**Analytical Framework for State Cost Containment Models: Oregon**

| Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting | |
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| **What types of administrative data does the state collect?** | The state of Oregon has extensive data collection initiatives and systems in place, capturing eligibility and enrollment data, claims data, and provider data from public payers, and private payers with at least 5,000 covered lives. The repository for this data is the All Payer All Claims (APAC) Database, maintained by the Oregon Health Authority (OHA) Office for Oregon Health Policy and Research. Oregon's APAC database includes claims information from commercial payers, Medicaid managed care organizations, Medicare Advantage plans, pharmacy benefit managers, Oregon Educators Benefit Board (OEBB), and Public Employees' Benefit Board (PEBB)). Medical and pharmacy claims data are included.<br><br>The state's Hospital Reporting Program collects key measures of acute hospital finances and utilization including profitability, charity care, bad debt, and inpatient, outpatient, and emergency department visits. Data are self-reported to the Oregon Association of Hospital and Health Systems (OAHHS), which then makes the files available to OHA on a quarterly basis. The state also collects and makes available to the public data on community benefits as well as inpatient discharge data.<br><br>The state is in the process of developing a Behavioral Health Mapping Tool, which will collect data to assist OHA and its partners to assess public resource and service needs while tracking resource and service delivery.<br><br>In addition to these state-led initiatives, the state's non-profit sector offers the following reporting activities:<br>• The Oregon Health Quality Corporation (Q-Corp) publishes public reports on provider-specific HEDIS quality measures, including: women's and children's health; diabetes, asthma, heart disease and low back pain care; and using antibiotics and generic drugs.<br>• The OAHHS reports hospital quality scores, where available. Data reported by OAHHS includes: utilization and financial trends by hospital, quality data, cholesterol-lowering drugs given at discharge, aspirin given at discharge, death within 30 days of heart attack.<br><br>*Sources:*<br>*For more information about Oregon's APAC database, click here. An APAC database fact sheet may be found here.*<br>*For more information about the state's Hospital Reporting Program, click here.*<br>*Information about the state's Behavioral Health Mapping Tool may be found here.*<br>*For more information about Q-Corp's public reports, click here.*<br>*To access reports provided by the Oregon Association of Hospitals and Health Systems, click here.* |
| **What types of** | As part of its Health System Transformation initiatives, Oregon collects clinical data on selected quality measures |

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| **clinical data does the state collect?** | from Coordinated Care Organizations (CCOs), which serve approximately 90 percent of Medicaid enrollees. Data are obtained via chart reviews and submitted to the OHA in accordance with a schedule published by the state. Results are published in annual reports.<br><br>The state's Hospital Transformation Performance Program collects clinical data on several measures, via either chart reviews/EHRs (as applicable) and in some instances, patient surveys. The quality health metrics show how well hospitals are advancing health system transformation, reducing costs, and improving patient safety.<br>The measures adopted for the first two years of the program require both administrative data and clinical data.<br><br>*Sources:*<br>*More information about Oregon's collection of clinical measures from CCOs may be found here.*<br>*Oregon's Annual Health System Transformation report may be accessed here.*<br>*More information about Oregon's Hospital Transformation Performance Program may be found here.* |
| **Does the state have a HIT strategy to promote use of clinical and administrative data to promote cost containment initiatives?** | Yes, the state has a comprehensive multiphase HIT strategy to support its health system transformation efforts. Described in a comprehensive business plan framework, the state has detailed its vision, goals and strategy for its HIT strategy. This strategy got its start in the fall of 2013, when OHA convened a Health Information Technology Task Force to draft an HIT Business Plan Framework that would guide the state's HIT and HIE strategy.<br><br>As described in their final report, "Oregon's Business Plan Framework for Health Information Technology and Health Information Exchange (2014-2017): Health Information Technology Task Force Recommendations" the Task Force envisions an HIT-optimized health care system, in which:<br>• Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver "whole person" care.<br>• Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention. In turn, policymakers use aggregated data and metrics to provide transparency and to inform policy development.<br>• Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.<br><br>The role of the state in realizing this vision is three-fold:<br>• Coordinate and support community and organizational HIT/HIE efforts.<br>• The State will align requirements and establish standards for participation in statewide HIT/HIE services.<br>• The State will provide HIT/HIE technology and services.<br>The Task Force considered a variety of potential technological approaches to a statewide HIT/HIE, from fully |

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| | localized with no centralized supports, to one that is fully centralized, with all local and regional HIT/HIE needs being met by a single state-designated entity. The Task Force's final recommendations strikes a balance between these two extremes, with some services being provided centrally and others left to local and regional entities:<br>1. Community/organizational HIEs and health systems provide HIT services and HIE coverage to some providers. Providers and hospitals adopt and use EHRs and HIT/HIE services to coordinate care.<br>2. Statewide Direct secure messaging provides a foundation for sharing information across organizations and differing technologies.<br>3. Oregon's current state HIE, CareAccord®, provides basic HIE services, including direct secure messaging, with a focus on providers without access to community HIEs and health systems' HIT services.<br>4. New statewide HIT/HIE services tie together local efforts and fill gaps, enabling exchange and HIT functions across community and organizational HIEs, health systems and providers.<br>5. State aggregation of core clinical metrics data supports Medicaid purposes. These data are used to improve care and reduce costs.<br><br>The ONC, which provided an $8.5 million grant, described Oregon's IT strategy as leveraging the variety of HIE activities within the state to expand exchange of and help health care providers achieve meaningful use of their electronic health records (EHRs). These activities include Integrated Delivery Networks (IDNs) providing exchange to their members, EHR vendors offering HIE services, regional health information organizations, and commercial and hospital laboratories delivering results directly to EHRs and to a nationwide e-prescribe network. The State will provide policy and standards for privacy, security and interoperability, a toolkit including a data sharing agreement template and connectivity via NHIN Direct among the exchange efforts.<br><br>*Sources:*<br>*To access the HIT Task Force's final report and recommendations, click here.*<br>*To access the ONC's summary of Oregon's IT strategy, and award highlights, click here.* |
| **Does the state have a centralized agency or entity responsible for collecting, analyzing and reporting health care data?** | Yes. The Office of Health Analytics within the OHA serves as "…the single point of accountability for continual improvement of health analytics coordination and data integration across OHA and DHS programs." The Office of Health Analytics website describes the Office's responsibilities as threefold:<br>• To be the single point of accountability for continual improvement of health analytics coordination and data integration across OHA and DHS programs;<br>• To develop analyses, data strategies, and monitoring tools to assess the performance of OHA programs;<br>• To support OHA policy development, implementation, and evaluation.<br><br>The Office of Health Analytics consists of four distinct units: |

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| | • Actuarial Services: Provides actuarial analyses in support of OHA programs, including global budget development for Oregon's CCOs.<br>• Health Program Analysis and Measurement: Collects and analyzes health care claims, survey, and program data to support Medicaid, and Addictions and Mental Health (AMH) programs and policy.<br>• Health Systems Research and Data: Compiles and analyzes statistical and technical information regarding Oregon's health care system to support policy formation and evaluation.<br>• CCO Metrics: Develops measure specifications and produces reports on the 17 CCO incentive metrics, 16 state performance metrics, and other measure sets that help track health system transformation in Oregon.<br><br>Separately within OHA, the Office for Oregon Health Policy and Research (OHPR) conducts impartial, non-partisan policy analysis, research and evaluation, and provides technical assistance to support health reform planning and implementation in Oregon. The office serves in an advisory capacity to Oregon Health Policy Board, the OHA, the Governor and the Legislature. OHPR has three key functions:<br>• Policy Design and Development — OHPR conducts analyses and makes recommendations on health policies to achieve the goals of the OHA, and provides support to the Oregon Health Policy Board.<br>• Clinical Services and Comparative Effectiveness Research — OHPR provides comparative effectiveness and benefit design research to inform OHA and private sector efforts. This work is conducted by the Health Evidence Review Commission (HERC), which manages the Oregon Health Plan's Prioritized List of Health Services, and analyzes and disseminates information on the effectiveness and costs of medical technologies.<br>• Community Health Initiatives – OHPR provides technical assistance and coordination for OHA's primary care, safety net initiatives and grant programs.<br><br>OHPR oversees the Oregon Health Research and Evaluation Collaborative (HREC), which disseminates information on evidence based-best practices and provides collaborative opportunities for researchers.<br><br>*Sources:*<br>*To learn more about the Office of Health Analytics, click here.*<br>*To learn more about the statutes that authorize Oregon's data collection activities, click here.*<br>*To learn more about OHPR, click here. To learn more about HREC, click here.* |
| **Does the state have a functioning APCD that it uses to collect data?** | Yes, Oregon has an APCD – the All Payer All Claims (APAC) database – maintained by the OHA Office for Oregon Health Policy and Research (OHPR). OHPR undertakes quarterly collection of the following APAC data:<br>• Eligibility files: patient demographic information including date of birth, gender, geography, and race/ethnicity. Criteria for inclusion are members living in Oregon, and members enrolled in a plan for which the state is a payer (such as PEBB, OEBB, or OMIP), regardless of residence. |

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| | • Medical claims and pharmacy claims: plan payments, member financial responsibility (co-pay, co-insurance, deductible), diagnoses, procedures performed, and numerous other data fields.<br>• Provider data: information on location and provider specialty, however, only limited information is available via this dataset.<br><br>*Source:*<br>*An APAC database fact sheet may be found here.* |
| **Does the state report cost and quality to the public?** | Yes, Oregon provides cost and quality reports to the general public, legislators, and policy makers for the purpose of achieving improvements in health care quality and cost. Data, in the form of raw public use data and reports are available to the public on various OHA websites, depending on the topic. Many are related to one of their two primary initiatives, the CCO program, and the Hospital Transformation Performance program.<br><br>The OHA is using quality health metrics to show how well CCOs are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care. The state is tracking 17 CCO incentive metrics and 16 additional state performance metrics. It is also tracking financial data, displayed both by cost and by utilization. By using quality, access and financial metrics together, the state can determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve. OHA publishes annual reports on CCO metrics.<br>• The most recent CCO report includes a subset of measures reported for Oregon Health Plan members with disability, and with severe and persistent mental illness (SPMI) or broader mental health conditions. Additional measures were published in the 2015 Final Report (published in June 2016).<br><br>Additionally, as directed by Oregon House Bill 2216 of 2013, the OHA is using quality health metrics to show how well hospitals are advancing health system transformation, reducing costs, and improving patient safety.<br>• Eleven outcome and quality measures have been developed by the Hospital Metrics Advisory Committee for two measurement years, October 2013–September 2014 (baseline year) and October 2014–September 2015 (performance year). Funds from a quality pool were awarded to hospitals based on their performance on these measures.<br><br>As directed by Senate Bill 231 (2015), the OHA and the Oregon Department of Consumer and Business Services (DCBS) are required to report on the percentage of medical spending allocated to primary care by the following health care payers:<br>• Health insurance carriers with annual premium income of $200 million or more.<br>• Health insurance plans contracted by PEBB and Oregon Educators Benefit Board (OEBB). |

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| | • Medicaid CCOs.<br><br>The results of CAHPS consumer surveys are also made available to the public, and are utilized in both CCO and Hospital Performance reporting datasets.<br><br>*Sources:*<br>*Technical specifications and guidance for CCO incentive measures may be found here.*<br>*Technical specifications and guidance for Hospital Transformation Performance Program may be accessed here.*<br>*Additional measures for CCO members with disability and with SPMI or broader mental health conditions may be found here.*<br>*Senate Bill 231 may be accessed here.*<br>*CAHPS survey results published by the Office of Health Analytics may be accessed here.* |
| **Does the state identify and track key cost drivers through analysis of administrative and clinical data?** | Yes. The state utilizes data from the APAC database to identify and track key cost drivers, and reports on such drivers to examine how well the state is achieving its health system transformation goals.<br><br>*Source:*<br>*To access OHA's September 2015 "Leading Indicators for Oregon's Health Care Transformation, Quarterly Data from the All-Payer, All-Claims Reporting Program," click here.* |
| **Does the state monitor health care cost growth?** | Yes, the state tracks this on a payer-by-payer basis, by service category, via the APCD; this data is reported in the "Leading Indicators" report referenced immediately above. The state also tracks hospital costs and spending, via the Hospital Reporting program. The Oregon Association of Hospitals and Health Systems provides an annual reporting of the median amounts paid, by commercial insurance companies, for common procedures performed by Oregon hospitals; this report is generated from APAC data.<br><br>Both the Office of Health Analytics and the Oregon Health Research and Evaluation Collaborative utilize data obtained from the various datasets described earlier to monitor health care cost trends in their respective domains. |
| **Does the state define cost growth targets?** | Under the CCO program that serves Oregon Health Plan enrollees under a waiver from CMS, in exchange for significant investment by CMS in the program, the state agreed to reduce per capita medical trend by 2 percentage points by the end of the second year of the waiver.<br>• The reduction is from an assumed trend of 5.4% for each year of the demonstration as calculated by OMB and based on the President's budget estimates of the national growth rate for Medicaid. Thus, CMS effectively capped cost increases for the state at 3.4 percent annually.<br>• There are penalties associated with not achieving the targets, ranging from $145 million for not achieving the second year goal, to $183 million in Years 4 and 5. |

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| | In 2015 – 2017, state legislature capped employee/teacher plan rate increases at 3.4 percent and based OHA budget on this cap.<br><br>*Sources:*<br>*Information regarding Oregon's Medicaid demonstration and waiver application may be found here.* |

| Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs | |
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| **Does the state coordinate Medicaid and state employee health plan performance requirements and cost control strategies?** | Yes. Oregon's Coordinated Care Model, described in greater detail below, was initially implemented in its Medicaid program, and has since been adopted by the state's Public Employees Benefit Board. The state Medicaid and employee health plans are aligned in other ways as well:<br>• The two programs are housed under one state agency.<br>• Medicaid, employees' and teachers' plans use the same quality metrics and performance goals, and both emphasize PCMH transformation.<br>• A shared Pharmacy and Therapeutics committee makes Rx coverage decisions for single formulary.<br>The Oregon Health Evidence Review Commission's (HERC's) research findings and recommendations are used to make coverage decisions for the state's PEBB, OEBB, and commercial carriers. Created by the legislature in 2011, HERC reviews medical evidence to:<br>• Prioritize Medicaid spending (creates a prioritized list of covered services which legislature uses to set funding levels); and<br>• Promote evidence-based practices (creates coverage recommendations).<br>To accomplish this, HERC reviews research of well-established medical evidence review organizations (AHRQ, Oregon Health and Science University's Center for Evidence-based Policy (CEBP)) to assess comparative effectiveness of services and pharmaceuticals. Of note, CEBP is a multi-state initiative to reduce overuse and misuse of services.<br><br>*Sources: To learn more about implementation of the Coordinated Care Model in Oregon's PEBB, click here.*<br>*To learn more about HERC, click here.*<br>*To learn more about the Center for Evidence-Based Policy, click here.* |
| **Is the state pursuing an all-payer or Medicare waiver with CMS in order to align** | No. |

| Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs | |
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| **cost control strategies?** | |
| **What other waivers, grants or federal demonstrations is Medicaid pursuing to promote cost containment?** | In July 2012, Oregon received approval with CMS for a Section 1115 Research and Demonstration Waiver to implement changes to the Oregon Health Plan. The waiver expires in 2017. As of December 2016, Oregon's Medicaid Demonstration renewal request has yet to be approved by CMS.<br><br>In early 2013, Oregon received a Round One $45 million State Innovation Model (SIM) Design Award Grant from the Center for Medicare and Medicaid Innovation (CMMI). The SIM grant focuses on three areas:<br>**Innovation and Rapid Learning**<br>• Resources and technical assistance to Oregon's CCOs;<br>• Facilitated learning collaborative and rapid improvement cycles; and<br>• Promotion of health equity across sectors and payers.<br>**Delivery Models**<br>• Evaluation methods of integrating and coordinating between primary, specialty, mental and behavioral health, and oral health;<br>• Improve community health through promotion and prevention activities; and<br>• Support CCOs collaborations with long term care, community health and social services.<br>**Payment Models, tested at two levels:**<br>• Global budget for CCOs; and<br>• A "starter set" of promising alternative models for provider payment; models that focus on the value, rather than the volume, of services provided.<br><br>*Source:*<br>*For more information about Oregon's 1115 waiver, click here. A summary of the waiver may be found here. Information about the waiver renewal may be found here.*<br>*For more information about Oregon's SIM grant, click here.* |
| **What APMs are being pursued by Medicaid?** | Oregon has two APM programs in place: 1) Coordinated Care Organizations under the state's 1115 Medicaid waiver program; and 2) an FQHC Alternative Payment Methodology demonstration project.<br>**Coordinated Care Organizations (CCOs)**<br>Under a Section 1115 Research and Demonstration waiver, a global budget is paid to CCOs for all services provided for enrollees.<br>• **Global Budgets**: CCO global budgets are comprised of two components: capitated and non-capitated. The capitated portion includes all medical, behavioral health and dental services. The non-capitated portion of the global budget includes quality incentive payments, and services provided outside of |

| Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs | |
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| | capitated rates. Generally, the 16 participating CCOs are responsible for all Medicaid-funded care in designated, non-overlapping regions.<br>o Each year the CCOs are restricted to an aggregate in costs to sustain growth; beginning in 2012, this cap was 3.4 percent. State agrees to reduce per capita medical trend by 2 percentage points by the end of the second year of the waiver. Penalties for the Oregon Medicaid Agency for not achieving this are significant ranging from $150 million for not achieving the second year goal, to $185 million in Years 3 and 4.<br>• **Federal Investment:** The waiver provides for federal investment of ~$1.9 billion over 5 years (Year 1: $620 million, Year 2: $620 million, Year 3 $290 million, Year 4: $183 million, Year 5: $183M). This funding comes through the Designated State Health Programs (DSHP).<br>• **Flexibility in use of federal funds:** COOs will have broad flexibility to provide services, provided they are health-related, necessary to improve care delivery and enrollee health.<br>• **Quality:** A 4 percent withhold of monthly payments to CCOs is held back by the OHA and put into a quality pool. These funds are distributed as an incentive payment to the CCOs based on their performance on specified quality metrics at the end of each year. Performance on 16 of the quality metrics are tied to financial incentives.<br>• **Transparency:** The terms of the waiver require the state to make public information about the quality of care provided by a CCO.<br>• **Workforce:** The waiver specifies that Oregon will establish a loan repayment program for primary care physicians who agree to work in rural or underserved communities in Oregon and training for 300 community health workers by 2015.<br>• **Governance:** Each CCO is governed by a board composed of community, delivery system and risk-holder representatives.<br><br>**<u>FQHC APM Demonstration Project</u>**<br>Under the state's FQHC APM demonstration project, a PMPM Medicaid payment is made to 10 FQHCs and one RHC for their attributed population in place of the traditional PPS encounter payment. This approach enables participating centers to use traditionally non-billable services to improve health outcomes for their attributed population. The state performs an annual reconciliation to determine if the APM payments total less than what each center would have received under the traditional PPS encounter payment methodology; any difference is paid back to the center. This demonstration is cost neutral for the state's Medicaid program. Under the project, the FQHCs are responsible for performance against a set of quality measures that include process measures, preventative care measures, clinical outcomes and |

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| | patient satisfaction.<br><br>*Sources:*<br>*To read more about Oregon's Medicaid 1115 waiver demonstration, click here. To read more about rate setting under the CCO program, click here.*<br>*The Role of State Medicaid Programs in Improving the Value of the Health Care System, National Association of State Medicaid Directors, Spring 2016.*<br>*To read more about Oregon's Alternative Payment Methodology demonstration project, click here.* |
| **What delivery system redesign strategies are being pursued by Medicaid?** | See previous discussion of implementation of CCO model, Oregon's version of the ACO for its Medicaid and public employee populations. |
| **What benefit designs are being pursued by Medicaid to incentivize effective use of health care services, good health behaviors and patient responsibility?** | OHA is not pursuing Medicaid benefit designs at this time that might incent effective use of health care services, e.g. directing consumers to low cost providers. However, CCOs have flexibility to create such incentives.<br><br>*Source:*<br>*For more information about Oregon's 1115 waiver, click here.* |
| **Does Medicaid use MMCOs to manage care?** | Not in the traditional sense. The state contracts with ACO-like entities, called CCOs and gives them the flexibility to manage care. |
| **What reimbursement policies has Medicaid implemented to promote cost containment?** | CCOs are paid a global budget for all services provided to their enrollees. This budget has a fixed growth rate, and a withhold to fund a quality pool to be distributed as incentive payments based on CCO performance on quality metrics. In 2015 this withhold was 4 percent of the monthly payment to CCOs and created a pool of almost $168 million. In order for a CCO to have received 100 percent of their withhold back, they had to meet benchmark or improvement targets for at least 12 out of 16 incentives metrics, plus have at least 60 percent of their members enrolled in a Patient-Centered Primary Care Home. For 2015, 15 out of 16 CCOs received 100 percent of their withhold funds back.<br><br>10 FQHCs and one RHC receive a per member per month Medicaid payment in lieu of the PPS encounter payment for their attributed patient population.<br><br>*Source:*<br>*For more information about the CCO quality incentive pool, click here.* |
| **What initiatives has** | Special populations are required to enroll in a CCO unless otherwise excluded. Under the CCO model, |

| Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs | |
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| **Medicaid pursued to manage cost of special populations of beneficiaries?** | CCOs are required to provide intensive case management services for members identified as aged, blind, or disabled, who have complex medical needs, high health care needs, multiple chronic conditions, chemical dependency or mental illness. Under the terms of the contract, intensive case management services may be requested by an enrollee (or representative), physician, other medical personnel serving the enrollees, or the enrollee's agency case manager.<br><br>Because CCOs have the flexibility to provide non-medical services that improve the health of their members and potentially lower costs, CCOs may implement innovative approaches to serving these populations.<br><br>The Oregon Health Transformation Center facilitates a Complex Care Learning Collaborative for CCOs, which creates opportunities for peer-to-peer learning and networking, identifying and sharing information on evidence-based best practices and emerging best practices, and helping advance innovative strategies for enrollees with complex health care needs.<br><br>*Sources:*<br>*To learn more about terms of contract under CCO model, including for special populations, click here.*<br>*To learn more about the Transformation Center's Complex Care Learning Collaborative for CCOs, click here.* |

| Domain #3: State Employee Health Plan Coverage and Payment Strategies to Contain Costs | |
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| **What APMs is the state employee health plan using to control health care costs?** | Oregon's Public Employees Benefit Board (PEBB) offers a variety of health plan options to state employees, including CCO options. The PEBB also states that health plan offerings for state employees have adopted a 'coordinated care model' approach to better manage chronic conditions and improve health outcomes.<br><br>*Source:*<br>*To read more about the coordinated care model within PEBB's offerings for state employees, click here.* |
| **What benefit design is the state employee health plan using to control health care costs?** | In 2010, the PEBB and the Oregon Educators Benefit Board (OEBB) implemented value-based insurance design programs for state workers. The plans increase copayments for overused or preference-sensitive services of low relative value, and they cover preventive and high-value services at low or no cost.<br><br>The current CCO model provides incentives for employees to select lower-cost options, specifically by |

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| | requiring a lower employee premium contribution for the lower-cost plan options. The PEBB program offers "Better Choices, Better Health," which are online health self-management workshops.<br>*Sources:*<br>*For access to a Health Affairs article about the PEBB's benefit design, click here.*<br>*For more information about the PEBB's online self-management programs, click here.* |

| Domain #4: State Actions to Enhance Competition in the Marketplace | |
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| **Does the state certify or otherwise regulate Accountable Care Organizations?** | Oregon's CCOs are based on the ACO model envisioned by Affordable Care Act and the Center for Medicare and Medicaid Innovation.<br><br>In 2012, the OHA selected Coordinated Care Organizations via a non-competitive RFA process. CCOs submitted applications to OHA describing their capacity and plans for meeting the goals and requirements established by legislation (HB 3650), including readiness to enroll all eligible persons within the CCO's proposed service area. OHA awarded multi-year contracts to CCOs, with annual renewal determined by CCO compliance with Department of Consumer and Business Services (DCBS) and OHA requirements.<br><br>*Sources:*<br>*For more information about implementation of the CCO model, click here.*<br>*For a NEJM perspective article on early implementation of the CCO model, click here.* |
| **Does the state collect data regarding the structure of the state's health care market, such as ACO information on number of participating physicians?** | Yes, the Oregon Health Policy Board collects information on the 16 CCOs approved for Oregon Health Plan. Specifically, the Board collects the following information, which is available to the public at here: governing boards, community advisory councils, transformation plans, quarterly progress reports, financial information, model contract example, report templates, community health improvement plans.<br><br>*Source:*<br>*To view the information that the Oregon Health Policy Board collects on CCOs, click here.* |
| **Does the state use the collected data to produce reports to encourage marketplace competition,** | Yes, the state releases detailed reports on hospital finances and utilization including profitability, charity care, bad debt, and inpatient, outpatient, and emergency department visits.<br><br>It also publishes Health System Transformation metrics, which include detailed performance metric |

| Domain #4: State Actions to Enhance Competition in the Marketplace | |
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| **such as hospital quality and cost report cards, cost impact reports?** | results for both CCOs and hospitals.<br>• The state's Hospital Transformation Performance Program report describes how hospitals are doing on 11 quality health metrics.<br>• The state's CCO Metrics Reports track 17 CCO incentive metrics and 16 additional state performance metrics.<br><br>*Source:*<br>*To view reports from Oregon's Hospital Reporting Program, click here.*<br>*To view Oregon's Health System Transformation performance metrics, click here.* |
| **Does the state promote or set limits on consolidation of health care providers of similar services?** | No. |
| **Does the state promote or set limits on vertical integration of health care providers?** | No. |
| **Does the state promote or limit other types of affiliations among health care providers?** | No. |
| **What strategies, if any, has the state's insurance department taken to ease insurer entry?** | No. |
| **Does the state have consumer protection regulations that promote cost containment?** | The Division of Financial Regulation has implemented efforts to promote transparency in its health plan rate review process. These include:<br>• A consumer-oriented website, www.oregonhealthrates.org, devoted to rate review. The site provides access to new and historical rate decisions, as well as opportunity for public comment.<br>• Consumer-friendly reports on health insurance in Oregon and consumer guides to health insurance and the rate review process.<br>• All rate review hearings are public, and available via streaming on the Web.<br>• Three health actuaries on staff review and question rate requests on behalf of the public. |

| Domain #4: State Actions to Enhance Competition in the Marketplace | |
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| | ACA grant funding enabled the Division of Financial Regulation to contract with Oregon State Public Interest Research Group (OSPIRG) to provide consumer advocacy during the rate review process. OSPIRG reviews a selection of rates in consultation with an independent actuary, and provides comments during the rate review hearings on behalf of the public. This program, the Health Insurance Rate Watch Project, is now funded by a grant from the Robert Wood Johnson Foundation.<br><br>*Sources:*<br>*Learn more about the Division of Insurance's rate review process here.*<br>*Learn more about OSPIRG's Health Insurance Rate Watch Project here.* |

| Domain #5: State Regulatory Actions to Contain Health Care Costs | |
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| **Does the state limit price increases by providers?** | No. |
| **Has the state mandated payment and delivery system reform?** | Yes, CCO's are expected to use alternative payment methodologies for provider compensation, and considerations for requiring CCOs to do so is underway.<br><br>*Source:*<br>*For more information regarding the state's expectations regarding CCO implementation of APMs, click here.*<br>*For more information regarding the status of CCO APM implementation as of June 2016, click here and see "Value Based Payments discussion."* |
| **Does the state have a Certificate of Need program or other programs to limit introduction of high cost services?** | Yes, Oregon has a Certificate of Need program for the "offering or development of any new hospital or new skilled nursing or intermediate care service or facility," as defined in Oregon Administrative Rules Division 550 – Projects or Proposals Subject to Certificate of Need Review.<br><br>*Source: For a description of Oregon Health Authority's CoN review process, click here.* |
| **Are there any requirements of commercial payers to provide comparative cost and quality data regarding contracted providers?** | As part of their rate filings, commercial payers submit description of cost containment and quality improvement efforts (pursuant to OAR 836-053-0473 (2)(k)).<br>• "DCBS is authorized by 2009 legislation to consider carriers' health care cost containment and quality improvement efforts as part of its rate review. Every small group and individual rate filing is currently required to provide a description of changes in these efforts since their last filing. However, inconsistency in quality improvement/cost containment reports across carriers does not currently allow for meaningful and actionable comparisons for purposes of rate review." |

| Domain #5: State Regulatory Actions to Contain Health Care Costs | |
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| | *Source: For more about these requirements, click here.* |
| **Is the state insurance department implementing any strategies to limit provider cost increases?** | No. |

| Domain #6: Payment Reform and Delivery System Reform | |
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| **What entities are driving payment and delivery system reform in the state?** | The key driver for system reform is the OHA, which serves as the single policymaking and oversight body – and as the health care purchaser for all public employees and Medicaid. The state legislature is also a key driver of payment and delivery system reform in the state. The March 2012 legislation that created CCOs was a bipartisan effort that passed by large margins in both houses.<br>*Source: To read more about the history of Oregon's health reform activities, click here to access a case study prepared by the Urban Institute.* |
| **What support has the state received to promote payment and delivery system reform?** | The Centers for Medicare and Medicaid Innovation awarded a State Innovation Model (SIM) grant to Oregon in September 2012 for up to $45 million through September 30, 2016. The state also received $1.9 billion in CMS Designated State Health Programs funding over 5 years (Year 1: $620 million, Year 2: $620 million, Year 3 $290 million, Year 4: $183 million, Year 5: $183M).<br><br>*Source: For more information about Oregon's SIM grant, click here.* |

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| **Does the state's culture promote cost reform?** | Historically, Oregon has a collaborative and activist culture when it comes to health reform – as well as a track record of bipartisan agreement on key health reforms. –Previous efforts at expansive health reforms led to the consolidation of health care purchasing power into a single agency, the OHA, in 2009.<br><br>*Source:*<br>*The Urban Institute's examination of Oregon's past and present health reform efforts may be found here.* |

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| **What are/were the governmental facilitators?** | Oregon provides a case study of two key facilitators: 1) a consolidated state agency with aligned strategies; and 2) strong data analytics to support policy development.<br>• The consolidated agency role of OHA has been critical to implementing cost containment strategies. The OHA is led by a single director who is accountable to the Governor. The consolidated agency structure creates opportunities for inter-departmental collaboration. Public health and Medicaid directors' speak weekly at cabinet meetings. The Oregon Health Policy Board provides informed constituent input to OHA.<br>• The state has made heavy investments in analytical capabilities to enable agencies to make informed, thoughtful policy decisions. OHA has also forged partnerships with academic medical centers – providing them with easier access to data and securing for OHA early research results. |
| **Are there any key insurers that are driving cost containment strategies?** | No. |
| **Do health plans promote use of high-quality, low cost providers in their plan designs?** | The Oregon Health Leadership Council's Value-Based Benefits initiative provides a model for health benefits that encourages a cost-effective approach to prevention, chronic care management and preference sensitive treatments. The model provides a three-tiered level of benefits with the third tier providing coverage for health service that are nationally recognized as overused and driven by provider preference or supply rather than evidence-based need. The Council reports on promising results from employers who have adopted elements of the Council's proposed value-based benefit design, including Legacy Health, a non-profit health system in Portland, and the Public Employees and Oregon Educators Benefit Boards.<br>*Source:*<br>*For more information about the Health Leadership Council's Value-Based Benefits initiative, click here.* |
| **Have health plans implemented alternative payment models with providers?** | While most CCOs sub-capitate services to existing providers some CCOs are now working to implement integrated and innovative models of care, including graduated risk tiers calculated based on patient acuity, and partial capitation combined with shared savings for participating providers.<br><br>*Source:*<br>*More information about the Oregon CCOs' and their implementation of APMs may be found in the Spring 2016 National Association of State Medicaid Directors report, The Role of State Medicaid Programs in Improving the Value of the Health Care System, click here.*<br>*In a December 2014 report, the OHSU reports on three CCOs that are pursuing APMs. Click here to access.*<br>*For more information regarding the status of CCO APM implementation as of June 2016, click here and see "Value Based Payments discussion."* |

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| **How have health plans promoted delivery system transformation?** | Yes, the state's CCOs play a key role in statewide delivery system transformation. A January 2016 OHA report described several successes associated with the CCOs' activities, including a reduction of 23 percent in emergency department visits since 2011, an increase of 61 percent in PCMH enrollment since 2012, and an increase of 137 percent in developmental screenings for children since 2011.<br>*Source:*<br>*To access the OHA's January 2016 report, click here.* |
| **Are there any multi-stakeholder coalitions facilitating cost containment strategies?** | Yes, there are several multi-stakeholder coalitions that facilitate cost containment discussions and strategies.<br><br>Oregon Health Care Quality Corporation (Q Corp), an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon. Q Corp plays a unique role as an independent multi-stakeholder organization that leads community-based initiatives focused on improving the quality, affordability and patient experience of health care in Oregon. Q Corp's Board of Directors includes 21 senior representatives of state agencies, health plans, hospitals, employers and consumer and medical groups. Q Corp's reporting initiative is described in Domain #1.<br><br>The Oregon Health Leadership Council is a collaborative organization working to develop practical solutions that reduce the rate of increase in health care costs and premiums so health care and insurance are more affordable to people and employers in the state.<br>• The Council includes 30 individuals from health care organizations across the state including eight major medical groups and the Portland Coordinated Care Association; eight major hospitals/health systems and the Oregon Association of Hospitals and Health Systems; 12 local and national health plans. The OHA Director participates on the Council.<br>• The Council's Data Aggregation initiative has brought together stakeholders to define a process for aligning data collection activities, reducing duplication and fostering administrative simplification.<br><br>The Collaborative Health Information Technology of Oregon (CHITO) is another multi-stakeholder coalition created to improve planning and execution of HIT with an emphasis on alignment of data efforts and analytics in Oregon. CHITO works to complement the efforts of the OHA HIT Business Plan Framework and to collaborate with the State and other stakeholders to achieve additional shared goals.<br><br>*Sources:*<br>*For more information about Q-Corp, click here.* |

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| | *For more information about the Oregon Health Leadership Council, click here.*<br>*And for more information about CHITO, click here.* |
| **Is there a strong employer purchaser coalition in the market facilitating cost containment strategies?** | No, there is no employer coalition devoted specifically to health policy and reform.<br><br>The Oregon Business Council is an association of more than 40 business community leaders focused on public issues that affect Oregon's life and future. While the Council is not focused exclusively on health reform topics, it has nonetheless been an active participant in Oregon health reform activities since 2004, when it formed a Health Care Task Force to look at health care costs and related issues.<br>• The Council hosts two business community initiatives to improve health care performance and the health of Oregonians: The Healthiest State and the Oregon Health Leadership Council.<br><br>*Source:*<br>*For more information about the Oregon Business Council, click here.* |
| **Are there any individual employers that are driving cost control discussions and actions within the state?** | No. |
| **Does the state have a centralized agency or designated work group responsible for overseeing/driving health care cost strategies?** | Yes. The Oregon Health Authority (OHA) is responsible for overseeing and driving health care cost-containment strategies. OHA is overseen by the nine-member Oregon Health Policy Board; Board members are nominated by the Governor and approved by the Senate.<br><br>The OHA was established in 2009 by the state legislature to transform the state's health care system. OHA oversees most health-related programs in the state, including the Addictions and Mental Health Division, Medical Assistance Programs, the Public Health Division, the Public Employees' and Oregon Educators Benefit Boards, Oregon State Hospital, the Office of Equity and Inclusion, and Office of Health Policy and Research. Establishment of the OHA consolidated all health purchasing, health policy development, HIT infrastructure, and analytic support capabilities within a single agency.<br><br>*Source:*<br>*To read more about the OHA, click here.* |
| **Has the state or any of its executive branch agencies adopted a formal cost control strategy or roadmap?** | Yes. The Oregon Health Policy Board created an Action Plan for Health that requires action from a variety of stakeholders — the legislature, consumers, businesses, health care providers and others. The action plan was intended to meet the legislative mandate to "provide and fund access to affordable, quality care for all Oregonians by 2015." |

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| | *Source:*<br>*The OHPB's 2010 Action Plan for Health may be accessed here.* |
| **Does the state have any funding mechanism to support cost containment initiatives by unaffiliated providers such as independent primary care practices, small community hospitals or safety-net hospitals?** | No but, the Oregon Primary Care Association also provides technical assistance to providers, including hosting a quarterly Advanced Payment and Care Model (APCM) learning collaborative for APM providers, and providers interested in joining the program to share best practices around topics such as implementing multi-disciplinary care teams, and engaging the patient population in innovative new ways like telephone, telemedicine, text, videoconferencing, small groups, support groups, etc.<br><br>*Source:*<br>*To learn more about the technical assistance provided by the Oregon Primary Care Association, click here.* |
| **Does the state have any resources and program initiatives to assist health care providers to increase quality and efficiency?** | Yes. The Oregon Health Authority Transformation Center used SIM funds to create the Transformation Center, which provides assistance to CCOs by means of targeted technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices among CCOs and other health plans and payers. A transformation team of experts is assigned to each CCO to support changes needed to achieve cost and quality goals. Recently 15 emerging health system leaders from across Oregon completed a year-long Clinical Innovation Fellows program. This learning experience, led by the Transformation Center, aims to build the capacity of health system transformation leadership and support the success of CCOs.<br><br>The Patient-Centered Primary Care Institute was created in 2012 as a public-private partnership between OHA, the Oregon Health care Quality Corporation and the Northwest Health Foundation. The Institute offers programs to build practice transformation capacity, including behavioral health integration training, learning collaboratives focused on PCPCH program standards, a Technical Assistance Expert Learning Network, and online learning modules. The Institute offers CME and CE credits.<br>During the 2015 legislative session, a bill that sought to ensure sufficient resources are allocated to the state's primary care system was enacted. Senate Bill 231 requires commercial insurers and CCOs to report the percentage of their total medical expenditures that are directed to primary care. The OHA must report results to the legislature during its 2016 legislative session. In addition, the legislation required the OHA to convene a Primary Care Payment Reform Collaborative to "share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments towards supporting and facilitating health care innovation and care improvement in primary care."<br><br>*Source: To learn more about the Transformation Center, click here.*<br>*To read more about the Clinical Innovation Fellows program, click here.* |

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| | *To read more about the Transformation Center's Primary Care Payment Reform Collaborative, click here.* |

| **What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?** | |
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| **Key Findings** | **Summary and Citation** |
| **A recent NAMD report described successes associated with the first phase of Oregon's FQHC APM Demonstration Project.**<br>**1. Inpatient hospitalizations were 20.3 percent below trend.**<br>**2. Emergency department utilization was 5.6 percent below trend.**<br>**3. Billable office visits decreased by 2.8 percent.**<br>**4. Patient engagement activities increased by 142 percent.** | A recent report by the National Association of Medicaid Directors described early successes associated with Oregon's FQHC APM Demonstration Project, described in Domain #2 above.<br><br>*Source:*<br>*To access the Spring 2016 NAMD report, The Role of State Medicaid Programs in Improving the Value of the Health Care System, click here.* |
| **A January 2016 OHA report described the following successes associated with health system transformation activities.**<br>**1. Emergency department visits by people served by CCOs decreased 23 percent since 2011.**<br>**2. Patient-centered primary care home enrollment increased 61 percent since 2012.**<br>**3. Developmental screening for children increased 137 percent since 2011.**<br>**4. Screening for alcohol or other substance use (SBIRT) increased significantly.** | Oregon provided a January 2016 report on its health system transformation activities, which reflected a number of successes in terms of emergency department usage and other indicators.<br><br>*Source:*<br>*To access the OHA's January 2016 report, click here.* |
| **An 2015 evaluation of Oregon's Section 1115 waiver, reached the following conclusions:**<br>**1. "Despite a strain on staff resources, OHA has made good progress in supporting the spread of patient-centered primary care homes (PCPCHs), promoting the use of EHRs, and establishing transparent reporting on quality metrics."**<br>**2. "…inpatient admissions declined among members of the three CCOs in the most advanced stages of their transformation activities relative to those who were members of the three CCOs in the earliest stages of their** | The state commissioned a midpoint evaluation of the Medicaid Section 1115 demonstration for the md-2012 through mid-2014 period.<br><br>*Source:*<br>*To access the evaluation, click here.* |

| What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies? | |
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| **activities."** | |