MEDICAL ASSISTANCE PROGRAMS

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## Memorandum

**To:** The Honorable Senator Alan Bates, Co-Chair
The Honorable Representative Nancy Nathanson, Co-Chair
Joint Ways and Means Human Services Subcommittee

**From:** Judy Mohr Peterson
Director, Medical Assistance Programs
Oregon Health Authority

**Date:** February 22, 2013

**Subject:** Response to questions asked during the Medical Assistance Programs presentation to the Subcommittee on February 11 through 13, 2013

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Thank you for the opportunity to provide information about Medical Assistance Programs to your committee. The following are responses to the questions committee members asked during our presentation.

1. What is the amount of the Medicare Part D clawback payments (listed on slide 4)?

   **Response:** The following are clawback payment amounts or budgeted amounts by biennium:

   - $122 million paid during the 2007-09 biennium
   - $117 million paid during the 2009-11 biennium.
   - $149 million budgeted for the 2011-13 biennium
   - $164 million budgeted for the 2013-15 biennium

2. What percent of dentists accept OHP clients?

   **Response:** From the data collected from dentists as they renew their licenses, approximately 28% of those practicing in Oregon have Medicaid patients or are open to new Medicaid patients.

3. What is the percentage of Oregon children are covered below 300 percent of the federal poverty level?

   **Response:** Please see the attached one-page document titled, "*Children's Uninsurance in Oregon, Uninsured Children under 300% FPL, and Anticipated Healthy Kids Enrollment*."

4. Please provide a description of the Breast and Cervical Cancer Medical Program?

   **Response:** This is an optional Medicaid program providing medical coverage to women who are diagnosed with breast or cervical cancer through Public Health's Breast and Cervical Cancer Program, which helps women gain access to screening for early detection of breast and cervical cancer. For each woman found to need treatment for cancer, the state evaluates eligibility under the Oregon Health Plan (OHP) programs that provide the OHP Plus benefit package. If not eligible for an OHP Plus program, the woman qualifies for medical assistance through the Breast and Cervical Cancer Medical program and receives coverage consistent with the OHP Plus benefit package. The woman remains eligible until she reaches age 65, obtains other health coverage, or no longer needs treatment for her breast or cervical cancer. Clients receive services from medical providers who accept Medicaid fee-for-service payments. For the 2011-13 biennium, the program has a budget of $41 million and serves a monthly average of almost 800 women.

5. What is the impact of cost-shifting from Oregon Health Plan rate reductions to other payers, including PEBB/OEBB?

   **Response:** As part of an analysis of the fiscal impacts of the Affordable Care Act (ACA) Medicaid expansion, consultants estimated potential savings to PEBB and OEBB as a result of reduced cost shift from the uninsured to commercial payers. The analytic approach used to derive these estimates, however, cannot be directly applied to reductions in Medicaid reimbursements.

   We did identify a research paper that points to many different studies on cost shifting that you may find of interest. The paper is Austin Frakt's "How Much Do Hospitals Cost Shift? A Review of the Evidence" available online at:
   http://www.hcfe.research.va.gov/docs/wp_2011_01.pdf

6. Please provide more information about the Health System Transformation performance metrics.

   **Response:** Please see the attached documents titled, *"Summary: Oregon's 1115 Medicaid Demonstration Accountability Plan and Expenditure Trend Review"* and *"CCO Incentive and State Performance Metrics."* These documents and other information are available on the Metrics and Scoring Committee website, which is at the following address:
   http://www.oregon.gov/oha/pages/metrix.aspx

Please note that the OHA made presentations on the Health System Transformation metrics to Senate and House committees this week and would gladly make a presentation to your committee, as well.

7. What metrics are included in the APS contract for fee-for-service clients?

   **Response:** The APS contract, which is effective through August 2013, includes a metric for each of the following areas:

   - Evidence-based practices and strategies that improve health outcomes
   - Strategies and interventions to reduce medical costs
   - Reduction in hospitalization of ambulatory care sensitive conditions
   - Reduction in non-emergent utilization of emergency departments
   - Reduction in tobacco and chemical dependency
   - Reduction in under-immunized children and adults
   - Reduction in health and racial disparities
   - Cost effectiveness disease management and case management services
   - Use of strategies and interventions that reduce or prevent the progression of chronic conditions or acute catastrophic events
   - Reduction in barriers to access and care from both the provider and enrollee
   - Increase the number of clients with a Medical Home

8. Please provide the federal match rates for those determined "newly eligible" as part of the ACA Medicaid expansion.

   **Response:** The federal match rates for those individuals "newly eligible" under the ACA Medicaid expansion are as follows:

   - 100% for calendar year 2014
   - 100% for calendar year 2015
   - 100% for calendar year 2016
   - 95% for calendar year 2017
   - 94% for calendar year 2018
   - 93% for calendar year 2019
   - 90% for calendar year 2020, and thereafter

9. Provide a basic table that outlines the federal poverty levels using dollars amounts.

   **Response:** The below is a table of the current monthly income standards for the current Medicaid and CHIP eligibility groups based on the 2013 federal poverty levels (FPLs). The table is also attached separately for your convenience.

| Number in household | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 100% FPL | $958 | $1,293 | $1,628 | $1,963 | $2,298 | $2,633 | $2,968 | $3,303 | $3,638 | $3,973 |
| 133% FPL | $1,274 | $1,720 | $2,165 | $2,611 | $3,056 | $3,502 | $3,947 | $4,393 | $4,838 | $5,284 |
| 138% FPL | $1,322 | $1,784 | $2,246 | $2,709 | $3,171 | $3,633 | $4,096 | $4,558 | $5,020 | $5,483 |
| 185% FPL | $1,772 | $2,392 | $3,011 | $3,631 | $4,251 | $4,871 | $5,490 | $6,110 | $6,730 | $7,350 |
| 200% FPL | $1,925 | $2,598 | $3,272 | $3,945 | $4,618 | $5,292 | $5,965 | $6,639 | $7,312 | $7,985 |
| 300% FPL | $2,883 | $3,891 | $4,900 | $5,908 | $6,916 | $7,924 | $8,933 | $9,941 | $10,949 | $11,958 |

10. Provide more details on the Hospital Transformation Performance Program.

**Response:**

*Hospital Transformation Performance Program:* In addition to current assessment of 4.32%, the hospital assessment will be raised by an additional 1% (to a combined total maximum of 5.32%), as allowable under current federal law. The Director of the Oregon Health Authority (OHA) will create the Hospital Transformation Performance Program, which will be paid for through the federal proceeds derived from the additional 1% hospital assessment, thus requiring no state General Fund investment. The underlying 1% assessment liability would be returned to the assessed entities, in the aggregate, through a model approved by the Centers for Medicare and Medicaid Services (CMS). CMS also will need to approve the details of the Transformation Performance Program, such as the metrics, as well.

Individually assessed hospitals will be eligible to earn the proceeds from this pool through an incentive system designed in partnership between the OHA, Oregon Association of Hospitals & Health Systems and key stakeholders. This pool will be managed by the OHA, outside of CCO global budgets. The pool will be designed to advance the goals of Health System Transformation and the performance payouts would be based upon data submission and improvement on 3-5 attainable quality and patient safety goals. The entire pool will be paid out in the 2013-15 biennium as follows:

- 50% of pool to be paid out in SFY 2013 for regular submission of data on the goals agreed upon for measurement and improvement.
- 50% of pool to be paid out in SFY 2014 against mutually agreed upon improvement targets.

Allocation of pool dollars by hospital and frequency of payments will be mutually agreed upon by OHA and Association.

11. Please provide more detail for General Fund, Other Funds and Federal Fund dollars in the MAP budget, along with descriptions for Other Fund revenue sources.

    **Response:** The following provides more detail for General Fund, Other Funds and Federal Funds in our budget.

| Medical Assistance Programs - Governor's Balanced Budget<br>Revenue Sources | Total |
|---|---|
| General Fund | $1,145,550,000 |
| Insurers Assessment - Existing | $32,070,000 |
| Hospital Assessment - Existing | $82,000,000 |
| Hospital Assessment - Renewal | $600,000,000 |
| Hospital Assessment - Transformation Performance Program | $145,000,000 |
| Tobacco Master Settlement | $120,600,000 |
| Tobacco Tax Revenue | $313,150,000 |
| Law Enforcement Medical Liability Account (LEMLA) | $1,350,000 |
| CareAssist & Oregon Prescription Drug Program | $58,840,000 |
| Leveraged Other Funds (OHSU programs & school-based services) | $78,820,000 |
| Drug rebate revenue and other collections | $117,830,000 |
| DSHP Other Funds | $338,000,000 |
| DSHP Federal Funds | $572,000,000 |
| Medicaid and CHIP Federal Funds | $6,643,420,000 |
| Totals: | $10,248,630,000 |

    We will provide additional budget detail as part of our Phase II presentation to the committee.

12. Of the different agencies or local governments that need to purchase pharmaceuticals, which are in the program and which are not, but with a little more work could be in the program?

    **Response:** The Oregon Prescription Drug Program (OPDP) provides bulk purchase of drugs to the following groups:

    - State Accident Insurance Fund (SAIF)
    - Oregon Health & Science University Hospital (OHSU)
    - Oregon Home Care Commission (OHCC)
    - Southern Oregon Child and Family Council (SOCFC)
    - Oregon Educators Benefit Board (OEBB)
    - Multnomah County
    - Masonry Welfare Trust
    - Cement Masons Employer Health, Welfare Trust
    - Salem Hospital

In addition to the above, OPDP is in active discussions with:

- Department of Corrections (DOC)
- Oregon Youth Authority (OYA)
- Public Employees Benefit Board (PEBB)
- Oregon State Hospital

Each one of these has their own unique needs and concerns. While cost savings have been shown in all cases, there are also restrictions of existing contracts (PEBB), distribution of the drugs (OYA has 11 locations where drugs need to be shipped), and packaging requirements (State Hospital and OYA) that must be addressed. Other entities across the state that could join OPDP or some other bulk purchase organization are:

- County Jails
- County Health divisions
- Emergency Medical Services Agencies

13. Are there opportunities with counties under the Oregon Prescription Drug Program?

    **Response:** Yes. County agencies, both for their own employee health benefit and for their health divisions, that purchase prescription drugs must explore the cost and benefit of changing programs based on their unique needs and resources. OPDP has had discussions with Washington and Clackamas Counties to explain the program.

14. Please describe our participation with other states on pharmacy programs.

    **Response:** Since 2006, when Oregon and Washington Governors signed an interstate agreement forming the Northwest Prescription Drug Consortium, the two states have worked together in building the interstate purchasing pool that now includes 870,000 members. OPDP and Washington's prescription drug program have performed joint solicitation and negotiation for its administrative contract. That umbrella contract forms the basis of the program that all participating members are covered under. It is 100% transparent, delivers market competitive rates, excellent service with financial guarantees, and innovative program development.

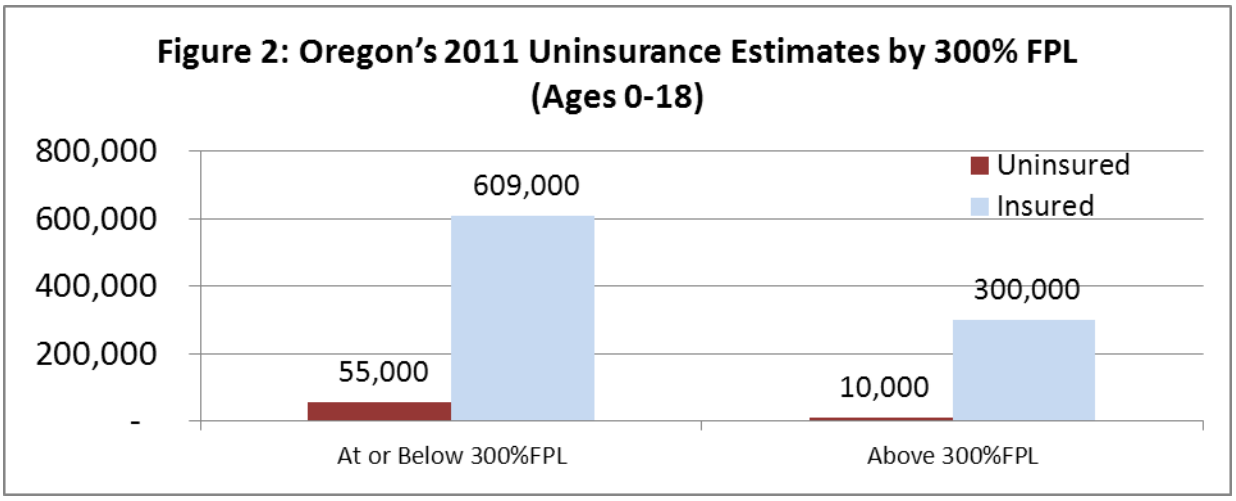
    We have also reached out to other states including Alabama, Virginia, and Minnesota to learn about their pharmacy programs and obtain feedback about ours. In addition, we have recently been approached by U.S. Communities, a national group purchasing organization that services counties and government agencies. They don't currently offer pharmaceutical purchasing, but want to explore how the Northwest Prescription Drug Consortium might offer a model that could be taken nationally.

15. What is the impact if one agency drops from the program? Will the remaining agencies and local governments (e.g. counties) be negatively affected as a result?

    **Response:** No. OPDP has 450,000 members in its pool and combined with the Washington program the consortium has 870K members. The consortium purchasing pool leverages the buying power of all groups to buy a commodity, prescription drugs, as well as, the service delivery for its various programs. The buying power of the consortium enables it to deliver transparent contracting, market competitive rates and guaranteed service levels that smaller purchasers cannot reasonably negotiate on their own. Although some small group agencies have left the program as their benefit structures change or funding is scaled back, their leaving has had no impact on the overall pool.

## Children's Uninsurance in Oregon, Uninsured Children under 300% FPL, and Anticipated Healthy Kids Enrollment

In 2011, approximately 5.6% to 7.2% of children (0-18) were uninsured in Oregon.[1] For children at or below 300% of the Federal Poverty Level (FPL), approximately 55,000 are uninsured.




Source: American Community Survey

Healthy Kids averaged enrollment of 383,000 children at or below 300% FPL in 2012 (includes Healthy KidsConnect children, Oregon's subsidized insurance program for families 201%FPL to 300%FPL.

The Patient Protection and Affordable Care Act (ACA) proposes an expansion of Medicaid eligibility among adults, and Oregon anticipates that ACA-related publicity and encouragement to gain coverage would also result in additional children enrolling in Healthy Kids. This is sometimes referred to as the "Welcome Mat" effect. In collaboration by the State Health Access Data Assistance Center (SHADAC), OHA has projected that approximately 11,500 children will enroll in Healthy Kids.

[1] Statistics cited are mid-point estimates from the Oregon Health Insurance Survey and the Census's American Community Survey (ACS). As is the case in other states, the Census's ACS produces higher rates of uninsurance than seen in statewide surveys. In Oregon this is seen with the ACS approximately 1.5 percentage points higher than the Oregon Health Insurance Survey (OHIS) in estimating children's uninsurance in 2011. For on the reasons for this differing estimates see the technical brief on Oregon's Health Insurance coverage websites http://www.oregon.gov/oha/OHPR/RSCH/Pages/Insurance_Data.aspx. ACS is used in the figure above because it provides a better source of estimates of federal poverty level.

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

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

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

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

The Accountability Plan is divided into two sections:

Section A:

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

Section B: Draft Expenditure Review Plan

### Section A, Part I: Quality Strategy

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

Highlights include:

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

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

### *Statewide Quality and Access Test*:

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

### *Evaluation:*

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

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

## Section A, Part III: Measurement Strategy

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

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

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

## Section B - Draft Expenditure Trend Review:

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

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

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

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

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

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

## Oregon Measures

### CCO Quality Pool Metrics

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

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

[1]An NQF (National Quality Forum) designation indicates that the measure has been endorsed as meeting consensus standards for measuring and publicly reporting on performance.
[2] CAHPS – Consumer Assessment of Healthcare Providers and Systems survey

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

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

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

## Oregon Accountability Metrics

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

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

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

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

## CCO Incentive and State Performance Metrics

| **CCO Incentive Measures**<br>*CCOs are accountable to OHA* | **State Performance Measures**<br>*OHA is accountable to CMS* |
|---|---|
| Alcohol or other substance misuse (SBIRT) | Alcohol or other substance misuse (SBIRT) |
| Follow-up after hospitalization for mental illness (NQF 0576) | Follow-up after hospitalization for mental illness (NQF 0576) |
| Screening for clinical depression and follow-up plan (NQF 0418) | Screening for clinical depression and follow-up plan (NQF 0418) |
| Follow-up care for children prescribed ADHD meds (NQF 0108) | Follow-up care for children prescribed ADHD meds (NQF 0108) |
| Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517) | Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517) |
| PC-01: Elective delivery (NQF 0469) | PC-01: Elective delivery (NQF 0469) |
| Ambulatory Care: Outpatient and ED utilization | Ambulatory Care: Outpatient and ED utilization |
| Colorectal cancer screening (HEDIS) | Colorectal cancer screening (HEDIS) |
| Patient-Centered Primary Care Home Enrollment | Patient-Centered Primary Care Home Enrollment |
| Developmental screening in the first 36 months of life (NQF 1448) | Developmental screening in the first 36 months of life (NQF 1448) |
| Adolescent well-care visits (NCQA) | Adolescent well-care visits (NCQA) |
| Controlling high blood pressure (NQF 0018) | Controlling high blood pressure (NQF 0018) |
| Diabetes: HbA1c Poor Control (NQF 0059) | Diabetes: HbA1c Poor Control (NQF 0059) |
| CAHPS adult and child composites:<br>• Access to care<br>• Satisfaction with care | CAHPS adult and child composites:<br>• Access to care<br>• Satisfaction with care |
| EHR adoption (Meaningful Use 3 question composite) | EHR adoption (Meaningful Use 3 question composite) |
| Mental and physical health assessment within 60 days for children in DHS custody | |
| | Prenatal and postpartum care: Postpartum Care Rate (NQF 1517) |
| | Plan all-cause readmission (NQF 1768) |
| | Well-child visits in the first 15 months of life (NQF 1392) |
| | Childhood immunization status (NQF 0038) |
| | Immunization for adolescents (NQF 1407) |

| **CCO Incentive Measures**<br>*CCOs are accountable to OHA* | **State Performance Measures**<br>*OHA is accountable to CMS* |
|---|---|
| | Appropriate testing for children with pharyngitis (NQF 0002) |
| | Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027) |
| | Comprehensive diabetes care: LDL-C Screening (NQF 0063) |
| | Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057) |
| | PQI 01: Diabetes, short term complication admission rate (NQF 0272) |
| | PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275) |
| | PQI 08: Congestive heart failure admission rate (NQF 0277) |
| | PQI 15: Adult asthma admission rate (NQF 0283) |
| | Chlamydia screening in women ages 16-24 (NQF 0033) |
| | Cervical cancer screening (NQF 0032) |
| | Child and adolescent access to primary care practitioners (NCQA) |
| | Provider Access Questions from the Physician Workforce Survey:<br>• To what extent is your primary practice accepting new Medicaid/OHP patients?<br>• Do you currently have Medicaid/OHP patients under your care?<br>• What is the current payer mix at your primary practice? |

# 2013 Federal Poverty Levels by Monthly Income and Household Size

| Number in household | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 100% FPL | $958 | $1,293 | $1,628 | $1,963 | $2,298 | $2,633 | $2,968 | $3,303 | $3,638 | $3,973 |
| 133% FPL | $1,274 | $1,720 | $2,165 | $2,611 | $3,056 | $3,502 | $3,947 | $4,393 | $4,838 | $5,284 |
| 138% FPL | $1,322 | $1,784 | $2,246 | $2,709 | $3,171 | $3,633 | $4,096 | $4,558 | $5,020 | $5,483 |
| 185% FPL | $1,772 | $2,392 | $3,011 | $3,631 | $4,251 | $4,871 | $5,490 | $6,110 | $6,730 | $7,350 |
| 200% FPL | $1,925 | $2,598 | $3,272 | $3,945 | $4,618 | $5,292 | $5,965 | $6,639 | $7,312 | $7,985 |
| 300% FPL | $2,883 | $3,891 | $4,900 | $5,908 | $6,916 | $7,924 | $8,933 | $9,941 | $10,949 | $11,958 |