Oregon Health Plan

Section 1115 Annual Report

7/1/2016 – 6/30/2017

Demonstration Year (DY): 15 (7/1/2016 – 6/30/2017)

Oregon Health Authority

Oregon HEALTH PLAN

Table of contents

I. Introduction

A. Letter from the State Medicaid Director

I am pleased to tell you the Oregon Health Authority (OHA) continued to move forward in meeting the goals of the Oregon Health Plan (OHP) demonstration. As you will find detailed in the full report, OHA and Coordinated Care Organization (CCO) activities continue to press toward health system transformation (HST) "levers" as identified in the waiver agreement and Accountability Plan. Highlights from the report include the following.

- **Lever 1: Improving care coordination**

  OHA improved care coordination primarily through Patient-Centered Primary Care Homes (PCPCHs). The number of recognized PCPCH clinics increased to approximately 60% of the estimated number of primary care clinics in Oregon. Nearly all recognized PCPCHs chose to reapply for PCPCH recognition under the revised criteria, implemented in January 2017. The dynamic model continues to improve with each revision to the standards, which are based on the most recent evidence-based research, feedback from a stakeholder advisory committee, and firsthand experience from PCPCH site visits across the state. PCPCH enrollment has steadily increased for OHP members that are served through CCOs, and data show the PCPCH program is effectively meeting OHA's goals of better health, better care, and lower costs.

- **Lever 2: Implementing alternative payment methodologies (APMs)**

  OHA has continued working toward value-based payments through several programs including the Hospital Transformation Performance Program (HTPP), the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) program, and the CCO quality pool. In June 2017, we made quality pool incentive payments to CCOs and HTPP hospitals based upon performance metrics. During this demonstration year, OHA also worked to implement both the Comprehensive Primary Care Plus (CPC+) program and the Certified Community Behavioral Health Clinic (CCBHC) program, and we continue to provide assistance to providers on reporting metrics and meeting quality measures.

- **Lever 3: Integrating physical, behavioral and oral health care**

  Oregon's CCOs continue to make strides toward benchmarks for performance measures related to health care integration. CCO incentive measures that increased this demonstration year include:

  - Follow-up after hospitalization for mental illness;
  - Mental, physical, and dental health assessment within 60 days for children in Department of Human Services (DHS) custody; and
  - Screening for clinical depression and follow-up plan.

  Also during this demonstration year, several oral health reports were released to support a cross-agency work plan to improve oral health equity, population oral health, and access to oral health, while increasing the integration and coordination of care for all Oregonians.

- **Lever 4: Increased efficiency in providing care**

  Although, potentially avoidable hospital admissions increased slightly for Chronic Obstructive Pulmonary Disease (COPD), diabetes short-term complications, and congestive heart failure, OHA and its partners continue to work toward more efficient and effective care for OHP members as indicated by:

  - A decline in avoidable utilization of emergency departments;
  - Decreased potentially avoidable hospital admissions for asthma in younger adults; and
  - Increased developmental screenings during the first 36 months of life.

  OHA also increased CCO adoption and coordinated use of PreManage, a companion to the Emergency Department Information Exchange (EDIE), which brings real-time hospital event notifications from EDIE to health plans, CCOs, providers, and care coordinators. All 59 Oregon hospitals contribute admit, discharge, and transfer (ADT) data to the EDIE, and CCOs health plans, and providers can subscribe to PreManage to access ADT data to better manage their high utilizers of hospital services.

- **Lever 5: Implementation of health-related flexible services**

  OHA completed contract negotiations with Oregon Health & Science University's (OHSU) Center for Health System Effectiveness (CHSE) for the summative evaluation of the 2012-2017 1115 demonstration period. The evaluation will include data from all five years, and OHA expects data comparison to another state's Medicaid population and Oregon's commercial plan members to estimate the waiver's effect on health care spending, quality, and access.

  The summative evaluation will also review transformation activities' findings. OHA's evaluation contractor will include findings about the effectiveness of flexible services in its final evaluation report, which will be delivered to CMS and OHA by the end of 2017. In addition, the contractor will provide recommendations for evaluating flexible services following the end of the 2012 – 2017 1115 demonstration period.

- **Lever 6: Innovations through the Transformation Center**

  OHSU evaluators completed an evaluation of Transformation Center technical assistance to CCOs. Findings indicate that CCOs value webinars and trainings because they provide the latest evidence-based approaches, tools for sharing content with stakeholders, and practical resources. CCOs also value expert consultations because they assist in operationalizing and implementing interventions and provide an external perspective that helps generate buy-in for interventions.

  Final reports for the Community Health Improvement Plan Implementation grants to CCOs showed that all CCOs made significant progress on their grant activities, supporting implementation of their community health improvement plan priorities.

  The Transformation Center continues to provide supportive services to CCOs including targeted metrics technical assistance, health equity consultations, and support through the Technical Assistance Bank.

This annual report closes the 2012-2017 1115 demonstration waiver for OHP with marked accomplishments in meeting the goals of better health, better care, and lower health care costs. OHA looks forward to continuing to invest in HST through conditions set forth in the recently renewed waiver.

David Simnitt, Interim State Medicaid Director

B. Demonstration description

The Oregon Health Plan (OHP) is the state's demonstration project under Section 1115 of the Social Security Act, funded through titles XIX and XXI of the Social Security Act.

Phase I of OHP started on February 1, 1994, for Medicaid clients in the Poverty Level Medical (PLM) and Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance to Needy Families/TANF) populations. One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.

Following the creation of the Title XXI Program in 1997, the State Children's Health Insurance Program (SCHIP) was incorporated into the OHP, providing SCHIP-eligible people with the same benefits and delivery system available to Medicaid clients.

The OHP 2 demonstration, which established the OHP Plus and OHP Standard benefit packages, began November 1, 2002 and included the Family Health Insurance Assistance Program (FHIAP). In 2007 and 2009, more children became eligible through expanded SCHIP eligibility and the creation of the Healthy Kids program.

On July 5, 2012, the Centers for Medicare and Medicaid Services (CMS) approved an extension and amendment to the 1115 demonstration related to Oregon's Health System Transformation, through June 30, 2017. Key features included:

- **Coordinated care organizations (CCOs):** The State established CCOs as the delivery system for Medicaid and CHIP services.
- **Flexibility in use of federal funds:** The State has the ability to use Medicaid dollars for flexible services (*e.g.,* traditional health care workers): health-related care that is authorized under managed care rules and regulations. CCOs have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health.
- **Federal investment:** The federal government agreed to provide federal financial participation (FFP) for several health care programs that had previously been supported entirely by State funds, known as Designated State Health Programs (DSHP). Expenditure authority for DSHP is limited to $704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by Demonstration Year (DY) as follows:

DY	Time Period	FFP Limit
11	07/1/12-06/30/13	$230 M
12	07/1/13-06/30/14	$230 M
13	07/1/14-06/30/15	$108 M

DY	Time Period	FFP Limit
14	07/1/15-06/30/16	$ 68 M
15	07/1/16-06/30/17	$ 68 M

- **Workforce:** To support the new model of care within CCOs, in 2013 Oregon established a loan repayment program for primary care physical, oral and behavioral health providers who agree to work in clinics that see a high percentage of Medicaid patients. To date, 68 providers have been provided loan repayment under this program. Oregon also completed training for 300 community health workers by 2015. As mandated by House Bill 3396 (2015 Regular Session), the Oregon Health Policy Board, through its Workforce Committee conducted further evaluation and research to determine how to best recruit and retain health care providers to practice in rural and medically underserved areas of the state. A report to the legislature was provided in November 2016. The OHA is continuing to implement the Legislature's statutory changes around incentives for health care professionals.

The primary goals of the Oregon demonstration are:

- **Improving health for all Oregonians**: The State is committed to fostering innovative approaches to improving population health through a focus on linking community health and services with the clinical delivery system. Population health efforts, Public Health Modernization and alignment with schools and the education system are integral to improving the health of all Oregonians by going beyond the walls of the clinics and hospitals.
- **Improving health care:** The state is working to coordinate physical, behavioral and oral health care and increase the focus on prevention and improved care. Individuals can get the care and services they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language.
- **Reducing the growth in Medicaid spending:** The state agreed to reduce per capita medical trend, the growth in per capita spending, by 2 percentage points by the end of the second year of the demonstration period (June 30, 2014) from an assumed trend rate of 5.4 percent as calculated by federal Office of Management and Budget.

In January 2017, the Tribal Uncompensated Care Program under the 1115 Demonstration was discontinued, and the previously uncompensated services were added to the covered benefits for members of Oregon's nine federally-recognized Tribes.

C. State contacts

Demonstration and Quarterly Reports

Jennifer R. Smith, Medicaid Policy Coordinator (Quarterly and Annual Reports)
503-945-9717 phone
503-945-5872 fax

Veronica Guerra, Senior Policy Analyst (Demonstration Manager)
503-915-3411 phone
503-945-5872 fax

State Plan

Jesse Anderson, State Plan Manager

503-945-6958 phone
503-945-5872 fax

Coordinated Care Organizations
Rhonda Busek, Provider Services Director
503-945-6552 phone
503-373-7689 fax

Quality Assurance and Improvement
Wes Charley, Quality and Compliance Director
503-269-7295 phone
503-945-6548 fax

For mail delivery, use the following address
Oregon Health Authority
Health Policy and Analytics
500 Summer Street NE, E54
Salem, OR 97301-1077

II. Title

Oregon Health Plan Section 1115 Annual Report
7/1/2016 – 6/30/2017
Demonstration Year (DY): 15 (7/1/2016 – 6/30/2017)

III. Events affecting health care delivery

A. Overview of significant events across the state

Table 1 – Significant events, impact, and interventions

Category of event	Impact? (Yes/No)			Interventions or actions taken? (Yes/No)
	Demonstration goals	Beneficiaries	Delivery system	
A. Enrollment progress	No	No	No	N/A
B. Benefits	No	No	No	N/A
C. CCO Complaints and Grievances	-	-	-	N/A
D. Quality of care – CCO / MCO / FFS	-	-	-	N/A
E. Access	No	No	No	N/A
F. Provider Workforce	No	No	No	N/A

Category of event	Impact? (Yes/No)			Interventions or actions taken? (Yes/No)
	Demonstration goals	Beneficiaries	Delivery system	
G. CCO networks	No	No	No	N/A

Detail on impacts or interventions

No report at this time

B. Complaints and grievances

For fiscal year 2017, all CCOs reported using the updated complaint categories as reflected in the chart below. Complaints received within OHA are reported in the narrative portion of this report.

There are six main categories required under the Special Terms and Conditions of Oregon's current 1115 demonstration:

1. Access to providers and services
2. Interaction with provider or plan
3. Consumer rights
4. Clinical care
5. Quality of services
6. Client billing issues

CCO complaints

Table 2 – Complaints and grievances

This chart shows the individual line items that are required under each main category. All CCOs are reporting in these updated categories for this annual report. The chart includes:

- The total of all complaints reported statewide by the 16 CCOs
- Total number of statewide complaints that were resolved
- Total number of statewide complaints that were pended
- Average rate of enrollment as reported by the CCOs
- Rate per enrollee, based on the average total enrollment and calculated per 1000 members

Complaint or grievance type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Number reported
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	107	592	472	502	**1673**
b) Plan unresponsive, not available, difficult to contact for appointment or information.	29	28	26	25	**108**
c) Provider's office too far away, not convenient	21	21	26	41	**109**

Complaint or grievance type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Number reported
d) Unable to schedule appointment in a timely manner.	119	170	95	110	**494**
e) Unable to be seen in a timely manner for urgent/emergent care	21	20	15	28	**84**
f) Provider's office closed to new patients.	65	37	55	40	**197**
g) Referral or 2nd opinion denied/refused by provider.	47	38	24	31	**140**
h) Referral or 2nd opinion denied/refused by plan.	13	21	5	10	**49**
i) Provider not available to give necessary care	32	38	47	57	**174**
j) Eligibility issues	42	37	73	57	**209**
k) Female or male provider preferred, but not available	22	10	4	4	**40**
l) NEMT not provided, late pick up w/missed appointments, no coordination of services	1249	912	893	847	**3901**
m) Dismissed by provider as a result of past due billing issues	0	1	0	4	**5**
n) Dismissed by clinic as a result of past due billing issues	11	1	2	3	**17**
TOTAL	**1778**	**1926**	**1737**	**1759**	**7200**
INTERACTION WITH PROVIDER OR PLAN					
a) Wants to change providers; provider not a good fit.	158	110	125	122	**515**
b) Provider rude or inappropriate comments or behavior	307	268	276	289	**1140**
c) Plan rude or inappropriate comments or behavior	48	35	28	28	**139**
d) Provider explanation/instr. inadequate/incomplete	248	326	482	553	**1609**
e) Plan explanation/instr. inadequate/incomplete	113	126	175	170	**584**
f) Wait too long in office before receiving care	11	28	37	49	**125**
g) Member not treated with respect and due consideration for his/her dignity and privacy	24	15	34	42	**115**
h) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.	3	5	1	5	**14**
i) Plan's office or staff exhibits language or cultural barriers of lack of cultural sensitivity.	6	2	3	3	**14**
j) Member has difficulty understanding provider due to language or cultural barriers.	3	3	1	4	**11**
k) Lack of communication and coordination among providers.	61	65	28	24	**178**
l) Dismissed by provider (member misbehavior, missed appointments, etc.)	17	43	34	21	**115**
m) Dismissed by clinic (member misbehavior, missed appointments, etc.)	18	19	16	19	**72**
TOTAL	**1017**	**1045**	**1240**	**1329**	**4631**
CONSUMER RIGHTS					
a) Provider's office has a physical barrier	1	23	18	19	**61**
b) Concern over confidentiality.	25	25	22	32	**104**
c) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.	172	104	98	100	**474**
d) No choice of clinician	24	33	17	36	**110**
e) Fraud and financial abuse	6	13	9	12	**40**
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)	25	30	12	19	**86**

Complaint or grievance type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Number reported
g) Complaint/appeal process not explained, lack of adequate or understandable NOA	4	5	3	5	**17**
h) Not informed of consumer (Member) rights	0	3	4	5	**12**
i) Denied member access to medical records	1	7	4	4	**16**
j) Did not respond to member's request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)	3	4	6	7	**20**
k) Advanced or Mental Health Directive not discussed, offered or followed	0	0	0	0	**0**
l) Freedom from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion; restraint or seclusion used other than to assure members immediate safety	1	1	0	0	**2**
TOTAL	**262**	**248**	**193**	**239**	**942**
QUALITY OF CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.	154	130	104	141	**529**
b) Testing/assessment insufficient, inadequate or omitted	27	14	33	58	**132**
c) Concern about prescriber or medication or medication management issues	116	109	80	142	**447**
d) Member neglect or physical, mental or psychological abuse	11	23	8	20	**62**
e) Unsanitary environment or equipment	33	73	54	41	**201**
f) Lack of appropriate individualized setting in treatment	2	5	4	14	**25**
TOTAL	**343**	**354**	**283**	**416**	**1396**
QUALITY OF SERVICE					
a) Delay in receiving, or concern regarding quality of materials and supplies (DME) or dental	62	68	52	56	**238**
b) Lack of access to medical records or unable to make changes	15	7	7	15	**44**
c) Benefits not covered	49	53	51	53	**206**
TOTAL	**126**	**128**	**110**	**124**	**488**
CLIENT BILLING ISSUES					
a) Co-pays	8	3	5	15	**31**
b) Premiums	0	5	8	2	**15**
c) Billing OHP clients without approved waiver	290	308	298	293	**1189**
TOTAL	**298**	**316**	**311**	**310**	**1235**
Miscellaneous					-
Total	3857	4070	3930	4225	**16082**
Total average CCO enrollment	880,662	862,040	865,701	882,453	872,714
Total rate per 1000 members	4.38	4.72	4.54	4.78	4.605

A summary of the statewide complaints and grievances reported by each CCO in six main categories is below. The chart includes the following, per CCO:

- Summary totals per main category
- Number of complaints pended per category at the end of this reporting period

- Number of complaints resolved per category at the end of this reporting period
- Range of number of complaints and grievances per category in this reporting period (Range indicates the following: **lowest number** = lowest number of complaints received in the category; **highest number** = highest number of complaints received in the category.)

Complaint or grievance type	AllCare	Cascade Health	Columbia Pacific	Eastern Oregon	Family Care	HealthShare	IHN	Jackson Care	PSCS CO	PSCS CG	Primary Health	Trillium	Umpqua	Western Oregon	Willamette Valley	Yamhill County	TOTALS
ACCESS TO PROVIDERS AND SERVICES																	
Total:	21	10	20	37	192	651	30	80	86	9	19	175	15	73	289	52	**1759**
Pending:	0	0	1	0	9	35	2	2	6	0	0	11	0	0	24	2	**92**
Resolved:	21	10	19	37	183	616	28	78	80	9	19	164	15	73	265	50	**1667**
Range:	0-7	0-5	0-8	0-10	0-98	0-313	0-12	0-66	0-48	0-1	0-6	0-108	0-4	0-18	0-213	0-22	
INTERACTION WITH PROVIDER OR PLAN																	
Total:	43	10	30	19	128	573	29	52	73	7	13	127	28	94	81	22	**1329**
Pending:	2	1	3	1	11	47	2	6	14	0	0	11	2	0	7	4	**111**
Resolved:	41	9	27	18	117	526	27	46	59	7	13	116	26	94	74	18	**1218**
Range:	0-16	0-5	0-9	0-8	0-90	1-346	0-9	0-25	0-26	0-2	0-4	0-57	0-9	0-53	0-39	0-7	
CONSUMER RIGHTS																	
Total:	3	0	6	13	19	78	16	8	11	2	4	16	9	34	10	10	**239**
Pending:	0	0	1	0	2	3	2	1	3	0	0	0	0	0	0	3	**15**
Resolved:	3	0	5	13	17	75	14	7	8	2	4	16	9	34	10	7	**224**
Range:	0-2	0-0	0-2	0-5	0-12	0-30	0-7	0-4	0-5	0-1	0-4	0-6	0-9	0-20	0-5	0-5	
QUALITY OF CARE																	
Total:	8	0	13	11	33	168	34	10	27	3	3	60	7	15	11	13	**416**
Pending:	0	0	1	0	3	30	3	3	4	0	0	11	1	1	1	3	**61**
Resolved:	8	0	12	11	30	138	31	7	23	3	3	49	6	14	10	10	**355**
Range:	0-4	0-0	0-7	0-4	0-14	4-70	0-20	0-7	0-16	0-2	0-2	4-16	0-2	0-7	0-7	0-10	
QUALITY OF SERVICE																	
Total:	3	0	4	2	3	54	5	6	8	1	1	10	1	0	22	4	**124**
Pending:	1	0	0	0	0	10	0	0	3	0	0	0	0	0	1	0	**15**
Resolved:	2	0	4	2	3	44	5	6	5	1	1	10	1	0	21	4	**109**
Range:	0-2	0-0	0-2	0-2	0-2	3-26	1-3	0-3	0-7	0-1	0-1	1-6	0-1	0-0	3-13	0-3	
CLIENT BILLING ISSUES																	
Total:	1	0	22	5	8	90	2	11	3	0	0	5	17	0	118	28	**310**

Complaint or grievance type	AllCare	Cascade Health	Columbia Pacific	Eastern Oregon	Family Care	HealthShare	IHN	Jackson Care	PSCS CO	PSCS CG	Primary Health	Trillium	Umpqua	Western Oregon	Willamette Valley	Yamhill County	TOTALS
Pending:	0	0	8	0	0	7	0	1	1	0	0	0	1	0	4	1	**23**
Resolved:	1	0	14	5	8	83	2	10	2	0	0	5	16	0	114	27	**287**
Range:	0-1	0-0	0-22	0-5	0-8	2-76	0-2	0-11	0-3	0-0	0-0	0-4	0-16	0-0	0-118	0-28	
Other	0	0	0	0	0	21	2	0	9	0	0	0	0	0	16	0	48
Pending	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Grand Total	**79**	**20**	**95**	**87**	**383**	**1635**	**118**	**167**	**217**	**22**	**40**	**393**	**77**	**216**	**547**	**129**	**4225**
Per 1000 members	1.59	1.15	4.02	1.84	3.29	7.63	2.11	5.91	4.43	1.78	4.15	4.28	2.95	10.48	5.82	4.95	4.79

Trends related to complaints and grievances

This demonstration year, the statewide total complaints and grievances rate for the fourth quarter is 4.78 per 1,000 members[1]. This is an increase from the previous year's fourth quarter rate (4.178 per 1,000 members).

For total complaint rates among the individual 16 CCOs:

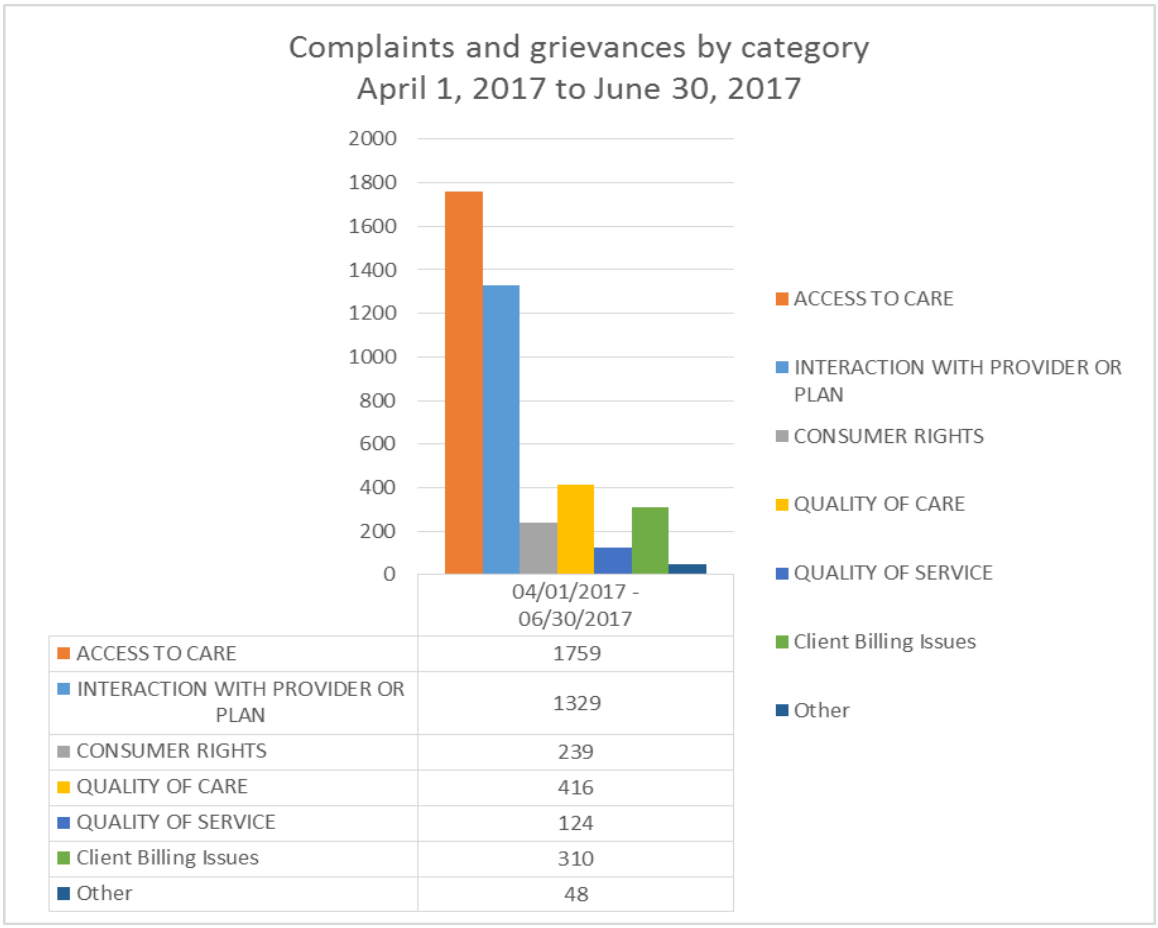
- The lowest rate was 1.15 per 1,000 members
- The highest rate was 10.48 per 1,000 members

CCOs continue to standardize data collection among their contracted delegates to improve reporting of complaints. One CCO is implementing new case management software. Another CCO is creating a reference manual for staff to improve accuracy in complaint classification.

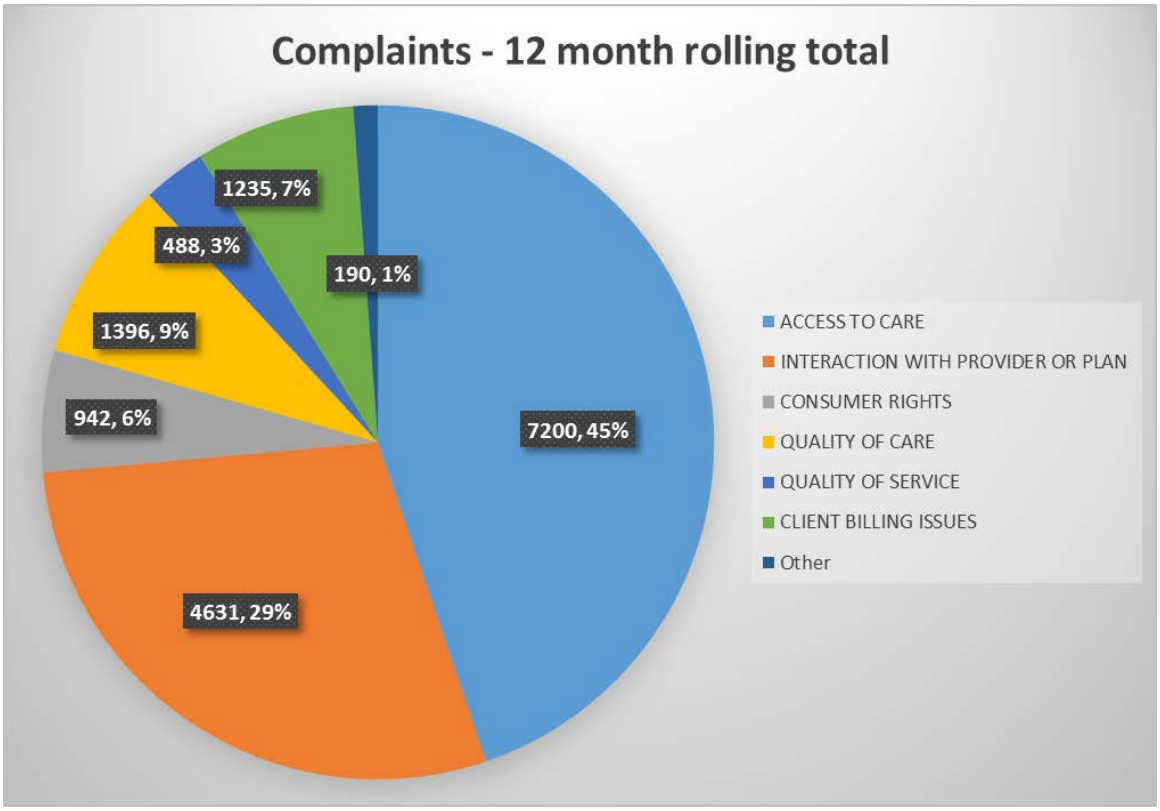
NEMT complaints have steadily decreased each quarter. The CCOs and Health Systems Division staff continue to monitor issues with NEMT services. Some CCOs are reporting they are taking additional steps to resolve the high number of complaints, such as new tracking methods and software communication solutions.

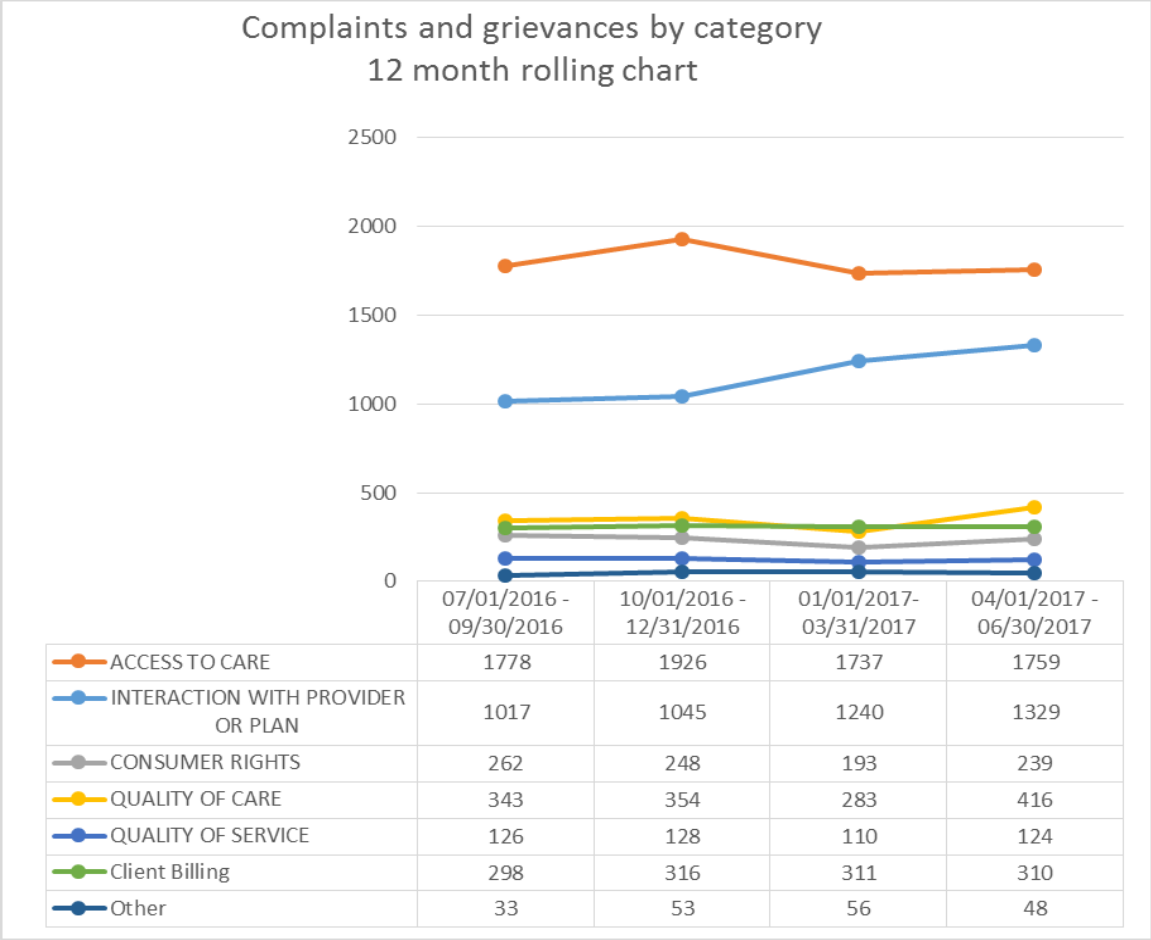
Access to Care and Interaction with Provider or Plan categories showed modest increases while the Billing Issues categories remained steady. The Quality of Care category showed an increase in subcategories related to provider care and medication management.

[1]The rate per 1000 members is based on an average of the monthly member enrollment totals for all 16 coordinated care organizations (CCOs) during the reporting period.



	04/01/2017 - 06/30/2017
ACCESS TO CARE	1759
INTERACTION WITH PROVIDER OR PLAN	1329
CONSUMER RIGHTS	239
QUALITY OF CARE	416
QUALITY OF SERVICE	124
Client Billing Issues	310
Other	48





	07/01/2016 - 09/30/2016	10/01/2016 - 12/31/2016	01/01/2017- 03/31/2017	04/01/2017 - 06/30/2017
ACCESS TO CARE	1778	1926	1737	1759
INTERACTION WITH PROVIDER OR PLAN	1017	1045	1240	1329
CONSUMER RIGHTS	262	248	193	239
QUALITY OF CARE	343	354	283	416
QUALITY OF SERVICE	126	128	110	124
Client Billing	298	316	311	310
Other	33	53	56	48

Interventions

Some CCOs report they are hiring additional key staff and working closely with their sub-delegates, providing additional training, and assisting in working through issues that might lead to complaints. OHA staff continue to work on improving the reporting process, focusing specifically on improving how data is collected and reported to OHA.

Table 2.1 – Appeals and hearings – statewide report – all categories of CCO appeals and contested case hearings for the current reporting period

The following table lists the total number of Notices of Action (NOAs) issued by CCOs for the State fiscal year by NOA reason, followed by the total number of appeals and contested case hearings requested in response to these NOAs and the range reported across all CCOs.

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
a) Denial or limited authorization of a requested service.	36,979	1,267	12-218
b) Single PHP service area, denial to obtain services outside the PHP panel	191	5	0-2
c) Termination, suspension or reduction of previously authorized covered services	380	37	0-25
d) Failure to act within the timeframes provided in § 438.408(b)	13	0	---
e) Failure to provide services in a timely manner, as	1	0	---

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
defined by the State			
f) Denial of payment, at the time of any action affecting the claim.	33,855	486	0-218
Total	**71,419**	**1,795**	**12-463**
Number per 1000 members	**81.02**	**2.03**	**1.08-4.10**
Number overturned at plan level		**540**	**2-87**
Appeal decisions pending		**35**	**0-12**
Number of contested case hearings requested		**648**	**4-157**
Overturned prior to hearing		**194**	**0-45**
Overturn rate		**29.94%**	**0-48.91%**
Hearing decisions pending		**0**	**---**
Hearing requests per 1000 members		**0.73**	**0.30-1.24**

Contested case hearings

The following table[2] represents contested case hearings that were processed during this demonstration year.

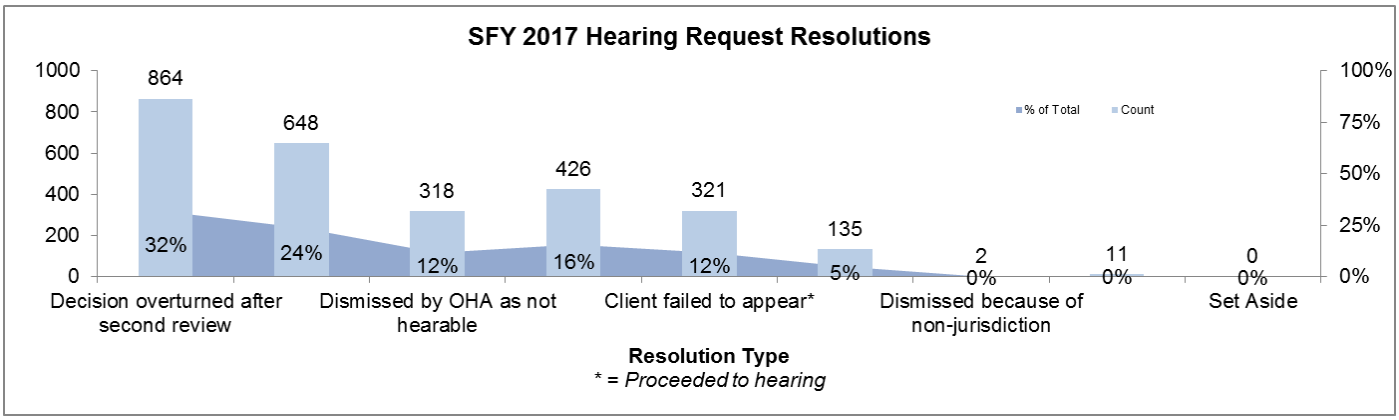
Plan Name	Total requests received	Average plan enrollment *	Per 1000 members
ALLCARE HEALTH PLAN, INC.	111	66402	1.6716
CASCADE HEALTH ALLIANCE	55	22461	2.4487
COLUMBIA PACIFIC CCO, LLC	58	33363	1.7385
EASTERN OREGON CCO, LLC	66	64322	1.0261
FAMILYCARE, CCO	396	175947	2.2507
HEALTH SHARE of Oregon	529	288660	1.8326
INTERCOMMUNITY HEALTH NETWORK	102	72246	1.4118
JACKSON CARE CONNECT	65	39444	1.6479
PACIFICSOURCE COMM. SOLUTIONS	207	68003	3.0440
PACIFICSOURCE COMM. SOLUTIONS - Gorge	28	16586	1.6882
PRIMARYHEALTH JOSEPHINE CO CCO	25	15256	1.6387
TRILLIUM COMM. HEALTH PLAN	249	117885	2.1122
UMPQUA HEALTH ALLIANCE, DCIPA	147	35502	4.1406
WESTERN OREGON ADVANCED HEALTH	87	26505	3.2824
WILLAMETTE VALLEY COMM. HEALTH	436	125976	3.4610
YAMHILL CO CARE ORGANIZATION	49	33097	1.4805
ACCESS DENTAL PLAN, LLC		4140	0.0000
ADVANTAGE DENTAL	12	40283	0.2979
CAPITOL DENTAL CARE INC		26503	0.0000
CARE OREGON DENTAL		4273	0.0000
FAMILY DENTAL CARE	1	4245	0.2356
MANAGED DENTAL CARE OF OR		4251	0.0000
ODS COMMUNITY HEALTH INC	3	13062	0.2297
FFS	104	790721	0.1315
Total	**2,730**	**2,089,558**	**1.3065**

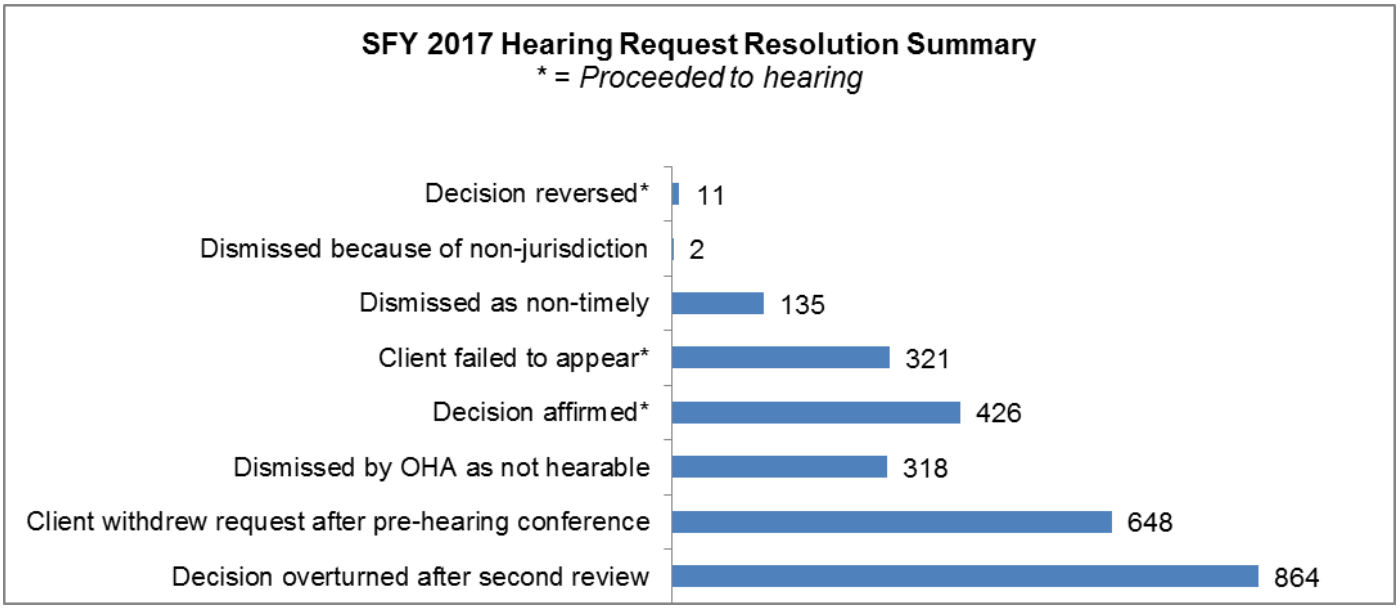
[2] Data Source: New_HearingLog.mdb; Data Extraction Date: 08/16/2017

The following chart shows outcomes of the hearings completed this demonstration year.

Outcome	Count	% of Total
Decision overturned after second review	864	32%
Client withdrew request after pre-hearing conference	648	24%
Dismissed by OHA as not hearable	318	12%
Decision affirmed*	426	16%
Client failed to appear*	321	12%
Dismissed as non-timely	135	5%
Dismissed because of non-jurisdiction	2	0%
Decision reversed*	11	0%
Set Aside	0	0%
Total outcomes	**2725**	

Trends[3]





[3] Data Source: New_HearingLog.mdb & DSSURS; Data Extraction Date: 08/16/2017

Interventions

No report at this time

D. Implementation of 1% withhold

Health Systems Division analyzed encounter data received for completeness and accuracy for the subject months of July 2016 through June 2017. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

Future reports may contain the following information:

Table 3 – Summary

Metric	Frequency	
	Quarterly	Annually
Actual amount paid of monthly PMPM capitation rate broken out by: ■ Average/mean PMPM ■ Eligibility group ■ Admin component ■ Health services component For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy)	X	X
Actual amount paid in incentives monthly broken out by: ■ Total by CCO ■ Average/mean PMPM incentive ■ The over/under 100% of capitation rate by CCO and by average enrollee PMPM	X	X
Best accounting of the flexible services provided broken out by: ■ Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers) ■ Services that are not reflected in encounter data (e.g., air-conditioners, sneakers)	X	X
CCO sub-contractual payment arrangements – narrative ■ Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network		X
Encounter data analysis ■ Spending in top 25 services by eligibility group and by CCO ■ To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well	X	X

E. Statewide workforce development

Traditional Health Workers

The Traditional Health Worker (THW) program works to promote the roles, engagements, and utilization of the traditional health workforce, which includes Community Health Workers, Peer Wellness Specialists, Patient Health Navigators, Peer Support Specialists, and Doulas. Traditional Health Workers are uniquely positioned to work with communities to identify and address the underlying causes of health problems. The THW program helps THWs in Oregon become trained and certified to meet current standards.

Early 2017, the Office of Equity and Inclusion (OEI) held a two-day strategic planning retreat for the Traditional Health Worker Commission. This was the first time since the THW Commission was established in 2013 that commission members had the opportunity to come together for two full days and engage in facilitated strategic planning sessions to explore and achieve the following overarching issues facing the commission:

- Establishing group agreements
- Creating mission and vision statements
- THW Commission structure
- Environmental scan with SWOT analysis
- Core priorities and goals

The retreat format was designed to stimulate dialogue and teamwork among the commission members. Spirited and thoughtful conversations considered the many ideas, interests, and issues and offered practical solutions to challenging issues. There was clear consensus among the participants that the commission needs additional organizational capacity and continued strategic planning. The group articulated many challenges and opportunities as well as ideas for working with each other.

The THW Commission members came to a consensus on the five areas they would like to focus on in the next three to five years. Participants explored variations of strategies and issues associated with each. The following are the five strategic priorities that the participants identified as the most important to achieve in the next three to five years:

- Improve communication, brand awareness, messaging, registry, technology.
- Expand and improve education, community engagement, system engagement, and workforce engagement.
- Invest in/launch research and data collaborations.
- Improve internal processes (meetings, recruitment or board members, diversity, inclusion, commitment, sustainability).
- Launch environmental awareness and collaboration.

Based on the outcomes of the strategic retreat, the THW Commission has set up new work groups in addition to the two existing subcommittees: Systems Integration Subcommittee and Training Evaluations Metrics and Program Scoring Subcommittee. These are:

- Environmental Awareness Workgroup
- System Outreach & Education
- Payment Model Workgroup

Table 4 - Traditional Health Workers (THW)

THW Program	Total number certified statewide		Number of approved training programs	
	Current Qtr.	Cumulative	Current Qtr.	Cumulative
Community Health Workers (CHW)	24	500	0	8
Personal Health Navigators (PHN)	0	6	0	0
Peer wellness Specialists	2	47	0	5
Other THW (Doulas)	4	41	0	1
Peer Support Specialists	186	1524	1	25
TOTAL	216	2118	1	39

New Developments from April to June, 2017

Effective October 1, 2017, all Traditional Health Workers will be required to take basic oral health training in order to be certified (new and renewal). OEI has consulted with the Oregon Oral Health Coalition which culminated into a "train the trainer" session on Oral Health for Traditional Health Workers. This training will be compliant with the new state standards regarding training on oral health and rolled out across Oregon. This workshop is offered by the Oregon Oral Health Coalition in partnership with the Community Capacitation Center of the Multnomah County Health Department. THW training programs that attend the "train the trainer" session will be able to use the Oral Health module in their own training program at no cost.

In the process of development and approval are three new training programs (one has been approved) that are targeted to serve rural areas of the state, including a tribal training program that is tailored to provide family peer support specialist training to the nine tribes in Oregon.

A series of presentations by CCOs for the THW Commission has been organized. Health Share Oregon, FamilyCare, and AllCare made presentations focusing on the various forms and options for integrating traditional health workers as part of the CCO workforce.

OEI has provided three mini grants to two community-based organizations representing community health workers and doulas for conducting community-based participatory project providing statewide needs assessment on the two workforce.

OEI staff and the THW Commission have developed presentations for other divisions within OHA focusing to provide technical assistance on best practices and the most effective way of integrating THWs in health care systems.

The THW Commission has adopted two resolutions, effective October 1, 2017, that affect training programs for THWs:

- The completion of one training cannot be used for multiple certifications. The training needs to be supplemented with course time that meets the need for each of the specific certifications.
- Approved training programs will provide successful graduates with either a certificate of participation or a certificate of completion. Only the certificate of completion may be used for acceptance to the State certification in order to be placed on the state registry. A certificate of participation denotes that the person does not meet the course requirement for graduation, either because of lack of prerequisites (e.g. lived experience) or less than requisite attendance or performance in class.

Health professional graduates participating in Medicaid

The statewide results from the professional graduates participating in Medicaid report from OHSU are below. Oregon had a total of 330 health professional graduates, 73 (22%) of which are currently Medicaid-enrolled.

- 330 Health Professional Graduates
  - 69 Dentists
  - 156 Physicians
  - 7 Adult Acute Care Nurse Practitioners
  - 15 Family Nurse Practitioners
  - 11 Nurse Anesthetists
  - 12 Nurse Midwives
  - 7 Pediatric Nurse Practitioners
  - 11 Physical and Mental Health Nurse Practitioners
  - 42 Physician Assistants
- 73 Oregon Medicaid-enrolled Health Professional Graduates

F. Table 5- Significant CCO/MCO network changes during current period

Approval and contracting with new plans	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No significant changes	-	-	-	-

Changes in CCO/MCO networks	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No significant changes	-	-	-	-

Rate certifications	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Contracts for all seven DCOs and one MHO had a rate amendment on July 1, 2016	-	-	-	-

Enrollment/disenrollment	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No significant changes	-	-	-	-

CCO/MCO contract compliance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No significant changes	-	-	-	-

Relevant financial performance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No significant changes	-	-	-	-

Other	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No significant changes	-	-	-	-

G. Transformation Center

Patient-Centered Primary Care Home program

The **Patient-Centered Primary Care Home (PCPCH) program** continued supporting clinics offering high-quality, patient-centered care.

- **Recognition and verification** – Revised PCPCH recognition criteria were implemented in January 2017. By the end of June 2017, 604 clinics were recognized under the revised standards. So far 14 clinics have achieved 5 STAR designation, which requires a site visit for verification. The team plans to complete over 50 site visits to 5 STAR designation applicants in 2017.
- **Clinician Academy** – The Patient-Centered Primary Care Institute (PCPCI), under contract with OHA, held an 8-week networking and training program to advance clinicians' roles as community advocates and leaders. Seven clinicians completed the program.

Behavioral Health Integration

This year, the Transformation Center supported several behavioral health integration initiatives:

- **Behavioral health integration resource library –** The Patient-Centered Primary Care Institute (PCPCI) created a behavioral health integration resource library, which includes five virtual site-visit videos, 12 content expert videos and over 150 additional online resources.
- **Behavioral health integration technical assistance** – Each CCO was offered 40 hours of targeted technical assistance for behavioral health integration. Fourteen CCOs made 29 requests, and 23 projects were completed. Project topics included value-based payment, trauma-informed care, integrated pediatrics, and provider roles in an integrated practice.
- **Project ECHO (Extension for Community Healthcare Outcomes)** – Project ECHO is an evidence-based tele-mentoring program that uses videoconferencing to connect primary care providers with specialty providers. Implementation this year included the following:
    - Oregon Health and Science University (OHSU) held a Transformation Center-funded child psychiatry Project ECHO for 28 primary care providers at 17 clinics – most of them in rural areas. Each week for eight months, participants connected to a live session that included lectures and case reviews with child psychiatrists, pediatricians and a pharmacist. Topics included psychiatric assessment, psychotropic prescribing, anxiety and depression, marijuana, suicide, helping overwhelmed parents, and referrals. Providers reported increased comfort treating depression, anxiety, Attention Deficit with Hyperactivity Disorder (ADHD), learning challenges, and substance use.
    - The Oregon Rural Practice-based Research Network (ORPRN), in partnership with CareOregon, completed a five-week Project ECHO on team-based care strategies to enhance behavioral health integration into primary care. Twelve practices and 30 clinicians and administrative staff participated. Topics included effective teams, roles and goals, financial sustainability, and chronic pain management in primary care.

- ORPRN completed a business and financial sustainability plan for a Project ECHO Oregon Hub. Under the plan, subscribing organizations would share costs and hold a seat on the hub's governing board.

- **Sustaining Integrated Care for Persons with Serious Behavioral Health Conditions –** The Transformation Center partnered with the PCPCI to convene an event to identify and spread best practices for integrating physical and behavioral health services for persons with serious mental illnesses and substance use disorders. The event brought together 124 representatives of physical health, behavioral health and payers. Evaluation respondents said the most helpful aspects were networking and discussing funding and metrics.
- **Behavioral Health Collaborative Governance and Finance Committee** – The Behavioral Health Collaborative Governance and Finance Committee convened to develop recommendations and action plans for the Oregon Health Policy Board to implement the Behavioral Health Collaborative's recommendations related to a single point of shared accountability and payment.

Population Health

Community advisory council support

The Transformation Center continues to provide targeted supports to CCO community advisory councils (CACs) for CAC member recruitment and engagement through the following resources:

- **Member engagement webinars** for all CAC members on shared decision-making, meetings that work, and how to manage conflict in meetings
- **Outreach materials and a best-practices document** for recruiting and engaging Oregon Health Plan members to CACs
- **Annual CAC leader meeting** for CAC leaders to focus on CAC member recruitment and engagement

The Transformation Center also engaged CAC members in six listening sessions convened by the Oregon Health Policy Board to gather input from key stakeholders about coordinated care through Oregon's CCOs. This input helped shape recommendations for a report to the Legislature.

Community health improvement plan implementation grants

The Transformation Center awarded Community Health Improvement Plan Implementation grants to all 16 CCOs. Each CCO received up to $30,000 to implement strategies identified in their community health improvement plans. Activities included partnership with local public health, chronic disease self-management, diabetes prevention, tobacco treatment specialist training, trauma-informed care training, motivational interviewing training, health and early learning program expansions, and member education through social marketing.

Community health assessment and improvement plan curriculum

The Transformation Center contracted with consultants to develop a curriculum for a training on community health assessment and community health improvement plan development. The focus is on collaboration among CCOs, local public health authorities and hospitals.

Health Equity

The Transformation Center, in collaboration with the OHA Office of Equity and Inclusion, provided each CCO a health equity consultation with Ignatius Bau, a national health equity expert. Consultations focused

on the CCOs' transformation plans, community health improvement plans and incentive measures. Ten hours of follow-up technical assistance was available to each CCO, and ten CCOs requested this support. Bau summarized the lessons learned in a presentation, webinar, and final report.

Clinical Delivery Support

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The Transformation Center facilitated six statewide CCO learning collaborative sessions this year. Topics included a review of the 2016 CCO incentive metrics, childhood immunizations, emergency department information exchange, applied behavior analysis, trauma-informed care, and opioids.

Council of Clinical Innovators: Clinical Innovation Fellows

The third cohort graduated from the Clinical Innovation Fellows program. This year-long learning experience aims to build the capacity of innovation leaders to implement health system transformation (HST) projects in their communities and create a network of expertise supporting Oregon's HST efforts. The 12 fellows included doctors, nurses, public health professionals, a social worker, a pharmacist, and a paramedic. Learn more about the Clinical Innovation Fellows and their projects on OHA's Transformation Center – Council of Clinical Innovators website.

Clinician vitality technical assistance

The Transformation Center, in partnership with the Patient-Centered Primary Care Institute (PCPCI), launched an online clinician and organizational vitality resource library. Over 40 resources are now posted on PCPCI's Resources – Clinician and Organizational Vitality website, including two new webinars on clinician wellness and mindfulness training.

Value-based Payment Methodology Support

- **Value-based payment technical assistance –** The Transformation Center provided support to six CCOs to develop value-based payments (VBPs). Examples of CCO projects include developing VBP options for an integrated maternal health and substance use disorder project, and developing appropriate cost parameters to estimate per-member-per-month costs for primary care practices and analyzing cost savings for primary care clinics implementing high-impact initiatives.
- **Comprehensive Primary Care Plus –** The Transformation Center supported the federal Comprehensive Primary Care Plus (CPC+) application for the Medicaid fee-for-service population and began supporting implementation once Oregon was selected as a CPC+ region.
- **Primary Care Payment Reform Collaborative –** The Primary Care Payment Reform Collaborative required through Senate Bill 231 met seven times and finalized recommendations to the Oregon Health Policy Board to support sustainable primary care payment reform. The recommendations were considered as part of the legislative development process for Senate Bill 934. The collaborative will continue to be a forum for sharing and aligning primary care payment reform across Oregon.
- **Behavioral health integration value-based payment grants –** Two payers advanced VBPs for integrated care through grants from the Transformation Center. One payer integrated VBPs across its Medicaid, Medicare and commercial plans and will implement the payment models across provider networks starting in at least two practices in 2017. The other payer developed a sustainable VBP

model to support behavioral and physical health integration that is capable of cross-regional and bi-directional implementation.

Incentive Metrics Technical Assistance

Innovation Café: Improving Key Health Metrics

The Innovation Café brought together 213 Oregon HST champions for peer-to-peer learning and networking. CCO, clinic, and other innovative health system leaders presented 30 projects and discussed learning focused on three CCO incentive metrics:

- Increasing effective contraceptive use to reduce unintended pregnancy
- Reducing tobacco prevalence
- Reducing emergency department use with a focus on behavioral health

Targeted technical assistance for CCO incentive metrics

- **Childhood immunization** – A pilot root-cause analysis was completed with one CCO, and resulting interventions increased that CCO's childhood immunization rate by 14 percentage points between 2015 and 2016. Five additional CCOs completed immunization projects with consultants during the 2016-2017 fiscal year.
- **Colorectal cancer screening** – Consultants provided targeted technical assistance for colorectal cancer screening by facilitating five webinars for all CCOs and providing follow-up consultations with 10 CCOs. Fifteen CCOs participated in at least one webinar.
- **Adolescent well-care visits**
    - The Oregon Pediatric Improvement Partnership completed a series of 10 webinars on improving adolescent well-care visits. Fourteen CCOs participated in at least one webinar.
    - The Oregon School-Based Health Alliance and Statewide Youth Action Council held three in-person, youth-led, Eye-to-Eye trainings focused on youth-centered care and improving health care providers' ability to communicate with teens. Sixty-nine CCO staff and providers participated.
    - The Transformation Center convened three meetings with the Oregon School Activities Association, Oregon Public Health Division, and CCO staff to align efforts to improve adolescent health. The group created a comparison of the adolescent well-care visit and sports physical to improve provider knowledge and move toward more comprehensive services.
- **Smoking cessation –** The Transformation Center contracted with consultants to address CCOs' needs for provider-level training on tobacco cessation counseling and CCO-level quality improvement. The following activities were completed this year:
    - Two in-person Rx for Change tobacco cessation train-the-trainer sessions for CCOs and clinics, along with a follow-up webinar
    - Resource document of leading tobacco cessation resources for health care systems, CCOs, health care providers, and clinic staff
    - Resource document of culturally specific tobacco cessation resources
- **Effective contraceptive use**
    - The Transformation Center began a 10-webinar series for clinics and CCOs working to increase effective contraceptive use and improve contraception care. Topics included clinic-

level strategies, managing long-acting reversible contraceptives, health literacy in family planning, and understanding marginalized populations.
    - A consultant developed messaging around immediate postpartum, long-acting reversible contraceptive use and tested the messages with focus groups.
- **Emergency department use for people with mental illness –** The Transformation Center held two needs assessment calls with CCOs to identify technical assistance opportunities for this new 2018 metric.

Oral health integration

The Transformation Center contracted to develop an **oral health communications toolkit** to increase Oregon Health Plan members' awareness of their dental benefits and the importance of preventive dental care. Messages were tested with members in English and Spanish.

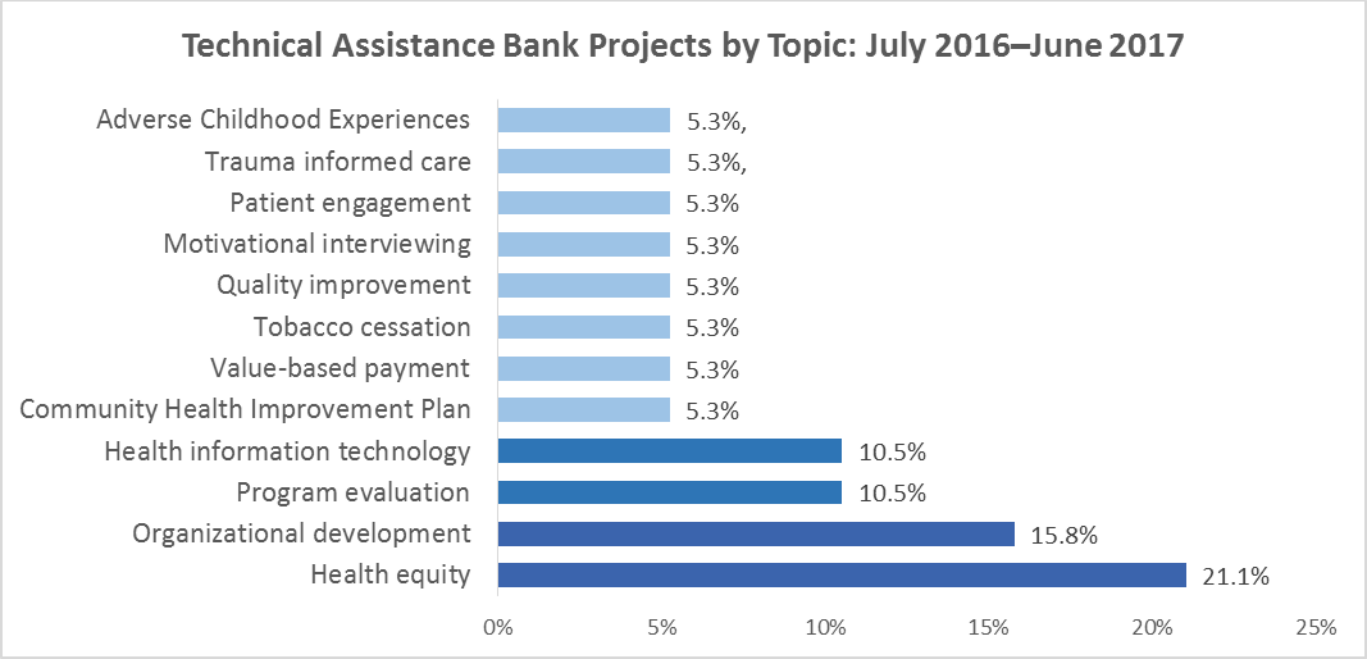
A consultant conducted an **environmental scan of local and national oral health integration efforts** and interviews with state staff and partners to assess current transformation efforts. The resulting white paper includes recommendations for strategic approaches for further integration.

Transformation Center CCO Technical Assistance Bank

The Transformation Center offered CCOs and their CACs the opportunity to receive technical assistance in key areas to help foster HST. This includes projects with consultants on contract with the Transformation Center, in addition to support and technical assistance provided by various parts of OHA. Each CCO could access up to 60 hours between October 2015 and April 2017.

By June 30, 2017, the Transformation Center had received 62 requests from 16 CCOs, for a total of 906 anticipated hours. Many of these requests focused on organizational development, primarily for community advisory councils, including supporting their development of CCOs' community health assessments and community health improvement plans. Other requests have focused on health equity, member engagement, evaluation, value-based payment, and health information technology. The vast majority (97%) of CCOs who responded rated the assistance as very valuable (77%) or valuable (20%), and 97% of CCOs rated the assistance as very effective (65%) or effective (32%) in meeting their project goals.

Technical Assistance Bank projects by topic during this reporting year (14 projects, each project with up to three identified focus areas):



More information about the Technical Assistance Bank is available at transformationcenter.org/tabank.

Table 6 - Innovator Agents – Summary of promising practices

Innovator Agent learning experiences

Summary of activities	During the demonstration year innovator agents have received updates and participated in training as follows. ■ Public Health Modernization training ■ Community and Public Health partners collaboration to identify systems level focus areas as related to modernization legislation ■ Informational meetings in Blue Zones communities – Blue Zones is part of the Oregon Healthiest State initiative and encourages changes in communities to make them healthier places to live. ■ Opioid reduction continued education ■ Trauma-informed care continued education ■ Bridges Out of Poverty – Ongoing Training for Central Oregon community advisory council (CAC) members presented by Central Oregon Health Council ■ Eye-to-Eye - Improving the Adolescent Well Check Metric – Sponsored by Oregon School-Based Health Alliance and the Statewide Youth Action Council ■ NEAR (neuroscience, epigenetics, ACES and resiliency) three-part training by ACE interface as part of ongoing investment into Trauma-Informed Care – presented through the collaboration of three CCOs, Jackson Care Connect, AllCare and Primary Health of Josephine County ■ The Oregon Rural Health Conference provided information about efforts to improve rural supports for clinical care including recruitment mechanisms, community engagement and hospitals, FQHCs, and CCOs

	collaboration – sponsored by Oregon Health Sciences University. ■ The Transformation Center hosted a CAC event in April with a focus on recruitment and retention activities for CACs. ■ The Transformation Center's Innovation Café in May provided ongoing metrics learning and a presentation with PrimaryHealth staff on the One Key Question work in Southern Oregon. ■ June's Southern Oregon Success (SORS) Key Leaders meeting facilitated conversations related to ongoing work in the community for improving health and education outcomes. ■ American Public Health Association online meetings ■ Project ECHO Opioid program through University of Washington ■ Health Information Exchange (HIE) Onboarding Program ■ Public Health Issue Forum (OHSU) focused on gun violence ■ Preconception webinar focused on efforts to improving birth outcomes and reducing unintended pregnancies in Jackson and Josephine Counties ■ Tobacco Cessation Clinical Workflow webinar – helping CCOs and clinics reduce tobacco use prevalence and to explore team based approaches within clinics that can improve cessation outcomes ■ Contraception self-assessment webinar – highlighting a tool for providing high quality services through an assessment designed to define and encourage the adoption of standards for both primary care and family planning ■ Transforming Behavioral Health Care in Oregon through the Information Technology Forum – eHealth collaborative with OHA in the advancement of behavioral health information exchange ■ Multiple Health Evidence Review Commission (HERC) updates
Ongoing/future opportunities	■ Continued engagement in health equity work as a social determinant of health ■ Continued work with CCOs and Public Health partners on modernization opportunities ■ Continued engagement in trauma-informed care
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Learning collaborative activities

Summary of activities	No report at this time
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Assisting and supporting CCOs with Transformation Plans

Summary of activities	During the demonstration year innovator agents performed the following activities to assist and support CCOs with Transformation Plans. ■ Attended CCOs' internal quality committees and provided support and feedback for ongoing efforts to improve quality incentive metrics, the statewide performance improvement projects (PIPs), other PIPs, and Children's Health Insurance Program (CHIP) efforts ■ Attended Quality and Health Outcomes Committee (QHOC) as permissible to relay important information and materials to CCO staff ■ Monitored Metrics and Scoring Committee and Metrics Technical Advisory Group Meeting to assure all CCOs are represented and aware of metrics being considered for the future ■ Participated in local Regional Health Equity Coalitions and provided support for CCOs ■ Participated in local Early Learning Hubs to provide OHA perspective and support to CCOs ■ Provided technical assistance and feedback and fielded questions regarding alignment of the Children's Health Alliance (CHA), CHIP and the Transformation Plan ■ Participated in ongoing meetings with Population Health Teams and Grants Management to further assess Transformation Plan activities and better link them to other initiatives ■ Participated in CCOs' Internal Quality Committees that focus on strategy and implementation of efforts to improve quality incentive metrics, the statewide PIP and other PIPs, as well as CHIP efforts ■ Attended and participated in CCO health councils to review CHA, CHIP, Quality Incentive Metrics and Transformation Plan activities
Ongoing/future opportunities	Innovator agents continue to perform the following activities in an effort to assist and support CCOs with Transformation Plans. ■ Assist CCOs and CAC as they implement the new Transformation and Quality Strategy report ■ Provide ongoing support to CCOs to ensure appropriate submission timelines and continual improvement in quality assurance measures
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Assist CCOs with target areas of local focus for improvement

Summary of activities	During the demonstration year innovator agents performed the following activities to assist CCOs with target areas of local focus for improvement. ■ Connected CCO staff with Regional Outreach Coordinators (ROCs) to discuss best opportunities for members who have a lapse in coverage, or

	have demographic changes needed ■ Engaged CCOs and community partners in ongoing discussion of housing needs in Oregon communities ■ Coordinated efforts between CCOs and community partners, such as Public Health, Child Welfare, and senior services, regarding overcoming barriers and development of solutions ■ Provided research for proper understanding of metrics and exceptions ■ Participated in Regional Early Learning Hub meetings and activities ■ Assisted with planning for improvement in Transformation Plan and CHIP reporting internally within CCOs and to OHA ■ Attended and provided guidance for Ombudsman Council and Disability Services Advisory Council (DSAC) meetings relevant to non-emergency medical transportation (NEMT) ■ Attended and presented to the Multnomah County's Healthy Birth Initiative staff on and working with OHA and CCOs ■ Assisted in connecting Sacred Roots Community Doula Program with areas across the state – the program is a combined effort of FamilyCare and the Black Parent Initiative to impact healthy birth outcomes, and it allows for a doula program that focuses on culturally specific care. ■ Assisted with Regional Social Determinants of Health Proposal and workgroup regarding Pathways Model (Tri County Region; Project Access Now) ■ Continued collaboration with Child Welfare to develop improved service alignment and identification of foster children across the state – efforts include development of best practices and providing tools to CCOs and DHS offices throughout the state ■ Collaborated with OHA's Home CCO Enrollment team to develop supportive memorandum of understanding (MOU) language that ensures quicker access and immediate services for children requiring Behavior Rehabilitation Services (BRS)
Ongoing/future opportunities	Innovator agents continue to perform the following activities in an ongoing effort to assist CCOs with target areas for improvement. ■ Continued research and discussions related to housing needs and program development ■ Continued CCO staff engagement with ROCs ■ Integrated eligibility assistance as needed
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Communications with OHA

Summary of activities	Innovator Agents:

	■ Worked with Transformation Center staff to update the CHIP reporting document as required by the legislature for all CCOs ■ Participated in bi-monthly calls with OHA staff related to legislation, training, and contractual requirements ■ Worked with Transformation Center staff on engagement of CCO and CAC partners in upcoming webinars, trainings, and opportunities ■ Worked with staff from OHA and CCOs to encourage the collection and submission of member stories to 95percentcovered.com ■ Responded to questions about community related issues and service related changes ■ Supported Early Learning Hub and CCO related stories and efforts for the state-wide report ■ Maintained contact with CCO account representatives to resolve individual member issues
Ongoing/future opportunities	Innovator agents continue to provide ongoing communication and assistance between OHA and the CCOs to promote collaboration.
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Communications among Innovator Agents

Summary of activities	■ Established communication between different CCOs for learning and sharing opportunities ■ Weekly phone calls, monthly in-person meetings, and other communication as needed through phone calls and e-mails to assure updated information
Ongoing/future opportunities	■ Continuous sharing of OHA information/news ■ Continuous sharing of public OHA communications to ensure delivery to CCOs
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Community advisory council activities

Summary of activities	■ Attended CAC meetings and provided OHA updates and answered questions ■ Provided support and consultation for CHIP activities ■ Provided support to CAC in recruitment and retention of CAC members ■ Participated in and provide consultation to specific CAC workgroups ■ Connected CAC with OHA's Transformation Center for technical assistance

	■ Assisted members with obtaining ongoing training through the Transformation Center
Ongoing/future opportunities	■ Continued support in recruitment and retention of diverse CAC members ■ Assistance with further development of CHIPs and CHAs
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Rapid-cycle stakeholder feedback (to identify and solve barriers; assist with adapting innovations; simplify and/or improve rate of adoption; and increase stakeholder engagement)

Summary of activities	■ Participated in Collaborative Community Partner weekly webinars to address eligibility issues ■ Provided assistance to CCOs with policy concerns or questions
Ongoing/future opportunities	Innovator agents continue to promote collaboration between CCOs and OHA to resolve individual member issues around enrollment and eligibility.
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Database implementation (tracking of CCO questions, issues and resolutions to identify systemic issues)

Summary of activities	No report at this time
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Information sharing with public

Summary of activities	■ Provided legislative updates to CACs and community groups as requested ■ Identified concerns within communities and provided updates as needed ■ Participated in community collaborative meetings where ONE assisters discussed system issues and specific community related projects ■ Facilitated community meetings that addressed member and population health and are developing community health assessments ■ Worked with stakeholders involved in health equity, school health and high school graduation focus areas to improve systems and make connections for community and CCO resources ■ Worked on NEMT issues, both internally and with CCO partners, including the office of the Ombudsperson, who has been actively seeking feedback from both fee-for-service and CCO members

	■ Assisted OHA in developing a white paper with recommendations for sharing best practices and addressing complaints through a potential webinar in coordination with the Transformation Center ■ Addressed enrollment/eligibility questions as needed
Ongoing/future opportunities	No report at this time
Promising practices identified	No report at this time
Participating CCOs	16
Participating IAs	9

Table 7 - Innovator Agents – Measures of effectiveness

No data for this period

Other evaluation results from the Transformation Center can be found in Section V, Table 9.

H. Legislative activities

The 2017 Session of the Oregon Legislative Assembly adjourned sine die on July 7, 2017 and many important bills passed in the waning days of the fiscal year. Most importantly, looming budget holes for Oregon's Medicaid program, the Oregon Health Plan (OHP) were filled, securing funding for the 2017-2019 biennium.

House Bill 2391, which received final Senate approval on June 21st, provided the mechanism for filling the $900+ million projected budget shortfall for OHP. The majority of funds will be raised through various assessments on insurers, managed care organizations and hospitals. These funds were included and accounted for in OHA's budget (HB 5026).

Other 2017 legislation impacting Oregon's Medicaid program included:

- HB 5006 – Allocated $10 million to OHA to assist providing coverage of Hepatitis C treatments at Stage 2 and $10,000 for system updates necessary to facilitate the enrollment of foster children into CCOs
- HB 2015 – Provides for review of doula reimbursement rates and a development on a report of the status of doulas in the state
- HB 2300 – Establishes the Mental Health Clinical Advisory Group in OHA to develop evidence-based algorithms for prescription drug treatment of mental health disorders in medical assistance recipients
- HB 2675 – Requires community health improvement plans adopted by CCOs and community advisory councils to focus on and develop a strategy for integrating physical, behavioral and oral health care services
- HB 2882 – Requires the governing body of each CCO to include a representative from at least one dental care organization that serves members enrolled in the CCO
- SB 934 – Prohibits CCOs from spending less than 12 percent of the global budget on primary care and community health
- SB 558 – Extends OHP-like coverage to all Oregon children regardless of immigration status. Coverage will be funded through State General Fund (GF) dollars only.

I. Litigation status

No report at this time

J. Two-percent trend data

The state reports quarterly on its progress of reducing the per capita expenditure growth trend. For state fiscal year (SFY) 2017, the state limits the per-member-per-month (PMPM) growth to 3.4 percent—two percentage points below the 5.4 percent trend assumed without health system transformation.

Oregon's quarterly reports demonstrate that the state's PMPM growth, which included $87 million in bonus payments for the CMS-approved Hospital Transformation Performance Program, remained within the parameters of the test for SFY 2017. Oregon completes the five-year demonstration meeting the requirements for the expenditure growth trend reduction test. Data are contained in Appendix C – Two-percent Trend Reduction Tracking.

K. DSHP terms and status

See Appendix D.

IV. Status of Corrective Action Plans (CAPs)

Table 8 – Status of CAPs

Entity (CCO or MCO)	Columbia Pacific CCO
Purpose and type of CAP	Ensure the children's fidelity wraparound requirements are being met
Start date of CAP	3/3/2016
Action sought	Get CCO in line with contract requirements (Exhibit B, part 2, sections m and n)
Progress during current period	CCO met all the requirements of their work plan in August 2016.
End date of CAP	9/30/2016
Comments	CCO is no longer being monitored for the issues identified in February 2016.

V. Evaluation activities and interim findings

In this demonstration year, independent evaluators delivered a report that assessed the implementation and impact of Oregon's Coordinated Care Model (CCM). Evaluators at Oregon Health & Science University's (OHSU) Center for Health Systems Effectiveness (CHSE) assessed the performance of the 2012-2017 1115 demonstration and how that performance compares to fee-for-service, a comparison state, and pre-post analysis for 70 outcome measures.

Also in this demonstration year OHA:

- Published Oregon's Health System Transformation (HST) CCO Metrics for 2016, which is an on-going report to provide comprehensive demographic information about Oregon Health Plan members at the CCO level, and an overall summary of performance across multiple measures using an "at-a-glance" display.
- Was selected by CMS as one of 14 regions to implement Comprehensive Primary Care Plus (CPC+) to encourage outcomes and provide financial incentives for health care providers when they meet performance measures. This work helped align payment methods with a focus on alternative payment methodologies, patient engagement and care coordination.
- Published an evaluation of the Patient-Centered Primary Care Home (PCPCH) program that examined utilization and expenditure patterns of patients who receive their care at a PCPCH versus a non-PCPCH. Results indicated the PCPCH program had been successful at meeting goals of cost-effectiveness, and OHA's system-wide triple aim of better health, better care and lower costs.
- Completed work on the State Innovation Model (SIM) grant to study the impact of implementing the Coordinated Care Model. Final metrics were reported on performance for such measures as: the percentage of hospitals on Emergency Department Information Exchange (EDIE) and the number of hospitals that received an EHR incentive payment indicating health care transformation.

While there is still work to be done in health care integration, the number of hospital emergency departments exchanging information with primary care providers has reached 100%.

Table 9 - Evaluation activities and interim findings

In the narrative below, relevant OHA and CCO activities to date are reported by the "levers" for transformation identified in the waiver agreement and Accountability Plan.

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes (PCPCH)

Evaluation activities:

In this demonstration year, the PCPCH program conducted an in-depth evaluation looking at utilization and expenditure patterns of patients who receive their care at PCPCH compared to non-PCPCH clinics. Findings showed that the PCPCH program was effective at meeting the goals of the Triple Aim: better health for patients, better health care and lowered health care costs.

Interim findings:

- The number of recognized PCPCH clinics in the state increased from 589 in quarter two, 2015, to 647 in quarter four, 2016. This surpasses Oregon's goal of 500 clinics by 2015 and represents 60% of the estimated number of primary care clinics in Oregon.
- PCPCH enrollment is also a CCO incentive metric, and data shows that enrollment into PCPCH clinics has increased steadily. This shows that coordinated care organizations (CCOs) continue to increase the proportion of members enrolled in recognized PCPCHs. It is notable that CCOs have sustained the increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

Improvement activities:

Oregon's Patient-Centered Primary Care Institute (PCPCI) provides technical support and transformation resources to practices statewide, including learning collaborative opportunities. In this demonstration year, PCPCI closed out the 2015 contract, and executed a new contract for 2016, designed and piloted a regional primary care extension program, aligned resources, facilitated communication and coordinated collaboration among related initiatives, developed partnerships, and expanded its role as a resource hub. In late 2016 they had completed six webinars and published Briefings on Payment Reform and Population-Based Payment Models.

Additionally, the Oregon Health Care Quality Corporation (Q Corp) launched a new initiative called the Clinician Academy in 2016. This initiative paired residents and new providers with seasoned providers to work on community-based projects. The goal was to increase the network of providers with similar practical skill sets and mentors outside the clinic.

Lever 2: Implementing alternative payment methodologies (APMs) to focus on value and pay for improved outcomes

Evaluation activities:

Oregon's coordinated care organizations

OHA published Oregon's HST CCO Metrics 2016 Final Performance Report, and made its third annual quality pool payments to CCOs in June 2017.

Hospital Transformation Performance Program

The Hospital Transformation Performance Program (HTPP) continued its work with a technical advisory group, completed the HTPP program for the third year with CMS, including final benchmarks for year 3, and made its third quality pool payments to hospitals in June 2017. The program switched to a full calendar year of measurement beginning in January, 2017. A fourth and final measurement year is currently underway with dispersion of quality pool payments to occur in June 2018.

Federally Qualified Health Center Alternative Payment Methodology Program

Eight Federally Qualified Health Centers (FQHCs) participated in the FQCH Alternative Payment Methodology (APM) program, which provides an advanced payment and care model through per-member-per-month (PMPM) payments for each health center's attributed patient population, rather than the traditional fee-for-service encounter rates. This allows practitioners to engage their communities in more patient-centered health engagement strategies.

OHA tracks several metrics on a quarterly basis, including the Uniform Data System (UDS) measures, and a subset of CCO inventive measures to hold clinics accountable for the quality of care offered. Additionally, each FQHC submits a quarterly "touches" report, which tallies the total number of engagement touches, or non-billable alternative/enabling services occurring for their OHP patient populations. See the results below in interim findings.

Certified Community Behavioral Health Clinics

Oregon Health Authority

Oregon was selected as one of eight demonstration states to pilot the Certified Community Behavioral Health Clinic (CCBHC) program. The two-year demonstration went live in Spring, 2017. CCBHCs will be eligible to bill for allowable costs, identified as "demonstration services." OHA will continue to monitor compliance with state and federal standards, as well as provide ongoing technical assistance to CCBHCs as they move beyond the early phases of launch. OHA continues to work with the clinics to develop processes to collect and report metrics required by the federal government.

Interim findings:

Medicaid Transformation

In June 2017 OHA published two key reports on Medicaid Transformation.

- **Oregon's HST CCO Metrics 2016 final report** – This report contains comprehensive demographic information about Oregon Health Plan members at the CCO level, and it includes an overall summary of performance across multiple measures using an "at-a-glance" display. Findings from the report demonstrated that there have been continued improvements in a number of areas, including but not limited to, hospital readmissions, access to primary care for children and adolescents, rates of dental sealants, use of effective contraceptives, and PCPCH enrollment (see Appendix E). See OHA's Quality and Accountability – Oregon's Health System Transformation: Performance Metrics website for the full report.
- **Oregon's Hospital Transformation Performance Program (HTPP) Performance Report** – The HTTP Year 3 Performance Report details how hospitals are performing on 11 outcome metrics and compares the third year of the program to the second year. Findings from the report demonstrate that hospitals improved in follow-up after hospitalization for mental illness, sharing results with primary care providers after emergency department visit (EDIE) and screening, brief intervention, referral and treatment (SBIRT) in the emergency department (ED). The report also includes areas for improvement, which include, but are not limited to, central-line bloodstream infection rates and patient experiences reported through the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey (See Appendix E). See OHA's Office of Health Analytics website for the full report. Whereas the first three years of the HTPP spanned calendar years, the fourth year of measurement will represent one full calendar year in 2017.

CCO financial reports

During this demonstration year, an internal analysis showed that 37.6% of all plan payments were non-fee-for-service (FFS). This is a significant decrease of about 15% from previous reports, in which 52.8% of plan payments were non-FFS. However, in 2015, OHA held a Financial Reporting Workgroup meeting with CCOs to better standardize reporting and definitions. Since then, the percentage of non-FFS payments has hovered between 35.3% and 38%, indicating normal fluctuations and increased reliability. The revised Financial Reporting template seems an effective tool for future reporting into 2017.

Federally Qualified Health Center Alternative Payment Methodology Program

During this reporting period, the FQHC APM program found that engagement touches among the cohorts steadily increased. It is estimated that, as the program becomes more efficient and additional technical assistance is available for health centers, numbers will continue to improve.

Other evaluations occurring for the FQHC APM program in this demonstration year included monitoring clinical quality measures, estimating the value of engagement touches, measuring the total cost of care, and monitoring utilization trends. Clinical quality measures continue to maintain a consistent level, or improve significantly, demonstrating that detaching FQHC revenue from the office visit does not reduce quality.

Oregon contracted with actuarial consulting firm Optumas, who has authored two reports showing significant reductions in emergency department and inpatient utilization for Phase 1 FQHCs' patient populations. The study also showed a direct correlation between increased touches and reduced emergency department and inpatient hospital utilization.

Improvement activities:

Federally Qualified Health Center Alternative Payment Methodology Program
The Oregon Primary Care Association hosted a quarterly Advanced Payment & Care Model Learning Collaborative. The event focused on assisting health centers in aspects such as implementing clinical care teams, studying and understanding their patient populations, segmentation of the patient population, social determinants of health, as well as other technical components of the program. Additionally, OHA commissioned Optumas, an actuarial consulting firm, to produce another report on Phase 1, 2, and 3 FQHCs in the program and to include a Total Cost of Care measurement. This report will be completed later in 2017.

Transformation Center
This year the Transformation Center supported implementation of value-based payments (VBPs).

- **Comprehensive Primary Care Plus (CPC+)** – The Transformation Center supported the federal CPC+ application for the Medicaid fee-for-service population and began supporting implementation once Oregon was selected as a CPC+ region. CPC+ launched January 1, 2017, and since then a CPC+ webpage was created that includes resources for practices. Webinars were held in December and February for CPC+ practices to share information about CPC+ in Oregon, including the quality and utilization measures selected by OHA.
- **Value-based payment technical assistance** – The Transformation Center provided support to six CCOs to develop VBPs. Examples of CCO projects include developing VBP options for an integrated maternal health and substance use disorder project, and developing appropriate cost parameters to estimate per-member-per-month costs for primary care practices and analyzing cost savings for primary care clinics implementing high-impact initiatives.
- **Primary Care Payment Reform Collaborative** – The Primary Care Payment Reform Collaborative required through Senate Bill 231 met seven times and finalized recommendations to the Oregon Health Policy Board to support sustainable primary care payment reform. The recommendations were considered as part of the legislative development process for Senate Bill 934. The collaborative will continue to be a forum for sharing and aligning primary care payment reform across Oregon.
- **Behavioral health integration value-based payment grants** – Two payers advanced VBPs for integrated care through grants from the Transformation Center. One payer integrated VBPs across its Medicaid, Medicare, and commercial plans and will implement the models across provider networks starting in at least two practices in 2017. The other payer developed a sustainable VBP model to support behavioral and physical health integration that is capable of cross-regional and bi-directional implementation.

Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care

Evaluation activities:

The Behavioral Health Home Learning Collaborative (BHHLC) was supported by Oregon's Adult Medicaid Quality Grant to assist organizations with integrating primary care into behavioral health settings. The BHHLC concluded in December 2016 and produced a report in 2017.

The OHA Oral Health Team completed the early phases for development of an evaluation. The Team developed a logic model, evaluation plan, and performance measures to define successes and identify areas of challenge. This action builds on the existing work that the Oral Health Team has been doing over the last year to enhance coordination and collaboration across the agency (see improvement activities below).

Interim findings:

Oregon's coordinated care organizations

Six of the CCO incentive and state performance measures relate to physical and behavioral health care integration. Performance on all measures was published in the CCO Metrics 2016 Final Performance Report, released in June 2017.

CCO incentive measures:

- **Screening, Brief Intervention and Referral for Treatment (SBIRT)** for alcohol and other substance misuse increased almost 60 percent between calendar years 2015-2016, the results are not directly comparable due to changes in the data source, including ICD-10 implementation in October 2015, which resulted in additional screening services (not just SBIRT) being counted. OHA is developing EHR-based measure specifications to better capture SBIRT beginning in 2019.
- **Follow-up after hospitalization for mental illness** increased from 76.7% in 2015 to 78.8% in 2016, approaching the aspirational benchmark of 79.9%.
- **Mental, physical, and dental health assessment within 60 Days for children in DHS Custody** (foster care) increased more than 27 percent in 2015, from 58.4% to 74.4%. The benchmark is set at 90.0%.
- **Screening for clinical depression and follow-up plan** increased from 37.4% in 2015 to 48.0% in 2016 and remains above the target of 25.0%.

The Metrics and Scoring Committee voted during this demonstration year to add a new incentive measure beginning in 2018: Emergency Department Utilization among Members Experiencing Mental Illness.

State performance measures

- **Follow-up care for children initially prescribed ADHD medications** continued to increase, reaching 62.2% in 2016 and remaining above the Medicaid national 90th percentile of 53.0%. The percentage of children who had at least two follow-up visits within 270 days after the initiation phase (i.e. continuation and maintenance of care) also continued to increase, reaching 69.7% in 2016 and remaining above the Medicaid national 90th percentile of 69.7%.

- After large gains in 2014, **initiation of alcohol or other drug treatment** for members newly diagnosed with alcohol or other drug dependence decreased in 2016 to 34.4%. Continuation and engagement of treatment (percentage of members who had two or more additional services within 30 days of their initial treatment) declined almost 40 percent in 2016 to 11.1%. OHA plans to explore these measures to help understand the root cause of this decline in performance.

Improvement activities:

Oral health

The Oral Health Team continued to build on the work completed through the State Innovation Model (SIM) to evaluate the effects of integrating funding for dental services into CCOs' global budgets. This work is in addition to the key SIM-funded reports produced for OHA by Health Management Associates in this demonstration year:

- **Oral Integration in Oregon: Environmental Scan & Recommendations** – This report, published November 2016, includes an environmental scan of both local and national efforts toward oral health integration and extensive interviews with state officials and their key partners to better understand transformation efforts. Some key findings from the report are:
  - The oral health status of Oregonians is improving, but further work remains.
  - A limited oral health workforce continues to be a challenge.
  - Local oral health integration efforts are ahead of other states, but there is more to do including consensus on the definition of "integration."
  - Some national models of oral health integration and local efforts for behavioral health integration can be applied.
  - Potential innovative payment models could further oral health integration.
- **Oral Health Toolkit: Resources for Supporting Oral health Integration in Oregon –** This report, published November 2016, is a collection of resources to help the state, CCOs, oral health and primary care providers, and practice transformation leaders as they continue down the path of oral health integration.
- **Oral Health Authority Oral Health Roadmap: Moving into the future –** This report, published in December 2016, supports the development of the oral health strategic planning process to clarify a vision and goals and to enhance coordination and collaboration across the agency.

The findings from these reports support the development of a cross-agency work plan that outlines multiple activities such as collaboration, policy, education, communication, direct service, data analytics, and community partnerships, to improve oral health equity, improve population oral health, improve access to oral health, and increase the integration and coordination of care for all Oregonians.

Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources

Evaluation activities:

Evaluating Oregon's Medicaid waiver

Oregon Health Authority

In this demonstration year, OHA started contract negotiation with Oregon Health & Science University's (OHSU) Center for Health System Effectiveness (CHSE) for the summative evaluation of the 1115 waiver. The summative evaluation will expand on the waiver midpoint evaluation and other preliminary efforts to assess the implementation and impacts of Oregon's Medicaid waiver. Specifically, the evaluation will include data from all five years of the demonstration (with allowances for lag associated with some types of data).

OHA expects the contractor will use Medicaid members from another state and "weighted" Oregon commercial plan members as comparison groups, enabling the contractor to rigorously estimate the effect of the waiver on health care spending, quality, access, and other key outcomes. The contractor will also synthesize findings about OHA's and CCOs' transformation activities from existing evaluations, and provide actionable recommendations for advancing Medicaid transformation beyond the current waiver period. The contractor will deliver evaluation findings to CMS and OHA by the end of 2017.

Sustainable Relationships for Community Health Program

The Sustainable Relationships for Community Health (SRCH) program is made possible through a Centers for Disease Control and Prevention (CDC) grant, and is a technical assistance initiative designed to develop sustainable community-based models that address hypertension, pre-diabetes and diabetes prevention, and early detection and self-management. The full report of the first phases of this project was published in 2015.

The SRCH Program 2016-2017 grantee consortia attended a two-day learning institute in February 2017 and received technical assistance from OHA's Public Health Division staff and contractors to assist in pilot planning and implementation, collection and reporting of project data elements, scalability of pilot projects and work plan milestones. SRCH grantees also received technical assistance from the Quit Line to determine effective referral processes to the Quit Line via the CCOs and clinics.

Additionally, OHA's Public Health Division staff coordinated with the National Association of Chronic Disease Directors Promoting Medicaid Delivery Models for the National Diabetes Prevention Program (NDPP) Through Managed Care Organizations and/or Accountable Care Organizations grant, which seeks to identify promising practices for NDPP referral and payment systems. OHA staff from the Public Health Division and Health Systems Division take part in monthly check-ins with NACDD to provide updates and identify areas of technical assistance for SRCH grantees (CCOs, local public health authorities and DPP provider organizations). SRCH grantees funded to work on the NACDD grant are building partnerships with seven DPP provider organizations to contract with in order to enroll 300 CCO members into NDPP. These SRCH grantees implemented strategies for patient and provider engagement for NDPP. SRCH grantees have met with seven clinic providers in Multnomah, Washington and Clackamas County to review the NDPP program and promote referrals to the NDPP programs. Outreach materials for NDPP were created and distributed to patients and providers, including CCO member-facing materials translated into other languages (Spanish, Chinese, Vietnamese).

Interim findings:

Measures of efficient and effective care collected by OHA

The following measures of efficient and effective care were reported in 2016 (see Appendix E for details):

- Emergency department visits declined for the first time since 2011, returning to 2014 levels (47.3 per 1,000 member months in 2016 up from 45.7 in 2015). It is important to note that avoidable utilization of the emergency department continues to decline. A lower percentage is better for this measure.
- Potentially avoidable hospital admissions decreased for asthma in younger adults from 52.8 per 100,000 member years in calendar year (CY) 2015 to 47.5 in CY 2016. A lower percentage is better for this measure.
- Potentially avoidable hospital admissions increased slightly for the following conditions, but it is important to note that all measures have improved over 2011 baseline data. In particular, admissions for COPD (or asthma in older adults) has declined from 1102.1 admissions per 100,000 member years in CY 2011.
    - Chronic obstructive pulmonary disease (COPD) admission increased from 432.9 per 100,000 member years to 440.1.
    - Diabetes short-term complications admission increased from 154.1 per 100,000 member years in CY 2015 to 163.0 in CY 2016.
    - Congestive heart failure increased from 235.4 per 100,000 member years in CY 2015 to 246.5 in 2016.
- Developmental screening in the first 36 months of life increased from 54.7% in 2015 to 62.2% in 2016, and adolescent well-care visits continue to show positive improvement from 37.5% in 2015 to 42.9% in 2016. Despite this improvement, less than half of adolescents had a well-care visit in 2016.

Improvement activities:

Sustainable Relationships for Community Health Program

In this demonstration year, the Sustainable Relationships for Community Health (SRCH) program completed an interim evaluation that showed teams have made progress towards implementing closed-loop referrals and have advanced their partnerships. All teams have increased their performance on a series of teamwork indicators by 87% from the beginning of the grant year.

Summary of Health Information Technology initiatives

OHA's Office of Health Information Technology (OHIT) continues to make progress on state Health Information Technology (HIT) initiatives and ensure OHA's efforts align with and support CCO needs through various activities that include stakeholder support and programmatic activities. Major HIT activities throughout the year include the following.

- Health Information Technology Oversight Council (HITOC)
- Medicaid Electronic Health Records (EHR) incentive program
- CareAccord
- Emergency Department Information Exchange (EDIE)/PreManage
- Oregon Medicaid Meaningful Use Technical Assistance program
- Office of the National Coordinator for Health Information Technology (ONC) Interoperable Cooperative Agreement

Health Information Technology Oversight Council

OHA's OHIT convened HITOC, which is tasked with setting goals and developing a strategic HIT plan for the state, overseeing implementation of the HIT plan, and monitoring progress with HIT goals. During this demonstration year the HITOC team updated the strategic plan for the state of Oregon.

Medicaid EHR Incentive Program

Oregon's Medicaid EHR Incentive program was approved by CMS to add pediatric optometrists as an eligible professional type to the program starting with program year 2016. Since the program's inception in 2011, 7,703 Oregon providers and 61 hospitals have received a total of $458.1 million in federal incentive payments ($300.5 million under the Medicare EHR Incentive Program and $157.6 under the Medicaid EHR Incentive Program, as of March 31, 2017).

CareAccord

CareAccord is a direct secure messaging system that allows providers to send protected health information (PHI) over the internet safely, securely, and privately. CareAccord is administered by OHIT. CareAccord is a member of DirectTrust and has been accredited as a Health Information Service Provider (HISP) by the Electronic Healthcare Network Accreditation Commission (EHNAC). The number of direct exchange transactions nearly tripled in 2016 and continues to grow in 2017. OHA has also initiated a pilot with DHS Vocational Rehabilitation to use direct secure messaging as one electronic option for moving toward a paperless program.

Emergency Department Information Exchange/PreManage

The Emergency Department Information Exchange (EDIE) collects emergency department and inpatient Admit Discharge Transfer (ADT) data from hospitals and pushes notifications back to emergency departments (ED) in real time. EDIE alerts inform ED providers when a patient has sought care in an ED more than six times over the last 12 months. The alert contains brief information about the prior ED visits and, if available, information about the patient's primary care provider and care plan. EDIE helps ED providers coordinate with primary care providers, provide the most appropriate care for the patient, and avoid unnecessary ED costs for all patients and payers, including Medicaid.

In March, Unity Center for Behavioral Health, the first collaborative medical initiative of its kind in Oregon, went live with EDIE. The Unity Center offers a 24-hour mental and behavioral health emergency service for adults and longer-term inpatient mental health care for both adults and adolescents. Having access to EDIE data will help Unity Center providers understand patients' histories and provide better, more patient-centered care. Many of the Unity Center's patients are Medicaid members. The addition of the Unity Center brings the count to 61 Oregon hospitals contributing data to EDIE (in addition to data from Washington hospitals).

PreManage is a companion to EDIE. PreManage brings real-time hospital event notifications from EDIE to health plans, CCOs, providers, and care coordinators. Users can choose patient demographics or particular patients to monitor, and when a patient in that demographic presents at an ED, the user will get a real-time notification. This helps CCO care coordinators follow up with appropriate referrals or re-engage a patient with primary care after an ED visit, or even enable care coordinators/providers to connect with a member during the ED visit to ensure the most appropriate care is being provided.

OHA recently increased adoption of PreManage and was co-sponsor of this effort. OHA is responsible for coordinating CCO use of the tool. All 59 Oregon hospitals contribute admit, discharge, and transfer (ADT)

data (both ED and inpatient data) to the EDIE, which serves as the data infrastructure for PreManage. CCOs, health plans, and providers can subscribe to PreManage to access the hospital event data and better manage their populations who are high utilizers of hospital services.

The EDIE Utility Governing Committee, of which OHA is a member, has utilized the following methods to assess the impact of these tools and report on progress in the prior year.

- An EDIE/PreManage Behavioral Health User Community is meeting quarterly to develop behavioral health use cases, share best practices, and network.
- A statewide EDIE/PreManage online Learning Community launched mid-December, 2016 and already has more than 250 users who are sharing use cases and best practices and attending webinar presentations through the Learning Community.
- Oregon Health Leadership Council (OHLC), in partnership with Collective Medical Technologies (CMT), the vendor for EDIE/PreManage, completed a survey of nearly every hospital in Oregon to assess the use of EDIE. Findings showed significant value in the EDIE notifications to support care of patients in the emergency department. Suggestions were made for some improvements. OHLC/CMT continue to work in partnership with EDIE users to develop plans to address the opportunities identified. OHLC completed an evaluation of the use of EDIE within hospitals, including workflows, challenges, successes and improvements, or potential supports to maximize the value of the tool.

Oregon Medicaid Meaningful Use Technical Assistance Program

Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) provides technical support to providers who are participating in the Medicaid EHR Incentive program. OMMUTAP offers resources that help providers use their EHRs in ways that maximize the value of their investments in EHRs and to improve efficiency and coordination of care. In the middle of this demonstration year, there were over 500 providers participating.

Office of the National Coordinator Interoperable Cooperative Agreement

In 2015, the Office of the National Coordinator for Health Information Technology (ONC) awarded OHA, and our program collaborator, Reliance eHealth Collaborative (formerly known as Jefferson Health Information Exchange), a $1.6 million grant to advance the adoption and expansion of health information technology infrastructure and interoperability. A primary goal of the grant is to overcome barriers to information sharing and care coordination across care settings and integrate behavioral and physical health data for more robust health information exchange.

Participating CCOs find the technology infrastructure allows them to access their patients' information from providers, including data on behavioral health, controlled substance prescriptions, hospital event notifications, ambulatory care, and notifications on significant life events.

At the end of 2016, ONC awarded OHA and Reliance $625,000 in supplemental funds to expand multistate Admit Discharge Transfer (ADT) notifications. The project will support the routing of EDIE ADT messages through Reliance to facilitate more actionable data across care teams, through encounter notifications and provider directory lookup that improve patient outcomes and keep users within their workflows.

CCO Metrics dashboards

OHA continues to release quality metric progress reports for CCOs using a custom-designed automated metric reporting tool ("dashboard") developed by Providence's Center for Outcomes Research and Education (CORE). During this reporting year measures were updated to the latest version, validated, and added to the dashboard. Performance and Quality Improvement (PQI) measures include the following.

- PQI 01 – Diabetes, short-term complication admission rate
- PQI 05 – Chronic obstructive pulmonary disease admission
- PQI 08 – Congestive heart failure admission rate
- PQI 15 - Adult asthma admission rate)

These quality metrics dashboards are calculated and released to CCOs on a monthly basis so they can track their own performance over time and ask questions regarding the metrics in the dashboard.

Clinical Quality Metrics Registry

The Clinical Quality Metrics Registry (CQMR) will collect, aggregate, and provide clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. Initially, the CQMR will support the Medicaid EHR Incentive Program and the CCO incentive measures that are EHR-based. Over time, other quality reporting programs could use the CQMR as well. The Michigan Health Information Network (MiHIN) was selected as the vendor for the CQMR in late 2016 through Oregon's prime vendor, Harris Corporation. The implementation date is still under discussion but is anticipated to take place in 2018. OHA continues to work with both the new contractor and the CCOs to prepare them for this launch.

Lever 5: Implementation of health-related flexible services aimed at improving care delivery, enrollee health, and lowering costs

Evaluation activities:

Transformation Center

The summative waiver evaluation will include flexible services to better understand how they are deterring higher-cost care. Our contractor, Oregon Health and Science University's (OHSU) Center for Health Systems Effectiveness (CHSE), has reported on a detailed analysis for evaluating flexible services, which includes both quantitative and qualitative methods. Results will show a mixed understanding of CCOs about how to use flexible services in actual practice with some interpreting them as community-based services and others interpreting them as services for individual patient needs.

Evaluating Oregon's Medicaid waiver

During this demonstration year, the evaluation plan with OHA's prospective contractor for the waiver summative evaluation (see Lever 4, above) was revised to include a proposal to evaluate the impact of flexible services on health care spending and other key outcomes. The contractor will report their findings in a Summative Evaluation Report.

Interim findings:

Transformation Center

Among the 10 CCOs interviewed, the Transformation Center found that flexible services usually addressed chronic conditions. Successes reported by CCOs included gym memberships and pool passes to support physical activity and wellness, rental assistance to stabilize mental health, early childhood programs to address trauma, incentives to increase adolescent well child visits, and health resilience specialists to identify member needs. CCOs expressed interest in learning about flexible services definitions and design, member communication, relationship of flexible services to rate setting, and examples of flexible services that worked at other CCOs.

The following themes emerged from the flexible services state wide learning collaborative:

- CCOs provide very different flexible services and capture information about them differently.
- Providers need help to understand and use flexible services.
- CCOs are concerned about potential demand and costs of flexible services if availability of the services is advertised.
- CCOs want to evaluate and demonstrate the effectiveness of flexible services, but clearly identifying their effects is challenging.

Improvement activities:

Evaluating Oregon's Medicaid Waiver

In this demonstration year, as mentioned above and under Lever 4, OHA's evaluation contractor will include findings about the effectiveness of flexible services in its final evaluation report, which will be delivered to CMS and OHA by the end of 2017. In addition, the contractor will provide recommendations for evaluating flexible services following the end of the 2012 – 2017 demonstration period.

Transformation Center

In this demonstration year, the Transformation Center:

- Convened a meeting of internal stakeholder to discuss OHAs recent posting of revised Oregon Administrative Rules (OARs) for flexible services. It was decided that the OARs will need to be revisited as a result of Oregon's CMS 1115 waiver renewal. In the meantime, OHA will address any questions about the OAR on a case-by-case basis.
- Hosted a Flexible Services Learning Collaborative in Salem, Oregon. This collaborative brought together 48 participants (30 in person and 18 by webinar) from CCOs around the state, including 15 of the 16 CCOs.

The evaluation feedback for the learning collaborative was very positive overall. Almost all of the 20 evaluation respondents (95%) found the collaborative to be very valuable or valuable in supporting their work. Participants indicated that the most helpful aspect of the event was hearing from other CCOs about their flexible services programs.

Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Transformation Center

Evaluation activities:

The Transformation Center's evaluation plan is aligned with the its strategic plan initiatives. The Center continues working in collaboration with OHSU to evaluate key activities.

Oregon Health Authority

In September 2016, OHA released a report from Portland State University that highlights the overall savings of the Patient-Centered Primary Care Home (PCPCH) Program. Key findings of the PCPCH implementation report are listed below in the interim findings section.

Also in September, evaluators from OHSU completed a qualitative analysis of final reports from the 2015-2016 Clinical Innovation Fellows. The fellowship's multi-pronged approach to training new innovation leaders appeared synergistic by combining a strong curriculum, hands-on experience with project implementation, and support from mentors and others across a range of disciplines.

The Transformation Center also surveyed the first two cohorts of Clinical Innovation Fellow graduates to assess longer-term program impact. Graduates are continuing to move into leadership roles and spread what they've learned through trainings, presentations and mentorship. Respondents said that because of the fellowship, they have greater confidence in leadership, their projects were propelled, and they made valuable professional connections.

In June 2017, OHSU evaluators completed an evaluation of Transformation Center technical assistance to CCOs for colorectal cancer screening, adolescent well-care and behavioral health integration in 2016. Findings from 11 CCO interviews include:

- CCOs valued webinars and trainings because they provided the latest evidence-based approaches, tools for sharing content with stakeholders, and practical resources.
- CCOs valued expert consultations because they helped CCOs operationalize and implement interventions, tailored support to the CCO, and provided an external perspective that helped generate buy-in for interventions.
- Requests included more detailed descriptions of the assistance offered; help to understand how to select and tailor technical assistance services to meet CCOs' specific needs; and more time to plan for and use the technical assistance.

The Oregon Rural-based Practice Research Network completed an evaluation of the OHSU child psychiatry Project ECHO. The project engaged 28 primary care providers from 17 clinics – most of them in rural areas, and all outside the metro area. Each week for eight months (30 sessions), participants connected to a live session that included lectures and case reviews with child psychiatrists, pediatricians and a pharmacist. Results (based on pre-program and post-program surveys) from participating clinicians include:

- Ninety-five percent of participants reported that ECHO sessions increased their confidence to treat pediatric patients with mental health disorders.
- Percentage of participants very comfortable or comfortable assessing and treating pediatric patients with mood and anxiety disorders increased from 39% to 79%.
- Percentage of participants who were very comfortable or comfortable medically treating pediatric patients with depression increased from 48% to 84%.
- Participants' familiarity with pediatric substance abuse resources in their community improved from 30% to 67%.

The May 2017 Innovation Café: Improving Key Health Metrics brought together 213 Oregon HST champions to engage in peer-to-peer learning and networking. CCO, clinic and other innovative health system leaders presented 30 projects and discussed learnings. Evaluation findings include:

- 94% of evaluation respondents said the event was valuable or very valuable.
- 99% of evaluation respondents planned to take action based on what they learned at the event.
- The most helpful parts of the event for participants were hearing about successful local approaches, networking and the plenary presentation on patient-centered reproductive goals and contraceptive counseling.

Final reports for the Community Health Improvement Plan Implementation grants to CCOs showed that all CCOs made significant progress on their grant activities, supporting implementation of their community health improvement plan priorities. Completed projects include:

- A photo-voice project that used participatory photography and storytelling to authentically engage community members.
- Development of a train-the trainer curriculum and a media campaign to increase the health literacy of transition-age youth.
- Applied Suicide Intervention Skills Training (ASIST) Suicide Prevention trainings.
- The creation of materials to highlight the importance of preventive oral health care and navigating Oregon Health Plan dental benefits.

Findings from the Transformation Center's ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives and technical assistance activities are below.

Interim findings/ Improvement activities:

This year, the CCO learning collaborative met six times. An average of 60 people attended each session. On average, 85% of evaluation respondents rated the sessions valuable or very valuable to their work and 75% said the sessions were effective for meeting their needs. Respondents identified the most helpful aspects were hearing best practices from other CCOs and reviewing tools and guidelines. One CCO Learning Collaborative focused on opioids, and 47 people attended. Of evaluation respondents, 77% found the session valuable or very valuable to their work. Respondents shared the most helpful aspect of the session was reviewing various approaches and interventions.

The third cohort of Clinical Innovation Fellows met 11 times. On average, 88% of evaluation respondents rated the sessions as very valuable or valuable, and 96% of respondents said they planned to take action based on the sessions.

Key findings from the September 2016 PCPCH implementation report:

- For every $1 increase in primary care expenditures for this comprehensive model of care, the Oregon health care system saves an average of $13.
- Clinics in their third year of PCPCH designation had total expenditure reductions of $28 per-member-per-month compared to non-PCPCH clinics.
- Program implementation has resulted in $240 million in savings to Oregon's health system over its first three years.

Reports for the Transformation Center's Community Health Implementation Grants to CCOs were due December 31, 2016. The CCOs that received grant extensions completed a second progress report, while the remaining seven completed final reports. Reports showed that two CCOs (13%) completed all grant activities and two CCOs (13%) had met all grant outcomes. Another eleven CCOs (69%) had made progress on all

grant activities and ten CCOs (63%) had made progress on all grant outcomes. Additionally, during this demonstration year the Transformation Center provided the following supportive services.

Targeted metrics technical assistance

- **Colorectal cancer screening** – Four webinars, with an average of 29 participants from 10 CCOs; on average, 88% of evaluation respondents rated the sessions as very valuable or valuable. Ten CCOs also participated in individual follow-up consultations.
- **Adolescent well-care visits** – Six webinars, with an average of 10 participants and 14 CCOs represented; 89% of evaluation respondents rated the sessions as very valuable or valuable and effective in meeting their needs. Three in-person Eye-to-Eye trainings were also held, with 69 CCO staff and providers attending. Ninety-five percent of evaluation respondents rated the trainings as very valuable or valuable.
- **Tobacco cessation** – Two Rx for Change train-the-trainer trainings, with 36 participants representing CCOs, affiliated clinics and tribal health organizations; 100% of evaluation respondents indicated the training was very valuable or valuable in supporting their work. The most helpful aspects were pharmacology information and resource sharing. Eleven people also attended a follow-up webinar.
- **Childhood immunization** – Root-cause analysis projects with five CCOs to prioritize interventions to increase childhood immunizations; 100% of evaluation respondents indicated the assistance was very valuable or valuable in supporting their work.
- **Effective contraceptive use** – Seven webinars, with an average of 21 participants and nine CCO regions represented; 87% of evaluation respondents rated the sessions as very valuable or valuable

Health equity consultations with all 16 CCOs

- Overall, 119 of 144 participants completed evaluations (82.6% response rate). On a scale of 1–5, the majority of CCOs rated the overall value of the health equity consultation at 4.33 or higher and the effectiveness for meeting the CCO's needs at 4.25 or higher.
- Ten CCOs requested follow-up technical assistance.

Support through the Technical Assistance Bank

- Between October 2015 and May 2017, the Transformation Center received 62 requests from CCOs for a total of 906 technical assistance hours.
- Evaluation results show that 97% of CCOs who responded rated the assistance as very valuable (77%) or valuable (20%), and 97% of CCOs rated the assistance as very effective (65%) or effective (32%) in meeting the project goals.

VI. Public forums

Public comments received

Health Evidence Review Commission (HERC)

March 9, 2017:

Dr. Carl Stevens, CareOregon Medical Director, testified on potential criteria for the appropriate use of gallbladder removal. He said the standard test in the Emergency Department is to perform a bedside ultrasound to confirm Murphy's sign. He indicated his CCO is approving surgery for patients when they think it would be risky for them to undergo emergent gallbladder removal, such as a patient with diabetes or immunosuppressed patients.

May 18, 2017:

Testimony for this meeting related to a new process being developed regarding the prioritization of services with marginal or no clinical benefit and/or with low cost effectiveness.

Jim Slater, the Executive Director of Pharmacy at CareOregon, represents 4 CCOs, both rural and metro, and is a voting member of the Pharmacy and Therapeutics Committee (P&T). He said he did not represent P&T today. Slater said he would like HERC and P&T to work together, perhaps in a joint meeting, to look at the difficult drug issues. He viewed the term "novel treatments" as hope for the people we serve because it allows for a development of a rational structure to use Medicaid dollars as wisely as possible. He said the financial aspect of a medication should be reviewed after the body of evidence.

Lauren Sandt, Caring Ambassadors, a non-profit advocacy group for the treatment of hepatitis C and lung cancer. She said the organization takes funding from the public, including pharmaceutical companies, and their financial records are online. Sandt said a disease that affects a large population should be effectively treated. She urged the Commission to continue to look at medications as the price drops, as well.

BJ Cavnor, One-in-Four Chronic Health, a non-profit who receives funding from the public and pharmaceutical companies. Their financial records are disclosed to the Secretary of State and the IRS. Cavnor said his advocacy group wants to work with the Commission to ensure proper treatments and medications are available. He urged the members to think about adjusting QALY against an OHP member's income, which would be a factor of the Federal Poverty Level (FPL).

Saha, Smits and Coffman clarified that QALYs are not based on a person's income; they are meant to take income OUT of the equation.

HERC Value-based Benefits Subcommittee

February 2, 2017:

Scott Holman, from Hologic (manufacturer of Digital Breast Tomosynthesis – DBT), gave testimony regarding a handout he provided on estimated cost saving for Medicaid with DBT. This handout included estimates of 20% of eligible Medicaid women getting screening and 25% of that group getting DBT would result in a $8.14 savings per woman screened (reducing cost of recall and cancer treatment).

In response to a question from a committee member, Holman said that more low-stage cancers are found with DBT. Contracted staff to the committee noted that there is no published literature showing a change in stage of cancer detected with DBT. This staff noted that with the minimal recall reduction reported in the literature (2.3%), costs actually increase by $5 per-member-per-month; further, if you take out reduced costs from earlier stage detection from the manufacturer's model, then it is not cost savings in any scenario.

Holman said DBT is an improved version of mammography with lower false positives. Short-term reduction in costs from not having to investigate false positives is cost savings. He said 27 states currently cover DBT for Medicaid. He also noted that the Medicaid population has a lower rate of screening, so it is more important to have a more accurate mammogram when they are screened.

Jennifer Valley, a cannabis grower and breeder, testified about her own experience with the benefits of cannabis oil for treatment of cancer. She notes that research into the impacts of cannabis are limited by federal rules. She testified that cannabis oil helps lower opioid use. She would like cannabis oil covered for pain, diabetes, cancer, and seizures for OHP patients. She would also like studies done on outcomes of medical marijuana.

March 9, 2017:

Jay Halaj with Allevia Health, representing the manufacturer of Alpha Stim for cranial electrical stimulation (CES), provided testimony. Mr. Halaj testified to the utility of this device in terms of the treatment of pain, depression, anxiety, etc. Patients stop using medications such as opioids or SSRIs due to the utility of the device. Mr. Halaj indicated that he will be coming in May with practitioners to further testify regarding the utility of this therapy. CES is inexpensive, with no side effects. He and Dr. Heather Kahn previously sent staff literature to review and he provided additional information for the Commission to review.

In response to a committee member question on what this technology involved, Mr. Halaj described CES as an electrical device that stimulates cranial nerves. CES is indicated for depression, anxiety and insomnia. The same instrument is also used locally for pain. In response to another question, Mr. Halaj indicated that CES is not covered by most insurers, which he argued is due to pharmaceutical company pressure, rather than lack of evidence of effectiveness. He answered a final question from the committee by saying that that there are several billing codes used for this technology.

May 18, 2017:

Testimony for this meeting related to a new process being developed regarding the prioritization of services with marginal or no clinical benefit and/or with low cost effectiveness.

Public testimony was heard from Lorren Sandt, from Caring Ambassadors. She said her organization does receive funding from pharmaceutical companies. She requested that the HERC consider the definitions used to place various treatments into these guidelines be carefully thought out and specific. She requested that if cost-effectiveness is used as a criteria, that the HERC re-review those therapies on a regular basis as the cost of therapies could possibly come down. She also noted that many cancer therapies may qualify, which might be in conflict with federal law regarding inability to discriminate on stage of disease or length of life in coverage.

HERC Evidence-based Guidelines Subcommittee

February 2, 2017:

Dr. David Sibell, a pain management physician from Oregon Health Sciences University (OHSU), offered comment on the scoping of a proposed coverage guidance topic on urine drug testing. He said that despite marijuana being legalized under state law, from the point of view of people issuing Drug Enforcement Administration licenses, it is not a grey area since marijuana is still a controlled substance. He said it is a violation of federal law to prescribe a controlled substance to someone who is known to be diverting a controlled substance, and as long as marijuana remains a Schedule 1 drug at the federal level, it will be diversion no matter how it is being used. The prior administration did not enforce this, but the current administration may decide to. Thus, from the perspective of a prescriber, marijuana needs to be considered illicit. He said at OHSU there is a tacit understanding that if providers are prescribing a controlled substance, and find marijuana is also being used, they will stop prescribing the other substance. Based on that feedback the subcommittee listed marijuana with other illicit substances under type of drug tested.

The remaining testimony for this meeting related to a draft coverage guidance on the use of corticosteroid injections for the treatment of low back pain that recommended non-coverage of epidural steroid injections for all types of low back pain.

Dr. Kim Mauer, an OHSU pain medicine physician, offered testimony by reading a letter from Dr. Roger Chou, lead author of the systematic review which served as a basis for the coverage guidance. Dr. Chou's letter highlighted the finding of the review that for patients with radiculopathy, steroid injections are associated with relatively modest benefits, principally a short-term reduction in pain after several weeks. The impact on pain is not that far out of line with other treatments for low back pain. He does not believe that pain relief should be ignored as it is important for quality of life. He said that, for patients with radiculopathy, the evidence is stronger for epidural steroid injections than for anything else. He said that surgery is the only other evidence-based treatment for radiculopathy, so a trial of an epidural steroid injection for these patients would be a reasonable option. The committee chair noted that pain was not selected as an important outcome because the committee wanted to incorporate the effect that pain would have on function.

Dr. Sandy Christianson, an OHSU pain medicine physician, offered testimony on behalf of Dr. Steven Cohen, a professor of anesthesiology, neurology, physical medicine and rehabilitation at Johns Hopkins University. His letter referenced presidents, generals and famous doctors who have received epidural steroid injections, and gave the opinion that patients feel better after receiving these injections. The letter said that despite the incomplete, short-term benefit, other treatments are inadequate as well.

Tracy Titus offered comments as a patient. She said that people who haven't had chronic pain have difficulty understanding the impact of not being able to do everyday activities like carrying groceries or bending down or walking down stairs. She also noted the impact on families of patients as well as on their social life. She said she has had neck, back and brain surgery. The injections only last a short period of time, sometimes a bit longer, but they allow her to participate in social activities and daily activities like shopping for groceries.

Dr. David Sibell, an OHSU pain medicine physician and member of the Spine Intervention Society, presented articles and described them by saying that transforaminal epidural steroid injections have clinical and statistical effectiveness in the treatment of radiculopathy when using the appropriate technique. Using

other forms of the procedure and giving the injections for other indications is not effective. Failing to pay attention to pain as a variable for a treatment whose primary effect is pain relief is inappropriate. He said safety has improved over the last decade, eliminating the risks of arterial injection by using imaging guidance.

Dr. Brian Mitchell, an anesthesiologist at the Portland Veteran's Administration hospital, said that he does not perform these procedures. He added that we are in the midst of an opioid crisis, with 91 people dying of an overdose every day in the United States, with over 505 dying in Oregon in 2015. He cited a CDC guideline which said that epidural steroid injections can provide short-term improvement, saying that access to this procedure could help fight opioid overuse and abuse. The committee chair pointed out that the evidence shows no reduction in opioids or surgery with the use of these injections.

Jordan Johnson, a pain medicine fellow at OHSU, expressed concern about dropping coverage for these procedures. He said these procedures are helpful for certain patients. He said he understands that not every patient gets a benefit but that some patients do show improvement in function. In addition he said future OHSU residents and fellows may have less training in this procedure if coverage is reduced.

Tim Grabe, a Multnomah circuit court arbitrator, said he has represented both insurance companies and patients as an attorney. He said that in the legal world this treatment is accepted. When insurance companies don't want to pay for the injections, they tend to lose in arbitration and dollars flow back to the Oregon Health Plan after this treatment is provided.

Martha Sevick testified that she has experienced pain relief and improvements in her function in daily life like many other patients. More detailed, controlled studies may be needed to show these kinds of improvements. She said that each pain patient is different, which is why observational and clinical evidence is important. The patient's ability to move and function in society must be considered. She said that the injections can help patients live with fewer opiates. Injections are less risky than surgery and they allow her to participate in volunteer activities.

April 6, 2017:

Initial testimony for this meeting related to a draft coverage guidance on the use of corticosteroid injections for the treatment of low back pain that recommended noncoverage of epidural steroid injections for all types of low back pain.

Several members of the audience (Tracy Titus, Martha Sevcik, Mary Ellen Edwards, Laura Samdow, Marjoy Cicerich, Richard Bancroft, Lucille Guill, Mary Steimens) gave testimony about personal experience as patients who received steroid injections or similar treatments. Each spoke of the pain they and their loved ones experience, and the disabling impact on their life as well as the lives of their families. Each spoke in support of coverage of these procedures. Some mentioned lasting benefits from these injections, reductions in opioids or surgery, and the improved ability to function in daily life. Some mentioned the risk of suicide in patients whose pain cannot be treated. They said these injections improved their ability to drive, walk, leave a wheelchair, and live a normal life with family and friends in meaningful ways.

Members of the subcommittee were asked if they had personal experience with these procedures. Wiley Chan spoke of his own experience, clarifying that his experience wasn't like the experience of those who

testified. He had radicular back pain, and at the time he would have said those injections prevented him from seeking surgery. The problem is that this is anecdotal evidence. He does not know whether he would have gotten better or worse without the injection. In fact, there was a cardiologist undergoing the same procedure the same day but had no benefit and required surgery, ending up with post-laminectomy back pain. Individuals can have an effect that's better or worse than the average, but the evidence is the best thing we have to go on. Note: The individual testifying reacted negatively to Dr. Chan's personal account and, sadly, Dr. Chan resigned from HERC the following day as a result of this interaction.

Staff and committee members acknowledged that these stories are common, but explained that randomized trials are the best way to understand the effect of medical treatments and the evidence appears to show no greater benefit than placebo injections and no difference in surgery rates or opioid use. Some patients brought other information supporting the use of these procedures.

In addition, several health care professionals spoke of the benefits of these interventions.

Sydney Rose, from OHSU, compared this to uncomplicated hernias. If surgery is not covered for hernia patients they generally don't seek further treatment, whereas chronic pain patients generally seek treatment. Patients may end up seeking care in the emergency room or seeking surgery.

Chidi Ani, an anesthesiologist from OHSU, said that he could not recognize disparities when his practice was limited to surgical anesthesia. Anesthetics are the same regardless of payer. When he went into chronic pain he saw disparities for Medicaid patients. Medicaid patients and those with few resources are most affected by these recommendations. These patients report having been rejected by various providers. Even a request for four visits may not be available for these patients. Cuts like this take away from people who have nothing and have the least ability to compensate for potential errors.

Carl Balog introduced himself as a pain management physician in Portland. First, he supported the information that was provided by several professional societies in support of their guidelines and criticisms of the Chou review. He said that the world of pain is watching Oregon. There will be vocal criticism because of some of the methodology the committee followed. He expressed concern that no interventional pain specialist is involved. He said these injections are diagnostic and guide therapy. They help patients confirm the nature of their problem, then send them to a physician or surgeon as appropriate. Patients will suffer if they get no specialty or guideline-approved treatments.

Rebecca Monreal, a pain physician from Salem, she said she brought a stack of evidence she sees as strong evidence. There would be no pain medicine specialty if there were no evidence. How is it possible other insurers find enough evidence but the subcommittee sees a lack of evidence? She also said that chiropractic and acupuncture, while they can be helpful to some patients, are no better than placebo but are now covered for the Oregon Health Plan. Obley briefly reviewed the studies offered and determined that either they did not meet criteria to review, are related to other interventions or are already included in the coverage guidance.

Further testimony at this meeting related to a draft coverage guidance on the use of minimally invasive noncorticosteroid percutaneous interventions for the treatment of low back pain, including a recommendation for noncoverage of radiofrequency denervation for facet joint pain, which all of the following public testimony was directed towards.

Several patients (Veronica Tofflemeier, Ginger Pearson, Richard Bancroft) gave testimony about the benefits of radiofrequency ablation and other technologies for the disability and pain caused by various low back pain conditions. Some reported reductions in opioid use and ineffectiveness of other treatments. One reported abusing alcohol and contemplating suicide after opioid medications were cut off and before receiving a radiofrequency ablation which restored his quality of life.

Dr. Sandy Christiansen read a statement to Medicare contractor Noridian on behalf of Dr. Steve Cohen (OHSU) describing a study comparing intra-articular injections, medical branch blocks and sham saline intramuscular injections. Patients in the first two groups have had a higher success rate than the sham groups. He asked to withhold the decision until the study is published.

Sydney Rose identified herself as a physician and anesthesiologist at OHSU but also a patient and relative of patients who have benefitted from this procedure. She expressed concern about opioid overdoses and deaths related to opioids. Oregon has the second-highest rate of drug abuse in the nation. At the same time, chronic pain is undertreated. Medical practitioners are in a bind—they need to find effective treatments without endangering public health. She referred to the CDC opioid guideline that refers to epidural steroid injections, medial branch blocks and denervation as alternatives for short-term relief. She recommended coverage of these procedures to best serve patients.

David Sibell, professor at the OHSU Comprehensive Pain Center, discussed medial branch blocks and radiofrequency ablation. He said that there are a number of studies showing efficacy and others which do not. He said that the techniques used correspond with the outcomes. Studies using pulsed radiofrequency, inappropriate needle placement or the wrong enrollment criteria should not be weighted equally. He listed several studies which use the Spine Intervention Society (SIS) criteria, and suggested these be weighted more heavily. He also encouraged looking at studies reporting 100 percent relief, and the studies have been repeated. The evidence is mixed but the good evidence is solid. He said he would be more likely to see patients on the Oregon Health Plan if he were allowed to treat them.

Kim Mauer, director of the OHSU Comprehensive Pain Center, spoke next and offered studies meeting the criteria above. She advocated for coverage for medial branch blocks and radiofrequency denervation. Patients don't have a lot of options, and few clinics will see them. She expressed appreciation for the work of the Commission and the difficult decisions before them.

June 1, 2017:

The testimony for this meeting related to a draft coverage guidance on the use of minimally invasive noncorticosteroid percutaneous interventions for the treatment of low back pain, including a recommendation for noncoverage of radiofrequency denervation for facet joint pain, which all public testimony was directed towards.

David Sibell, physician in the OHSU comprehensive pain center and spine center provided public comment. His practice includes lumbar medial branch denervation procedures. He said his comment was restricted to radiofrequency denervation; he said he was not advocating the disc or sacroiliac denervation procedures. He recommended the subcommittee consider those procedures separately if at all. He is a member of the SIS. He said the higher quality studies are performed by leaders from that society. He expressed disappointment in the subcommittee's confusion about the technique, as he submitted his review to identify the studies that

were done with poor technique. He said the document he submitted was about 85 percent his work, with input from others in the SIS. He said this is one of the few treatments where we can make a difference in people's lives. He said that for people who benefit from an initial denervation, the nerve grows back but in most cases they will benefit from an additional procedure later on. Repeating it does not have a higher failure or adverse outcomes. The rate of serious adverse consequences is negligible. He believes the coverage guidance overstates the cost, compared to other interventions discussed in the report.

In 2008 he said that Noridian decided not to cover the intervention. After public outcry they adopted the SIS standards, which reduced the population eligible for the intervention to limit expenses. They required 6 physical therapy visits, which may benefit some patients, plus an MRI or CT scan which is not required for the procedure.

His suggestion is to reconsider the high quality evidence. He recommended the subcommittee excluded studies which didn't use appropriate technique. He also expressed concern that a consultation with a pain management specialist is approved in Oregon Medicaid, but none of the interventions a pain management specialist can perform are approved. In that context it makes little sense to approve the consultation.

Stecker thanked Sibell for his testimony. Livingston asked Sibell why the studies using optimal technique are relatively old and why studies published since then have not met criteria. Sibell said that in the 1990s and early 2000s, the studies were done to develop the guidelines. Many researchers believe the necessary science has been done. He also said that he and Dr. Friedly have sought funding together for a large multisector trial of the procedure and have not found success.

Kansagara asked whether the heterogeneity reflected in the literature is reflected in practice in the community (not just at OHSU). Sibell said that prior to Noridian's guidelines there was a lot of heterogeneity, but that practice has aligned about the Noridian criteria since then, since most payers use these criteria and providers don't get paid to provide the procedure unless they follow the criteria. He said that even in his clinic, the proportion of patients experiencing a 50 percent improvement in pain at six months is higher than it was previously because of stricter patient selection.

Dr. Chidi Ani offered additional testimony. He declared no conflicts of interest and is a Pain Fellow at OHSU. He said that it would be intellectually lazy to deny coverage of the procedure just because there's a difficult pathway to identify the patients likely to benefit. He asked that the committee disregard studies that do not reflect current standard of practice, which requires multiple medial branch blocks. He said using the Dreyfuss criteria would be acceptable to him.

Kim Mauer, medical director of the OHSU Pain Center, testified next. She said she had no conflicts of interest that she knows of. She said that a lot of the state is covered by Medicaid. Of those patients in Medicaid there are a huge number of patients with chronic pain, and very few interventions covered. She said that this intervention can treat a common source of chronic pain. She highlighted recent data showing a decrease in opioid prescribing for low back pain and other painful conditions. She said that clinics don't have a lot of other treatments to offer these patients.

HERC Health Technology Assessment Subcommittee

June 15, 2017:

The testimony for this meeting related to a draft coverage guidance on the use of continuous glucose monitoring for the management of diabetes mellitus.

Rene Taylor of Dexcom offered public comment. She said that Dexcom will be a Medicare supplier and will accept the Medicare allowable rate. She said the Medicare fees are around $2,500.

Medicaid Advisory Committee

Medicaid Advisory Committee public comment: June 26, 2016 – June 28, 2017

The Medicaid Advisory Committee met nine times between July 27, 2016 and June 28, 2017. Public comment was submitted on two occasions detailed below:

Meeting Date	Public Comment
July 27, 2016	No Public Comment
September 28, 2016	No Public Comment
October 26, 2016	**One public comment from:** Jeremiah Rigsby, Senior Manager for State and Federal Regulatory Affairs at Care Oregon provided public testimony, highlighting three issues: • Jeremiah thanked the Medicaid Advisory Committee for its input and discussion with regard to the future of CCOs. As someone connected to a CCO, he appreciates hearing from community advisory members who are not connected with CCOs about how the model is working. The MAC is often a voice for challenges and issues in the Medicaid program that CCOs and OHA may not be aware of. • Jeremiah expressed concern about the rate of churn in the OHP. • Jeremiah also asked the committee take a closer look at the role of community health workers/traditional health workers and consider the best ways to use community health workers in the OHP delivery system.
December 7, 2016	No public comment
February 22, 2017	Webinar, no public comment submitted
March 13, 2017	No public comment
April 26, 2017	No public comment
May 24, 2017	No public comment
June 28, 2017:	**One public comment from:**

BJ Cavnor, Executive Director of One in Four Chronic Health gave public testimony on the coverage of Hepatitis C. He raised questions about the waiver and amount of money available for Hepatitis C treatment in the waiver. Mr. Cavnor also discussed the high rates of HIV infection in Oregon and suggested HIV should be included as a metric for CCOs. (Note: staff explained the waiver did not address high cost pharmaceuticals or Hepatitis C packages.)

Public comments and questions during 1115 Medicaid Waiver Post Award Forum (Post Award Forum summary to be included in quarterly report submission for November 2017):

- HTTP - What does that entail? How are we measuring health outcomes? *Big hospitals are paid for performance around 11 metrics. There is a public Quality Metrics committee that decide those metrics. The Director appoints this group, approved by Legislature. Hospitals submit their metrics and then get paid. This program sunsets June 30, 2018.*
- Do the hospitals allow their patients to weigh in on the metrics? *There are patient surveys that are included in the metrics.*
- Paying for value – What is the timeline for this? *There will be a roadmap for value based payments within the year. There is an OHA internal workgroup leading this effort.*
- How does a person stay on a Medicaid CCO? Can they switch from one CCO to another? *Yes, members can request and switch CCOs. You are only auto-enrolled in one CCO if you do not make a selection. If a person was on FFS, then they will be auto-enrolled into a CCO.*
- Do individuals get choice counseling before moving out of FFS? *Yes, they will have time to make that choice before they enroll into a CCO. They will have the opportunity to opt-out.*
- Do we have a contract with CCOs that shows what they are expected and contracted to do concerning the waiver? *These contracts are public and can be viewed online. There are new contracts coming up in 2018.*
- It will be good to have more input in the State Plan Amendment (SPA) process. Are there more SPAs being submitted? *David Simnitt and Amanda said that we could get a presentation for a future meeting to explain the SPA process to this committee.*
- Was there any input from medical schools of health, dentistry? *The Healthcare Workforce committee works on issues related to this.*
- CCOs may be reluctant to use flexible services in the waiver. *There is not a requirement of a dollar amount in the waiver. They are encouraged to do so. There are incentivized to use flexible services.*

Questions/feedback that came through the webinar:

	1. As a member of the public who has had way too much experience with the medical system in my 66 years, it seems that all these convoluted policies make the system more expensive than it needs to be. Wouldn't a single payer plan without so many restrictions be less expensive? 2. Wouldn't a single payer plan with everyone in one giant risk pool be more cost effective? For instance I have had medical conditions my whole life, but my dad, who lived to be 91, didn't need medical care until he was in his 70s? 3. Discussion on ESI – Oregon has a program in place to utilize ESI for Medicaid recipients, but it is voluntary. See http://www.dhs.state.or.us/spd/tools/additional/workergd/d.11.htm 4. Healthcare should refer to eating healthfully and exercising on a regular basis. Medical care having access to the services of doctors and other medical providers. I think there should be a distinction between these two concepts. 5. Does OHP reimburse for these health care quality services for Fee for service members? 6. Should we expect to see the value based payments have any significant impact on DME and DME providers? 7. Why can't low income seniors stay on OHP when they turn 65? I lost OHP even though my financial and transportation situations had not changed.

Metrics and Scoring Committee

July – September 2016

DR Garrett (Trillium CCO) testified to call attention to the fact that a CCO can be a top performer on a measure, yet still not qualify for payment if improvement from the previous year was negligible or went slightly backward. This will likely become more common as the program matures and initial large gains give way more steady high performance.

American Association of Retired Persons (AARP) testified to applaud the Committee's commitment and visionary approach to address of issues of health disparities.

Jennifer Johnston, Director of Health Strategy for PrimaryHealth of Josephine County CCO, submitted written testimony to share concerns regarding the benchmark for the follow-up after hospitalization for mental illness measure.

Alison Martin, a member of OHA's Child & Family Wellbeing Measures Workgroup, spoke in support of shared care plans for children and youth with special health care needs, and the inclusion of actionable, shared care plans for this population as a component of the proposed kindergarten readiness metric.

October – December 2016

No testimony

January – March 2017

Sandra Clark, Director of Population Health at FamilyCare, provided advice to the Committee regarding what FamilyCare learned during their efforts to develop a health equity measure. Key points included the differences between a disparity (difference) and an inequity (difference driven by a historical disadvantage/social issue that can be addressed; an avoidable disparity) and expressed support for adopting emergency department (ED) utilization for members with severe and persistent mental illness as the equity measure in 2018.

Deborah Loy (Capital Dental Care) testified to express concern with the idea of requiring dental risk assessment codes in an incentive measure.

April – June 2017

Colleen Reuland, Director of the Oregon Pediatric Improvement Partnership and a member of the Health Plan Quality Metrics Committee, testified to express concern about conversations the Committee previously had about changing the age range for developmental screenings for children in the first 36 months of life metric and to express support for creating a future measure of whether follow-up was received when needed.

Chandra Elser of Health Share provided testimony regarding the cadence of electronic health record (EHR) based measures, and suggested that if new EHR-based measures are developed, have one year with reporting only. She noted that it takes significant time to narrow reporting to the Medicaid population, and had concerns around benchmarking if some clinics are reporting for Medicaid-only, while others include the commercial population.

Sara Love, Policy Director at CCO Oregon provided testimony in support of an adult oral health metric and noted specifically that a metric measuring periodontal evaluations in diabetic adults would meet the Committee's measure selection criteria.

Jeramiah Rigsby, Public Policy and Regulatory Affairs Director at CareOregon, provided public testimony about the childhood immunizations measure for the four CCOs represented by CareOregon, raising concerns about the timing and recalculation of targets, which CareOregon felt made it difficult to make quality improvements based upon the data they received.

Hospital Performance Metrics Advisory Committee

July – September 2016

Dr. Josh Cott testified to share concern about the proposed opioid prescribing in the emergency department measure, and that the inclusion of the measure might mean that patients may not have their pain adequately managed. Dr. Cott also shared his belief that prescribing practices in the emergency department have already changed in a positive way.

October – December 2016

No meetings

January – March 2017

Public testimony was received from the American Chapter, Oregon College of Emergency Physicians with concerns about the voluntary measure related to the opioid prescribing in the emergency department measure. The Committee expressed appreciation for the input, and that the analysis included in the testimony may be helpful in the future.

Jeremy Lynn, Medical Director of Providence Emergency Services testified to express concern about the construction of the Emergency Department Information Exchange (EDIE) measure, specifically that the denominator may be more impacted by efforts to reduce high emergency department utilization, which would inappropriately result in a deterioration in performance in terms of the metric.

April – June 2017

No meetings

Oregon Health Policy Board

October 4, 2016:

John Mullin from the Oregon Law Center spoke about the amount of complaints resolved as identified in the HST quarterly report and non-emergency medical transportation (NEMT) complaint tracking as well as NEMT brokerage and provider issues.

November 1, 2016:

John Mullen of the Oregon Law Center testified regarding the CCO listening session, Oregon's waiver, community collaboration and transportation. His testimony may be viewed here.

VII. Transition Plan, related to implementation of the Affordable Care Act

Transition plan finalized and approved by CMS in 2015.

VIII. Appendices

Appendix A. Quarterly enrollment reports

1. SEDS reports

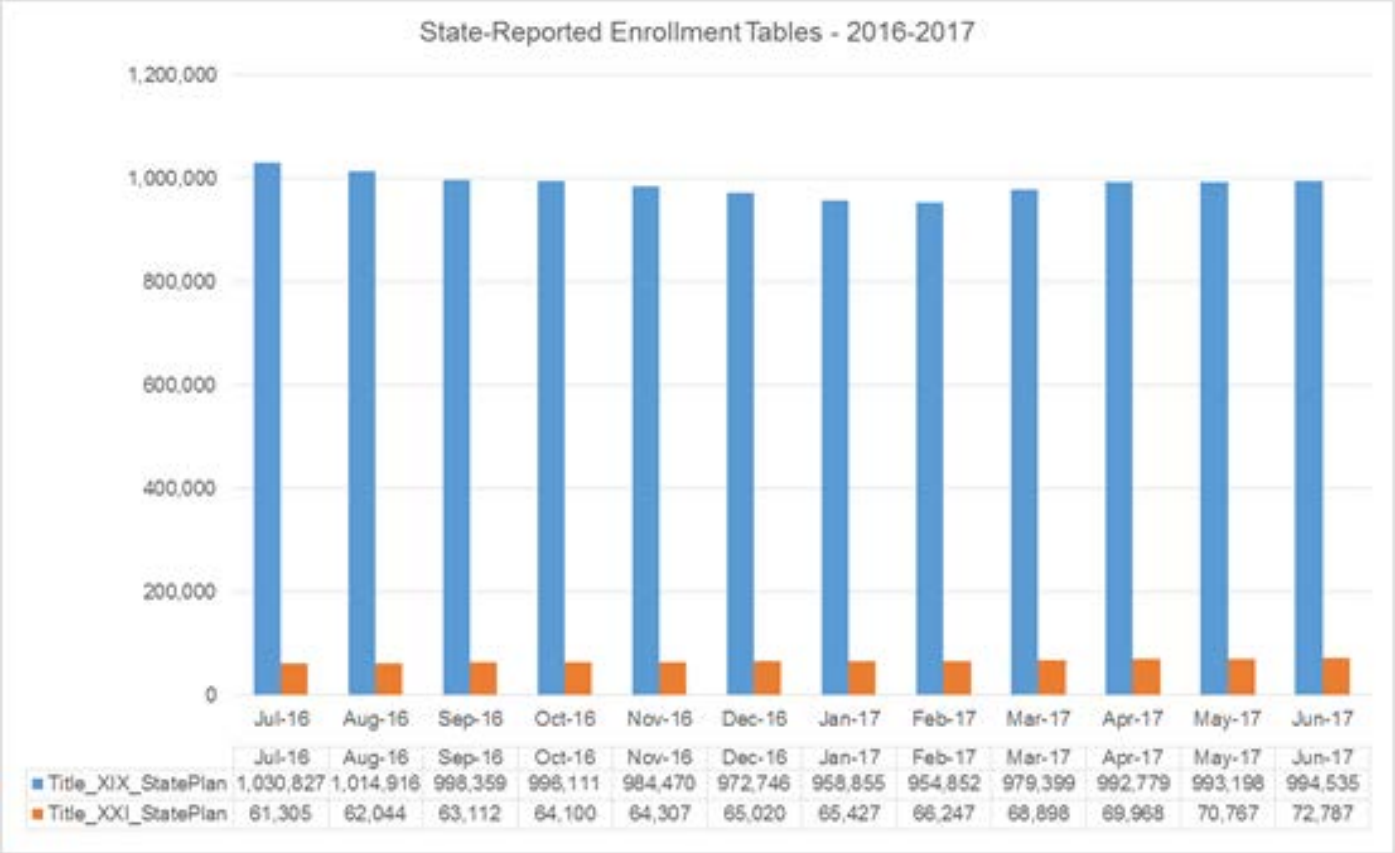
Attached separately as Appendix A – SEDS Reports SFY 2017 (Apr-Jun 2017, as posted at this link, is a preliminary report prior to finalization in October 2017.)

2. State reported enrollment tables

Enrollment	April 2017	May 2017	June 2017
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	992,779	993,198	994,535
Title XXI funded State Plan	69,968	70,767	72,787

Enrollment	April 2017	May 2017	June 2017
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH Funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A

Enrollment current as of	April 30, 2017	May 31, 2017	June 30, 2017



3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months
Expansion	**Title 19**	PLM Children FPL > 170%	59	346
		Pregnant Women FPL > 170%	19	139
	Title 21	SCHIP FPL > 170	94,964	729,619
Optional	**Title 19**	PLM Women FPL 133-170%	404	3,336
	Title 21	SCHIP FPL < 170%	92,236	602,985
Mandatory	**Title 19**	Other OHP Plus	184,178	1,872,392
		MAGI Adults/Children	1,006,954	9,179,412

POPULATION			Total Number of Clients	Member Months
		MAGI Pregnant Women	31,631	173,231
		QUARTER TOTALS	1,410,445	

OHP eligibles and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
July	1,018,823	870,336	1,794	52,641	4,078	1,094	36,227
August	1,005,897	860,226	1,154	51,621	4,275	1,020	38,519
September	992,067	840,024	856	50,287	4,278	904	38,866
October	990,970	833,196	786	50,322	4,197	850	37,380
November	980,907	838,906	837	50,041	4,121	746	36,448
December	970,047	825,212	861	48,813	3,955	723	35,229
January	956,790	810,242	745	47,018	3,921	709	35,014
February	953,384	810,669	890	45,862	3,806	749	34,437
March	978,379	829,396	954	46,250	3,820	720	34,615
April	991,424	844,916	860	47,118	3,831	746	34,760
May	992,172	858,837	1,211	47,560	3,875	757	34,872
June	995,082	857,641	741	47,665	3,782	672	33,646
Average	985,495	839,967	974	48,767	3,995	808	35,834
		85.23%	0.10%	4.95%	0.41%	0.08%	3.64%

**Total OHP Eligibles include TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/ Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.*

***CCOA: Physical, Dental and Mental Health; CCOB: Physical and Mental Health; CCOE: Mental Health only; CCOG: Mental and Dental*

Appendix B. Neutrality reports

Attached separately as Appendix B – Neutrality Reports SFY 2017

As required by Oregon Health Plan Demonstration Special Terms & Conditions (i.e., STC 82), the Oregon Health Authority certifies that the demonstration expenditures reported for budget neutrality the period of July 1, 2012, through June 30, 2017, are consistent with the amounts reported by the state on the CMS-64 report.

Appendix C. Two-percent trend reduction tracking

Attached separately as Appendix C – Two-percent Trend Reduction SFY 2017

Appendix D. Designated State Health Programs (DSHP) tracking

Attached separately as Appendix D – DSHP Tracking SFY 2017

Appendix E. Oregon Measures Matrix

Accompanying data, including the Oregon CCO Measures Matrix and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, are attached separately as Appendix E – Oregon Measures Matrix SFY 2017.

Throughout the demonstration year, OHA continued its standardized reporting to coordinated care organizations, hospitals and the public as well as ongoing measure development. During this year of the transformation demonstration, OHA distributed the fourth quality pool payment to CCOs and the third quality pool payments to hospitals. CCO and hospital data are provided in the measures matrices within the attached Appendix E – Oregon Measures Matrix SFY 2017 file.

CCO incentive metrics updates

CCO measure development and reporting

During this reporting period, OHA produced regular reports as well as final calendar year 2016 data at the state and CCO level. OHA continued to work with stakeholders to refine measure specifications, such as improving the effective contraceptive use measure (by including histories of tubal ligations), and to develop new measures, including food insecurity screening. OHA has maintained updated measure specifications and guidance online.

Clinical quality measures

All 16 CCOs had performance data successfully reported for the year. Notably, EHR-based data was submitted for three clinical quality measures (diabetes HbA1c poor control, controlling hypertension, and depression screening and follow-up). In addition, 2016 was the first year of reporting a state-specific smoking prevalence measure from EHRs. For the smoking measure, all 16 CCOs submitted data, although one CCO's data was excluded from measurement calculation because of data quality concerns. Year four (2016) data was used to calculate statewide and CCO level smoking rates, which were published in the 2016 final report.

The percentage of CCO members included in clinical quality measure reporting has continued to increase. For 2016, CCOs were required to meet a minimum population threshold for reporting of 25% for the new smoking prevalence measure and 65% for the other three clinical quality measures. All of the CCOs met the population thresholds. During this demonstration year, CCOs did test submissions of patient-level data on clinical quality measures using an Excel template, as a building block toward future reporting in Quality Reporting Document Architecture (QRDA) Category I.

Progress reporting

OHA continued to provide CCOs with monthly metrics dashboards, an interactive tool to analyze performance on CCO incentive and quality and access test measures. Measure results are reflected for a rolling 12-month period and member-level detail is included for claims-based measures to facilitate measure validation and quality improvement activities. OHA continued to work with its vendor to add measures as well as refine dashboard filters, including gender, race/ethnicity, disability status, and geography.

CCO Metrics 2016 Final Performance Report

OHA published two reports on the CCO incentive, state performance, and core performance measures to the Oregon Health Policy Board and the general public. A mid-year report was published in January 2017, and the final 2016 report was published in June 2017. All reports are available on OHA's Quality and Accountability – Oregon's Health System Transformation: Performance Metrics website.

The report indicates that the coordinated care model continues to demonstrate improvement in a number of areas, such as reductions in emergency department visits and increases in both depression screening and enrollment in Patient-Centered Primary Care Homes (PCPCH).

Specific improvements include:

- **Adolescent well-care visits** – All but one of the 16 CCOS improved in 2016 with 13 meeting their individual improvement targets. Statewide, performance on this metric has increased 47% since CCOs were formed in 2013. Unfortunately, while improvements are being made, overall performance is still less than half receiving a well-care visit as recommended by clinical guidelines.
- **Developmental screening in the first three years of life** – Major strides have been made since the beginning of the program. In 2011, only 21% of young children received an appropriate screening. Since then, the percentage has more than doubled to 62% in 2016.
- **Effective contraceptive use among women at risk of unintended pregnancy** – Although a new measure in 2015, the percentage of women ages 18-50 who are using an effective contraceptive has increased 19 percent in two years.
- **Health assessments for children in DHS custody** – The percentage of children in foster care who received a mental, physical and dental health assessment has increased 168% in only two years.

Areas for improvement include:

- **Initiation and engagement of alcohol or other drug treatment** – Statewide the percentage of members who continued their treatment and had two or more visits within 30 days of initial treatment was only 11.1%, representing a 40% decline since 2015.
- **Emergency department utilization** – Although emergency department utilization is very low in Oregon compared to national rates, in 2016 the utilization of the emergency department increased slightly over the previous year. However, avoidable hospital utilization continues to decline. Apparently, members used the emergency department more but for appropriate reasons.

OHA will continue to monitor these trends.

Quality Pool – 2016

OHA made the fourth annual quality pool payments to CCOs in June 2017. This year, OHA held back 4.25% of the monthly payments to CCOs (for a total of almost $179 million) which were put into the common quality pool. To earn their full incentive payment, CCOs had to meet the benchmark or improvement target on at least 13 of the 18 incentivized measures and have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from the quality pool formed the challenge pool, which was distributed to CCOs that met the benchmark or improvement target on a subset of four measures:

1. Depression screening and follow-up plan

2. Diabetes HbA1c poor control
3. Alcohol and substance use screening – Screening, Brief Intervention, and Referral for Treatment (SBIRT)
4. Developmental screening

As the program matures, we see that targets and benchmarks become more difficult to reach than in prior years as change requires greater transformation toward excellence. This year, only seven of the 16 CCOs earned 100% of their quality pool, as opposed to last year's 13. CCOs are having to demonstrate continued excellence and change to obtain their improvement targets.

	Phase 1 distribution			Challenge pool		Total	
CCO	Measures met	Payment earned in Phase 1*	% of quality pool funds earned	Measures met	Payment earned	Total payment	% of total quality pool earned
AllCare Health Plan	14.9	$9,289,825	100%	3	$1,231,864	$10,521,689	113%
Cascade Health Alliance	10.8	$2,394,930	70%	3	$413,799	$2,808,729	82%
Columbia Pacific	12.9	$4,598,806	80%	4	$947,924	$5,546,730	96%
Eastern Oregon	12.9	$8,877,570	80%	3	$1,203,801	$10,081,371	91%
FamilyCare	11.9	$16,432,704	80%	3	$3,049,131	$19,481,835	95%
Health Share of Oregon	11.9	$35,401,115	80%	3	$5,575,833	$40,976,948	93%
Intercommunity Health Network	11.8	$9,226,570	80%	3	$1,358,709	$10,585,279	92%
Jackson Care Connect	11.8	$4,490,390	80%	4	$1,122,541	$5,612,931	100%
PacificSource Central	13.9	$10,628,001	100%	3	$1,287,801	$11,915,802	112%
PacificSource Gorge	11.0	$1,877,837	70%	3	$319,133	$2,196,970	82%
PrimaryHealth Josephine Co.	16.0	$2,206,010	100%	4	$423,661	$2,629,671	119%
Trillium	12.8	$14,953,435	80%	3	$2,263,925	$17,217,360	92%
Umpqua Health Alliance	14.0	$5,277,015	100%	4	$1,022,051	$6,299,066	119%
Western Or. Advanced Health	14.9	$4,701,278	100%	4	$765,102	$5,466,380	116%
Willamette Valley Comm. Health	14.0	$18,540,644	100%	4	$3,761,895	$22,302,539	120%
Yamhill CCO	13.9	$4,616,761	100%	3	$579,163	$5,195,924	113%
Total		**$153,512,891**			**$25,326,333**	**$178,839,224**	

* Quality pool distribution is based on the number of measures met and CCO size (number of members enrolled).

Hospital metrics updates

Hospital Transformation Performance Program

During this reporting period, data from the third year of the Hospital Transformation Performance Program (HTPP) were finalized and published, and hospitals received their third payments from the quality pool. This was the second year hospitals were paid for performance as the first year was paid for reporting. The third HTPP report details how hospitals are doing on 11 key quality and outcome metrics focused on improving the quality of care and improving patient safety. The Oregon Hospital Transformation Program – Year 3 Performance Report covers the third year of the program (October 2015 – September 2016). Results for prior years were rebased for appropriate comparisons. The report was compiled and published in June 2017.

Highlights from the report:

- **Follow-up after hospitalization for mental illness** – In year three of the program, 23 hospitals of the 27 eligible on this measure improved their performance, and 22 met the benchmark or improvement targets set.
- **Hypoglycemia in inpatients receiving insulin** – This measure is part of an effort to avoid adverse drug events while in the hospital, particularly since insulin is a required component of diabetes care. If not properly monitored in the hospital, blood sugar drops and hypoglycemia ensues. For this metric 17 hospitals improved over the prior year with 24 of the 28 eligible hospitals achieving their benchmark.
- **Emergency Department Information Exchange (EDIE)** – For this measure, there was a 20.5% improvement statewide since the prior year. In addition, 23 of 27 eligible hospitals achieved benchmark or improvement targets.

Key areas needing improvement for hospital measures are: readmissions (this measure includes readmission to other hospitals), central-line associated bloodstream infection rates, and patient experience measures reported through the Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Year 3 Quality Pool

OHA made the third quality pool payments to hospitals in June 2017. In this third year, a total of almost $87.5 were awarded based on hospitals attaining benchmarks or improvement targets on the 11 measures.

A two-phase distribution method determined amounts awarded. In the first phase, all participating hospitals were eligible for a "floor" payment of $500,000 if they achieved at least 75 percent of the measures for which they were eligible (achieved meant meeting benchmarks or improvement targets). Thirteen hospitals achieved this floor, resulting in $6.5 million payments. During the second phase, the remaining $81 million was distributed based on the value of each metric where targets were met and the relative hospital size.

HTTP Quality Pool measures weighting

Measure	Measures weight	Total amount available for measure	Hospitals achieving measure
CAUTI in all tracked units	9.38%	$7,592,097	17
CLABSI in all tracked units	9.38%	$7,592,097	23

HTTP Quality Pool measures weighting			
Measure	**Measures weight**	**Total amount available for measure**	**Hospitals achieving measure**
Adverse drug events due to opioids	6.25%	$5,061,398	28
Excessive anticoagulation with warfarin	6.25%	$5,061,398	27
Hypoglycemia in inpatients receiving insulin	6.25%	$5,061,398	24
HCAHPS: Staff always explained medicines*	9.38%	$7,592,097	10
HCAHPS: Staff gave patient discharge information	9.38%	$7,592,097	15
Hospital-wide all-cause readmissions	18.75%	$15,184,193	15
Follow-up after hospitalization for mental illness	6.25%	$5,061,398	22
SBIRT: Screening for alcohol and other substance misuse in the ED*	6.25%	$5,061,398	23
EDIE: Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits*	12.50%	$10,122,796	23
Total	**100.00%**	**$80,982,365**	

HTPP Quality Pool – Year 3					
Hospital	**Medicaid discharges**	**Measures met**	**Phase 1 payment earned**	**Phase 2 payment earned**	**Total amount earned**
Adventist	2,959	7	$0	$2,792,616	$2,792,616
Asante Rogue Regional	2,548	9	$500,000	$4,249,047	$4,749,047
Asante Three Rivers	1,743	8	$0	$1,971,345	$1,971,345
Bay Area Hospital	1,235	6	$0	$822,183	$822,183
Good Samaritan Regional	1,368	4	$0	$598,508	$598,508
Kaiser Sunnyside	625	8	$0	$605,447	$605,447
Kaiser Westside	30	10	$500,000	$54,903	$554,903
Legacy Emanuel	5,641	7	$0	$8,302,932	$8,302,932
Legacy Good Samaritan	1,385	9	$500,000	$2,847,854	$3,347,854
Legacy Meridian Park	611	9	$500,000	$708,580	$1,208,580
Legacy Mount Hood	1,584	11	$500,000	$2,916,424	$3,416,424
McKenzie-Willamette	1,152	5	$0	$1,207,499	$1,207,499
Mercy	1,738	8	$0	$2,005,539	$2,005,539
OHSU Hospital	8,024	8	$0	$12,771,063	$12,771,063
PeaceHealth Sacred Heart RiverBend	5,395	7	$0	$4,737,389	$4,737,389
PeaceHealth Sacred Heart University	531	9	$500,000	$1,386,200	$1,886,200
Providence Medford	1,203	8	$0	$1,725,312	$1,725,312
Providence Milwaukie	828	9	$500,000	$1,049,890	$1,549,890
Providence Portland	4,875	8	$0	$7,850,798	$7,850,798
Providence St Vincent	4,326	10	$500,000	$8,640,046	$9,140,046
Providence Willamette Falls	1,087	10	$500,000	$1,606,468	$2,106,468
Salem Health	3,817	8	$0	$3,713,448	$3,713,448
Samaritan Albany General	1,020	9	$500,000	$1,328,723	$1,828,723

HTPP Quality Pool – Year 3					
Hospital	Medicaid discharges	Measures met	Phase 1 payment earned	Phase 2 payment earned	Total amount earned
Hospital					
Shriners Hospital for Children	203	7	$500,000	$300,535	$800,535
Sky Lakes	1,332	9	$500,000	$1,558,266	$2,058,266
St Charles Bend	2,679	7	$0	$2,470,299	$2,470,299
Tuality Healthcare	1,269	7	$0	$1,269,776	$1,269,776
Willamette Valley	848	10	$500,000	$1,491,275	$1,991,275
Total	**60,056**		**$6,500,000**	**$87,482,365**	**$87,482,365**

Committee and technical advisory workgroup updates

CCO Metrics and Scoring Committee

This legislatively-appointed Committee met almost monthly during the demonstration year to select measures and benchmarks and refine overall methodology for the CCO incentive program. All meeting materials are available on OHA's Office of Health Analytics – Metrics and Scoring Committee website.

CCO Metrics Technical Advisory Group

The CCO Metrics Technical Advisory Group (CCO TAG) met monthly during the demonstration year to select measures and benchmarks and refine overall methodology for the CCO incentive program. All 16 CCOs and a variety of stakeholders participated in these statewide discussions. Meeting materials are available on OHA's Office of Health Analytics – Metrics Technical Advisory Group website.

Hospital Performance Metrics Advisory Committee

This legislatively-appointed committee met twice during the demonstration year to develop measures and domains, establish benchmarks, and refine specifications and methodology for the hospital incentive program. All meeting materials are available on OHA's Office of Health Analytics – Hospital Performance Metrics Advisory Committee website. The committee plans to meet in July to review The Oregon Hospital Transformation Program – Year 3 Performance Report.

Hospital Metrics Technical Advisory Workgroup

The Hospital Metrics Technical Advisory Group (Hospital TAG) convened by OHA in July 2015 to address details related to incentive measures and overall analytic activities. All Diagnosis-Related Group (DRG) hospitals and a variety of stakeholders participated. Meeting materials are available on OHA's Office of Health Analytics – Hospital Metrics Technical Advisory Group website.

Quality and access

CCO metrics

During the demonstration year, OHA has been working with its contractor, Center for Outcomes Research and Education (CORE), to conduct the quality and access test. CORE has independently produced the quality and access test measures to verify OHA's reporting.

Together with OHA, CORE conducts multi-directional validation procedures on the CCO incentive measures and quality and access test measures that include code review and process checks on multiple measurement

periods and for various subsets of groups. Validation is an ongoing and intensive work process for the measurement periods in order to reflect annual updates to specifications. Throughout the year weekly meetings have ensured that OHA and CORE work closely to reconcile differences found in data and to ensure quality and accuracy of the quality and access test.

Annual performance of quality and access for all CCOs are available on OHA's Quality and Accountability – Oregon's Health System Transformation: Performance Metrics website.

Consumer Assessment of Healthcare Providers and Systems

Background

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. Users of CAHPS survey results include patients and consumers, quality monitors and regulators, provider organizations, health plans, community collaborative, and public and private purchasers of health care. These individuals and organizations use the survey results to inform their decisions and to improve the quality of health care services.

The CAHPS program is funded and overseen by the U.S. Agency for Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private research organizations. AHRQ and its grantees and contractors develop and maintain the CAHPS surveys. Over the past 15 years, the CAHPS Consortium has established a set of principles to guide the development of CAHPS surveys and related tools. These principles include identifying and supporting the consumer's or patient's information needs, conducting thorough scientific testing, ensuring comparability of data, maintaining an open development process, and keeping products in the public domain.

Oregon has been administering the CAHPS Health Plan survey among its Medicaid adult and child population since 1998 and is one of the pioneer states that has pilot tested numerous quality improvement measures through the survey in collaboration with AHRQ.

Introduction to the CAHPS 2017 (MY 2016) Health Plan Survey

CAHPS is a key component of health care quality measurement. The surveys reflect members' experience with their health plan and providers. The results obtained allow OHA and the individual CCOs to determine how well they are meeting their member's expectations, provide feedback to improve the quality of care, encourage CCO accountability, and help develop an action plan to improve members' quality of care.

OHA fielded the 2017 (MY 2016) CAHPS Health Plan surveys to monitor Medicaid member experience under the coordinated care model. There are separate versions of the survey for adults and children. Conducting multiple versions of the survey helps OHA meet multiple requirements, including two CCO incentive measures (Access to Care and Satisfaction with Care) and one state performance measure (Medical Assistance with Tobacco Cessation). CAHPS survey results are a required element for the 1115 demonstration waiver evaluation.

Oregon Health Authority

The 2017 CAHPS (MY 2016) Health Plan survey included a random sample drawn from each of the 16 CCOs providing managed care and from the fee-for-service population. The final survey sample included 16,200 adult Medicaid enrollees and 16,200 child Medicaid enrollees. Adults are defined as members aged 18 years or older and children as 17 years old or younger, both as of November 30, in the measurement year. For inclusion in the 2017 CAHPS survey, members had to be enrolled in Oregon Health Plan (OHP) for at least six months as of November 30, 2016, with no more than a 45-day gap at the time of survey fielding. An appropriate representation of minority populations was achieved through oversampling of minority race and ethnicity populations.

The survey was administered over a 10-week period from January 2017 through April 2017, using a mixed-mode five-wave protocol. This protocol consisted of a pre-notification letter, an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and reminder postcard to non-respondents. Phone follow-up was conducted for members who had not responded to the mailings. Respondents were surveyed in English and Spanish.

The CAHPS Health Plan Survey produces the following composite measures of patient experience by combining survey results of similar questions:

- Getting Care Quickly
- How Well Doctors Communicate
- Customer Care Service
- Members' Overall Ratings for their Health Care, Personal Doctors, Specialists, and Health Plan

Key findings

Getting care quickly (Access to Care)

Improving access to timely care and information helps increase the quality of care and reduce costs. Measuring access to care is an important part of identifying disparities in health care and barriers to quality care, including a shortage of providers, lack of transportation, or long waits to get an appointment. This composite measure addresses whether members thought they received appointments and care when they needed them.

- Four CCOs met the statewide benchmark or improvement target.
- Seven CCOs demonstrated improvement over last year.
- Access to care statewide increased by 0.1%.

Customer care service (Satisfaction with Care)

Access to health plan information from the customer service department is essential to members' ability to understand their health care correctly, coordinate health care personally, and make more cost-effective choices for care. This composite measure addresses whether members received needed information or help and thought they were treated with courtesy and respect by customer service staff.

- Six CCOs met the statewide benchmark or improvement target.
- Seven CCOs demonstrated improvement over last year.
- Satisfaction with care statewide increased by 0.6%.