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MEDICAID HEALTH HOMES IN OREGON:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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Oregon's Health Home Program at a Glance	
Health Home Eligibility Criteria	2 chronic conditions, 1 chronic condition and at risk of another, Serious Mental Illness
Qualifying Conditions	<u>Chronic Health Conditions</u> • Asthma • Overweight • Cancer • Chronic kidney disease • Chronic respiratory disease • Diabetes • Heart disease • Hepatitis C • HIV/AIDS • Substance use disorder <u>Serious Mental Health Conditions</u> • Alzheimer's • Anorexia nervosa • Attention deficit disorder • Autism • Bipolar disorder • Dementia • Depression • Post-traumatic stress disorder • Schizophrenia
Enrollment*	93,253
Designated Providers	Patient-Centered Primary Care Homes (PCPCHs)
Administrative/ Service Framework	Health home services are delivered through Medicaid-enrolled providers who meet the state's PCPCH standards.
Required Care Team Members	It is required that the health home team is inter-disciplinary and inter-professional. Team of health care professionals may include nonphysician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavior health professional, or other traditional or nontraditional health care workers.
Payment System	Per member per month (PMPM) care management fee
Payment Level	PMPM fee based on provider qualification level: **Tier 1**--$10 PMPM **Tier 2**--$15 PMPM **Tier 3**--$24 PMPM
Health Information Technology (HIT) Requirements	Health home providers are encouraged to develop or use their current HIT systems and certain provider measures are linked to HIT capacity. For example, although an electronic medical record (EMR) is not required, those who have an EMR are able to earn additional points towards their qualification as a Tier 3 PCPCH. Another of the measures for Tier 3 qualification is the ability of a PCPCH to share clinical information electronically in real-time with other providers and care entities.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

Introduction

Oregon's Medicaid State Plan Amendment (SPA) instituting a Section 2703 Health Home benefit was approved by the Centers for Medicare and Medicaid Services (CMS) on March 13, 2012, with a retroactive effective date of October 1, 2011.[1] Oregon's health home program builds on the state's Patient-Centered Primary Care Home (PCPCH) program, established in 2009.[2] To be eligible for health home services, enrollees must have a serious mental health condition, two or more chronic conditions, or one chronic condition and be at risk of developing another. The state specified 11 chronic illnesses and nine serious mental health conditions in the list of health home qualifying conditions. It based its definition of "at-risk" on guidelines from the U.S. Preventive Services Task Force, the Health Resources and Services Administration Women's Preventive Services, and Bright Futures. (See Table 1 for a full list of qualifying conditions.)

The health homes program represents just one component of a larger state effort to transform how medical care is delivered in Oregon. Health home services, which are aligned with the state's PCPCH Standards, are to be delivered through qualified PCPCHs and are available to a PCPCHs entire patient population. However, the state will provide a supplemental per member per month (PMPM) payment only for those patients identified by the provider as meeting the health home eligibility criteria. The state is also working toward providing supplemental payments to PCPCHs for other populations including all Medicaid enrollees, government employees, and state education personnel. The state's goal is to make PCPCH services available to 75% of all Oregonians by 2015.[3] Any recognized PCPCH can apply to become a health home through submission of an addendum to its PCPCH agreement with the state, as described below.

PCPCHs (inclusive of their health home services) are also a central component of Oregon's health system transformation efforts, particularly through their role in Coordinated Care Organizations (CCOs, described in more detail below). The CCO program was proposed by the Legislature June 2011, and the first CCOs began operations in August 2012. A CCO is a community-based network of health care providers who have agreed to collaborate in the provision of services for people with Medicaid and/or Medicare coverage. CCOs receive a fixed global payment for mental and physical health care services and, in return, are accountable for the health outcomes of the population they serve.[4] These CCO payments are separate from the health home payments, which go to the PCPCHs. The state also plans to integrate oral health care services in the future. The state's hope is that these integrated health care organizations will provide more efficient delivery of and better access to care, strengthen primary care networks while integrating services, and better align incentives to generate substantial savings. CCOs are required to include recognized PCPCHs in their networks of care to the extent possible and to support their member practices in achieving PCPCH recognition.[4] The emphasis on coordinated care, integration of physical and mental health care services, and community linkages is consistent with

health home goals but, under the state's PCPCH program, they are applied to a broader population.

Oregon's health home benefit is managed through the Oregon Health Authority (OHA), which was established in 2009 and is charged with purchasing health insurance for approximately 850,000 Medicaid enrollees, government employees, and state education personnel (representing about one in four people in Oregon).[4] Oregon has approximately 645,000 people enrolled in its Medicaid program (known as the Oregon Health Plan [OHP]), which it has operated under a Medicaid Section 1115 waiver (described below) since 1993.[4,5] The state managed care program covers approximately 80% of OHP beneficiaries. Prior to August 2012 and the formation of CCOs, acute and ambulatory physical health care services were provided by managed care organizations (MCOs), while mental health, chemical dependency, and dental services were carved out and paid for on a capitated basis.4 Oregon does not have large, national health plans participating in its Medicaid program; most of the MCOs and CCOs are local, community-based nonprofits that serve only publicly insured enrollees; many are physician-owned and run. In some sparsely populated areas, the state contracts directly with providers for primary care case management.

Implementation Context

Oregon has several initiatives underway that have goals that are similar to those of the health home benefit or involve the same type of provider. Some of the initiatives have been developed by the state, while others are part of national demonstration projects. These initiatives are seen as complementary and as part of a broad evolution towards a more integrated system of care in the state. These programs are described in greater detail in Appendix A.

In 2009, the state legislature passed two bills (HB 2009 and HB 2116) that included provisions to provide health insurance coverage for all children and bring more low-income adults into Medicaid. The HB 2009 legislation also created the OHA and the Oregon Health Policy Board and established the PCPCH Program within the Office for Oregon Health Policy and Research.[6]

As the state began to implement the PCPCH program, many stakeholders felt that the 2008 National Committee for Quality Assurance (NCQA) medical home standards for care coordination did not include a strong enough emphasis on health outcomes and accountability, and so encouraged the state to develop its own. In response, the state convened the Patient-Centered Primary Care Home Standards Advisory Committee and charged it with developing the framework of core attributes, standards, and measures that would be used to define a PCPCH.[7] These standards were released in 2010. (See Appendix B for a list of PCPCH attributes and standards.)

During the 2011 legislative session, the state authorized the creation of the Oregon Integrated and Coordinated Health Care Delivery System, which aimed to move the

Medicaid managed care system towards an integrated care management model, and passed legislation to establish CCOs.[4] As noted above, CCOs are community-based networks that are to contract with the state to provide integrated, comprehensive health care, mental health care, and eventually dental care for a defined patient population. CCOs focus on patients with chronic conditions, as well as on people with addiction problems and mental illnesses who have traditionally received care through the OHA's Addictions and Mental Health Division.[8] CCOs have flexibility within their budgets to provide services alongside traditional OHP medical benefits with the goal of meeting the "Triple Aim" of better health, better care, and lower costs for the population they serve, but they are required to include PCPCHs within their networks to the extent possible.[6] By making CCOs responsible for the full array of services and paying a fixed global payment, the state hopes these coordinated networks will improve quality outcomes and be more cost-efficient. The state staggered the rollout of CCOs; the first wave of eight CCOs was launched August 1, 2012. In 2013, there were 16 CCOs operating in all regions of the state, serving more than 600,000 Oregonians enrolled in Medicaid.[9,10]

Oregon was also one of 15 states that received a grant from CMS to develop a pilot program to better "coordinate care across primary, acute, behavioral health and long-term services and supports (LTSS) for dual eligible individuals."[2] Under the State Demonstrations to Integrate Care for Dual Eligible Individuals program, CMS has provided funding and technical assistance to the selected states to develop enhanced patient-centered methods to coordinate the entire continuum of care for dual eligible individuals and to identify delivery system and payment models that can be replicated in other states. The state eventually decided not to move forward with the financial alignment of the duals demonstration.

As part of the state's efforts to align payment methods to support its primary care home model, Oregon is participating in the CMS Comprehensive Primary Care Initiative, which began in fall 2012. In this multi-payer initiative, Medicare collaborates with public and private insurers in the selected regions with the goal of strengthening primary care. Participating practices receive a PMPM care management fee and be given technical assistance to help them better coordinate and manage care. After two years, providers will also have the opportunity to participate in a shared savings model.[11] In Oregon, six health insurance plans and 70 practices were selected to participate.[12]

Oregon is also participating in the Tri-State Child Health Improvement Consortium (T-CHIC), a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Project funded by CMS. T-CHIC is an alliance among the Medicaid/Children's Health Insurance Programs of Alaska, Oregon, and West Virginia, led by Oregon, with the goal of improving children's health care quality. In February 2010, the consortium was awarded approximately $11.5 million over a five-year period ($2.2 million was awarded in the first year). The overarching goal of the CHIPRA quality demonstration is to establish and evaluate a national quality system for children's health care.[13] In Oregon, this demonstration is linked to two additional pediatric medical home practice improvement projects through the Oregon Pediatric Improvement Partnership,

which aims to improve children's care through a range of collaborative and educational activities.[14]

Many practices in Oregon have been or are in the process of being recognized as a Patient-Centered Medical Homes (PCMHs) by the NCQA.[6] While the PCMH model shares many common concepts with Oregon's PCPCH, there are a few areas in which the two models are not fully aligned. PCMH practices attempting to gain recognition as PCPCHs must contractually attest to being NCQA-certified but must also submit additional information, centered on the contractual attestation of screening strategies for mental health and substance abuse conditions, hospice and palliative care, and quality measurement and patient tracking.[6]

Implications for the Oregon Section 2703 Medicaid Health Homes Evaluation

These various initiatives have several implications for both implementation and evaluation of the health home program. The state has envisioned health homes as an integral part of its effort to transform the primary care delivery system across the state for all payors. Other initiatives are key to this overall transformation as well, particularly the development of CCOs and the contractually required encouragement of PCPCHs by the CCOs. The providers of health home services are not designated as "health homes" but rather health home enrollees are identified within the PCPCHs by their receipt of health home services once they meet the qualifying criteria. The state intends for the changes that providers make to care for health home beneficiaries to permeate the PCPCH practice for all patients, but the enhanced payments for health home services apply only to identified eligibles. The state's plan is to institute a care coordination payment for other beneficiaries in the future but at a much lower level.

In many practices that have become PCPCHs and are thus eligible to serve health home beneficiaries, practice transformation began before the implementation of the health homes initiative, and providers are charged with identifying health home services recipients. Thus, it will be difficult--and may be impossible--to disentangle a health home effect from the effect of ongoing transformation.

Population Criteria and Provider Infrastructure

Oregon offers health home services to categorically needy beneficiaries (there is no medically needy program in Oregon) who have two or more chronic conditions, one chronic condition and are at risk of contracting another, and those with a serious mental illness.[1] (Oregon uses the term "ACA-qualified" for beneficiaries meeting the condition criteria for health home eligibility.) Both fee-for-service (FFS) and managed care enrollees are eligible for these services. Table 1 below provides a full list of the population criteria, the designated providers, and the health home team composition requirements.

Health homes are based on the state's PCPCH model, described in further detail below; thus, PCPCH standards are health home standards and the two designations will be used interchangeably with respect to providers. Payment for health home services, however, is limited to the health home-eligible population and this distinction will be maintained. Any designated PCPCH is eligible for a health home payment if specific service and documentation requirements are met for each patient. These requirements include: (1) providing at least one core service each quarter (described in Table 2); (2) performing panel management at least once per quarter, using data for all clients or for sub-groups of clients for such functions as care management or quality assurance; (3) performing patient engagement and education and obtaining patient agreement; and (4) developing a person-centered health plan.

PCPCH/health homes include, but are not limited to, physical and behavioral health care providers, solo practitioners, family and group practices, community mental health centers, drug and alcohol treatment facilities, rural health clinics, federally qualified health centers, and school-based health centers.[1] A PCPCH/health home is not required to provide all of the health home services on-site, but it is responsible for coordinating and/or offering those services through partnerships within their community.

All PCPCH-recognized providers wishing to participate in Medicaid and provide health home services must submit an addendum to their Medicaid provider enrollment agreement to the OHA's Division of Medical Assistance Programs (DMAP).[6] This is true for providers serving both FFS and MCO/CCO-enrolled members. PCPCH providers serving MCO/CCO-enrolled members will also have a contract with the MCO/CCO, and the payment arrangement will be negotiated between the MCO/CCO and the provider.[15]

Member Identification and Assignment

Health home-eligible beneficiaries are identified through a referral process managed by DMAP. The process begins with providers, who draw up a list of the patients they believe are eligible from among their FFS and MCO/CCO clients. They then submit the list of FFS patients directly to DMAP and the list of MCO/CCO-enrolled patients to the appropriate MCO/CCO, which will in turn submit the list to DMAP.[6] DMAP then screens these patients for eligibility and sends a report to each recognized provider or health care entity identifying which of their patients were successfully assigned to their health home. This list must be updated and submitted quarterly. DMAP worked with CMS to determine how best to coordinate sending a letter to the qualified health home patients notifying them that their provider is now their primary care health home. Enrollees are informed that they may opt-out of health home coverage or may select a different provider.

Service Definitions and Provider Standards

There are six core health home services, at least one of which must be provided once per quarter for each patient on a provider's list. (See Table 2 for the service definitions found in the SPA.) These services do not require an office visit and can be performed by any member of the health care team. Health home services do not require or replace treatment or medical services, and they cannot include services for which a provider is already billing. The provider attests to providing one of these six core services through submitting the quarterly list of health home-eligible enrollees, and must document the services provided in each patient's medical record.[6]

Core Attributes and Corresponding Standards for Patient-Centered Primary Care Homes

Oregon based their provider qualifications on the six attributes of the state's pre-existing PCPCH model, which are cross-walked in the SPA with the core health home functions outlined by CMS in the State Medicaid Director's letter of November 2010.16 These six core PCPCH attributes (Access to Care, Accountability, Comprehensive Whole-Person Care, Continuity, Coordination and Integration, Person-Centered and Family-Centered Care) each have corresponding standards and measures, divided into "Must-Pass Measures" and "Tiers 1-3". These are described in greater detail below.

PCPCH Measures and Tiers

To practice and be recognized as a PCPCH, a provider must demonstrate the ability to meet the guideline PCPCH measures that correspond to each standard. PCPCH measures are divided into ten "Must-Pass" measures and a range of other measures that place the PCPCH practice in one of three Tiers.[6] Must-Pass and Tier 1 measures focus on the basic foundational structures and processes of a PCPCH. Foundational elements should be achievable by most practices, and are not considered to require significant financial expenses. Tier 2 measures reflect intermediate PCPCH functions, demonstrating performance, structural, and process improvements. Tier 3 reflects advanced PCPCH functions, in which the provider demonstrates mature performance improvement capacity, and is accountable for quality. (See Appendix B for a full list of attributes, standards, and measures.)

Except for the ten Must-Pass measures, each measure is assigned a point value corresponding to a tier. Tier 1 measures are worth 5 points, Tier 2 measures are worth 10 points, and Tier 3 measures are worth 15 points. For a practice to be recognized as a PCPCH, it must meet all of the 10 Must-Pass measures. Practices must score 30 to 60 points to qualify as Tier 1, 65 to 125 for Tier 2, and 130 or more for Tier 3.[6]

Practices demonstrate their current level of practice by contractually attesting to meeting certain of the standards and by submitting data on others. Contractual attestation is contained in the agreement negotiated between a practice and any payer the practice contracts with and is also submitted to the state through a web-based

process described in further detail below. (Contractual attestation measures are marked with a "C" in Appendix B.) No other documentation on these measures is required at the time of application, but practices are subject to random audit by the OHA, and all contractual attestation measures must be reported annually for a practice to maintain its PCPCH status.

Six of the PCPCH measures require quantitative data submission (marked with a "D" in Appendix B).[6] These measures will be used by the state to track PCPCH progress and will also be reported to the PCPCHs to help them identify trends in care and identify areas for quality improvement. Recognized PCPCH providers must also submit patient experience of care survey data. Tier 2 and Tier 3 providers are required to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools for this purpose.[6]

The OHA has developed a web-based provider portal system where practices can submit all required data to the state (see Health Information Technology section below for more details). Based on the point system, the OHA will score PCPCHs by combining the contractual attestation information with the quantitative data received. Practices and various plans, insurance carriers, and/or other entities will then be notified of their score.

Use of Health Information Technology

Health home providers are encouraged to develop or use their current health information technology (HIT) capacity to perform a range of functions, including:

- Gather and report data and group it by subset.
- Create and maintain electronic health records (EHRs).
- Share clinical information with clients and other providers.
- Link to, manage, and track health promotion activities and referrals to community-based or social services.
- Communicate with other providers, family members, and local supports.

Oregon links certain of its provider measures to HIT capacity. For example, although implementation of an electronic medical record (EMR) is not required, those who have an EMR are able to earn additional points towards their qualification as a Tier 3 PCPCH. The state has indicated that they will encourage providers to implement an EMR that contains at a minimum a problem list, medication list, allergies, basic demographic information, preferred language, Body Mass Index (BMI)/BMI percentile chart, and immunization record. Another of the measures for Tier 3 qualification is the ability of a PCPCH to share clinical information electronically in real-time with other providers and care entities.

As noted above, OHA also maintains a provider portal and patient panel management system. This system is run by a contractor, Quality Corporation. Use of this system is required as part of the provider's demonstration of "comprehensive care management," but it also allows the provider to review data on services they have provided to their patient panel, and identify any gaps.

Payment Structure

Payment for health home services is made on a PMPM basis that varies by the provider's qualification level: Tier 1--$10 PMPM; Tier 2--$15 PMPM; and Tier 3--$24 PMPM.[1] For FFS patients, DMAP makes payments directly to PCPCH/health home providers; for MCO/CCO-Enrolled members, DMAP makes payments to the MCO/CCO, which then make payments to the health home. Any portion of the payment that is retained by the MCO/CCO must be used to carry out health home-related functions and is subject to approval and oversight by the OHA.[17] Providers are eligible for the PMPM payment if the service and documentation requirements are met for each patient. Submission of the quarterly patient list serves as attestation of meeting the quarterly health home service requirements.

The health home must engage in panel management activities at least once quarterly. One team member from each health home provider practice must log on to the OHA's provider portal, which can be used as a panel management tool and for tracking quality measures. A health home has six months to engage and obtain consent from each eligible patient assigned to their care.[17] Education about PCPCH/health home services and benefits can be done in-person, by phone, or by mailing a letter or brochure. (OHA provides patient brochures to all PCPCH/health home providers.) Engagement and member agreement to participate must be active but does not require a patient visit; if a patient declines to participate or the health home is unable to get agreement after 6 months of attempts, the provider should notify DMAP and omit that patient from future patient list submissions.[17]

Quality Improvement Goals and Measures

The state has identified five quality improvement goals, each with defined clinical outcome and quality of care measures:

- Reducing the rate of potentially avoidable hospital readmissions.
- Decreasing potentially avoidable hospitalizations and increase the ratio of ambulatory care to emergency department visits.
- Improving transitions of care between primary care providers (PCPs) and inpatient facilities.

- Improving care transitions for people with mental health conditions.

- Improving documentations, tracking, and reporting of health risks and use of preventive services.

The state has also identified two service-based measures, both tied to comprehensive care management. Table 3 below lists each goal with its corresponding measures. Data for these measures will be drawn mostly from administrative data, CAHPS survey data, claims data, and EMRs.

Evaluation Measures and Methods

The state will rely primarily on administrative data, the Medicaid Management Information System (MMIS), provider-reported measures, and patient survey results in their evaluation of the health home program. A Learning Collaborative composed of providers and patients will also provide information on program implementation, processes, and lessons learned. For most health home measures, beneficiaries who have been enrolled for at least one year will be compared with beneficiaries not enrolled in a health home. It is not clear how comparison groups will be identified. Table 4 below excerpts the information provided in the SPA.

TABLE 1. Target Population and Designated Providers--Oregon	
SPA Approval (Effective Date)	March 13, 2012 (October 1, 2011)
Designated Provider(s)	Any Medicaid-enrolled provider that meets the state's PCPCH health home standards; includes FFS providers, managed care plans, PCPs, home health agencies, certified nurse practitioners, clinical group practices, rural community health centers, community mental health facilities, and substance abuse treatment facilities.
Health Home Team Composition	Required: The team is inter-disciplinary and inter-professional. Optional: Team of health care professionals includes nonphysician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavior health professional, or other traditional or nontraditional health care workers. These professionals can operate as free-standing, virtual, or based at any of the clinics/facilities expressed above.
Target Population	Beneficiaries must have: • 2 chronic conditions • 1 chronic condition and the risk of developing another • A serious mental condition
Qualifying Chronic Conditions	Chronic Health conditions: • Asthma • BMI over 25 (for adults 20 years or older) • BMI 85th percentile or higher (for patients under age 20) • Cancer • Chronic kidney disease • Chronic respiratory disease • Diabetes • Heart disease • Hepatitis C • HIV/AIDS • Substance abuse disorder Serious Mental Health conditions: • Alzheimer's • Anorexia nervosa • Attention deficit disorder • Autism • Bipolar disorder • Dementia • Depression • Post-traumatic stress disorder • Schizophrenia

TABLE 2. Health Home Service Definitions--Oregon	
Care Coordination	Patients will choose and be assigned to a care team, which will develop a care plan based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable and information on ways the patient participates in this care coordination. Care coordination functions can include but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, and direct collaboration or co-management of patients with specialty mental health, substance abuse, and providers of services and supports to people with developmental disabilities and people receiving LTSS. Co-location of behavioral health and primary care is strongly encouraged.
Comprehensive Care Management	Providers will be able to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. Care management activities include but are not limited to defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and end-of-life care planning when appropriate.
Health Promotion	The provider will develop a treatment relationship with the individual, other primary care team members and community providers. The health home provider will promote wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient/family education and self-management of the chronic conditions.
Comprehensive Transitional Care	The provider will have either a written agreement and/or procedures in place with its usual hospital providers, local practitioners, health facilities and community-based services to ensure notification and coordinated, safe transitions, as well as improving the percentage of patients seen or contacted within 1 week of facility discharges.
Individual and Family Support Services	The provider will have processes for patient and family education, health promotion and prevention, self-management supports, and obtaining available nonhealth care community resources, services and supports. The care plan will reflect the client and family/caregiver preferences for education, recovery and self-management. Peer supports, support groups and self-care programs will be utilized to increase the client and caregivers knowledge about the client's individual disease.
Referral to Community and Social Supports	The provider will demonstrate processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. Care coordination functions will include the use of the care plan to manage such referrals and monitor follow-up as necessary.

TABLE 3. Health Home Goals and Quality Measures--Oregon	
Goal-Based Measures	
Reduce the Rate of Potentially Avoidable Hospital Readmissions	Clinical outcome measures: • Pneumonia--Hospital 30-day, all-cause, risk standardized readmission rate following pneumonia hospitalization.
Decrease Potentially Avoidable Hospitalizations and Increase the Ratio of Ambulatory Care to Emergency Room Visits	Experience of care measures: • Percentage of adult health plan members who reported how often their doctor and other health provider talked about specific strategies for self-managed illness prevention. Quality of care measures: • Number of outpatient visits, emergency department visits, ambulatory surgeries/procedures, and observation room stays.
Improve Transitions of Care Between PCPs and Inpatient Facilities	Experience of care measures: • Percentage of adult health plan members who reported how often their personal doctor seemed informed and up-to-date about care they got from other doctors or other health provider. Quality of care measures: • Percentage of patients, regardless of age, discharged from an emergency department setting to ambulatory care or home health care, or their caregiver(s), who received a transition record at the of emergency department discharge.
Improve Transitions for People with Mental Health Conditions	Quality of care measures: • Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.
Improve Documentation, Tracking, and Reporting of Health Risks and Use of Preventative Services	Quality of care measures: • Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior.
Service-Based Measures	
Comprehensive Care Management	Clinical outcome measures: • Percentage of patients, regardless of age, discharged from an emergency department setting to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of emergency department discharge. Quality of care measures: • Percentage of members who had an outpatient visit and who had their BMI documented during the measurement year or the year prior.

TABLE 4. Evaluation Methodology--Oregon	
Hospital Admission Rates	Using MMIS, Risk-adjusted Prevention Quality Indicators will be compared to non-PCPCH/health home members. Assessments will be stratified by risk, tier, and length of enrollment. Propensity scores and difference scores will be used to assess the rates, lengths of stay, and billed charges. Hospital admission evaluation will also be adjusted by the type of hospital (critical access, geographic location, etc.). Data collection will be taken up at baseline, year 2, and 3.
Emergency Room Visits	Using annual MMIS data, the state will compare emergency department use that did not result in an admission for noninjury and illness diagnosis for clients who have been enrolled in a health home for at least 1 year versus clients not in a health home.
Skilled Nursing Facility (SNF) Admissions	Using annual MMIS data, the state proposes to compare skilled nursing admissions for clients in a PCPCH/health home for at least 1 year versus clients not in a PCPCH/health home.
Chronic Disease Management	Through administrative data, MMIS and submitted quality measures required for PCPCH recognition, a series of national chronic disease-specific measures will be monitored and compared between patients in versus not in a PCPCH/health home.
Coordination of Care for Individuals with Chronic Conditions	Centered on patient experience of care, administered through CAHPS surveys by the state annually.
Assessment of Program Implementation	Oregon will use Learning Collaborative models throughout the implementation of PCPCH/health homes. A select group of practices and a select group of patients identified as being the highest risk will meet to discuss challenges and opportunities.
Processes and Lessons Learned	Cites the Learning Collaborative models process--these collaborative meetings will be public and results become a public record so that dissemination of results is easy to access and is transparent.
Assessment of Quality Improvements and Clinical Outcomes	Data sources will include administrative data, MMIS, additional quality measures submitted by PCPCH/health home providers and contracted MCOs/CCOs.
Estimates of Cost Savings	The state will use administrative data, MMIS, and will compare members enrolled versus not enrolled in PCPCH/health home providers for their primary care. Analysis will focus on looking at care utilization, cost, and cost savings related to inpatient admissions, emergency department visits, diagnostic use, specialty care, pharmacy claims, and emergent and nonemergent transportation.

APPENDIX A: Pre-Existing Initiatives in Oregon				
	CCOs	**Comprehensive Primary Care Initiative[19]**	**T-CHIC**	**Demonstration to Integrate Care for Dual Eligibles[20]**
Timeline	• State authorized the creation of CCOs in July 2011[21] • First wave of CCOs began enrolling beneficiaries in September 2012	• Practices began delivering enhanced services in fall 2012 • Demonstration will run for 4 years	• Oregon was awarded $11.3 million in February 2010 • Planning was conducted from March-November 2010 • Implementation stage will run from November 2010-March 2015	• Oregon submitted its proposal to CMS in May 2012 • Pending approval, full implementation is scheduled to begin in January 2014
Geographic Area	Statewide	Statewide	Statewide	Statewide
Sponsors	OHA	CMS/CMMI	CMS	CMS
Scope	• Eventually will include all Medicaid beneficiaries • Plans also underway to extend the coordinated care model to state employees • Standards for the Qualified Health Plans in the state Health Insurance Marketplace will include elements of the coordinated care model	• 70 primary care practices • 517 providers • 49,000 Medicare beneficiaries • 6 payers, including Medicaid and Medicare	8 pilot sites in Oregon, 3 in Alaska, 10 in West Virginia[22]	All full-benefit Medicare-Medicaid enrollees, excluding individuals in the Program of All-Inclusive Care for the Elderly (forecasted at 68,000 individuals)
Goals	• Provide and coordinate physical, behavioral, and dental care services • Reduce health care costs • Improve care quality through the alignment of financial incentives and integration of care	Participating practices will:[11] • Provide care management for high-need patients • Ensure 24/7 accessibility to care • Provide timely and appropriate preventive care • Encourage patient and caregiver self-management • Coordinate care across the care spectrum	• Develop, implement, and evaluate pediatric quality measures • Establish pilot EHR projects and health information exchanges • Pilot different models of care delivery for pediatric patients	• Coordinate and integrate physical, behavioral, and oral health care for dual eligibles within CCO networks • Ensure that CCOs coordinate with the long-term care system and share accountability for outcomes
Payment Approach	Global payment	• Risk-adjusted PMPM care management fee; Medicare beneficiary payment average of $20 for years 1-2, then $15 for years 3-4 • Shared savings available to practices in years 3-4	Incentives for Learning Collaborative participation vary by state	• Capitation payment to CCOs for mental, physical, and dental care. • The state is also considering various quality incentive payment models

APPENDIX A (*continued*)				
	CCOs	**Comprehensive Primary Care Initiative[19]**	**T-CHIC**	**Demonstration to Integrate Care for Dual Eligibles[20]**
Technical Assistance (TA)	• With input from CMS, the state will provide technical assistance to CCOs in the development and implementation of a mandated Quality Assurance and Performance Improvement Plan[23] • Oregon Transformation Center will provide technical assistance and tools to support system transformation	CMMI will provide resources to participating practices to assist them in practice evolution	Oregon is convening a series of Learning Collaboratives focused on practice improvement and implementing core quality measures	No information found
HIT Use	CCOs are required to develop HIT infrastructure that links providers across the continuum of care	CMMI required that all practices have an EHR or electronic registry, and preference was given to those who had obtained stage 1 meaningful use[24]	HIT system integration and quality measure reporting through EHRs are major goals of the demonstration	• In addition to general • requirements placed on CCOs, the state proposes to implement technology solutions that will permit patient data-sharing between the relevant state agencies, CCOs, and long-term care providers
Evaluation Methods	The state will use independent entities to conduct routine audits of performance against quality metrics, and establish an annual review process for evaluating the appropriateness of those metrics[25]	CMMI will hire an independent contractor to evaluate the impact of the initiative on health, care experience, and costs	• CMS has hired an independent contractor to evaluate the entire CHIPRA demonstration, which includes Oregon • Oregon will also conduct its own evaluation	The state proposes both ongoing evaluation of CCO and long-term care metrics, as well as a post-implementation evaluation to assess how shared accountability is working, best practices, and lessons learned

APPENDIX B: Initial Implementation Measures for PCPCHs--Oregon[18]					
	Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #1: Access to Care	**In-Person Access**	N/A	PCPCH surveys a sample of its population on satisfaction with in-person access to care and reports results (C)	PCPCH surveys a sample of its population using 1 of the CAHPS survey tools and reports results on the access to care domain (C)	PCPCH surveys a sample of its population using 1 of the CAHPS survey tools, reports results on access to care and meets a patient satisfaction benchmark in access to care (C)
	After Hours Access	N/A	PCPCH offers access to in-person care at least 4 hours/week outside traditional business hours (C)	N/A	N/A
	Telephone and Electronic Access	PCPCH provides continuous access to clinical advice by telephone (C)	N/A	N/A	N/A
Core Attribute #2: Accountability	**Performance and Clinical Quality Improvement**	PCPCH tracks 1 quality metric from core or menu set of PCPCH Quality Measures (C)	N/A	PCPCH tracks and reports to the OHA 2 measures from core set and 1 measure from the menu set of PCPCH Quality Measures (D)	PCPCH tracks, reports to the OHA and meets benchmarks on 2 measures from core set and 1 measure from the menu set of PCPCH Quality Measures (D)

APPENDIX B (*continued*)					
	Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #3: Comprehensive Whole Person Care	**Preventive Services**	N/A	PCPCH offers or coordinates 90% of recommended preventive services (C)	N/A	N/A
	Medical Services	PCPCH reports that it routinely offers: Acute care for minor illnesses and injuries; Ongoing chronic disease management; Office-based procedures and diagnostic tests; Patient education and self-management (C)	N/A	N/A	N/A
	Mental Health, Substance Abuse, and Developmental Services	PCPCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources (C)	N/A	PCPCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers (C)	PCPCH documents actual or virtual co-location (with the use of telemedicine or telepsychiatry) with specialty mental health, substance abuse, or developmental providers (C)
	Comprehensive Health Assessment and Intervention	N/A	PCPCH documents comprehensive health assessment and intervention for at least 3 health risk or developmental promotion behaviors (C)	N/A	N/A

APPENDIX B (*continued*)					
	Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #4: Continuity	**Personal Clinician Assigned**	PCPCH reports the percentage of active patients assigned a personal clinician and/or team (D)	N/A	N/A	PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team (D)
	Personal Clinician Continuity	PCPCH reports the percent of patient visits with assigned clinician/team (D)	N/A	N/A	PCPCH meets a benchmark in the percent of patient visits with assigned provider (D)
	Organization of Clinical Information	PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record (C)	N/A	N/A	N/A
	Clinical Information Exchange	N/A	N/A	N/A	PCPCH shares clinical information electronically in real-time with other providers and care entities (health information exchange) (C)
	Specialized Care Setting	PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care (C)	N/A	N/A	N/A

APPENDIX B (*continued*)					
	Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #5: Coordination and Integration	**Population Data Management**	N/A	PCPCH demonstrates the ability to identify, aggregate, and display up-to-date patient data (C) PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients (C)	N/A	N/A
	Electronic Health Record	N/A	N/A	N/A	PCPCH has an EHR and demonstrates meaningful use (C)
	Care Coordination	N/A	PCPCH assigns responsibility for care coordination, tells each patient or family the name of the team member responsible for coordinating his or her care (C)	PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs (C)	N/A
	Test and Result Tracking	N/A	PCPCH demonstrates tracking of tests ordered by its clinicians and ensures timely and confidential notification to patients, families, and ordering clinicians (C)	N/A	N/A

APPENDIX B (*continued*)					
	Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #5 (*continued*)	**Referral and Specialty Care Coordination**	N/A	PCPCH tracks referral or ders, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians (C) PCPCH either manages hospital or SNF care for its patients or demonstrates active involvement and coordination of care in these specialized care settings (C)	N/A	PCPCH tracks referrals and coordinates care where appropriate for community settings outside the PCPCH (C)
	Comprehensive Care Planning	N/A	PCPCH demonstrates the ability to identify high-risk patients, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with a written care plan (C)	N/A	N/A
	End-of-Life Planning	PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services (C)	N/A	N/A	N/A

APPENDIX B (*continued*)					
	Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #6: Person and Family-Centered Care	**Language/Cultural Interpretation**	PCPCH documents the offer and/or use of providers or telephonic trained interpreters to communicate with patients and families in their language of choice (C)	N/A	N/A	N/A
	Education and Self-Management Support	N/A	PCPCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources (C)	N/A	N/A
	Experience of Care	N/A	PCPCH surveys a sample of its patients and families at least Annually on their experience of care. The recommended patient experience of care survey is 1 of the CAHPS survey tools (C)	PCPCH surveys a sample of its population using 1 of the CAHPS survey tools (C)	PCPCH surveys a sample of its population using 1 of the CAHPS survey tools and meets benchmarks on the majo rity of the domains (C)
NOTES: (C) refers to contractual attestation measures. (D) refers to measures that require quantitative data submission					

Endnotes

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18. Office for Oregon Health Policy and Research. Table adapted from "Oregon Patient-Centered Primary Care Home Model: Implementation Reference Guide October 2011." Available from: http://cms.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/docs/PCPCH_Implementation_Guide_October2011_FINAL.pdf.

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This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report “***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***”. The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)
- Executive Summary: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.pdf

Alabama appendix only
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm#AL
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2-AL.pdf

Idaho appendix only
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