA Dispute Resolution	Creates a rule structure for the CCO/OHA Dispute Resolution process within the CCO environment.	01/01/16	New Rule	Yes
OAR 410-141-3040 CCO Service Area Change	Creates a rule structure for the service area change process within the CCO environment. *Concerns and resolution*: CCOs felt OHA did not listen to concerns related to rule design; OHA held multiple Rule Advisory Committee meetings, leadership reviewed concerns.	01/07/16	New Rule	Yes
OAR 410-141-0520 Prioritized List of Health Services	The Authority is temporarily amending 410-141-0520, the approved Health Evidence Review Committee Prioritized List of Health Services and incorporating interim modifications made October 1 with the biennial changes for January 1, 2016-December 31, 2017.	01/01/16	Amendment	No
All Primary Care Case Manager (PCCM) and Primary Case Manager (PCM) rules and references.	As of Nov. 1, 2012, PCM/PCCMs are no longer receiving new patients and OHA contracts ran out. Clients were enrolled in CCOs and there are no any longer clients enrolled in this program.	12/10/15	Repeal of rules and deletion of term use	No
OAR 410-141-0000 Acronyms and Definitions - housekeeping changes) / OAR 410-141-3000 Definitions refer to OAR 410-141-0000	Migrate applicable rule definitions from 141 Administrative Rules to 120 General Rules. The CCO contract will be synchronized in the 2017 contract	10/01/15	Amendment	No
OAR 410-141-3066 CCO Enrollment Requirements for Temporary Out-of-Area Behavioral Health Treatment Service	Framework for CCO member enrollment for adults and young adults receiving temporary out-of-area behavioral health treatment services. This also integrates the rule for substance use disorder treatment services, 410-141-3065, which will be repealed.	09/01/15	New Rule	No
OAR 410-141-0300 / OAR 410-141-3300 / OAR 410-141-0280 / OAR 410-141-3280 /	Updates and aligns OHP member educational / information rules affecting members and potential members.	04/15/15	Amendment	No

Appendix: 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. http://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.
http://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. http://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" http://www.oregon.gov/oha/healthplan/pages/reports.aspx.

Health Disparities

- Race, Ethnicity, Language and Disability (REAL-D) uniform standards for data collection, 2016 legislative update https://www.oregon.gov/DHS/ABOUTDHS/DHSBUDGET/20152017%20Budget/realD-OEMS-Legis-presentation.pdf
- Oregon Regional Health Equity Coalitions Evaluation Report, 2016 http://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. http://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

Appendix: Additional Transformation Reporting

Patient-Centered Primary Care Homes

- The Senate Bill 231 (2015) Primary Care Spending in Oregon first legislative report was published in February 2016.
  http://www.oregon.gov/oha/pcpch/Documents/SB231_Primary-Care-Spending-in-Oregon-Report-to-the-Legislature.pdf
- Additional reports including the PCPCH Program Annual Report, and evaluation results are available.
  http://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.
  https://www.oregon.gov/oha/bhp/CCBHC%20Documents/Oregon-Standards-for-CCBHCs.pdf

Evaluations

Evaluation reports include:

- Midpoint Evaluation of Oregon's Medicaid Section 1115 Demonstration, 2015.
  https://www.oregon.gov/oha/OHPB/Documents/Final%20Report%20for%20the%20Midpoint%20Evaluation%20%204-30-2015.pdf
- Patient-Centered Primary Care Home (PCPCH) utilization and expenditure evaluation, 2014
  http://www.oregon.gov/oha/pcpch/Documents/2014%20PCPCH%20Cost%20and%20Efficiency%20Evaluation.pdf
- Hospital Transformation Performance Program (HTPP) evaluation, 2016. Report available upon request.
- State Health Access Reform Evaluation (SHARE) of CCO organizational structures and governance, 2015
  http://www.shadac.org/publications/oregons-coordinated-care-organizations-governance-impacts
- State Health Access Reform Evaluation (SHARE) of CCO impact on access, quality, patient engagement, health behaviors, and health outcomes, 2015. Report available upon request.

Local Government

- Senate Bill 436 report on community health improvement plan (CHIP) development, 2014
  http://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
  https://public.health.oregon.gov/About/Pages/HealthStatusIndicators.aspx

Eligibility and Enrollment

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