# Oregon Health Plan

## Section 1115 Quarterly Report

7/1/2017 – 6/30/2018

Demonstration Year (DY): 16

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# I. Introduction

## A. Letter from the State Medicaid Director

As our first year operating under the renewed 1115 Medicaid Demonstration ends, I am pleased to report the Oregon Health Authority (OHA) is working diligently to meet the goals of the Oregon Health Plan (OHP) demonstration. Oregon's unique coordinated care model has made progress on the triple aim goals of better health, better care, and lower costs. As the source of health coverage for nearly one million Oregonians, OHP and its 15 coordinated care organizations (CCOs) have improved access to primary care, reduced costly emergency room visits, and saved the state an estimated $2.2 billion dollars in avoided health care costs.

To guide the next five years of coordinated care, the Oregon Health Authority has worked in partnership with the Oregon Health Policy Board (OHPB), policymakers, stakeholders, and OHP members to bring forward new ideas to address the gaps and challenges that persist in our health care system. We are calling this next phase of health care transformation "CCO 2.0." OHA's CCO 2.0 policy recommendations build upon Oregon's strong foundation of health care innovation and seek to make improvements based on best practices, evidence, and stakeholder and community input. Policy recommendations focus on four key areas that tackle Oregon's biggest health problems: 1) Improve the behavioral health system; 2) Increase value and pay for performance; 3) Focus on the social determinants of health and health equity; and 4) Maintain sustainable cost growth.

As you will find detailed in the full report, OHA and coordinated care organizations (CCO) continue to press toward health system transformation (HST) Levers, as identified in the waiver agreement. Highlights from the report include the following.

- **Lever 1: Improving care coordination**
  Oregon became the first state in the nation to issue payment of newly authorized state savings back into the tribal health system. New interpretation at the federal level of Section 1905(b) provides that health services coordinated by Indian Health Service (IHS) and Tribal 638 facilities are eligible for 100% federal matching funds. Oregon Governor Kate Brown followed up on this federal policy change with a letter to the tribes on directing the state to develop a method to direct these state savings back to the tribes for reinvestment into tribal health programs and services.

  This additional funding and reinvestment in tribal heath care provides a significant incentive for tribes to improve their care coordination systems and methods, particularly for those with multiple or complex conditions.

- **Lever 2: Implementing alternative payment methodologies (APMs)**
  In June, OHA made the fourth quality pool payments to hospitals participating in the hospital Transformation Performance Program (HTPP), and the HTTP's fourth-and-final year's report for January – December 2017 was published. A total of nearly $90 million was awarded based upon hospitals achieving benchmarks or improvement targets.

  The Alternative Payment and Care Model (APCM) continues to transition from an alternative payment methodology to a value-based payment method. Two additional Federally-qualified Health Centers

(FQHC) and two Rural Health Centers are set to launch on the APCM in July 2018, and three more FQHCs are set to launch in April 2019. Onboarding activities for the next phase of health centers are currently underway.

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

  OHA is making strides toward integrating physical, behavioral, and oral health care. OHA collaborated with the American Cancer Society to have a dental tract at the Oregon HPV Statewide Summit in May to highlight the need for medical and dental professionals to work together to decrease rates of oropharyngeal cancer by ensuring clients get the HPV vaccine.

  OHA is also currently in the process of implementing the most significant recommendations from the Behavioral Health Governance and Finance Workgroup: Risk Sharing with Oregon State Hospital (OSH) and Regional Behavioral Health Collaboratives (RBHC). OHA is establishing an RBHC in the tri-county Portland-metro area. FamilyCare CCO's decision to leave the Medicaid market has illuminated the different approaches within this region's behavioral health system and has identified the opportunity for timely attention to address the region's ongoing behavioral health challenges. Partners in the metro area are willing and ready to move forward in developing an RBHC.

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

  While innovator agents continue to connect OHA and the CCOs to achieve the goals of health system transformation, and OHA's Public Health and Health Systems divisions connect to advance the Sustainable Relationships for Community Health (SRCH) grant program, two new capacity building grants are supporting the development of the first Regional Health Equity Coalitions (RHEC) in Eastern Oregon.

  The grantees, Confederated Tribes of Warm Springs (the first group fully focused on a tribal population) and Euvalcree, are piloting the RHEC model with the health equity work they are doing. This funding offers an opportunity to complete foundational RHEC activities (i.e. coalition building, developing governance structures, assessing community needs, etc.). RHECs collectively represent regions that comprise 57.2% of Oregon's Medicaid population and 53.4% of Oregon's communities of color.

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

  OHA continues working to develop additional guidance to assist CCOs as they implement the revised definition of health-related services (HRS) and to improve communication on tracking and reporting the use of HRS and outcomes associated with flexible services.

  Key results of CCOs' Performance Improvement Projects show improvement in several areas including: medication-assisted treatment for those with a primary diagnosis of opioid-use disorder; increases in adolescent well-care visits; decreased self-reported cigarette smokers age 13 +; and decreased all-cause readmissions to the hospital.

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

  The spread of best practices and innovation continue through OHA's Transformation Center. The Transformation Center is developing a guidance document for CCOs on aspects of integrated care in both primary care and specialty behavioral health. OHA launched a one-year project to develop an aligned vision for the future of behavioral health in Oregon and establish a clear action plan. Following

the project, he state will implement a Regional Behavioral Health Collaborative in the Portland Metro area including aligned goals and metrics.

Two CCOs have started oral health integration projects with consultants through the Transformation Center. One CCO is reviewing the recent implementation of a pilot integrating oral health care in the primary care provider's office. The other CCO is working with stakeholders to develop a workplan for oral health integration that includes any relevant activities during the quarter related to CCO and tribal technical assistance or other activities.

As OHA continues to invest in health system transformation, we look forward to improving health outcomes and health care in Oregon by working with our partners and stakeholders to meet the goals of the demonstration while accomplishing the targeted changes included in the extended waiver.

*David Simnitt, State Medicaid Director*

## B. Demonstration Description

In July 2012, CMS approved an amendment and extension related to Oregon's 1115 Medicaid Demonstration waiver that transformed Oregon's health care delivery system to one of coordinated care. Sixteen Coordinated Care Organizations (CCOs) – which geographically cover the entire state – now deliver physical, oral and behavioral health services to approximately 90 percent of OHP members. During the previous five-year demonstration, which ended on June 30, 2017, Oregon sought to demonstrate the effectiveness of delivery system improvements under health system transformation.

In January 2017, CMS approved an extension to Oregon's 1115 Medicaid Demonstration waiver to continue and enhance Oregon's health system transformation initially approved in 2012. Moving forward, Oregon will continue to utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

Under the demonstration, Oregon strives to promote the objectives of Title XIX by:

- Providing a basic benefit package;
- Insuring broad participation by health care providers;
- Implementing a clinical-effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Structuring benefits, using a prioritized list of health care conditions and treatments; and
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing per capita costs of care for populations through such improvements.

The demonstration seeks to improve the coordinated care model to meet the following key goals:

1. Enhance Oregon's Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve;
2. Increase the state's focus on encouraging CCOs to address the social determinants of health and improve health equity across all low-income, vulnerable Oregonians to improve population health outcomes;
3. Commit to ongoing sustainable rate of growth and adopt a payment methodology and contracting protocol for CCOs that promotes increased investments in health-related services and advances the use of value-based payments; and
4. Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

The extension of the demonstration also includes the following targeted changes:

- Extension of the Hospital Transformation Performance Program through June 30, 2018, at which point hospital performance payments will transition to coordinated care organizations (CCOs);
- Conversion of the Tribal uncompensated care payments to a Medicaid benefit;
- Clarifying health-related services that meet the requirements as specified in the Code of Federal Regulations (CFR);
- Allowing passive enrollment of Medicare and Medicaid dually-eligible individuals into CCOs with the option for each individual to opt-out at any time;
- Specifying the demonstration will not impact American Indian and Alaska Natives (AI/AN) rights to exemption from managed care, or the requirements to comply with the Medicaid Managed Care Regulations;
- Providing for incentive payments for Patient-Centered Primary Care Homes (PCPCHs) and Comprehensive Primary Care Plus (CPC+) providers that reflect provider performance in these programs for Medicaid beneficiaries who are served through the fee-for-service delivery system; and
- Establishing minimum requirements for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

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## II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 07/01/2017 – 06/30/2018
Demonstration Year (DY): 16

## III. Overview of the current quarter

### A. Enrollment Progress

**1. Oregon Health Plan Eligibility**

During 2017, Oregon made a focused effort to finish transitioning Oregon Health Plan (OHP) member eligibility that remained in the state's Legacy system into the new Oregon Eligibility (ONE) system for MAGI Medicaid/CHIP programs and Former Foster Care Youth. This effort was completed in August 2017.

ONE system enhancements have continued to be implemented in order to correct minor system defects, implement eligibility functionality, which could not be included in the initial system launch, and improve overall process efficiencies. Significant system enhancements this year have included adding ex-parte renewal, or "automated renewal", functionality in November 2017, Hospital Presumptive Eligibility in April 2018, and 100% annual income gap-filling determinations in April 2018. Because these processes had been previously completed in ways which required more manual intervention, these system enhancements have not only improved accuracy but have also allowed for faster, more automated, and more consistent determinations.

OHP Statewide Processing Center has continued to prioritize incoming eligibility work and complete the more critical items first, which included anticipating and prioritizing the increased volume of account transfer referrals during this year's Federally Facilitated Marketplace's (FFM) open enrollment period.

Oregon has now also established a method of secure file transfer with the FFM Appeals Entity and has begun to receive, review, and re-process eligibility for individuals who have been referred to the state for Medicaid/CHIP determinations based on appeal findings.

### 2. Coordinated Care Organization Enrollment

The Oregon Health Authority's (OHA) enrollment strategies have remained consistent with previous reporting periods. During the 2017-2018 fiscal year, OHA successfully transitioned to the Oregon Eligibility (ONE) system and made significant advances in reducing the fee-for-service population, and Oregon Health Plan (OHP) eligibility determination transitioned to the Department of Human Services (DHS).

While there are no significant changes in eligibility and coordinated care organization (CCO) enrollment numbers, OHA continues to ensure eligible OHP members are appropriately enrolled into CCOs. While new member enrollment is an automatic process in the Medicaid Management Information System (MMIS), OHA's quality control measures verify member demographics to make sure members who can be enrolled in a CCO, are enrolled.

For related data see Appendix A: Enrollment reports, which is attached separately

## B. Benefits

The Pharmacy and Therapeutics Committee developed new or revised prior authorization (PA) criteria for the following drugs: drugs for asthma and chronic obstructive pulmonary disease (COPD), Hep-C direct-acting antivirals, biologics for autoimmune conditions, Vesicular Monoamine Transporter 2 (VMAT2) inhibitors, PCSK-9 inhibitors, drugs for bone metabolism, Luxturna (voretigene neparvovec), drugs for atopic dermatitis, Keveyis (dichlorphenamide), anti-Parkinson's agents, drug exclusion list (removed from PA guide), short-acting opioids, clostridium difficile drugs, and botulinum toxins.

Changes to drugs on the Preferred Drug List:

- Made Tacrolimus Preferred;
- Made Pimecrolimus Preferred;
- Made Dupilumab non-preferred;
- Made Benlysta (belimumab) non-preferred; and
- Made bezlotoxumab non-preferred

On January 1, 2018, the 2018-2019 Prioritized List, based on our biennial report, went into effect. Since then, the Health Evidence Review Commission (HERC) has made interim modifications to address changes in evidence, medical technology, and practice guidelines. These changes are described in the Interim Modifications letters sent to Oregon legislative leadership in March 2018.

## C. Access to Care

### Coordinated Care Organization Provider Delivery System Networks

#### *Analysis*

The 2017 Coordinated Care Organization (CCO) Contract requires all CCOs to demonstrate compliance with federal and state provider network standards. CCOs demonstrate this through the following reports they submit annually to the Oregon Health Authority (OHA): Delivery Service Network (DSN) Provider Narrative Report and DSN Provider Capacity Report. These contract deliverables, in combination with Hospital Network

Adequacy and Cooperative Agreements reporting, certify to OHA that all covered services are available and accessible to members and that the CCO demonstrates adequate provider capacity.

In April 2017, OHA collaborated with HealthInsight Assure (HIA) to provide training for the CCOs regarding the expectations for DSN annual reporting. At that time, OHA also approved the use of a standardized review criteria for evaluating CCO's DSN narrative reports. The DSN review criteria was shared with CCOs at the 2017 CCO training. The CCOs were encouraged to use this document as a tool to evaluate their narrative responses, in addition to meeting contract requirements for DSN analysis. This review criteria included five indicator categories, chosen based on contract requirements and areas for further development, and pilot scoring to assess the completeness of the CCO's responses in its DSN Narrative Report.

OHA also contracted with HIA to review and analyze the DSN reports submitted by CCOs in July 2017. HIA conducted their review using the new DSN criteria for evaluating these reports. All CCOs were reviewed to these criteria regardless of whether the CCO chose to directly address the five indicator categories in their DSN narrative. HIA also reviewed CCOs' 2017 DSN Provider Capacity Reports. This report shows CCOs' network capacity in 29 categories of service (practitioners and facilities), with required data elements.

### *Results*

**Strengths**

- The majority of CCOs provided the required data elements in 2017 DSN Capacity Reports.
- All CCOs reported incorporating member feedback through review and analysis of grievances. A few CCOs utilized member survey data. Several CCOs also described the use of their community advisory councils in providing feedback regarding network adequacy.
- CCOs reported giving members the opportunity to choose providers, provided information in alternate languages and formats, and supported members with special health care needs in accessing treatment through care coordination.
- Half of CCOs provide examples of commitment to providing culturally and linguistically appropriate services throughout their organization. Several CCOs reported working with the OHA's Office of Equity and Inclusion and the Transformation Center for equity consultation and technical assistance in addressing the delivery of services throughout their organizations.
- Some CCOs addressed how member needs for continuity of care and transition between levels of care is assessed. A few CCOs described how they use technology to deliver team-based care and other innovations. Several described how the electronic health record is used to coordinate care, including preventive health care, for all enrollees across the continuum of care.

**Areas for Improvement**

- Despite DSN Narrative report criteria requiring CCOs to "ensure to OHA, with supporting documentation, that all Covered Services are available and accessible to Members," CCOs' documentation generally did not establish the availability of all Covered Services.
- The majority of CCO submissions generally addressed DSN topics; however, descriptions and analysis of specific network areas (e.g., traditional health workers, non-emergent medical transportation (NEMT), continuum of care for treatment of behavioral health services, use of alternative therapies) were absent.

- Most CCOs did not identify a process for taking into account member characteristics when making provider assignments. However, CCOs reported multiple methods for meeting diverse member needs. Some CCOs described efforts to address patterns of underutilization and overutilization when addressing network adequacy.

- Most CCOs did not describe an integrated approach for analysis of the provider network. Often dental health and sometimes behavioral health were not mentioned in the DSN narrative report.

- All CCOs described the use of specialty providers, yet most did not analyze the prevalence of diseases that require access to specialists among their population.

- The majority of CCOs struggled to describe how interdisciplinary care teams are used to coordinate services across the continuum or adequately describe a process for identifying and assessing members with special health care needs (SHCN). Few provided comprehensive analysis of whether coordinating services provided by the CCO were adequate in reducing hospital readmissions and emergency room use.

### *Response*

OHA actions to address recommendations and opportunities for improvement identified by HIA:

- Implement time and distance standards for network adequacy *(effective January 1, 2018 for Oregon contracts)*. These standards are incorporated in Oregon Administrative Rule (OAR) 410-141-3220 and apply to:
    - Primary care – adult and pediatric;
    - Specialists – adult and pediatric;
    - Behavioral health (mental health and substance use disorder) – adult and pediatric;
    - OB/GYN;
    - Hospital;
    - Pharmacy; and
    - Dental – adult and pediatric.
- Language added to 2018 CCO Contract to incorporate reporting of average time and distance standards and improve the overall consistency of the information supplied by CCOs in DSN Reports. To ensure each CCO provides comparable data points (DSN Capacity and Narrative reports), OHA will require CCOs to provide DSN responses within a single template. Template was incorporated by reference in CCO 2018 Contract and posted on OHA's website, December 2017.
- DSN Guidance document for CCOs developed by OHA and posted on OHA website, December 2017. Guidance document communicates contractual requirements for DSN reports.
- OHA continues to encourage CCOs to use these annual network reports as a tool to assess and improve network adequacy, not simply as a contract deliverable.
- OHA will continue to administer, or Contract for, the adult (MHSIP), family (YSS-F), and youth (YSS) mental health surveys, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and share survey results with CCOs. Member surveys benefit CCOs and OHA and contribute to comprehensive picture of behavioral health provider network adequacy, enrollee access to care and the quality of the services provided. OHA will continue to work with CCOs to improve the functionality of the survey data collected.
- OHA will continue to work with CCOs and other stakeholders to clarify roles, responsibilities and opportunities for care coordination. OHA rule coordinators and internal subject matter experts did a great deal of work on the Care Coordination rule, OAR 410-141-3170, in 2017 to bring Oregon into compliance

with New Rules, however, there is still work to be done to complete the task of making this rule more user-friendly.

  - OHA Integrated Health Programs, in an agreement with OHA internal partners for these areas, agreed that remaining work will be completed with reopening the rule in 2018.
  - Language in the 2018 CCO Contract, Exhibit B Part 2 and Part 4 on Care Coordination, has been updated to comply with New Rules.
  - OHA will continue to support the CCOs in developing effective care coordination efforts to meet the needs of enrollees and decrease duplication of services and administrative efforts.

- OHA is currently working with HealthInsight Assure to incorporate CCO responses, clarification and resubmission of 2017 provider network data in response to Contractor's initial review results.
- In the context of CCO 2.0, OHA will reexamine the DSN Reports to ensure accurate reporting of comprehensive provider network and clarify objectives of these Contract deliverables. CCOs and stakeholder input will be solicited by OHA as part of CCO contracting process.

### Oregon Access Monitoring Review Plan

For the fee-for-service system, Oregon continues efforts to operationalize the primary monitoring activities identified in the Access Monitoring Review Plan (AMRP) by building a dashboard that incorporates quarterly utilization rates for the required service categories and quarterly beneficiary complaint rates. The primary monitoring functions are also able to hone in on specific regions of the state to compare access in those areas to the statewide baseline and threshold. Testing and updates to the dashboard continue to take place, and additional plans to add county level detail are being designed.

The Oregon Health Authority is continuing work with the nine federally recognized tribes through formal Tribal Consultation and additional meetings to better incorporate their feedback into the plan. In Oregon, approximately 50% of tribal Oregon Health Plan members have chosen not to enroll in managed care plans. Oregon intends to update the AMRP with an additional public comment period and re-submit the plan to the Centers for Medicare and Medicaid Services (CMS) by June 2019.

### Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses provide the Oregon Health Authority with access and quality data directly from Oregon Health Plan (OHP) clients. Regarding access, the survey asks clients how often they received urgent care when they needed it and how often they were able to make an appointment for routine care when they needed it. The latest survey was fielded in early 2018, and clients eligible to receive and complete the survey needed to be continuously enrolled in OHP from 6/1/2017 through 11/30/2017. Of the adults who responded, 78.5% reported that they were able to access care when they needed it. Responses for children's access reported that 86.8% were able to access care when they needed it. No significant differences in access to care were noted between coordinated care and fee-for-service clients.

## D. Quality of care

### Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses provide the Oregon Health Authority with access and quality data directly from Oregon Health Plan (OHP) clients.

Regarding quality, the survey asks clients how often their health plan's customer service teams provided them the information or help they needed and how often their health plan's customer service teams treated them with respect. The latest survey was fielded in early 2018, and clients eligible to receive and complete the survey needed to be continuously enrolled in OHP from 6/1/2017 through 11/30/2017. Of the adults who responded, 87.2% reported being satisfied with their health plan. Responses for children's satisfaction reported that 87.6% are satisfied with their health plan. Fee-for-service clients reported lower rates of satisfaction than coordinated care organization clients.

## Behavioral Health Quality Metrics

Oregon Governor Kate Brown has recommended that the state prioritize behavioral health care and its integration into the physical and oral health care systems. Five of the coordinated care organization (CCO) incentive and state performance measures assess this integration. Performance on all measures was published in the CCO Metrics 2017 Final Performance Report, published in June 2018.

### *CCO Incentive Measures*

- *Depression screening and follow-up plan* increased from 48.0% in 2016 to 58.2% in 2017, exceeding the 2017 benchmark of 52.9%. Fourteen CCOs improved from 2016, and 10 CCOs exceeded the benchmark for this measure.
- *Mental, physical, and dental health assessment within 60 Days for children in Department of Human Services (DHS) Custody* (foster care) increased more than 11 percent in 2017, from 74.4% to 82.8%. The benchmark is set at 90.0%.
- *Follow-up after hospitalization for mental illness* improved from 78.7% in 2016 to 84.7% in 2017, exceeding the 2017 benchmark of 82.7%. Fourteen CCOs improved from 2016, and 11 CCOs exceeded the benchmark for this measure.

### *State Quality and CMS Core Measures*

- *Follow-up care for children initially prescribed ADHD medication* rose slightly to 64.0%, beating the Medicaid National 90th percentile of 55.5%. All but one of the CCOs reported exceeding the benchmark, and 11 organizations improved from 2016. 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 ADHD care) also increased, reaching 75.4% in 2017 and exceeding the Medicaid National 90th percentile of 67.2%. At the CCO level, 12 organizations improved from 2016, and 14 exceeded the benchmark.
- After decreasing in 2016, *Initiation of treatment for members with alcohol or other drug dependence* increased slightly to 36.5%, but fell short of the benchmark of 38.1%. *Continuation and engagement of treatment* (percentage of members who had two or more additional services within 30 days of their initial treatment) was 11.3% for 2017. While this is a small increase from 2016, this rate is much lower than the 18.4% that was reported in 2015. The Oregon Health Authority (OHA) continues to explore these measures to help understand the root cause of this decline in performance and identify strategies for improvement.

## Oral Health Quality Metrics

Since 2015, Oregon has measured how well coordinated care organizations (CCO) deliver dental sealants to children. All 16 CCOs achieved the metric target in 2017, but only 14 out of 16 CCOs improved in the

percentage of students ages 6-14 receiving a dental sealant during the measurement year compared to 2016. The statewide change since 2016 was 12.1%.

The Metrics and Scoring Committee approved two oral health measures for the 2019 incentive measure set. Dental sealants on permanent molars for children will continue to be a measure, but the measurement specifications will change in 2020 to align with those of the Dental Quality Alliance, limiting the denominator to children with elevated risk codes or a restorative service. The Committee approved one new measure: oral evaluation for adults with diabetes. This measure will encourage CCOs to increase their efforts in integrating oral health within their systems of care for members.

## E. Complaints, grievances, and hearings

### Complaints

The information provided is a compilation of data from 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. One CCO closed January 31, 2018 and reported data through the first month of 2018 only. The FFS data became available in the 2nd quarter going forward. The annual reporting period covers July 2017 through June 30, 2018.

#### *Trends*

| | Jul – Sep, 2017 | Oct- Dec, 2017 | Jan-March, 2018 | April - June 2018 |
|---|---|---|---|---|
| Total complaints received | 4,157 | 4,995* | 5,537* | 5,882* |
| Total average members | 855,569 | 1,106,876* | 1,179,176* | 1,217,091* |
| Rate per 1,000 members | 4.71 | 4.51* | 4.70* | 4.83* |
| * FFS data is included in the totals beginning in October 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports. | | | | |

#### *Barriers*

CCOs report the *Access to Care* category continues to receive the highest number of complaints. There was an average increase in the overall *Access to Care* category of 26.9% during the four quarters of the reporting period. The Interaction with *Provider/Plan* category stayed somewhat steady during the reporting period with an increase during the 3rd quarter but decreasing again the following quarter. FFS data continues to show the highest number of complaints are in the *Quality of Service* category, with the *Access to Care* category the next highest.

#### *Interventions*

During the April-June 2018 quarter, CCOs reported they provided on-going training to case management staff, such as diversity and ethnicity workshops, and customer services receive literature and training on access to care, and cultural sensitivity. Some CCOs have changed Non -Emergency Medical Transportation (NEMT) brokerages as they continue to work on reducing the number of complaints associated with NEMT. Some CCOs report they are continuing to track and meet monthly to identify issues with billing. One CCO identified a trend that showed a providers' phone system was not working well, which was causing an increase in complaints. They are continuing to work with this provider and monitor the situation to ensure the issue is resolved.

Oregon Health Plan Member Services reports 568 complaints from FFS members for the April-June quarter. They reported an additional 476 records identified as complaints received from members enrolled in CCOs. In addition to the complaint calls, they took 2,473 calls from members asking for a variety of information, such as information about their coverage, CCO enrollment, and replacement ID cards.

### *Statewide rolling 12-month Complaints totals*

This chart includes the total of all complaints reported statewide by CCOs and FFS.

| Complaint category | Jul - Sep, 2017 | Oct- Dec, 2017 | Jan-March, 2018 | April – June, 2018 |
|---|---|---|---|---|
| Access to care | 1,719 | 2,343 | 2,213 | 3,076 |
| Client billing issues | 334 | 393 | 457 | 394 |
| Consumer rights | 215 | 205 | 230 | 220 |
| Interaction with provider or plan | 1,293 | 1,374 | 1,682 | 1,283 |
| Quality of care | 422 | 313 | 466 | 526 |
| Quality of service | 131 | 293 | 439 | 345 |
| Other | 43 | 74 | 50 | 38 |
| Grand Total | 4,157 | 4,995 | 5,537 | 5,882 |

### *Related data*

Reports are attached separately as Appendix B – Complaints and Grievances.

## Appeals and Hearings

### *Notices of Action – Adverse Benefit Determination*

The following table lists the total number of notices of action – adverse benefit determination (NOA-ABD) issued by coordinated care organizations (CCO) this demonstration year. The NOA-ABDs are listed by reason and are the total number of NOA-ABDs issued during each quarter, regardless of whether or not an appeal was filed. Federal rule changed January 1, 2018, which increased the timeframe to file an appeal from 45 days to 60 days, and some NOA-ABDs listed in the table below may not have an appeal request until the following quarter. CCOs report that pharmacy remains one of the top reasons for NOA-ABDs to be issued this quarter. One of the most common is for opioids/chronic pain, and dental has the next highest number of NOA-ABDs issued. CCOs report they are now using the new NOA-ABD format.

| **CCO Notice of Action-Adverse Benefit Determination (NOA-ABD)** | **Statewide rolling 12-month NOA-ABD totals** | | | |
|---|---|---|---|---|
| | Jul – Sep | Oct – Dec | Jan – Mar | Apr – Jun |
| a) Denial or limited authorization of a requested service. | 34,115 | 31,262 | 36,229 | 36,559 |
| b) Single PHP service area, denial to obtain services outside the PHP panel | 303 | 255 | 228 | 212 |
| c) Termination, suspension, or reduction of previously authorized covered services | 321 | 120 | 304 | 140 |
| d) Failure to act within the timeframes provided in § 438.408(b) | 17 | 9 | 12 | 31 |
| e) Failure to provide services in a timely manner, as defined by the State | 0 | 0 | 0 | 4 |
| f) Denial of payment, at the time of any action affecting the claim. | 22,757 | 19,346 | 15,087 | 19,111 |
| **Total** | **57,513** | **50,992** | **51,860** | **56,057** |
| Number per 1000 members | 67 | 46 | 56 | 61 |

**(Note:** *Per federal rule the name: Notice of Action changed to Adverse Benefit Determination. OHA decided to use the term: Notice of Action-Adverse Benefit Determination (NOA-ABD) for the current reporting year.)

### Appeals

The table below shows the total number of appeals that were received by the CCOs during the quarter. Federal rule changed January 1, 2018, and Oregon Health Plan (OHP) members are required to exhaust their appeal rights at the CCO level before a contested case hearing can be requested at the state level. The table below has been revised to reflect only CCO appeals information. CCOs reported that specialty care and outpatient services had a higher number of requests for appeal this quarter. CCOs continue to report that they provide education and training to their staff as well as providers to increase knowledge about covered benefits. CCOs continue to work with members to assist them in finding services they need or finding alternative covered options.

| **CCO Appeals** | **Statewide rolling 12-month appeal request totals** | | | |
|---|---|---|---|---|
| | Jul – Sep | Oct – Dec | Jan – Mar | Apr – Jun |
| a) Denial or limited authorization of a requested service. | 1,209 | 1,257 | 1,279 | 1,249 |
| b) Single PHP service area, denial to obtain services outside the PHP panel | 1 | 6 | 6 | 4 |
| c) Termination, suspension, or reduction of previously authorized covered services | 0 | 2 | 2 | 12 |
| d) Failure to act within the timeframes provided in § 438.408(b) | 0 | 0 | 0 | 0 |
| e) Failure to provide services in a timely manner, as defined by the State | 0 | 0 | 0 | 0 |
| f) Denial of payment, at the time of any action affecting the claim. | 435 | 320 | 320 | 318 |
| **Total** | **1,645** | **1,585** | **1,607** | **1,583** |
| Number per 1000 members | 1.9 | 1.4 | 1.73 | 1.73 |
| Number overturned at plan level | 495 | 522 | 495 | 455 |
| Appeal decisions pending | 24 | 8 | 51 | 50 |
| Overturn rate at plan level | 30.09% | 32.93% | 30.80% | 28.74% |

### Contested Case Hearings

The following information is a compilation of data from 16 CCOs, seven dental care organizations (DCO) and fee-for-service (FFS). One CCO closed January 31, 2018; the hearings data through the April – June quarter includes that CCO's data. During the last quarter, OHA received 504 hearing requests related to the denial of medical services which include NEMT services. The number of requests received for CCO-enrolled members was 485, and 19 were received for FFS.

The table below shows the outcomes of cases, some of which were decided after an administrative hearing. There were 22 cases approved prior to hearing where the CCO overturned the appeal resolution. Members withdrew from 32 cases after an informal conference with an OHA hearing representative and OHA dismissed 368 cases that were determined not hearable. Of the 35 cases that went to hearing, the administrative law judge upheld the OHA or CCO decision in 28 cases, and seven cases were dismissed because the member failed to appear. Six cases were dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

There was an increase in the cases determined not hearable due to a federal rule change effective January 1, 2018. OHP members must exhaust their appeal rights at the CCO level and receive notice of appeal resolution

(NOAR) before they can request a contested case hearing at the state level. Requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

| Contested Case Hearing Requests Processed | | | | | |
|---|---|---|---|---|---|
| Outcome Reasons | Jul – Sep | Oct – Dec | Jan – Mar | Apr – Jun | **Annual total** |
| Decision overturned after second hearing | 237 | 195 | 92 | 22 | **546** |
| Client withdrew request after pre-hearing conference | 188 | 188 | 95 | 32 | **503** |
| Dismissed by OHA as not hearable | 78 | 83 | 228 | 368 | **757** |
| Decision affirmed* | 89 | 86 | 75 | 28 | **278** |
| Client failed to appear* | 79 | 74 | 67 | 7 | **227** |
| Dismissed as non-timely | 35 | 35 | 30 | 6 | **106** |
| Dismissed because of non-jurisdiction | 0 | 0 | 0 | 0 | **0** |
| Decision reversed* | 3 | 2 | 5 | 0 | **10** |
| Set aside | 0 | 0 | 0 | 0 | **0** |
| **Total** | **709** | **663** | **592** | **463** | **2,427** |

* Resolution after an administrative hearing.

### *Related data*

Reports are attached separately as Appendix C – Appeals and Hearings.

## F. CCO activities

### 1. New plans

There are no new coordinated care organizations (CCOs) or other physical, behavioral, or dental plans serving the Medicaid population.

### 2. Provider networks

Oregon's second largest coordinated care organization (CCO), FamilyCare, Inc., told the Oregon Health Authority (OHA) that it would no longer serve Oregon Health Plan (OHP) members effective December 31, 2017. OHA, the Oregon Department of Justice, and FamilyCare, Inc. worked collaboratively to extend FamilyCare's contract for one additional month to assure an orderly transition of its 113,000 members to other CCOs. OHA's number one priority in the transition was protecting OHP members' access to and continuity of care. The agency's partnerships with CCOs in FamilyCare's service area—HealthShare of Oregon, Willamette Valley Community Health, and Yamhill Community Care—helped successfully transition members by January 31, 2018.

### 3. Rate certifications

The Oregon Health Authority (OHA) contracts with coordinated care organizations (CCO) to manage and deliver integrated services that include physical health, behavioral health, and oral health services to the majority of Oregon's Medicaid population. OHA pays CCOs with actuarially-sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's Oregon Health Plan (OHP) eligibility, age, and enrollment status. In addition to CCOs, OHA also retains seven dental care organization contracts and a mental health organization contract where capitation rates are developed separately.

In April and May of 2018, the 2019 calendar-year (CY) process to develop CCO capitation rates began. OHA engages and collaborates with CCOs monthly to discuss and receive feedback on the 2019 rate-development process. In May, OHA met with each individual CCO to discuss the triangulation process of CCOs financial data submitted compared to the CCO's encounter data. The purpose of the triangulation meetings is to discuss and compare all the data to ensure consensus on the starting point of the base data. Discussions centered around encounter data validation, and CY2017 financials. In June, OHA engaged with CCOs to develop the regional base data that will be used in the CY2019 rate development.

OHA plans to finalize the CY2019 CCO capitation rate development in late September 2018 and submit final rates to the Centers for Medicare and Medicaid Services (CMS) by October 3, 2018, which allows for the 90-day review window, per CMS rule.

### 4. Enrollment/disenrollment

The Oregon Health Authority (OHA) successfully transitioned to the Oregon Eligibility (ONE) system and made significant advances in reducing the fee-for-service population, and Oregon Health Plan (OHP) eligibility determination transitioned to the Department of Human Services (DHS).

FamilyCare, Inc. left Oregon's coordinated care organization (CCO) market effective January 31, 2018. The agency's partnerships with CCOs in FamilyCare's service area—HealthShare of Oregon, Willamette Valley Community Health and Yamhill Community Care—helped successfully transition FamilyCare's 113,000 Oregon Health Plan members.

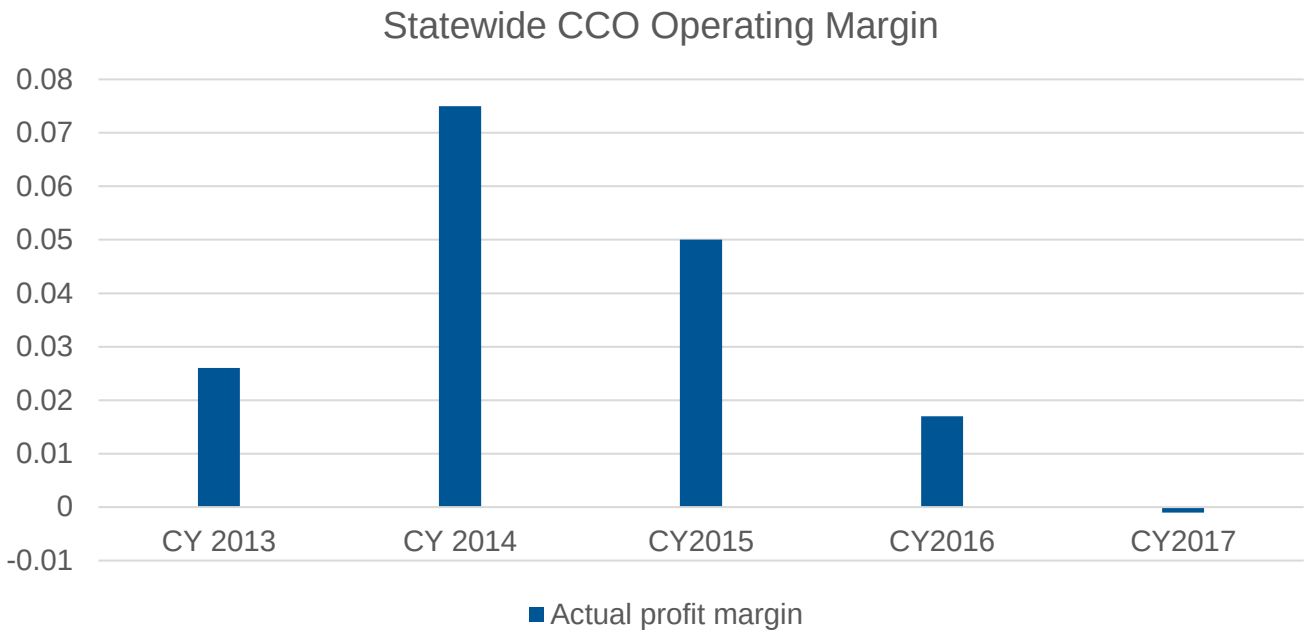
Enrollment data is listed in the actual and unduplicated enrollment table in Appendix A.

### 5. Contract compliance

There are no issues with coordinated care organization (CCO) contract compliance.

### 6. Relevant financial performance

Data for calendar year 2017 show that the coordinated care organizations' (CCO) statewide operating margin was at -0.1% compared to 1.7% for 2016. For reference, the capitation rates include a 1% profit margin and a 0.5% risk contingency. CCO statewide operating margins have been trending downward from 5.0% and 7.5% for calendar years 2015 and 2014, respectively.




The CCO member services ratio (MSR) is a key financial metric that calculates the costs of services a CCO provides (includes both medical and flexible services, costs that improve health care quality, reinsurance premiums and recoveries, and other adjustments) to its number of members enrolled as a percentage of total revenue. For calendar year 2017, member services accounted for 92.6% of expenses and administrative services accounted for 7.3%. In 2016, all CCOs met or exceeded the 80% MSR target, a key indicator for medical loss ratio (MLR), and half had MSRs above 90%. For 2017, the target MSR increased to 85%, and in 2017 all CCOs met or exceeded this target. Eleven of 16 CCOs had MSRs above 90%.

### 7. Corrective action plans (CAP)

There are no open corrective action plans for coordinated care organizations (CCO).

### 8. One percent (1%) withhold

The Oregon Health Authority's Health Systems Division analyzed encounter data received for completeness and accuracy for the 2017 calendar year (subject months January through December 2017). All coordinated care organizations (CCO) met the administrative performance standard for all subject months and no 1% withholds occurred.

### 9. Other significant activities

During this demonstration year, coordinated care organizations (CCO) submitted their first Technical Quality Strategy (TQS) plans, which replace the CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables. Innovator agents acted as conduits between the Transformation Center and CCOs to review plans and provide technical assistance as needed, and the Transformation Center developed a TQS Workplan Group to develop an ongoing process that assures the work of the CCOs is accurately represented.

## G. Health Information Technology

In 2011, the Oregon Health Authority established its Office of Health Information Technology (OHIT) to focus on supporting the adoption of electronic health records (EHR), the secure exchange of health information, and achievement of meaningful use in the state. Through collaboration and partnerships, OHIT seeks to increase the use of health information technology (HIT) across Oregon's health care community. Stakeholder engagement has led to a vision for Oregon of a transformed health system where HIT and exchange efforts are foundational.

OHIT works closely with the HIT Oversight Council (HITOC), Oregon's coordinated care organizations, the Oregon Health Leadership Council, and other key stakeholders to identify priorities and next steps for the state's HIT efforts. A coordinated statewide HIT approach centers on ensuring that the right information is available to the right people at the right time, so Oregonians experience better health and better care at lower costs. OHIT's work toward this seeks to leverage efforts already underway, connect to existing resources when possible, and support the development of services that fill gaps in areas where no other HIT options exist.

### Oregon Medicaid Meaningful Use Technical Assistance Program

The Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) provides technical support to Medicaid physicians, nurse practitioners, dentists, and physician assistants in certain circumstances. The program offers resources to help providers meet meaningful use, improve workflow, mitigate privacy and security risks, and achieve interoperability of health information exchange (HIE) to improve care coordination and service delivery.

Since the program’s launch in 2016, a total of 1,425 providers across 322 clinics have enrolled (as of June 30, 2018). Between April and June 2018, 20 providers across six clinics received technical assistance bringing the total number of providers who have received technical assistance to 1,065. The program will sunset in May 2019.

### Health Information Exchange Onboarding Program

The Centers for Medicare and Medicaid Services (CMS) released guidance to states in 2016 allowing for the use of 90% federal match funding to support health information exchange (HIE) onboarding for a broad array of Medicaid providers. In response to this, Oregon has developed the HIE Onboarding Program to support the costs of a HIE entity to onboard providers, with or without an EHR. The HIE Onboarding Program will connect key Medicaid providers to community-based HIEs that provide meaningful HIE opportunities and play a vital role for Medicaid in their communities.

OHA gathered significant stakeholder input for the development of the HIE Onboarding Program, including meetings with a short-term advisory group, meetings with stakeholder organizations, and a Request for Proposals (RFP) for prospective HIE organizations to apply to participate in the program. Reliance eHealth Collaborative was selected to provide onboarding services through an RFP process. Reliance will onboard priority physical, oral, and behavioral health Medicaid providers according to a work plan developed in consultation with Medicaid partners. OHA anticipates launching the onboarding program later in 2018, dependent upon timing of CMS approval of the contract.

### Oregon Provider Directory

The Oregon Provider Directory (OPD) will serve as Oregon's directory of accurate, trusted provider data. A common issue for provider directories today is that they are difficult to keep current and the processes to maintain them are burdensome and duplicative. The OPD addresses those issues by leveraging data sources to feed the OPD and using data stewards to oversee management of the data to maintain both initial and long-term quality information.

The OPD will benefit CCOs by supporting care coordination, health information exchange, and administrative efficiencies, while serving as a resource for heath analytics in the following ways. OPD will:

- Provide one place to go for accurate and complete provider data.
- Reduce burden on providers and staff time spent on data maintenance activities.
- Enable better care coordination for patients and ability to meet certain meaningful use objectives by supplying complete information on providers and how to contact them.
- Improve the ability to calculate quality metrics that require detailed provider and practice information.

The Oregon Health Authority (OHA) continues to meet with stakeholders monthly via the Provider Directory Advisory Committee and Provider Directory Subject Matter Expert group to provide input and oversight to OHA's development of this program. The current phase of implementation is focused on system testing which will be followed by user acceptance testing. The OPD will begin implementation in late 2018.

### Behavioral Health

The Oregon Health Authority (OHA) completed analysis of survey data gathered as part of a behavioral health information technology scan, which also included in-depth interviews. The scan collected information from behavioral health entities across the state regarding health information technology (HIT) and health information exchange (HIE) use, needs, challenges, and priorities. The online survey was sent to all 275 Oregon agencies that operate at least one state-licensed behavioral health program, reaching a total of 874 programs. Almost half (48%) of the agencies responded, representing 60% of state-licensed behavioral health programs. The respondents showed strong engagement with the survey, and 75% agreed to be contacted for follow-up.

A few highlights from the survey:

- 76% of the responding agencies are using electronic health records (EHR).
- Financial cost is a top barrier to EHR use for both agencies with and without an EHR.
- Though some agencies are exchanging patient information via electronic means, the most commonly used methods of information exchange remain fax, secure email, and paper.

OHA also completed 12 in-depth interviews with survey respondents which provided rich, detailed information and HIT/HIE successes and challenges experienced by behavioral health agencies. A draft report, which will be a resource for statewide HIT/HIE efforts within behavioral health, was released to the Health Information Technology Oversight Council (HITOC) and other stakeholders in December 2017. OHA is currently concluding further analyses of both the survey and interview data. At HITOCs request, OHA is in the process of convening a Behavioral Health HIT Workgroup that will review and provide feedback on the report recommendations and priorities. OHA will release a final report by the end of 2018.

### Network of Networks

The planned Network of Networks is a critical part of the Health Information Technology Oversight Council's (HITOC) strategy for statewide health information exchange (HIE) to support care coordination, population health, patient engagement, and value-based payment models. In its mature form, the Network of Networks may include:

- Coordinating and convening key stakeholders;
- Identifying and implementing needed infrastructure to facilitate exchange;
- Ensuring interoperability;
- Ensuring privacy and security practices;
- Providing neutral issue resolution; and monitoring environmental, technical, and regulatory changes and adapting as needed.

The Network of Networks will not include a state-run HIE.

In June 2018, after further study of the current Oregon HIE environment, HITOC chartered two workgroups to develop the Network of Networks concept. A technical definitions group will draft working definitions, which will inform the work of an advisory group. The advisory group will make recommendations to HITOC about key next steps after analyzing approaches and their relative merits in terms of effort, impact, and cost. HITOC anticipates that the HIT (health information technology) Commons, Oregon's public-private partnership for accelerating HIT, will lead the Network of Networks initiative beginning in 2019.

### HIT Commons

The HIT Commons is a public-private partnership to coordinate investments in health information technology (HIT), leverage funding opportunities, and advance health information exchange across the state. The Oregon Health Authority and Oregon Health Leadership Council, with the assistance of an interim governance advisory group, completed a business plan and appointed an initial Governance Board in 2017. In January 2018, the HIT Commons officially launched, and a HIT Commons Governance Board was appointed. HIT Commons is currently focused on two initiatives: the spread and adoption of the Emergency Department Information Exchange (EDIE) and PreManage; and a statewide subscription enabling Oregon Prescription Drug Monitoring Program (PDMP) integration with HIT systems.

The HIT Commons Governance Board meets every other month. Initial work has focused on approval of EDIE/PDMP project steering committees, review and updating of key HIT Commons policies, and development of a stakeholder communications plan.

### Emergency Department Information Exchange and PreManage

The Emergency Department Information Exchange (EDIE) collects emergency department (ED) and inpatient admit discharge transfer (ADT) data from hospitals and provides notifications back to EDs in real-time. EDIE notifications inform ED providers when a patient who is seeking care has:

- Been seen in an ED more than five times over the last 12 months.
- Been seen three different times in 60 days.
- A new care guideline provided by a PreManage user.
- Previously had a security alert added to their profile.

EDIE notifications contain brief information about all prior ED visits and, if available, information about the patient's care team (primary care, behavioral health, etc.) and care guideline. EDIE helps ED physicians coordinate with care providers outside of the hospital system, provide the most informed care for the patient, and support avoidance of unnecessary ED costs for all patients and payers, including Medicaid. All 61 Oregon hospitals actively use and contribute data to EDIE.

Beginning in the fall of 2017, hospitals with EDIE already integrated into their electronic health records (EHR) systems may work with the EDIE vendor to receive Prescription Drug Monitoring Program (PDMP) data added into their EDIE notification (more on this in the PDMP section below). In spring 2018, the EDIE vendor began piloting with St. Anthony's Hospital to add Physician Orders for Life Saving Treatment forms to the ED.

PreManage is a companion software tool to EDIE. PreManage brings the same real-time hospital event notifications (ED and Inpatient ADT data) to those outside of the hospital system, such as health plans, coordinated care organizations, providers, and care coordinators. PreManage is highly configurable and allows users to receive notifications in multiple Health Information Portability and Accountability Act compliant ways (text, pager, direct secure messaging, secure emails, etc.) at any frequency (real-time, daily, weekly, etc.) and based on criteria set by the user (patient demographics, monitored patients, patients who present at the ED with certain complaints, etc.). This helps PreManage users have data which is critical to providing the right care at the right time on behalf of the patient. This might include: discharge planning; follow up with appropriate referrals; re-engagement of a patient with primary care or behavioral health after an ED visit; or even enabling care coordinators/providers to case conference with each other to establish a multi-disciplinary plan-of-care around the patient's needs.

On June 15, 2018, Apprise Health Insights released an analysis and annual report on Oregon's use of EDIE during calendar year 2017. Highlights from the report include:

- A 2% decrease in the total number of ED visits.
- A 6% decrease in ED visits among high-utilizer (5+ hospital visits in 12 months).
- An 8% decrease in comorbid mental health and substance use disorder related visits.
- Potentially avoidable visits from high-utilizers decreased by 10%.
- Hospital visits decreased by 36% in the 90 days following an initial care guideline entered into EDIE or PreManage.

In addition to the work under HIT Commons to spread adoption of PreManage in Oregon, OHA coordinates a Statewide Medicaid Subscription for PreManage. Under the state subscription, many Medicaid providers are using PreManage to better manage their member populations and assist in the statewide reduction of ED utilizations

EDIE and PreManage are in use statewide and adoption for PreManage continues to grow. Community collaboratives, learning collaboratives, an online learning site, and various work groups under the HIT Commons EDIE/PreManage Steering Committee continue to experience growth and success around the tools, including: sharing best practices and workflows, bringing together teams to coordinate patient care, and aligning standards for tool usability and implementation.

**Statewide Adoption of EDIE and PreManage**

| Medicaid Partner | Count |
|---|---|
| Hospitals (EDIE) | 61 (all) |
| CCOs | 15 (all) |
| Government: Area Agency on Aging (AAA), Aging & People with Disabilities (APD), Developmental Disabilities, Pharmacy/DURM, Assertive Community Treatment (ACT) Teams | 38 (all AAA/APD districts) |
| Primary Care Clinics | 156 |
| Tribal Clinics | 4 |
| Dental Care Organizations (DCOs) | 6 |
| Mental/Behavioral Health Organizations | 49 |
| Health Plans | 6 |
| Federally Qualified Health Centers (FQHCs) | 61 |
| Other: Specialty, Skilled Nursing Facility, Home Health Care, Care Coordinating Agencies, PCP Group, Medical Center/Group, EMS | 42 |
| **Total** | **438** |

### Prescription Drug Monitoring Program Integration Initiative

The Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative is administered within the Oregon Health Authority's (OHA) Public Health Division and connects the Emergency Department Information Exchange (EDIE), health information exchanges (HIE), electronic health records (EHR) systems, and other health information technology (HIT) systems to Oregon's PDMP, which includes prescription fill information on controlled substances (Schedules II-IV). This initiative aligns with broader state and federal efforts to increase the use of PDMPs to reduce inappropriate prescriptions, improve patient outcomes, and promote more informed prescribing practices.

The Oregon PDMP Integration Initiative went live in late summer of 2017 with Phase I. OHA worked with Oregon hospitals who were already receiving EHR-integrated EDIE notifications, so those notifications would include PDMP data when certain triggers were met. The new feature had to be rolled out hospital-by-hospital to ensure compliance with state PDMP permission regulations and was only implementable by hospitals with integrated EDIE alerts in their EHRs (some hospitals receive EDIE notifications via fax or secure printer).

The PDMP Integration Initiative officially folded under the HIT Commons in January 2018. A PDMP Integration Steering Committee was formed in March 2018, and a statewide subscription was secured with Appriss Health for PDMP integrated services in early 2018.

Since the initiative began:

- Twenty-one hospitals across Oregon receive PDMP data as part of their EDIE notification. ED physicians share that having the PDMP data in their EDIE notifications has been one of the most valuable tools provided to them since EDIE itself.
- Reliance eHealth Collaborative and Inter-Community Health Network's Regional Health Information Collaborative are in process of rolling out implementation to their members.
- Grants for rural hospitals to integrate PDMP Gateway into their EHRs are available through the Oregon Association of Hospitals Research and Education Foundation. Grants may be used for hospital integration costs related to EDIE and/or PDMP Gateway solution.

- PDMP queries have trended upwards dramatically since EDIE/PDMP integrations have gone live. (Queries through EDIE/PDMP are matching PDMP web portal inquiries within six months of going live.)

### Clinical Quality Metrics Registry

Oregon's 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 be used for electronic clinical quality measures (eCQMs) for the Medicaid Electronic Health Records (EHR) Incentive Program and coordinated care organization (CCO) incentive metrics. Participants in those programs will also have the option to use the CQMR for reporting eCQMs to CMS for the Merit-based Incentive Payment System and the Comprehensive Primary Care Plus (CPC+) program. Over time, other quality reporting programs could use the CQMR as well, which will support the Oregon Health Authority's (OHA) goal of streamlining and aligning quality metric reporting requirements and reducing provider burden.

In 2018, the CQMR has been in its implementation phase. Implementation began with a kick-off in December 2017 with OHA's prime vendor, Peraton, and subcontractor, Michigan Health Information Network (also known as MiHIN). OHA has engaged stakeholders in a subject matter expert workgroup to obtain targeted input during implementation and to outreach with other stakeholder groups, including: the CCO Health IT Advisory Group; the CCO Metrics Technical Advisory Group; the Oregon Health Authority's (OHA) Metrics and Scoring Committee, and the CPC+ payer group and practices. Program work in preparation for implementation includes developing communications materials, drafting legal agreements, and contracting for technical assistance to clinics focused on patient-level eCQM reporting. In the first half of 2018, system implementation activities focused on project planning, architecture, enhancements, and component testing, with system testing scheduled to begin in August of 2018. The CQMR is expected to go live in December 2018, to be used for quality reporting submissions due in early 2019.

### Medicaid Electronic Health Records Incentive Program

Through the Centers for Medicare and Medicaid's (CMS) Electronic Health Records (EHR) Incentive Programs (also known as the Promoting Interoperability Programs), eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). Increasing the number of providers adopting, implementing, upgrading, or meaningfully using CEHRT helps promote better health outcomes for Oregonians by increasing access to and use of vital health information at the point of care.

Since the Oregon Health Authority program's inception in 2011, 3,793 Oregon providers and 60 hospitals have received over $187 million in federal incentive payments under the Medicaid EHR Incentive Program (as of June 30, 2018). Between April and June 2018, 572 Oregon providers received $6.3 million in Medicaid EHR incentive payments. The program sunsets at the end of 2021.

### Flat File Directory

Administered by the Office of Health Information Technology, the Flat File Directory (FFD) is Oregon's combined address book for Direct secure addresses. The FFD is a voluntary program that allows participants throughout Oregon to submit their Direct secure message addresses and then find or "discover" Direct addresses outside their own organizations. The addresses are compiled together into one document that is distributed monthly to the participating organizations. The FFD is offered at no cost to users. To join the FFD, participants

must use a fully accredited DirectTrust Health Information Service Provider, thus allowing for directed exchange to improve care coordination, and administrative efficiencies.

### CareAccord

CareAccord was launched in 2011 with the intent to fill gaps and support organizations that faced barriers to electronic health information exchange (HIE). Direct secure messaging was a flexible option for quickly and securely sharing health information under specific federal guidelines. Despite concentrated outreach efforts to engage additional participants, adoption and use of CareAccord was minimal, and the Oregon Health Authority (OHA) ended CareAccord and its Direct secure messaging services effective March 31, 2018. OHA evaluated program utilization, required resources, and Oregon's changing health information technology environment, and decided to realign resources to other HIE investments. OHA planned and executed a successful outreach and transition plan for all CareAccord users.

## H. Metrics development

During the 2017-2018 state fiscal year, the Oregon Health Authority (OHA) continued reporting on the 2017 coordinated care organization (CCO) and state performance measures in monthly dashboards, completed the transition of the Metrics and Scoring Committee (MSC) to a subcommittee of the Health Plan Quality Metrics Committee (HPQMC), and continued measure development and validation work. The Hospital Transformation Performance Program (HTPP) completed its last measurement year.

Throughout the demonstration year, OHA continued to engage stakeholders in the measurement strategy through public committees and work groups, including the CCO Metrics and Scoring Committee and the CCO Metrics Technical Advisory Workgroup. Both meet monthly.

### Health Plan Quality Metrics Committee

According to Oregon's 2017 Senate Bill 440 (SB440), the publicly funded health plans such as Medicaid, Public Employees Benefit Board and others should align their quality metrics by selecting from a common menu set of quality measures. SB440, created the Health Plan Quality Metrics Committee (HPQMC) and specified that the Metrics and Scoring Committee (MSC) would become a subcommittee that informs the larger committee. However, the MSC continues to select the specific incentive measures and benchmarks for coordinated care organizations (CCO). Because of this new relationship, many of the activities were brought jointly before both the MSC and the HPQMC to form a common knowledge of activities related to CCO quality measurement. The goal of the HPQMC is to develop a common menu set of quality and health outcomes measures to be used in Oregon that are coordinated, evidence-based, and focused on a long-term vision. The HPQMC has finalized the 2019 measure set that includes 51 measures. The committee also worked on prioritizing its current list of 20 developmental measures and on-desk measures. On-desk measures will likely move to the measure set in 2021.

During the fourth quarter of the state fiscal year, there were two main activities relating to the development of new measures: The Health Aspects of Kindergarten Readiness Technical Workgroup and the Evidence-Based Obesity Metric Workgroup.

### The Health Aspects of Kindergarten Readiness Technical Workgroup

The Health Aspects of Kindergarten Readiness Technical Workgroup will focus on the health aspects/health system's role in kindergarten readiness with the goal of creating a cross-sector measure of shared accountability. The workgroup is currently in Phase I of three phases of work. Phase I is focused on recommending one or more measures of the health sector's role in kindergarten readiness that can be applied as coordination care organization (CCO) incentive metrics. The recommended metrics may be:

- Ready to implement with validated measure with specifications, applied use, and benchmarks;
- Near ready to implement with specifications developed and have been applied in some settings but not at a CCO/health system level; or
- New glide-path metrics that do not have technical specifications developed and no applied use.

The workgroup can recommend any combination of the three measure types.

The workgroup had their second meeting in April 2018 and reviewed the draft conceptual framework of the health sector's role in kindergarten readiness. At their third meeting in May 2018 they reviewed measure selection criteria, application of the conceptual framework to the CCO incentive metrics, and potential measure for their phase-one recommendations. At the fourth and fifth meetings in June 2018 they reviewed measures that are near ready to implement.

### Evidence-Based Obesity Metric Workgroup

The Evidence-Based Obesity Metric Workgroup convened for the first time in May 2018. In this phase of their work (Phase I of three phases) the group would like to recommend a measure that goes beyond clinical intervention at the primary care level and includes a multi-component, cross-sector approach. At this meeting they received an orientation to the coordinated care organization incentive measure program and reviewed evidence of effective obesity intervention at both the clinic and community levels. At the second meeting in June 2018, the workgroup discussed components of a potential metric including community investment and clinical intervention. At the July meeting they discussed next steps including work to be completed during phases two and three. This will group will reconvene in November 2018.

### Metrics and Scoring Committee

The Metrics and Scoring Committee (MSC) entered its sixth year in 2018 with newly appointed members. For the first time, there are no members appointed to the group who experienced the launch of the committee in 2013. They continued their work without changing the structure of the incentive program, presiding over the 2017 measurement year and annual report.

In 2017 the MSC became a subcommittee of the Health Plan Quality Metrics Committee to advise and recommend measures for alignment across the state public funded plans.

One Oregon-specific metric, *Effective Contraceptive Use in women at risk for pregnancy*, continues to show improvements for women 18 to 50 years old from 2014 (33.4%) to 2017 (45.7%). For the first time, the committee lowered the age for this metric to include adolescent females between 15-17 years of age. That measure has remained relatively flat since 2014. The MSC has decided to add this age group to the overall measure to improve rates for sexually active adolescents.

Finally, the MSC is beginning to recommend more cross-agency and cross-sector work, particularly involving children. For example, in 2020, the Oregon Health Authority will align the specifications for health screenings to be more consistent with Department of Human Services-Foster Children health screenings guidelines. Current specifications require a 60-day health screening after child removal into state custody and that will change to 30 days. Both agencies are working with coordinated care organizations to ensure closer coordination of communication.

## I. Budget neutrality

In the development and reporting of budget neutrality, no significant issues are identified.

## J. 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 the Oregon Health Authority's (OHA) 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 by 2023
- 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.

The 2018 Session of the Oregon Legislative Assembly adjourned sine die, Saturday, March 3, 2018. Despite it being a short session, as is the case during even numbered years in the State of Oregon, it was active, and some significant legislation impacting Oregon's Medicaid program passed. Of note were the following:

- House Bill 4018 (Implementation: contract-related provisions, immediately; the remainder of the bill, January 1, 2019) –
    - Establishes meeting requirements for governing bodies of coordinated care organizations (CCO);
    - Modifies composition of a CCO's governing body;

- Requires a CCO to spend a portion of earnings above specified threshold on services designed to address health disparities and social determinants of health consistent with federal terms and conditions under Section 1115 of the Social Security Act;
- Modifies composition of a CCO's governing body specific to financial risk entities; and
- Codifies, in statute, provisions related to contract nonrenewal and compliance requirements.

- Senate Bill 1549 – Ensures that individuals in the Oregon State Hospital (OSH) may maintain medical assistance eligibility until: 12 months after the individual is admitted to OSH or upon eligibility recertification, whichever is earlier. Additionally, if medical assistance was terminated for an individual while in OSH, they may reapply for medical assistance up to 120 days prior to release, with benefits going into effect on the date of discharge.
- House Bill 4005 – While this bill does not impact Medicaid directly, it does:
  - Require prescription drug manufacturers to report, on an annual basis, information on prices of prescription drugs and costs associated with developing and marketing prescription drugs;
  - Authorize the state to impose civil penalties on manufacturers for failing to comply with reporting requirements;
  - Requires health insurers that offer prescription drug benefits to report specified information about prescription drug prices and impact of prescription drug prices on premium rates;
  - Requires the state to conduct an annual public hearing on prescription drug prices and related information reported by manufacturers; and
  - Establishes the Task Force on the Fair Pricing of Prescription Drugs.

## K. Litigation status

**Lawsuits and legal actions**

Open lawsuits and legal actions related to the Oregon Health Plan, to which the State Medicaid agency (Oregon Health Authority) is a party to, are listed, in aggregate. There are currently three pending actions. Lawsuits and legal actions include anything that is currently open in court, excluding estate recovery, during the reporting period.

Member appeals and hearings are not reported in this section, but they are included in this quarterly/annual report under section III. E. and in Appendix C.

## L. Public forums

### Health Evidence Review Commission

The Health Evidence Review Commission (HERC) reviews clinical evidence to prioritize health spending and guide the Oregon Health Authority in making benefit-related decisions for its health plans. HERC promotes evidence-based medical practice statewide. The HERC or one of its subcommittees holds a public meeting at least once-a-month, except in July. Public comment from HERC meetings is listed below.

#### *August 10, 2017*

No public testimony.

The committee discussed and approved coverage guidance on continuous glucose monitoring for Diabetes Mellitus. They also reviewed and approved the proposed multisector intervention: Prevention of Early Childhood Caries.

#### *September 28, 2017; November 9, 2017; and January 5, 2018*

During each of these meetings, the committee heard public comment related to the review of the prioritization of two drugs to treat Duchenne muscular dystrophy (DMD): deflazacort (Emflaza) and eteplirsen (Exondys 51).

#### *January 18, 2018*

The committee heard public comment related to the inclusion of the use of fractional exhaled nitric oxide (FeNO) for the management of asthma on the funded asthma line.

#### *March 8, 2018*

The committee heard public comment related to scoping statements for services HERC was considering developing coverage guidances on.

#### *May 17, 2018*

No public testimony.

The committee discussed 2018 Oregon House Bill 4020 regarding extended stay centers which will operated in conjunction with an ambulatory surgery center and the workplan and reporting on 2017 Oregon House Bill 3391 – Reproductive Equity Health Act. The committee also discussed and approved proposed coverage guidance for Genome Expression Profiling for Breast Cancer and proposed coverage guidance for Prostatic Urethral Lift for Treatment of Benign Prostatic Hypertrophy.

### HERC Value-Based Benefits Subcommittee

#### *August 10, 2017*

The committee heard public comment related to a new process being developed regarding the prioritization of services with marginal or no clinical benefit and/or with low cost-effectiveness. Testimony anticipated the Value-based Benefits Subcommittee review of two drugs to treat Duchenne muscular dystrophy (DMD), deflazacort (Emflaza) and eteplirsen (Exondys 51), which were to be discussed at its September 28, 2017 meeting.

#### *September 28, 2017*

The committee heard public comment related to the review of the prioritization of two drugs to treat DMD: deflazacort (Emflaza) and eteplirsen (Exondys 51).

#### *November 9, 2017 and January 18, 2018*

During each of these meetings, the committee heard public comment related to the review of the prioritization of the drug eteplirsen (Exondys 51) to treat DMD.

#### *March 8, 2018*

The committee heard public comment related to the inclusion of the use of fractional exhaled nitric oxide (FeNO) for the management of asthma on the funded asthma line.

***May 17, 2018***

No public testimony.

The committee discussed the Chronic Pain Taskforce Interim Report and voted to recommend adding a new statement of intent regarding treatment of chronic pain. The committee also voted to recommend code and guideline changes including modifications to diagnosis codes, procedure codes, and guideline notes.

## HERC Evidence-based Guidelines Subcommittee

### *September 7, 2017*

The committee heard public comment related to a draft coverage guidance on the use of minimally invasive non-corticosteroid percutaneous interventions for the treatment of low back pain, including a recommendation for non-coverage of radiofrequency denervation for facet joint pain.

### *June 15, 2017*

The committee heard public comment related to a draft coverage guidance on gene expression profiling for prostate cancer.

### *November 2, 2017*

The committee heard public comment related to a draft coverage guidance on the use of minimally invasive non-corticosteroid percutaneous interventions for the treatment of low back pain, including a recommendation for non-coverage of radiofrequency denervation for facet joint pain.

### *February 1, 2018*

The committee heard public comment related to a draft coverage guidance on urine drug testing.

### *April 12, 2018*

No public testimony.

The committee reviewed draft coverage guidance on urine drug testing and CardioMEMS, a heart failure monitoring system.

## HERC Health Technology Assessment Subcommittee

### *June 15, 2017*

The committee heard public comment related to a draft coverage guidance on gene expression profiling for prostate cancer.

### *September 14, 2017*

The committee reviewed public comment regarding Colorectal Cancer Screening Modalities and referred the draft coverage guidance to the Value-based Benefits Committee.

### *November 30, 2017*

The committee heard public comment related to a draft coverage guidance on gene expression profiling for prostate cancer.

### *March 1, 2018*

No public testimony.

The committee discussed gene expression profiling for breast cancer and prostatic urethral lift for treatment of Benign Prostatic Hypertrophy. The committee also discussed scope statements for newer interventional procedures for Gastroesophageal Reflux Disease (GERD), FoundationOne sequencing for advanced solid malignancies, single fraction radiotherapy for palliation of bony metastases, and spinal cord stimulators for Chronic Back Pain.

### *April 26, 2018*

The committee reviewed public comment regarding prostatic urethral lift for treatment of Benign Prostatic Hypertrophy and gene expression profiling for breast cancer.

### *June 28, 2018*

The committee reviewed public comment regarding single fraction radiotherapy for palliation of bone metastases. The committee also reviewed draft coverage guidance regarding U.S. Food and Drug Administration-approved Next-generation sequencing tests for tumors of diverse histology.

## Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) is a federally-mandated body which advises the State Medicaid Director on the policies, procedures, and operation of Oregon's Medicaid program, through a consumer and community lens. The MAC develops policy recommendations at the request of the governor, the legislature and the Oregon Health Authority (OHA).

### *July 26, 2017*

No public testimony.

The committee reviewed the legislative session report and discussed Department of Human Services (DHS)/OHA Integrated Eligibility, guiding principles for Oregon Medicaid, and social determinants of health in primary care.

### *September 27, 2017*

The committee heard public comment related to messaging to stakeholders about social determinants of health and forming partnerships with non-medical partners.

### *October 25, 2017*

No public testimony.

The committee discussed the purpose of the Social Determinants of Health Workgroup, reviewed the revised timeline for MAC social determinants of health work, discussed the stakeholder survey plan, and agreed upon a draft definition of the social determinants of health.

### *November 3, 2017*

The committee reviewed public comment regarding poor diet and food insecurity as underlying causes of health conditions and collaborating with coordinated care organizations (CCO) to show more interest in nutrition and health food access. The committee discussed how CCOs can and do address social determinants of health.

### *December 6, 2017*

No public testimony.

The committee discussed CCO 2.0, Oregon's re-launch of CCOs, and recommendations on the role of CCOs in addressing social determinants of health.

### *January 24, 2018*

No public testimony.

The committee discussed health-related services and MAC social determinants of health policy work.

### *March 28, 2018*

The committee heard public comment regarding social determinants of health within the CCO model. The committee also heard a member's experience and ideas for addressing Medicaid members' needs.

### *April 25, 2018*

No public testimony.

The committee discussed their social determinants of health recommendations and implementation and CCO 2.0 policy.

### *May 23, 2018*

The committee heard public comment from Yakima Valley Farm Workers, a non-profit system of community health centers in Oregon and Washington, that social determinants of health impact physical health, and they appreciate the time and hard work going into the Social Determinants of Health project.

## Metrics and Scoring Committee

The Oregon Legislature established the Metrics and Scoring Committee to recommend outcomes and quality measures for coordinated care organizations (CCO). The committee meets monthly.

### *July 21, 2017*

The committee heard public comment regarding concerns about adding a child obesity measure to the 2018 measure set and adding adolescents, ages 15-17, to the *Effective contraceptive use among women at risk of unintended pregnancy* incentive measure.

### *August 18, 2017*

The committee heard public comment regarding concerns that adolescents who previously received a well-visit as a member of the Job Corp are in the *Adolescent well-care visits* denominator. The committee requested this issue be referred to the Metrics Technical Advisory Group for further discussion and vetting.

The committee also reviewed previous public comment regarding adding adolescents, ages 15-17, to the *Effective contraceptive use among women at risk of unintended pregnancy* incentive measure and discussed differing feedback from providers about adding adolescents to the incentivized part of this measure. Currently this age range is reported, but not incentivized. A motion passed to include the incentivized *Effective contraceptive use among women at risk of unintended pregnancy* measure to include adolescents aged 15-17 beginning in 2018.

### September 15, 2017

The committee received public testimony regarding the Health Plan Quality Metrics Committee (HPQMC) around shared goals and value of the HPQMC and the metrics and Scoring Committee following each other's work.

The committee also reviewed written public testimony regarding concerns about the addition of adolescents, aged 15-17, to the denominator for the *Effective contraceptive use among women at risk of unintended pregnancy* measure. This testimony included concerns around confidentiality and privacy, provider readiness, mixed messages to adolescents, and public perception.

### October 20, 2017

The committee heard public testimony from CCO Oregon in support of two measures: *Dental care for adults with diabetes* and *Preventive dental services utilization for adults*. CCO Oregon advised the measure being considered does not include oral and periodontal evaluations; they are not opposed to the current metric but would like to work with the Metrics Technical Advisory Group on it.

The committee also reviewed several letters from Federally Qualified Health Centers and the Oregon Primary Care Association in support of including the food insecurity measure the committee proposed to the HPQMC. The committee discussed that, although there is not a validated measure of the social determinants of health, the food insecurity measure seems feasible, and there are a lot of underutilized resources to address food insecurity that this measure could help with.

### November 17, 2017

No public testimony.

The committee debriefed from the HPQMC and discussed input on health aspects of kindergarten readiness measure development.

### December – no meeting

### January 19, 2018

No public testimony.

The committee heard an update and overview of the process to develop new five-year contracts between the CCO and the Oregon Health Authority (OHA). They also received an overview of OHA's structure in terms of where metric units are in the agency, supports offered to the Committee and CCOs related to metrics work, and links with quality improvement.

### February 16, 2018

No public testimony.

The committee heard a presentation from OHA's metrics team on the CCO incentive metrics. CCO performance was broken down by year, race/ethnicity, utilization, and geography. The committee also heard a presentation on the key findings and recommendations from the 2012-2017 Summative Waiver Evaluation.

### March 16, 2018

No public testimony.

## *Oregon Health Authority*

This meeting focused on electronic health records (EHR) programs and measure sets and included an updates on the Clinical Quality Metrics Registry which is scheduled to go live in December. A panel of three guests provided their perspective on their biggest EHR measure challenges, success stories with EHR, and their experience with EHR measures.

### *April 20, 2018*

No public testimony.

The Committee prepared to select the 2019 Incentive Measure set by reviewing selection criteria for incentive measures, reviewing the Governor's priority areas for the Oregon Health Authority, and to review the goals and priorities of the Metrics and Scoring Committee. The Committee also received an update on Screening, Brief Intervention and Referral to Treatment (SBIRT) measure and the feasibility of reporting SBIRT from EHRs at the clinic level. The committee also reviewed the four oral health measures that are on the 2019 HPQMC measure set that they could choose from for the 2019 CCO incentive measures. The committee also received an update on the CCO 2.0 process to develop new 5-year contracts between the CCOs and the OHA.

### *May 18, 2018*

No public testimony.

The Committee continued its work to prepare for selection of the 2019 Incentive Measure set. The committee received an overview of the prenatal and postpartum care measures. Researchers from the Providence Center for Outcomes Research and Education (CORE) presented results of their study titled "Caring for the Whole Person: A Patient-Centered Assessment of Integrated Care Models in Vulnerable Populations". The study looked at the effects of patient stigma and its effect on integration. The committee also received a presentation on the first Public Health Accountability Report which shows how the state's public health system is doing on key health issues.

### *June 15, 2018*

No in-person public testimony. Anna Warner, Director of Quality for Advanced Health CCO, submitted a letter to the committee about how the 2017 emergency department utilization rate is calculated. ED visits that span two days (over the midnight time-period) can be counted separately by some hospitals and not by others depending on their billing practices. This issue will be referred to the Metrics and Scoring Committee's Technical Advisory Group (TAG) for more discussion. Anna Warner, Director of Quality for Advanced Health CCO and Jennifer Johnstun, Health Strategy Office for Primary Health CCO also submitted a letter to the committee about the Timeliness of Prenatal care quality metric. They proposed that this measure be removed from the incentive measure set and be replaced with the timeliness of postpartum care measure.

The committee also received an update on the CCO 2.0 work. Feasibility, impact, and resources needed for the different policy options are being considered along with feedback from the public input process. The committee also received a presentation about Oregon's health priorities and how the state was progressing on meeting state health improvement plans and other health priorities in Oregon. The committee also discussed the DHS custody metric and how to better align it with current policies and recommendations made by the American Academy of Pediatrics.

## Oregon Health Policy Board

The Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for the OHA. The board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health.

### *July 11, 2017*

The board heard public comment praising programs and advocacy for Oregon's 2017 House Bill 2391, which imposed new taxes and reporting requirements on Oregon health care providers and insurers.

### *August 1, 2017*

The board heard public comment related to coordinated care organization (CCO) rates and methodology.

### *September 12, 2017*

The board heard public comment related to pharmacy development and Oregon Health Authority (OHA) administration and referendum 301, which is a referendum to Oregon's 2017 House Bill 2391 to impose new taxes and reporting requirements on Oregon health care providers and insurers.

### *October 3, 2017*

The board heard public comment related to incoming Oregon Health Authority (OHA) Director Pat Allen's community discussions with recommendations to ensure the voice of those receiving public mental health services be heard. The board discussed Oregon Health Authority (OHA) leadership changes, Oregon Health Policy Board (OHPB) committee, collaborative, and workgroup updates, OHPB committee planning, Health Information Technology Oversight Council updates, and CCO 2.0 planning.

### *November 7, 2017*

No public testimony.

The board meeting included updates from OHA leadership regarding organizational changes and Children's Health Insurance Program (CHIP) funding, OHPB committee updates, CCO 2.0 planning, Healthcare Leaders panel and discussion, and Local Community Innovations panel and discussion. During this meeting, the board voted to establish a committee to tackle issues related to high-cost drugs and to introduce legislation to move all state agencies into the Oregon Prescription Drug Program (OPDP) unless they can demonstrate savings by remaining outside OPDP.

### *December 5, 2017*

The board heard public comment regarding Moda Health's Oregon Prescription Drug Program as a model for other entities, the CCO rate review process, the direction of clinical pharmaceutical services, and concerns with a single or aligned preferred drug list (PDL). The board meeting included an organization update from OHA leadership, OHPB committee updates, Healthcare Workforce Committee updates, Public Health Advisory board and Public Health Modernization updates, OHPB high-cost drugs update and committee development, and CCO 2.0 planning.

### *January 16, 2018*

No public testimony.

## *Oregon Health Authority*

This meeting focused on OHA leadership changes, the 2012-2017 Summative Waiver Evaluation, and policy analysis related to: sustainable cost growth; value-base payments; social determinants of health; health equity; and behavioral health. The board also reviewed and voted to approve the High Cost Drugs Committee Charter, approved new members of the Healthcare Workforce Committee, and approved the Healthcare Workforce Needs Assessment report.

### *February 6, 2018*

No public testimony.

The board heard a legislative briefing including an in-depth look at particular bills of interest to the OHPB and several OHA updates: the new Oregon State Hospital Superintendent, member transitions from FamilyCare, Inc., and federal legislation regarding CHIP and community health centers

### *March 6, 2018*

No public testimony.

The board meeting included an organizational and legislative update from OHA leadership, OHPB committee updates, an overview of OHA's Transformation Center and the work they do to support health system transformation, and a CCO 2.0 workplan presentation.

### *April 3, 2018*

No public testimony.

The board meeting included an organizational update from OHA leadership, OHPB committee updates, an update on the Healthcare Provider Incentive Program, CCO 2.0 development, and data and legislative action regarding the opioid epidemic.

### *May 1, 2018*

The board heard public comment regarding recommendations for CCO 2.0 development.

The board meeting included an organizational update from OHA leadership, OHPB committee updates, Public Health Advisory Board updates, including accountability metrics and public health modernization, updates regarding social determinants of health from the Medicaid Advisory Committee, a Health Equity Committee update, and CCO 2.0 development and timelines.

### *June 5, 2018*

The board heard public comment related to the rehabilitation workforce, behavioral health system funding, barriers to behavioral health investments and incentive metrics, OHA reorganization, the need for connections between Public Health and CCOs to address social determinants of health and health equity, recommendations for CCO 2.0. The board also heard from a community member in appreciation of the Oregon State Hospital's treatment of her daughter.

The board meeting included an organizational update from OHA leadership, an update from the Health Plan Quality Metrics Committee, and a discussion regarding Behavioral Health, Social Determinants of Health, cost, and value-based payment policy options in relation to CCO 2.0.

# IV. Progress toward demonstration goals

## A. Improvement strategies

### Evaluation activities

The evaluation plan for the 2017-2022 waiver has been approved by the Centers for Medicare and Medicaid Services (CMS). The Oregon Health Authority (OHA) is in the process of planning for the evaluation of the 2017-2022 demonstration period.

### Better health, better care, and lower costs

To meet the goals of the three-part aim, Oregon's coordinated care model and fee-for-service delivery systems rely on six key levers to generate savings and quality improvements and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that the Oregon Health Authority will take in the form of the stimuli and supports described below, they comprise a roadmap for achieving Oregon's vision for better health, better care, and lower costs.

#### *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*

**Patient-Centered Primary Care Homes**

During this demonstration year, the Patient-Centered Primary Care Homes (PCPCH) program staff conducted 88 site visits to primary care clinics. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers.

As of June 30, 2018, 650 clinics were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Forty-seven PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model. These clinics are in both rural and urban areas.

The PCPCH program held three "Transformation in Practice" webinars, which provided in-depth technical assistance on featured PCPCH measures. Future technical assistance will help coordinated care organizations (CCO) add PCPCHs to their networks and provide support to already recognized PCPCHs.

CCOs are required to include PCPCHs in their networks of care to the greatest extent possible. Over 900,000 CCO members (87% of the total CCO-enrolled population) receive care at a PCPCH.

**Certified Community Behavioral Health Clinics**

The Oregon Health Authority (OHA) is currently participating in a two-year Certified Community Behavioral Health Clinic (CCBHC) demonstration program. Following a one-year planning grant (2015- 2016), the CCBHC demonstration program was launched in Oregon on April 1, 2017 and will run through March 31, 2019. Oregon is one of eight states participating in the program, which emphasizes access to quality outpatient behavioral health services by meeting criteria grouped into six program areas:

1. Staffing;
2. Availability and accessibility of services;

3. Care coordination;
4. Scope of services;
5. Quality and other reporting; and
6. Organizational authority, governance, and accreditation.

In addition, OHA is required to report on 21 CCBHC specific metrics (nine led by clinics and 12 led by OHA), develop and monitor a prospective payment system, and monitor CCBHCs for compliance with program requirements. CCBHCs must meet numerous federal requirements, such as the ability to directly provide outpatient mental health and substance-use disorder (SUD) services to the full age range, regardless of payer. There are also nine Oregon CCBHC Standards, which enhance or expand on the federal requirements.

Oregon selected the Prospective Payment System (PPS) model in Oregon, which pays a daily rate based on a prospective payment methodology. The rate for each CCBHC is unique to each organization and was developed based on analysis of cost reports submitted to OHA during the planning grant. CCBHCs are expected to provide services to individuals regardless of payer. For services delivered, and considered allowable by the Centers for Medicare and Medicaid Services under the demonstration program, CCBHCs are eligible to receive the daily PPS rate. For enrolled Oregon Health Plan (OHP) members, CCBHCs bill as usual, and OHA issues a wraparound payment, if needed, to supplement any payments made by coordinated care organizations (CCO). Oregon's CCBHC demonstration program is modeled after the Federally Qualified Health Center payment structure and does not affect any billing policies or procedures which were already in place with CCOs prior to April 1, 2017.

**Tribal Care Coordination**

State Health Official letter SHO#16—002, issued on February 26, 2016, reinterpreted Section 1905(b) of the Social Security Act so that health services coordinated by Indian Health Service (IHS) and Tribal 638 facilities would be considered services "received through" such facilities, and thus eligible for 100% federal matching funds. Oregon Governor Kate Brown followed up on this federal policy change with a letter to the tribes on September 7, 2016, directing the state to develop a method to direct these state savings back to the tribes for reinvestment into tribal health programs and services.

The Oregon Health Authority has developed a process to implement this policy and, in doing so, has become the first state in the nation to issue payment of these state savings back into the tribal health system. The savings are available for IHS/tribal facilities who coordinate patient care with external health providers, providing a significant incentive for tribes to improve their care coordination systems and methods, particularly for those with multiple or complex conditions.

The Oregon Health Authority has also contracted with CareOregon, Inc. to provide care coordination services for tribal fee-for-service members. Approximately 51% of American Indian/Alaska Native (AI/AN) people enrolled in the Oregon Health Plan are fee-for-service patients, so this contract will provide a way to reach those patients who would not otherwise have care coordination services made available to them.

On March 1, 2018 the Oregon Health Authority (OHA) approved the new Tribal Consultation and Urban Indian Health Program Confer Policy. The state of Oregon and the OHA share the goal to form clear policies through establishing the tribal consultation and urban confer requirements. This policy will further the government-to-government relationship between the state and the nine federally recognized tribes of Oregon: Burns Paiute Tribe; Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians; Confederated Tribes of Grande

Ronde; Confederated Tribes of Siletz Indians; Confederated Tribes of the Umatilla Indian Reservation; Confederated Tribes of Warm Springs; Coquille Indian Tribe; Cow Creek Band of Umpqua Tribe of Indians; and Klamath Tribes, and it will strengthen the relationship with the Urban Indian Health Program.

Meaningful consultation between tribal leadership and agency leadership will result in information exchange, mutual understanding, and informed decision-making on behalf of the tribes and the state. The policy applies to OHA and all its divisions, programs, services, projects, activities, and employees and shall serve as a guide for the tribes to participate in OHA policy development to the greatest extent allowable under federal and state law.

### *Lever 2: Implementing value-based payment (VBP) models to focus on value and pay for improved outcomes*

**Federally Qualified Health Center Alternative Payment Methodology Program**

The Advanced Payment and Care Model (APCM), otherwise known as the FQHC/RHC APM, continues to transition from an alternative payment methodology to a value-based payment (VBP) method that places a portion of the health center's per-member per-month (PMPM) revenue at-risk. This is being accomplished through a collaborative workgroup consisting of the Oregon health Authority (OHA), the Oregon Primary Care Association (OPCA), and participating Federally-qualified health centers (FQHC) and rural health centers (RHC). The workgroup is focused on operationalizing two components that will transition the FQHC/RHC APM to VBP:

- Oregon Health Plan members attributed to a participating FQHC/RHC who have not been engaged through an encounter OR a Care STEP during the past eight quarters will be dis-enrolled with the health center, and the health center will stop receiving PMPM payments. Once again, "Care STEPs" (formerly known as touches) are traditionally non-billable, verifiable interactions with the patient that promote whole-person centered care and address social-determinants of health. Examples of Care STEPs include:
    - Helping members access community resources
    - Warm-handoffs during a clinic visit to another member of the care team of a different health discipline
    - Proactive research, outreach, and connection with members experiencing gaps in care
    - Assisting members with transitions on their care setting
    - Educational group visits, exercise classes, and support groups
    - Home visits with community health workers, RNs, and other members of the care team
    - Online portal visits, and other advanced technology interactions
    - Social determinants of health screenings

Upon the FQHC/RHC submission of the quarterly Care STEPs report, OHA will place all Care STEPs in a database and query for any member not engaged with a billable FQHC/RHC encounter or a Care STEP over the prior eight quarters. The resulting members will be reported to health centers on the Non-Engaged Closure Report (NECR) and dis-enrolled from their health center.

- Health centers currently submit quarterly Quality Metric Reports showing their performance on several coordinated care organization (CCO) incentive measures. The workgroup has agreed that health centers will be placed on a Performance Improvement Plan (PIP) for failing to reach the average CCO performance on three or more incentive measures over four consecutive quarters. Failure to achieve the

improvement targets set within the PIP will result in a 2 – 3.5% PMPM rate reduction depending on the number of targets missed (five total incentive measures). The CCO incentive measures are:

- Colorectal Cancer Screenings
- Depression Screening and Follow-up
- Diabetes Poor Control
- Hypertension Control
- Weight Assessment and Counseling in Children and Adolescents

Participating health centers are required to be recognized under Oregon's Patient-Centered Primary Care Home standards, which award primary care clinics a tier level from Tier 1 through Tier 5 based upon their level of comprehensive whole-person centered primary care offered, with Tier 5-STAR being the highest recognition level. The table below shows how APCM primary care clinics compare to all other PCPCHs (as of July 26, 2018):

| | All PCPCH Recognized Clinics | APCM Recognized Clinics | Non-APCM Recognized Clinics | APCM % |
|---|---|---|---|---|
| Total Clinics Recognized (2017 standards) | 642 | 104 | 538 | 16% |
| Total Tier 5-STAR Clinics | 48 | 17 | 31 | 35% |
| Average PCPCH Points/Score (Higher is better.) | 255.34 | 273.65 | 251.78 | |

Two additional FQHCs and two RHCs are set to launch on the APCM in July 2018, after about nine months of coordinated onboarding activities hosted by OHA and the OPCA. Three more FQHCs are set to launch in April 2019. Onboarding activities for the next phase of health centers are currently underway.

**Comprehensive Primary Care Plus (CPC+)**

The Oregon Health Authority continued implementing Comprehensive Primary Care Plus (CPC+), which launched January 1, 2017. Of the 156 Oregon CPC+ practices, 145 have contracts with OHA for Medicaid fee-for-service (FFS) members. The Oregon CPC+ payers meet monthly with a facilitator to discuss opportunities for coordination and alignment to support CPC+ practices. The group selected HealthInsight/Q Corp as the Oregon CPC+ data aggregator.

Care management fee payments for all participating practices are continuing. Modifications to Oregon's Medicaid Management Information System (MMIS) were made to calculate performance-based incentive payments. OHA moved a portion of anticipated FFS revenue to prospective payment, which aligns with the percentage selected by practices for the CMS alternative payment method. Performance-based incentive payments were paid prospectively every month at 50% of eligible and will be reconciled at the end of each year.

**Value-Based Payment Innovations and Technical Assistance**

The Transformation Center received technical assistance through a 12-month Centers for Medicare and Medicaid Services Innovation Accelerator Program and is working with national value-based payment (VBP) experts at Bailit Health to develop a VBP roadmap. The roadmap will include VBP targets for coordinated care organizations (CCO) and their contracted providers. OHA convened a CCO VBP roadmap work group and

collected input on definitions, targets and measurement. Stakeholder input was also collected through a provider survey, CCO 2.0 roadshow, and community forums. The roadmap will be finalized in October 2018 and released in January 2019.

**Primary Care Payment Reform Collaborative**

The Oregon Health Authority convenes the Primary Care Payment Reform Collaborative, a multi-stakeholder advisory group working toward developing a sustainable payment model for primary care. This model emphasizes paying for quality of care rather than quantity, as well as integrating behavioral health and addressing social determinants of health. The collaborative is developing recommendations to be presented to the Oregon Health Policy Board in early 2019.

**Hospital Transformation Performance Program**

During this demonstration year, data from the fourth and final year of the Hospital Transformation Performance Program (HTPP) were finalized and published and hospitals received their fourth payments from the quality pool. This was the third year that hospitals were paid for performance as the first year was paid for reporting.

The fourth Hospital Transformation Performance Program report details how hospitals are doing on 11 key quality and outcomes metrics focused on improving the quality of care and improving patient safety. The report covers the fourth year of the program, which spans January through December 2017. The report was compiled and published in June 2018. Key findings include:

- Hospitals continue to do very well in medication safety.
    - Adverse drug events due to opioids: All hospitals achieved the benchmark.
    - Excessive anticoagulation with warfarin: All hospitals achieved the benchmark.
    - Hypoglycemia in inpatients receiving insulin: 20 hospitals achieved the benchmark or target in year four with a 21.2 percent improvement statewide.
- Health care-associated infections: Central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) improved among participating hospitals (lower is better for this measure).
- Collaboration between hospitals and coordinated care organizations (CCOs) is another area in which hospitals continued to improve:
    - Follow-up after hospitalization for mental illness: 25 of 28 hospitals achieved the benchmark or improvement target on this measure.
    - Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the emergency department: 22 of 27 hospitals eligible for this measure achieved benchmark or improvement target.
- Reducing revisits for frequent emergency department visits: This measure changed from a process measure (sharing emergency department use with primary care providers) to an outcome measure (reducing revisits for frequent emergency department users) in year four. Fifteen of 27 hospitals eligible for this measure achieved the benchmark or improvement target. Statewide, this measure improved from 30.2 percent to 28.3 percent (lower is better for this measure).
- Some key areas with opportunities for improvement are:
    - Hospital wide all-cause readmissions remained flat statewide and only 12 out of 28 eligible hospitals achieved their target.

- The percent of patients who said that hospital staff provided discharge information upon leaving the hospital also remained flat at the statewide level. Nineteen of 28 hospital showed some improvement, and 15 hospitals achieved their target.

The Oregon Health Authority (OHA) made the fourth quality pool payments to hospitals in June 2018. In this fourth year, a total of almost $90 million was awarded based on hospitals attaining benchmarks or improvement targets on the 11 measures.

A two-phase distribution method determined amounts awarded. During 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). Eight hospitals achieved this floor, resulting in $4 million of payments. During the second phase, the remaining $85.8 million was distributed based on the value of each metric where targets were met, and relative hospital size.

***Year 4 HTPP Quality Pool Distribution by Measure (Phase 2)***

| **HTPP Quality Pool: Measures weighting** | Measure weight | Total amount available for measure | Number of hospitals that achieved the measure |
|---|---|---|---|
| CAUTI in all tracked units | 9.38% | $8,039,905 | 14 |
| CLABSI in all tracked units | 9.38% | $8,039,905 | 24 |
| Adverse drug events due to opioids | 6.25% | $5,359,937 | 28 |
| Excessive anticoagulation with warfarin | 6.25% | $5,359,937 | 28 |
| Hypoglycemia in inpatients receiving insulin | 6.25% | $5,359,937 | 20 |
| HCAHPS: Staff always explained medicines* | 9.38% | $8,039,905 | 14 |
| HCAHPS: Staff gave patient discharge information | 9.38% | $8,039,905 | 15 |
| Hospital-wide all-cause readmissions | 18.75% | $16,079,811 | 12 |
| Follow-up after hospitalization for mental illness | 6.25% | $5,359,937 | 25 |
| SBIRT: Screening for alcohol and other substance misuse in the ED* | 6.25% | $5,359,937 | 22 |
| EDIE: Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits* | 12.50% | $10,719,874 | 15 |
| **Total** | **100.00%** | **$85,758,990** | |

***Year 4 HTPP Quality Pool Distribution by Hospital (Phase 2)***

| **HTTP Quality Pool – Year Four** | | | | | |
|---|---|---|---|---|---|
| Hospital | Total Medicaid discharges | Number of measures met | Phase One payment earned | Phase Two payment earned | Total dollar amount |

| | | | | | |
|---|---|---|---|---|---|
| Adventist | 3,002 | 9 | $ 500,000 | $ 4,622,076 | $ 5,122,076 |
| Asante Rogue Regional | 4,384 | 10 | $ 500,000 | $ 8,213,212 | $ 8,713,212 |
| Asante Three Rivers | 1,964 | 9 | $ 500,000 | $ 2,701,441 | $ 3,201,441 |
| Bay Area Hospital | 1,556 | 6 | - | $ 1,046,664 | $ 1,046,664 |
| Good Samaritan Regional | 1,993 | 8 | - | $ 2,609,077 | $ 2,609,077 |
| Kaiser Sunnyside | 1,355 | 7 | - | $ 992,517 | $ 992,517 |
| Kaiser Westside | 406 | 8 | - | $ 441,281 | $ 441,281 |
| Legacy Emanuel | 7,825 | 7 | - | $ 6,682,779 | $ 6,682,779 |
| Legacy Good Samaritan | 2,270 | 9 | $ 500,000 | $ 2,995,359 | $ 3,495,359 |
| Legacy Meridian Park | 1,036 | 11 | $ 500,000 | $ 1,788,836 | $ 2,288,836 |
| Legacy Mount Hood | 2,053 | 8 | - | $ 1,826,301 | $ 1,826,301 |
| McKenzie-Willamette | 1,824 | 10 | $ 500,000 | $ 2,697,123 | $ 3,197,123 |
| Mercy | 1,844 | 8 | - | $ 2,624,527 | $ 2,624,527 |
| OHSU Hospital | 9,267 | 8 | - | $ 10,802,453 | $ 10,802,453 |
| PeaceHealth Sacred Heart – RiverBend | 5,698 | 9 | $ 500,000 | $ 7,318,880 | $ 7,818,880 |
| PeaceHealth Sacred Heart – University | 685 | 6 | - | $ 670,737 | $ 670,737 |
| Providence Medford | 1,379 | 8 | - | $ 1,175,041 | $ 1,175,041 |
| Providence Milwaukie | 544 | 8 | - | $ 469,181 | $ 469,181 |
| Providence Portland | 6,395 | 8 | - | $ 9,347,882 | $ 9,347,882 |
| Providence St Vincent | 4,891 | 7 | - | $ 4,548,135 | $ 4,548,135 |
| Providence Willamette Falls | 1,272 | 8 | - | $ 1,847,716 | $ 1,847,716 |
| Salem Health | 5,602 | 6 | - | $ 3,903,892 | $ 3,903,892 |
| Samaritan Albany General Hospital | 965 | 7 | - | $ 918,838 | $ 918,838 |
| Shriners Hospital for Children | 150 | 6 | $ 500,000 | $ 120,110 | $ 620,110 |
| Sky Lakes | 1,376 | 8 | - | $ 1,843,295 | $ 1,843,295 |
| St Charles Bend | 3,689 | 6 | - | $ 2,310,702 | $ 2,310,702 |
| Tuality Healthcare | 1,234 | 7 | - | $ 845,491 | $ 845,491 |

| | | | | | |
|---|---|---|---|---|---|
| Willamette Valley | 894 | 5 | - | $ 395,445 | $ 395,445 |
| **Total** | **75,553** | | **$ 4,000,000** | **$ 85,758,990** | **$ 89,758,990** |

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

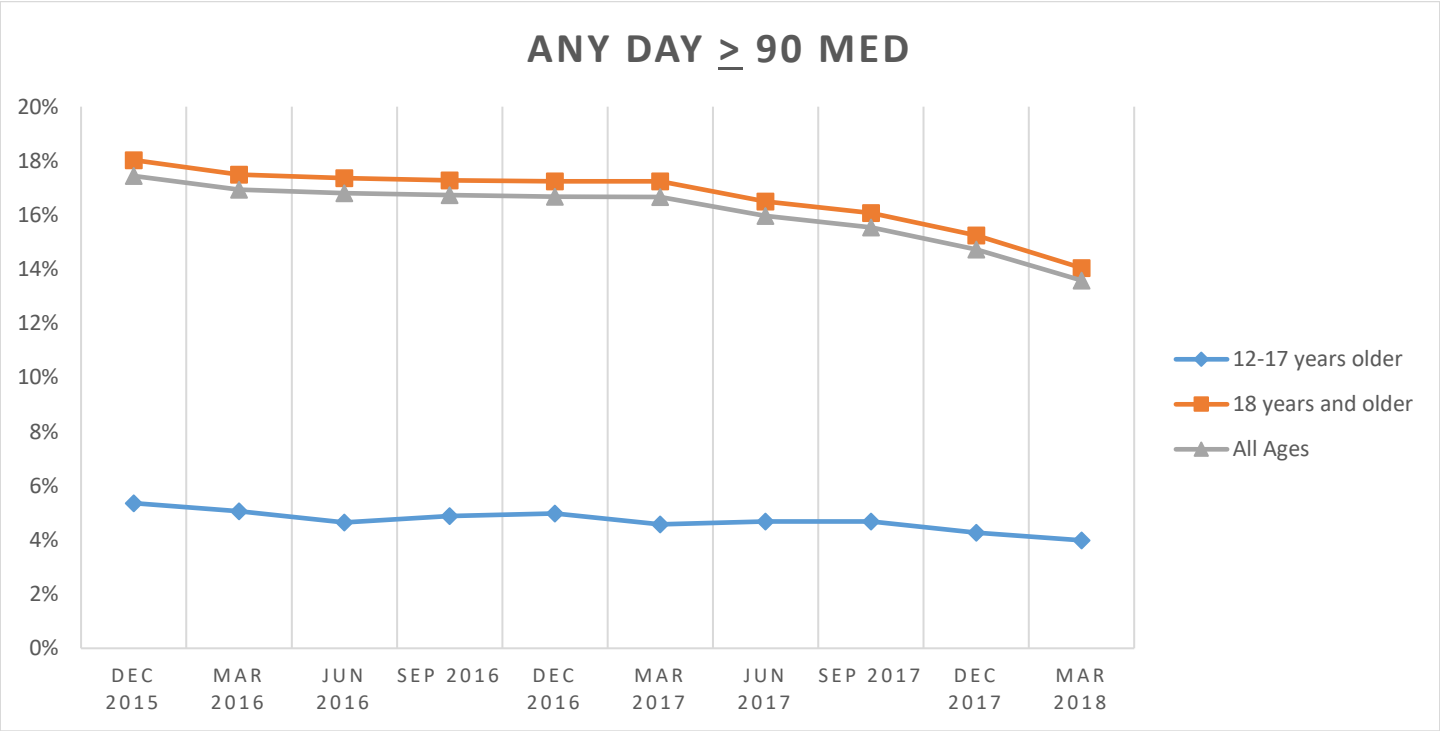
**Statewide Performance Improvement Project**

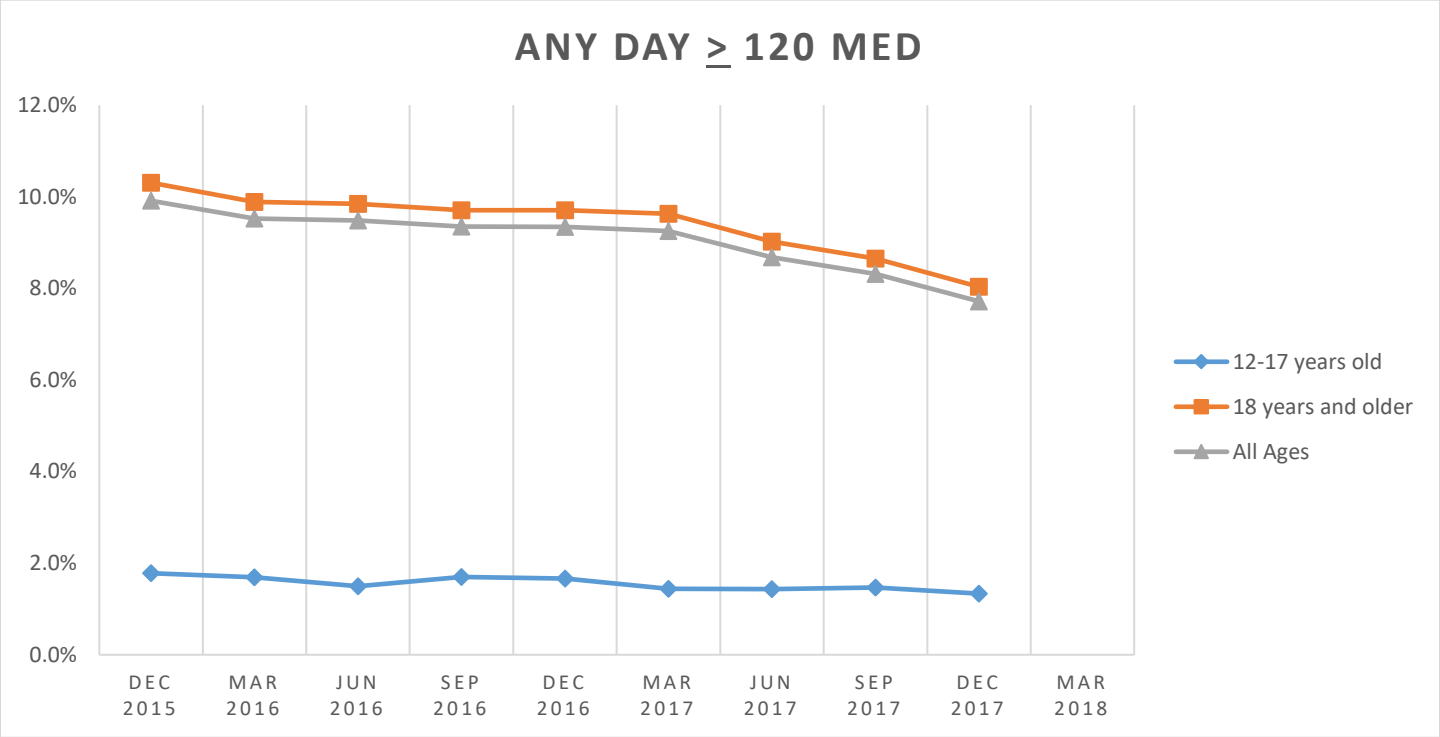
The Oregon Health Authority's (OHA) Statewide Performance Improvement Project (PIP) on Opioid Safety was adopted in July 2015 for calendar year performance monitoring for all 16 CCOs to adopt. Overall PIP project management is conducted through OHA's External Quality Review Organization (EQRO), HealthInsight Assure, in accordance with the 2012 Centers for Medicare and Medicaid Services' (CMS) PIP Protocol.

The EQRO met with Oregon's coordinated care organizations (CCO) in April 2018 to discuss progress of their Statewide PIPs and to provide the yearly update on performance. Each CCO was presented with their project metric and outcomes.

The project metric is the percentage of Oregon Health Plan (OHP) enrollees aged 12 years and older who filled prescriptions for opioid pain relievers of at least ≥ 120 mg morphine equivalent dose (MED) on at least one day and the percentage of enrollees with at least ≥ 90 mg MED on at least one day during the measurement year. Beginning in reporting period of January 2018, > 50 MED will be calculated and distributed to CCOs monthly. Monitoring and interventions will begin to be adapted to lead improvements in the > 50 MED populations.

A few key charts showing the progress to date are shown below. Decreased prescribing across ≥90 and ≥120 MED are seen across all CCOs. While the results are promising, continued monitoring and progress to ensure safety, quality of care and evidence-based treatment adoptions will occur into 2018.






**Behavioral Health Collaborative Implementation**

The Oregon Health Authority (OHA) created the Behavioral Health Collaborative (BHC) in 2016 to develop recommendations that would "build a 21st century behavioral health system in Oregon." The BHC included Oregonians representing peer support services, advocates, counties, behavioral health providers, courts, Department of Human Services, Oregon's coordinated care organizations (CCOs), hospitals, education, law enforcement, a representative from an Oregon tribe, and an Urban Indian organization. After eight months of work, the BHC published a report with recommendations designed to fully integrate behavioral health with physical and oral health care systems.

The BHC made high-level recommendations, and OHA responded by partnering with existing stakeholder groups to establish workgroups focusing on the following areas:

- Governance and finance
- Standards of care and competencies
- Workforce
- Peer delivered services
- Data and outcomes
- Health information technology and exchange

The workgroup focused on the areas above, convened between May and August of 2017. They recommended system changes that OHA can implement to attain the BHC's overarching goal: creating a coordinated, seamless health care system that treats each individual as a whole person and not a collection of problems and diagnoses.

OHA is currently in the process of implementing the most significant recommendations from each workgroup:

***Governance and Finance Workgroup***

- Risk Sharing with Oregon State Hospital (OSH): The Governance and Finance (G&F) workgroup has recommended OHA work in collaboration with coordinated care organizations (CCOs), community mental health providers (CMHPs), and hospitals to identify a risk-sharing model with the OSH. OHA convened a Risk Sharing workgroup to identify opportunities, barriers, and impact of implementing this recommendation.
- Regional BHC: The G&F workgroup has recommended OHA rename the "single point of shared accountability" referenced in the BHC report to Regional Behavioral Health Collaborative (RBHC). This will avoid the possible interpretation that a new entity is required. RBHCs will be formed by CCOs, CMHPs local mental health authorities (LMHAs), local public health authorities (LPHAs), tribes, individuals with lived experience, and other key system partners in each geographic region of the state to improve individual health outcomes.

OHA will implement the RBHC recommendation by establishing an RBHC in the tri-county Portland-metro area. FamilyCare CCO's decision to leave the Medicaid market has illuminated the different approaches within this region's behavioral health system and has identified the opportunity for timely attention to address the region's ongoing behavioral health challenges. Partners in the metro area are willing and ready to move forward in developing an RBHC.

***Standards and Competencies Workgroup***

The Standards and Competencies (S&C) workgroup has recommended implementation of a standardized suicide risk assessment in Oregon. This recommendation is in alignment with the Zero Suicide Initiative that Oregon committed to in 2016, when the state established the Oregon Youth Suicide Prevention Five-year Plan.

OHA has convened an internal workgroup to identify options for implementing standardized assessment and reporting by all providers. The options are being vetted through various stakeholder groups such as community mental health providers (CMHPs), substance use disorder (SUD) providers, Oregon Suicide Prevention Alliance, Certified Community Behavioral Health Clinics (CCBHCs), and others.

The S&C workgroup recommended that OHA assess the minimum core competencies of behavioral health providers in Oregon: merits, gaps, and minimum requirements for providers in various settings. OHA staff are consulting with the Eugene S. Farley Jr., Health Policy Center from the University of Colorado to develop core competencies for an integrated behavioral health workforce. The goal is to identify gaps in basic core competencies for behavioral health providers across the system and recommend key action steps to fill those gaps within an integrated system.

***Workforce Workgroup***

The BHC recommended a thorough assessment of Oregon's behavioral health care workforce: licensed, unlicensed, certified, uncertified, and registered. OHA, through a contract with the Eugene S. Farley Jr., Health Policy Center, is conducting this assessment. The assessment will identify gaps in workforce capacity (report to follow in February 2019), and the Behavioral Health Mapping tool will be updated to reflect the assessment's results. A recruitment and retention plan for the behavioral health workforce will be completed in spring 2019.

***Peer Delivered Services Core Team***

The Peer Delivered Services Core Team, largely comprised of peers, consumers and their family members, and traditional health care workers, worked over the summer of 2017 on the BHC recommendations. It developed policy recommendations regarding:

- Requirements for supervisors for the peer workforce.
- Standards and infrastructure for the development of statewide peer-delivered services (PDS) system.
- Monitoring for effective and appropriate use of peer services to be implemented through the OHA site review process.
- Technical assistance for OHA-approved treatment and recovery programs, to increase readiness to add PDS to the array of services offered.
- Ongoing PDS training requirement.

### *Information Exchange and Coordination of Care*

#### *Data and Outcomes*

OHA reconvened the BHC Data workgroup to identify behavioral health incentive metrics to recommend to the Oregon Health Policy Board and the Health Plan Quality Metrics Committee (HPQMC). The data workgroup presented the recommendations to the HPQMC in February, and accepted measures are being submitted to the Metrics and Scoring Committee for the next iteration of incentive metrics.

#### *Health Information Technology and Exchange*

Behavioral health integration is a core consideration for all core health information technology (HIT) strategies. Oregon's Office of Health Information Technology (OHIT) is approaching the work with the lens of how to best support behavioral health. The Health Information Technology Oversight Council (HITOC) served as the HIT and exchange workgroup for BHC. In 2017, OHIT conducted a survey of behavioral health providers' electronic health record and HIT status, needs, and barriers. HITOC requested an ad-hoc behavioral health workgroup to help HITOC identify specific action steps needed to improve health information exchange and care coordination across the behavioral health spectrum.

### Roadmap to Oral Health

Oregon continues to improve integrated oral health care for Medicaid members, building on ongoing efforts. In 2016, the Medicaid Advisory Committee convened a workgroup on oral health access that developed a definition and framework for improving oral health access in Medicaid. The workgroup identified lack of member awareness and understanding of benefits as one barrier to oral health access. In response, the Oregon Health Authority (OHA) developed a suite of member and provider education materials.

Key efforts to improve oral health integration for Medicaid members during the April – June 2018 quarter are:

- Collaboration with the American Cancer Society to have a dental tract at the Oregon HPV Statewide Summit on May 31, 2018. Sessions highlighted the need for medical and dental professionals to work together to decrease rates of oropharyngeal cancer by ensuring clients get the HPV vaccine.
- Continued work on an incentive program to encourage more dentist participation in treating fee-for-service dental patients. This program will provide financial bonuses for several thresholds for dentists and practices accepting more new patients and providing preventive procedures.

- Tailored oral health integration technical assistance to two coordinated care organizations through the Transformation Center.

Other key initiatives and activities during this demonstration year include:

- OHA finalized and distributed a brochure and poster highlighting the importance of oral health care as a part of overall health care and dental benefits available to Oregon Health Plan members. Oregon's coordinated care organizations (CCO) can customize the documents for their members.
- OHA's dental director and Medicaid fee-for-service dental program manager participated in the Center for Health Care Strategies' 2017 State Oral Health Leadership Institute and completed their state-specific project addressing dental opioid prescribing in Oregon. The tools developed and lessons learned from this project will help promote responsible, consistent and compassionate dental prescribing guidelines for opioids and increase registration and usage of the Prescription Drug Monitoring Program (PDMP) by dentists.
- The Transformation Center (TC) offered technical assistance to help CCOs envision and implement more integrated oral health throughout their systems of care.
- The TC conducted a needs assessment to determine focus areas, and found a range of needs, from increasing basic education for members about the importance of preventive care to improving health information exchange.
- Two Quality Health Outcomes Committee (QHOC) meetings featured oral health integration. QHOC brings together clinical leadership from Oregon's CCOs to coordinate and lead quality improvement efforts supporting implementation of innovative health care practices.
- Beginning January 1, 2018, OHA increased fee-for-service rates by 10 percent for specified diagnostic and preventive services and 30 percent for specified oral surgical codes with the goal of attracting additional providers and increasing access to dental care.
- OHA's Health Systems Division, in collaboration with OHA's Public Health Division, PDMP, Oregon Health and Sciences University's (OHSU) School of Dentistry and the Oregon Opioid Initiative, presented a brochure and guidelines regarding dental opioid prescribing in Oregon to dental care organizations, CCOs, internal OHA partners, Oregon College of Emergency Physicians, Board of Dentistry, Board of Pharmacy, OHSU's School of Dentistry, and the Oregon Dental Association.
- The legislature passed House Bill 4143, which will now require all prescribers of controlled substances, including dentists, to register with the PDMP.

### *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*

**Innovator Agents**

During this demonstration year innovator agents have focused on helping coordinated care organizations (CCO) as they completed their Transformation Plans and prepared and submitted their first annual Transformation Quality Strategies (TQS) in March 2018. The TQS will replace the Transformation Plan and the Quality Assessment and Performance Improvement deliverables. CCOs will submit a six-month progress report on their TQS efforts in September 2018. Innovator agents facilitated access to technical assistance and training through the Transformation Center, provided feedback on the TQS, connected CCOs to area experts, and participated in the TQS workgroup.

Innovator agents have continued their relationships with the communities they support. These relationships have been helpful as OHA prepares for CCO 2.0. Innovator agents assisted with OHA community forums to gather feedback about what has worked well in the past five years with CCOs and what can be improved in the future. Innovator agents also presented information and gathered feedback about CCO 2.0 to Community Advisory Councils (CAC) and other community partners.

Innovator Agents have been assisting CCOs, CACs, and communities as they prepare their new Community Health Assessments (CHA) and Community Health Improvement Plans (CHP). As social determinants of health, trauma-informed care, and health equity are incorporated into new CHPs, innovator agents have provided information, feedback, and connections to technical assistance as needed. They have also coordinated community and CAC members to participate in the one- day training: Planning a Collaborative CHA and CHP for Your Unique Community, that provides an opportunity for CCOs to collaborate with local public health, tribal health departments, hospitals, and local mental health authorities to collaboratively develop CHAs and CHPs.

**Public Health Modernization**

Since 2013, state and local public health authorities have been working to modernize how public health services are provided to people and communities across Oregon. This work has been directed by Oregon's legislature in the last three legislative sessions. Most notably, the legislature passed 2015 House Bill 3100, which established a new model for public health in Oregon based on the provision of foundational programs intended to improve health outcomes.

***Funding for Public Health Modernization***

For the 2017-2019 biennium, the Oregon legislature made an initial investment of $5 million for modernizing Oregon's public health system. In November, Oregon Health Authority awarded $3.9 million to eight regional partnerships of local public health authorities and other organizations for the period of December 1, 2017-June 30, 2019. Regional partnerships are using funding to:

- Develop regional systems for communicable disease (CD) control;
- Emphasize the elimination of communicable disease-related health disparities; and
- Build sustainable regional infrastructure for new models of public health service delivery.

In many regions, these funds are supporting new and enhanced partnerships with CCOs and other health system organizations. The table below describes these regional partnerships. An interim evaluation of the 2017-2019 legislative investment is underway and will be released later in 2018. State and local public health authorities will use evaluation findings to understand effective regional models for communicable disease control, so these models can be replicated and expanded into other areas of governmental public health.

| Regional Partnerships | Goals |
|---|---|
| Counties:<br>Clatsop, Columbia, and Tillamook | ■ Convene partners to assess regional data on sexually transmitted infections and develop priorities.<br>■ Identify vulnerable populations and develop regional strategies to address Population-specific needs. |
| Counties:<br>Deschutes, Crook, and Jefferson | ■ Form the Central Oregon Outbreak Prevention, Surveillance and Response Team which will improve: |

| | |
|---|---|
| Partners:<br>St. Charles Health System and Central Oregon Health Council | ○ CD outbreak coordination, prevention, and response in the region;<br>○ CD surveillance practices;<br>○ CD risk communication to health care providers, partners, and the public.<br>■ Funds will be directed to CD prevention and control among vulnerable older adults living in institutional settings and young children receiving care in child care centers with high exemption rates. |
| Counties:<br>Douglas, Coos, and Curry<br><br>Partners:<br>Coquille and Cow Creek Tribes and Western Oregon Advanced Health CCO | ■ Improve and standardize mandatory CD reporting.<br>■ Implement strategies for improving immunization rates.<br>■ Focus on those living in high poverty communities. |
| Counties:<br>Jackson and Klamath<br><br>Partners:<br>Southern Oregon Regional Health Equity Coalition and Klamath Regional Health Equity Coalition | ■ Work with regional health equity coalitions and community partners to respond to and prevent sexually transmitted infections and Hepatitis C, focused on reducing health disparities and building community relationships and resources.<br>■ Promote Human Papillomavirus (HPV) vaccination as an asset in cancer prevention. |
| Counties:<br>Lane, Benton, Lincoln, and Linn<br><br>Partners:<br>Oregon State University | ■ Establish a learning laboratory to facilitate cross-county information exchange and continuous learning.<br>■ Implement an evidence-based quality improvement program (AFIX) to increase immunization rates.<br>■ Pilot three local vaccination projects:<br>○ Hepatitis A vaccination among unhoused people in Linn and Benton counties;<br>○ HPV vaccination among adolescents attending school-based health centers in Lincoln County; and<br>○ Pneumococcal vaccination among hospital discharge patients in Lane County.<br>■ Establish an Academic Health Department model with Oregon State University to extend public health capacity and support evaluation. |
| Counties:<br>Marion and Polk<br><br>Partners:<br>Oregon State University and Willamette Valley Community Health CCO | ■ Focus on system coordination and disease- and population-specific interventions to control the spread of gonorrhea and chlamydia.<br>■ Increase HPV immunization rates among adolescents. |
| Counties:<br>Baker, Grant, Harney, Hood River, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, and Wheeler<br><br>Partners:<br>North Central Public Health District; Eastern Oregon CCO; and Mid-Columbia Health Advocates | ■ Establish a regional epidemiology team.<br>■ Create regional policy for gonorrhea interventions.<br>■ Engage community-based organizations to decrease gonorrhea rates through shared education and targeted interventions. |

| | |
|---|---|
| Counties:<br>Washington, Clackamas, and Multnomah<br><br>Partners:<br>Oregon Health Equity Alliance | ■ Develop an interdisciplinary and cross-jurisdictional communicable disease team to focus on developing and strengthening surveillance and communications systems to facilitate the timely collection of information and data, create surge capacity, and communicate about outbreaks.<br>■ With leadership and guidance from the Oregon Health Equity Alliance, this cross-jurisdictional team will develop culturally responsive strategies that:<br>○ Identify and engage at-risk communities; and<br>○ Reduce barriers (e.g., language, stigma, access to care) to infectious disease control, prevention, and response.<br>■ Both qualitative and quantitative evaluation methods are included in the overall design. Evaluation results will guide implementation of best practices across the region focused on reducing and eliminating the spread of communicable diseases. |

***Public Health Accountability Metrics***

Oregon Health Authority (OHA) and the public health system use a set of public health accountability metrics to track progress toward achieving population health goals. The Public Health Advisory Board established the initial set of public health accountability metrics in 2017 with a baseline accountability metrics report published in April 2018.

The Public Health Accountability Metrics Baseline Report provides an in-depth look at how Oregon's public health system is doing today on key health issues like improving childhood immunization rates, reducing tobacco use and opioid overdose, and ensuring access to clean drinking water. More than half of the public health accountability metrics align with coordinated care organization (CCO) incentive metrics, indicating opportunities for public health authorities and CCOs to engage in cross-sector efforts to improve outcomes. Key findings from the most recent report include:

- With 89% of public water systems meeting health-based standards in 2016, the public health system is close to meeting the statewide benchmark of 92%.
- In 2016, the rate of gonorrhea infections was considerably higher than the statewide benchmark of 72 cases per 100,000 people.
- For most accountability metrics, health outcomes vary across racial and ethnic groups. The report highlights variations across different racial and ethnic groups to better focus interventions on reducing health disparities in Oregon.

Moving forward, annual reports will provide the public health system and its partners and stakeholders information to understand where Oregon is making progress toward population health goals, and where new approaches and additional focus are needed.

**Regional Health Equity Coalitions**

Regional Health Equity Coalitions (RHECs) are community-driven, cross-sectoral groups. The RHEC model works by building on the inherent strengths of local communities to meaningfully involve them in identifying sustainable, long-term, policy, system, and environmental solutions to increase health equity for underserved and underrepresented populations experiencing health disparities.

## *Oregon Health Authority*

In 2011, the Oregon Health Authority (OHA) established RHECs to support local, community-driven, culturally-specific activities to reduce disparities and address social determinants of health. Once funded, the coalitions selected the region and populations they would focus their work on. Each RHEC conducted a community needs assessment to identify priority issue areas in which to concentrate their efforts and ultimately inform their strategic plans. Both strategic plans and contract deliverables (i.e. meaningful community engagement, strengthening organizational capacity, system change, social norm and environment change, and policy change) help provide guidance on RHEC annual work plan activities.

### *The RHEC Model*

The RHEC model is aimed at reducing local health disparities and promoting equity. Coalitions build on the inherent strengths of their communities. Additionally, coalitions utilize a policy, systems, and environment framework to craft and implement sustainable, long-term solutions to eliminate health inequities and address social determinants of health.

The basis for the RHEC model is a theoretical framework that states the foundations for system change are increased and authentic community engagement and strengthened organizational capacity. There is a special focus on healthcare systems and coordinated care organizations (CCOs). There is also a focus on social norms and environmental change, as well as policy change. These things, in turn, lead to healthier, more resilient communities that experience fewer health disparities.

### *RHECs and Priority Areas*

There are currently four RHECs: Linn Benton Health Equity Alliance; Mid-Columbia Health Equity Advocates; Oregon Health Equity Alliance; and Southern Oregon Health Equity Coalition SO Health-E, and they serve nine Oregon counties. Their work covers a wide range of underserved communities in urban, rural, and frontier regions with communities of color as a leading priority.

There are two new capacity building grants which are supporting the development of the first RHEC in Eastern Oregon, as well as the first group fully focused on a Tribal population. These grantees, Confederated Tribes of Warm Springs and Euvalcree (covering Malheur and Umatilla counties), are piloting the RHEC model with the health equity work they are doing, and this funding offers an opportunity to complete foundational RHEC activities (i.e. coalition building, developing governance structures, assessing community needs, etc.).

RHECs and capacity building grantees collectively represent regions that comprise 57.4% of Oregon's total population, 57.2% of Oregon's Medicaid population, 53.4% of Oregon's communities of color (i.e. American Indian/Alaska Natives, Asians, Black/African Americans, Native Hawaiians, and those who identify as some other race), and 60.4% of Oregon's Latino communities. RHECs held 37 community education events focused on health equity topics, reaching 100 organizations in their communities, and impacting 2,000 participants.

This funding from OHA's Office of Equity and Inclusion's general funds is a nominal investment for substantial returns in terms of cost savings to impacted systems by way of improving disparities. Sustaining the RHECs provides expertise and assistance to the state to demonstrate and implement regionally appropriate, concerted efforts to address issues of inequity across Oregon. Without continued support to the RHECs, Oregon would lose an immense capacity to address health equity issues in culturally specific and effective ways. Example successes are displayed in the table below.

| Success Areas | Examples |
|---|---|
| Economy and Jobs | ■ Successfully advocated to ban the box related to criminal histories to make employment more accessible<br>■ Ongoing collaboration with local CCO related to providing healthcare interpreter (HCI) training and certification in a region where there is a shortage of qualified and certified HCIs |
| Education | ■ Provided advocacy capacity building opportunities for high school youth of color and helped facilitate a conversation with their representative<br>■ Working to improve school districts' inclusion of diverse families |
| Equality and Social Justice | ■ Coalition members are part of a Mayor's Latino Advisory Council to advocate for equity issues. |
| Healthcare | ■ Effectively advocated for healthcare for all children, and reproductive health equity |
| Public Safety | ■ Successfully advocated to County Commissioners for a county ID card for all community members regardless of barriers related to age, housing transportation, immigration status, and cost. Having IDs improves access to basic services and helps makes law enforcement interactions less frightening.<br>■ Advocated to end law enforcement profiling through data collection, training, and accountability. |

**Sustainable Relationships for Community Health program**

Sustainable Relationships for Community Health (SRCH) teams are comprised of coordinated care organizations (CCO), local public health authorities and community-based organizations. The goal of SRCH is to bring together different organizations and sectors within a community to complete a shared systems-change project that will be sustained beyond the grant period. In the process of completing SRCH grants, teams build strong relationships, define roles in ongoing partnerships and programs, and build capacity for foundational skills in systems change, project management, communications, data analysis, and evidence-informed strategies. SRCH is designed to align with OHA's agency-wide goals, public health modernization, and is an actionable strategy that can be used to meet the triple aim of health systems transformation.

Two new SRCH Program grantee consortia, Yamhill CCO and Klamath County Public Health, started their year-long projects in January 2018 and finished their third and final institute in July 2018. This cohort of SRCH grantees participated in three two-day institutes in February, May, and July 2018. The teams are working on building closed loop referral systems to colorectal cancer screening, chronic disease self-management, and the National Diabetes Prevention Program. At the site visit and first institute, the teams mapped their local systems, defined the various roles of partners, identified their aims, drivers, and activities, and developed their workplans. In May, teams continued testing and evaluating new strategies.

The final SRCH grantee cohort evaluation was completed by contractors from Oregon Health and Sciences University (OHSU) in September 2017. The evaluation findings showed that all grantee teams reported considerable progress on their initiatives through increasing patient referrals to evidence-based self-management programs, piloting new intervention strategies, developing standardized workflows, implementing closed-loop referrals, developing patient identification and screening criteria, and creating new educational/communications materials. All teams also significantly increased inter- and intra- team collaboration and built new relationships. This SRCH grantee cohort was successful at building closed-loop

referrals to two different community-based programs per team, in addition to the other successes mentioned above.

The SRCH model continues to evolve based on feedback from participants, CCOs, and local health departments. In response to the stated need to build leadership and staff capacity prior to receiving grant funding, the Oregon Health Authority (OHA) has developed the SRCH Leadership Institute, a 3-day convening for local public health and CCO partners to build relationships, identify project and policy opportunities, and build core capacities for health systems transformation.

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

**Health-related services**

The Oregon Health Authority (OHA) is continuing to explore opportunities to encourage Oregon's coordinated care organizations (CCO) to increase strategic spending on health-related services (HRS) as a mechanism to invest in social determinants of health and equity in communities. Potential strategies are being discussed for the next CCO contracts.

OHA is also working to improve communication on tracking and reporting the use of HRS and outcomes associated with flexible services. This includes a frequently-asked-questions document that will facilitate greater investment in HRS by clarifying implementation options and analyzing evidence of the health impact of HRS spending on kindergarten readiness and traditional health workers.

**CCO Performance Improvement Projects**

In addition to the Statewide Performance Improvement Project (PIP), coordinated care organizations (CCO) are required to work on three PIPs. Specific PIPs for each CCO are detailed in the table below. CCOs report quarterly on the progress including updating outcome measures as data is available. CCOs are tying the organization's improvement work with the organization's measurement strategies to support further integration of operations and resources, resulting in collective impact of the work to health systems (hospitals, provider practices, and community-based organizations).

Several CCOs continue to work on reducing emergency department utilization and plan all-cause readmissions, and a sample of newer PIPs include:

- Hepatitis C screening;
- Social determinants of health screening;
- Increase in medication assisted treatment (MAT);
- Community health workers expansion;
- Substance abuse use in older adults; and
- Integrated pharmacy team within primary care.

A table of all CCO PIPs is included in this report as Appendix E – CCO Performance Improvement Projects.

Key results include:

- An increase of 5.4% of members with primary OUD diagnosis who receive MAT services for Health Share of Oregon CCO (Sept 2016-Aug 2017 baseline to Mar 2017-Feb 2018).
- An increase of 13.1% of adolescent well care visits for Eastern Oregon CCO (calendar year 2015 baseline to calendar year 2017)
- A decrease of 3.4% of members 13 and older who self-report as cigarette smokers for Columbia Pacific CCO (calendar year 2017 baseline to June 2018).
- A decrease of 2% of plan all-cause readmissions for Trillium CCO (calendar year 2016 baseline to June 2018).

**Traditional Health Workers**

The Traditional Health Worker (THW) program works to promote the roles, engagement, and utilization of the traditional health workforce, which includes Community Health Workers, Peer Wellness Specialists, Patient Health Navigators, Peer Support Specialists and Doulas.

The THW program, in partnership with stakeholders, community-based organizations, and health systems, strives to ensure that THWs are uniquely positioned to work with communities to identify and address the underlying causes of health problems and health inequities for some of the Oregon's most vulnerable populations. The key focal areas for the THW program during this demonstration year are:

- Continuing to pursue strategies to integrate THWs into coordinated care organizations (CCOs);
- Advancing community engagement opportunities; and
- Developing and implementing ongoing revisions to the THW scope of practice in the context of health system transformation.

OHA's Office of Equity and Inclusion (OEI) continues to support the training and certification of THWs by enrolling certified workers on the state registry, approving quality training programs, and developing processes and procedures to facilitate seamless integration of THW workforce in the health system.

***Traditional Health Worker Workforce***

Beginning in July 2017, the Oregon Health Authority (OHA) and the Office of Equity and Inclusion (OEI) collaborated with two community-based organizations, Oregon Community Health Workers Association (ORCHWA) and the Oregon Doula Association (ODA), in an effort to complete a statewide needs assessment on the integration and utilization of community health workers (CHW) and doulas. The purpose of this needs assessment is to identify gaps in supply and demand distribution, as well as barriers, challenges, appropriate utilization, and availability of culturally and linguistically specific THW services. This information will be used to inform community stakeholders and policy-makers about the needs facing CHWs and Doulas throughout the state.

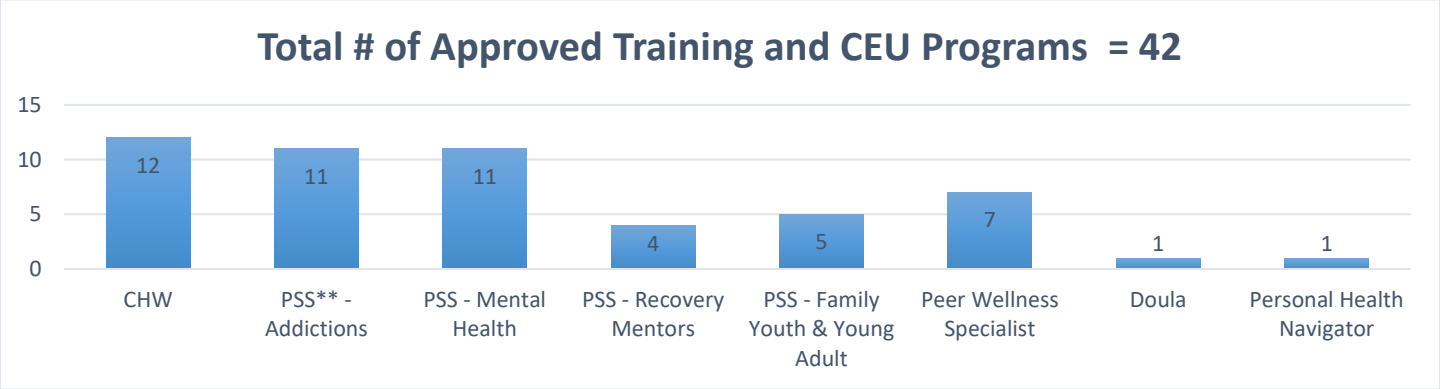
In early summer 2018, OEI supported the development the new Peer Health Navigator Workgroup, a collaboration between Providence Health and Kaiser Permanente, by offering technical assistance, co-facilitation, and logistics assistance. The outcome was another needs assessment, this time focusing on the utilization and implementation of Peer Health Navigators. The results of this needs assessment will also be used to inform community and stakeholders and policy-makers.

In May 2018, OEI began collaborating with coordinated care organizations (CCOs) to launch a series of statewide Information and Listening sessions for the purpose of providing information around different THW provider payments, certification pathways and statewide registry access. The events will also allow for THW workforce members to openly discuss their challenges and barriers with health system employers and stakeholders including representatives from area hospitals, county health departments, and consumers. These sessions will continue through fall of 2018.

***Traditional Health Workers (THWs) Certification Public Registry***

Oregon House Bill 3407 requires OHA to adopt rules and procedures for training and certification of THWs. The state certification process requires successful completion of approved training, completion of a background check, and continuing education to maintain certification. As of June 30th, 2018, OHA has certified a total of 3,028 THWs and approved 42 trainings and continuing education programs. The tables below displays statewide certifications and approved trainings and continuing education programs by THW type.

| | Statewide certifications | |
|---|---|---|
| | **Sub-type** | **Cumulative** |
| **Community Health Workers (CHW)** | | 559 |
| **Personal Health Navigators (PHN)** | | 9 |
| **Peer Wellness Specialists (PWS)** | Adult Addictions | 9 |
| | Adult Mental Health | 88 |
| | Family Support | 5 |
| | Youth Support | 1 |
| **Doulas** | | 41 |
| **Peer Support Specialists (PSS)** | Adult Addictions | 1,488 |
| | Adult Mental Health | 580 |
| | Family Support | 128 |
| | Youth Support | 112 |
| **TOTAL** | | **3,020** |




***Traditional Health Worker Commission***

The Traditional Health Worker (THW) Commission: promotes the THW workforce in Oregon's health care delivery system to achieve the state's goals of better health, better care, and lower costs; advises and makes recommendations to the Oregon Health Authority (OHA) on the development, implementation, and sustainability of the THW program; and ensures the program is responsive to consumer and community health needs, while delivering high-quality and culturally competent care.

During this demonstration year, the THW Commission, with the goal of strengthening CCO 2.0 contract language, proposed and requested the OHA to implement the measures outlined below to remedy the existing and future barriers to utilization of THWs. These measures were incorporated into CCO 2.0 policy recommendations:

- Require CCOs to create a plan for integration and utilization of THWs.
- Require CCOs to integrate best practices for THW services in consultation with the THW commission.
- Require CCOs to designate a CCO liaison as a central contact for THWs.
- Identify and include THWs affiliated with organizations listed under ORS 414.629.
- Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for THW services.

***Stakeholder Engagement***

During this demonstration year, the THW program coordinator continued to provide a series of presentations to THW training program participants, community-based organizations, federally-qualified health centers, coordinated care organizations (CCO), and other stakeholders. These presentations focused on certification, Medicaid enrollment, and the public registry process. In addition, Office of Equity and Inclusion (OEI) staff and the THW Commission developed presentations for CCO's Oregon 2018 conference which focused on ways to improve the integration and utilization of THWs in health care systems.

In February 2018, OEI staff and the THW Commission developed presentations for CCO's Community Advisory Council focusing on providing technical assistance on best practices and the most effective ways of integrating THWs in health care systems.

**Healthcare Interpreters**

The utilization of language services, such as interpretation by qualified and certified Healthcare Interpreters (HCI), has been shown to improve cross-cultural communication, leading to increased compliance with recommended treatment plans, improved health care outcomes, overall reduction of healthcare cost, and ultimately, reduction in health disparities. Evidence suggests that adverse events reported by limited English proficient (LEP) patients are more likely to be due to communication errors (Divi, Koss, Schmaltz, et al., 2007). Patients who used professional interpreters during hospital admission had shorter lengths of stay and were less likely to be readmitted within 30 days than those who did not have professional language interpreters during admission (Lindholm, Hargraves, Ferguson, et al., 2012). It can be inferred from the growing LEP population in Oregon (about 6.3% in 2015) and their need for health care services that the availability and use of trained HCIs for LEP patient health care encounters can improve LEP individuals': access to health care, quality of care received, enrollee health, and overall health care costs.

The legislatively mandated HCI program exists to enhance the state's health system transformation goals. Evidence suggests that LEP patients, including patients who communicate in sign language, often:

- Are unable to interact effectively with health care providers;
- Are excluded from health care services;
- Experienced delays or denials of health care services; or
- Received health care services based on inaccurate or incomplete information.

Based upon this evidence, the HCI program was implemented to set competency criteria, approve health care interpreter training programs, and qualify and certify spoken and sign language HCIs. The HCI recognition process includes training (60 hours of training) and state Registry enrollment. The legislatively mandated state HCI Registry currently has about 560 trained (qualified and certified) spoken and sign language HCIs. The table below shows a breakdown of Registry enrolled HCIs by main languages (note: the table does not include 51 HCIs from other minor language categories on the Registry).

| Languages | Certified | Qualified | Total |
|---|---|---|---|
| Arabic | 4 | 27 | 31 |
| Cantonese | 1 | 16 | 17 |
| Hispanic | 124 | 226 | 350 |
| Korean | 3 | 5 | 8 |
| Mandarin | 2 | 9 | 11 |
| Persian | 0 | 10 | 10 |
| Russian | 3 | 26 | 29 |
| Somali | 0 | 11 | 11 |
| Vietnamese | 0 | 25 | 25 |
| American Sign Language (ASL) | 17 | 0 | 17 |
| **Total** | **154** | **355** | **509** |

The need for continuous training and recognition of HCIs in Oregon is demonstrated by the growth in LEPs and their potential need for HCIs to improve their access to healthcare services. According to the American Community Survey, about 6.3% of the state's population in 2015 was considered LEP; they communicate in about 35 different languages. This data does not include LEP patient populations who need sign language interpretation.

In addition to the legislatively mandated responsibility to qualify, certify, and enroll HCIs on the state Registry, OEI initiated several activities to help address emerging gaps in the workforce development mission of the program. Activities include: an HCI community advisory council retreat; updating HCI laws; sponsoring and organizing new and remedial training; and testing for HCIs.

The first ever HCI community advisory council retreat focused on developing a five-year strategic plan. The planning process identified the following main strategic directions and various initiatives under each direction:

- Improving HCI training standards.
- Developing a new HCI Registry including an online application portal.
- Requiring CCOs to use certified and qualified HCIs and improving the working conditions for HCIs.
- Recruiting and diversifying HCI community advisory council membership.
- Improving the council's engagement of LEP populations.

OEI staff are working with OHA rules coordinators on proposed changes to existing HCI administrative rules to improve the Registry enrollment and working conditions for current interpreters. Staff are also planning to train a cohort of about 40 HCIs in Eastern Oregon and conduct remedial training and testing for HCIs. The training is necessary for sustaining previous gains in workforce development. Specifically, the remedial training and testing will focus on about 55 HCIs on the state Registry who have expired because they have not passed the certification exams for their respective languages (a requirement for renewing HCI Registry enrollment for

some interpreters). The training in Eastern Oregon is designed to increase the supply of HCIs in that region and improve access to healthcare services for the growing LEP populations.

### *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*

**Behavioral Health Integration**

The Transformation Center is offering each CCO up to ten hours of TA to work on a behavioral health integration project of their choosing. Eight CCOs requested assistance. Topics include practice coaching for clinics; developing and implementing learning collaboratives for clinics; identifying metrics; developing value-based payments (VBP); and facilitating stakeholder engagement. Two CCOs are combining these projects with TA hours for focusing on emergency department use among members with mental illness.

The Oregon Health Authority (OHA) launched a one-year project building on the Behavioral Health Collaborative to develop an aligned vision for the future of behavioral health in Oregon and establish a clear action plan. By the end of the project, the state and the largest regional behavioral health system (Portland metro area) will implement a Regional Behavioral Health Collaborative including aligned goals and metrics.

The Transformation Center is also developing a guidance document for CCOs on aspects of integrated care in both primary care and specialty behavioral health.

**Oral Health Integration**

Two CCOs have begun oral health integration projects with consultants through the Transformation Center. One CCO is reviewing the recent implementation of a pilot integrating oral health care in the primary care provider's office. The other CCO is working with stakeholders to develop a workplan for oral health integration that includes any relevant activities during the quarter related to CCO and tribal technical assistance or other activities (e.g., metrics collaboration with community partners, untested models).

**Community Advisory Councils**

The Transformation Center continues to provide targeted supports to coordinated care organization (CCO) community advisory councils (CAC) for CAC member recruitment and engagement. Activities during this demonstration year include:

- An annual CAC leader event. Over 80 CAC leaders attended, and nearly 85% of evaluation respondents said it was valuable in supporting their work. In preparation for the event, staff and consultants conducted 22 interviews with CAC members.
- Monthly calls with CAC leaders focused on member recruitment and engagement.
- Member recruitment materials (printed cards, fliers, and a web page) were created and shared with coordinated care organizations (CCO) and the state Supplemental Nutrition Program for Women, Infants and Children for helping recruit Oregon Health Plan (OHP) members to CACs.

The Transformation Center also held five webinars for CAC members, which focused on the community health assessment (CHA) and community health improvement plan (CHP) processes; peer-delivered services; traditional health workers; results from the key informant interviews; and available resources. Five CCOs participated in a one-day CHA/CHP development training grounded in the Mobilizing for Action through

Partnership and Planning framework, with a focus on collaboration to meet collective CHA/CHP requirements for CCOs, hospitals and local public health authorities. Consultants developed a guidance document and webinar to support CCO implementation of House Bill 2675, which requires CHPs to include a strategy for integrating physical, behavioral and oral health care services.

**CCO Incentive Metrics Technical Assistance**

***Adolescent well-care visits***

The Transformation Center is providing technical assistance (TA) to increase adolescent well-care visits for young adults 18–21 years old, as this group has the lowest use of well-care visits. A contractor convened leaders, who prioritized partnerships with community colleges as a key strategy. The contractor developed a lesson plan, piloted it in three classes at Portland Community College, and held a webinar for coordinated care organizations (CCO) to share lessons learned. The lesson plan was based on Health Hack, a curriculum for transition-age youth on navigating the health system. The Transformation Center also held a webinar introducing Health Hack, which was developed by a CCO and is now hosted by the Transformation Center.

***Childhood Immunization Rates***

Three CCOs participated in TA for increasing childhood immunization rates, with two of the CCOs transitioning from their TA to supporting clinic-level, evidence-based quality improvement efforts (AFIX) within their communities for improved alignment and collaboration. AFIX is the CDC's Assessment, Feedback, Incentives and eXchange quality improvement program that state and local public health authorities implement in partnership with immunization providers.

***Controlling High Blood Pressure***

The Transformation Center is producing two webinars to help clinics and CCOs improve high blood pressure control among their members. In addition, the Transformation Center is contracting with the Oregon Rural Practice-based Research Network to provide TA on quality improvement using high blood pressure control as the learning tool. The center also created a Million Hearts® resources catalog organized by audience and a tool for CCOs to compare in-person and online chronic disease self-management programs.

***Effective Contraceptive Use***

After individual consultation calls about increasing effective contraceptive use, 12 CCOs requested follow-up TA. Projects include provider trainings, train-the-trainer curriculums, patient education materials and workflow improvement. A webinar covered overall highlights and learnings. The Transformation Center hosted a six-webinar series focused on youth sexual health, as the CCO incentive metric now includes 15–17-year-olds. Presenters included public health and CCO staff. Attendees (of one or more session) included 147 people from 14 CCO regions.

***Emergency Department Use Among Members with Mental Illness***

Eight CCOs participated in peer-learning consultation calls focused on emergency department use among members with mental illness. The facilitated calls focused on quality improvement and opportunities for innovative care coordination and transitions of care. Four CCOs requested to use their 20 hours of follow-up TA offered. The Transformation Center also held four webinars to support the first year of this CCO incentive metric.

***Tobacco cessation***

The Transformation Center held three webinars to support tobacco cessation focused on how to use quit-line data, programs for pregnant women, and programs for African Americans. The Transformation Center also has a contractor working with seven CCOs to develop tobacco cessation benefits communications for members and developing a provider-focused e-module to provide training in the Five A's and brief intervention, as well cessation counseling during pregnancy. The training will be available later in 2018.

***Colorectal Cancer Screening***

Building upon colorectal cancer (CRC) screening TA successes of last year, the Transformation Center and Public Health Division are collaborating with consultants to deliver TA focused on reducing CRC screening disparities. Consultants will host an interactive, web-based learning collaborative for up to six CCOs on evidence-based approaches to increase CRC screening. One CCO increased CRC screening by 9.2 percent with the help of TA.

***Developmental Screening and Follow-up***

A contractor is developing a series of tip sheets, guides, and question-and-answer webinars for CCOs focused on identifying children not getting developmental screenings and improving the referral and follow-up process for children with potential delays. The contractor will also develop and facilitate an online seminar for primary care practices on follow-up to developmental screening.

***Innovation Café: Strategies for Improving Children's Health***

The 2018 Innovation Café focused on sharing innovation and best practices to improve children's health. Plenaries focused on parental screening of adverse childhood experiences, trauma-informed care, and mindfulness and resilience. The event included 35 small-group project presentations, with the most projects focusing on cross-sector partnerships affecting the social determinants of early childhood health. Two hundred and twenty-six people attended, and 98.8% of evaluation respondents said the event was valuable.

***Transformation and Quality Strategy technical assistance***

CCOs submitted their first Transformation and Quality Strategy (TQS), which is replacing the Transformation Plan and Quality Assessment and Performance Improvement deliverables. This streamlined approach aims to move health system transformation by providing CCOs an opportunity to align their transformation and quality work. Technical assistance included five webinars to prepare CCOs for the new process. Transformation Center staff coordinated TQS review and verbal feedback calls. Staff convened a CCO work group to inform future deliverables and assessment.

***Transformation Plans***

CCOs submitted the closeout reports for their 2015–2017 CCO Transformation Plans. Transformation Center staff coordinated the review process.

***Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee***

The Transformation Center facilitated three statewide CCO learning collaborative sessions, which focused on the role of data in advancing health equity, oral health integration, and collaborative projects between local public health and CCOs.

***Qualitative Database***

The Transformation Center created a database and reporting mechanisms to capture and share data about emerging and tested CCO, system, clinical and other Oregon health and health care innovations. Since November 2017, staff have responded to more than a dozen requests from internal and CCO partners about innovations at CCOs and other parts of the health system.

***Council of Clinical Innovators***

The Transformation Center convened the three cohorts of Clinical Innovation Fellow alumni for a day of cross-cohort peer learning. Content focused on diffusion of innovations and mentorship. Twenty-two alumni and previous faculty attended. All participants rated it as very valuable (95%) or valuable (5%) to their work.

***Early Childhood Health Coordination***

Transformation Center staff helped coordinate the Oregon version of ZERO to THREE's Infants and Toddlers in the Policy Picture: A Toolkit. This is Phase I of the Oregon Infant Toddler State Self-Assessment conducted by the Oregon Department of Education's Early Learning Division. The self-assessment includes data on state demographics, services, health outcomes and policies, and it draws from research on effective policies and best practices for a strong infant toddler system. Phase II will include analysis of responses from parent surveys, parent listening sessions, and a stakeholder survey.

Transformation Center staff also helped present to community organizations, the public, the Early Learning Council, and an early childhood funders' consortium to raise awareness of current early childhood work within health system transformation and emerging practices in health and early learning collaboration.

**Health equity training program (DELTA)**

In 2013, the Oregon Legislature passed House Bill 2611, a cultural competence continuing education (CCCE) bill. This bill called for developing a new CCCE program beginning in 2015. The Office of Equity and Inclusion (OEI), a division of the Oregon Health Authority (OHA), implemented this program.

This report fulfills requirements for the OEI and 22 professional board to report to the Legislature on their participation levels in CCCE during the legislatively required minimum reporting period of January 1 through June 30, 2017. Specifically, each biennial board report, beginning on July 1, 2017, must include:

- Licensee/membership requirements for CCCE participation.
- Number of regulated health care professionals who completed CCCE.
- Number of audited health care professionals who completed CCCE from the OHA-approved list.
- Level of reporting each board requires of members' CCCE participation.

Subsequently, biennial reports to the Legislature in even years, beginning August 1, 2018, must include a compilation of 22 health care professional board reports to the interim committees of the Legislature, including those related to health care, audits, information management, and information technology about health care professional boards' participation in CCCE, as the boards submitted to OHA.

As Oregon's CCCE legislative report, this is not an all-inclusive report of all 22 health care professional boards affected by HB 2611, primarily due to diverse timing of license renewal cycles (one- to two-year, every odd year, birth month of every odd year, etc.) among the boards, which do not align with the minimum legislatively

required reporting period. Eleven boards' renewal/reporting cycles coincided with the reporting period, while the other boards' cycles did not. Thus, OHA anticipates it may take up to four years for this legislative report to fully represent the CCCE information gathered by all 22 boards. Summary of findings:

- Oregon Board of Psychology and Oregon Board of Licensed Professional Counselors and Therapists, require licensees to complete four hours of CCCE, during each two-year reporting period.
- Beginning fall 2018, Oregon Board of Licensed Social Workers will require licensees to complete six hours of CCCE during each two-year renewal cycle.
- Thirteen boards allow CCCE to satisfy general CE requirements.
- In total, 10,413 health care professionals reported completing CCCE training between January 1 and June 30, 2017.
- Boards of psychology and nursing had the highest percentages of CCCE training completion (43%).
- Out of the 22 affected boards, level of reporting requirements are as follows:
    - Fifteen boards require licensees to report on CCCE during license renewal.
    - Fourteen of 17 boards participating in OHA's Health Care Workforce Survey chose to add a CCCE question to their survey.
    - Sixteen boards require licensees to report on CCCE during audits.
    - Two boards have no CCCE reporting requirements of licensees.
- Several boards cited "data not available during reporting period," "data not collected," or "does not conduct audits," and the OHA CCCE training approval process overlapped with the required legislative reporting period. As a result, there were no data to report of audited health care professionals who completed CCCE from the OHA-approved list of trainings.

As the list of OHA-approved CCCE trainings increases and additional boards (whose license renewal cycles did not coincide with this first reporting period) submit their audited reports, the agency anticipates this number will grow in future biennial legislative reports.

## B. Lower cost

Report is attached separately as Appendix F – Two-Percent Test Data.

## C. Better care and Better health

Throughout the demonstration year, the Oregon Health Authority (OHA) produced regular reports as well as final calendar year 2017 data at the state and coordinated care organization (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 an evidence-based obesity measure. OHA has also maintained updated measure specifications and guidance online.

### Progress reporting

The Oregon Health Authority (OHA) continued to provide coordinated care organizations (CCO) 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.

### Final 2017 Performance Report

The Oregon health Authority (OHA) published two reports on the coordinated care organization (CCO) incentive, state performance, and core performance measures to the Oregon Health Policy Board and the public. All 16 CCOs had performance data successfully reported for the year. A mid-year report was published in January 2018 and the final calendar year 2017 report was published in June 2018. All reports are available online. In 2017, for the first time the report included metric performance by household language.

The report indicated that the coordinated care model continues to demonstrate improvement in several areas, such as reductions in emergency department visits and increases in depression screening and enrollment in patient-centered primary care homes.

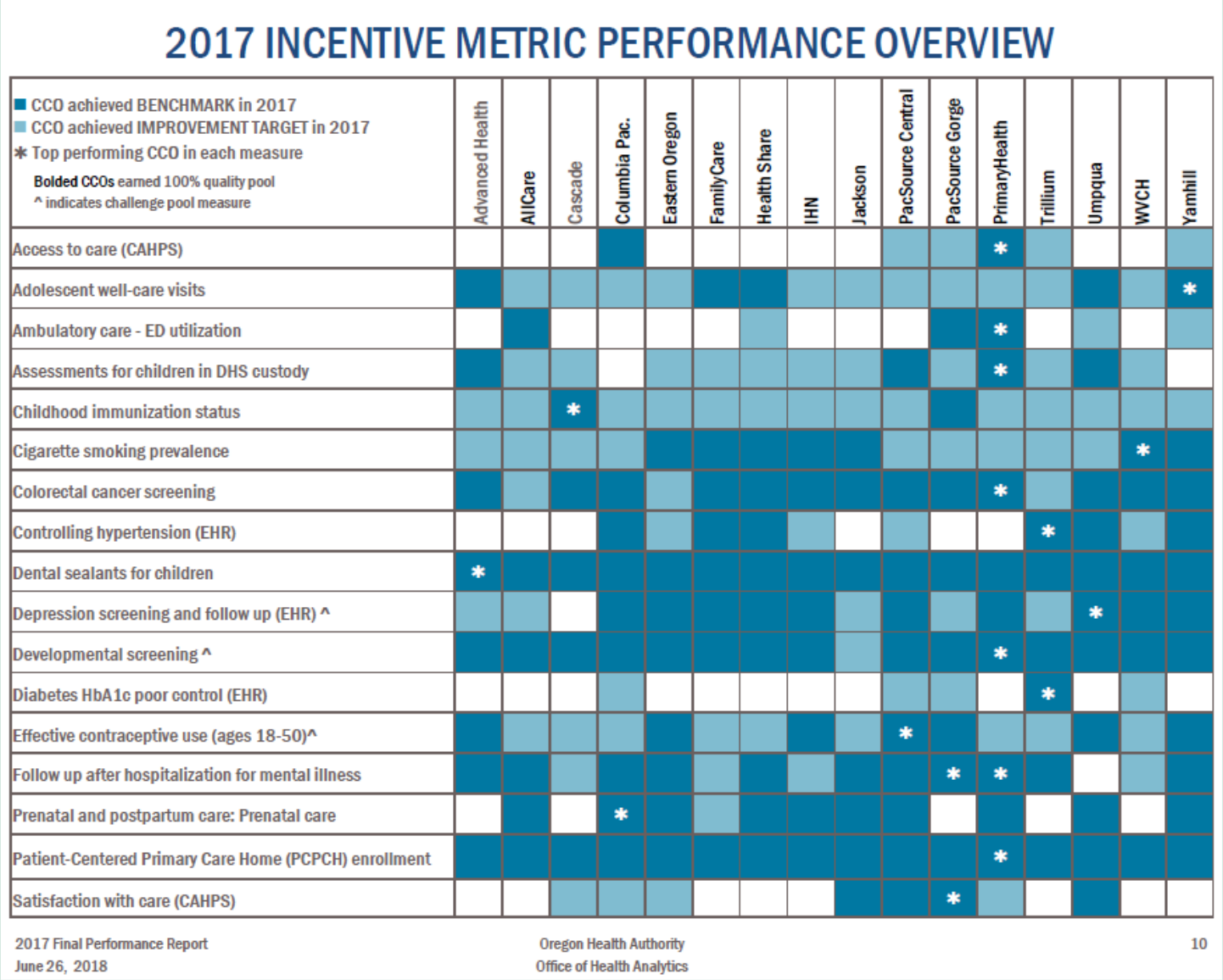
Specific successes include:

- All 16 CCOs improved in 2017 and achieved their individual improvement target on the adolescent well care visits measure.
- Statewide, there was a 15% improvement in the number of adolescents and young adults receiving a well-care visit as recommended by clinical guidelines.
- The health assessments for children in DHS custody measure showed improvement with the percentage of children in foster care who received a mental, physical and dental health assessment increasing 11% in 2 years.
- The colorectal cancer screening measure showed 10% improvement statewide over last year.
- Effective contraceptive use among women at risk of unintended pregnancy, a new measure in 2015, increased by 25% in just 2 years.

Areas for improvement include:

- Postpartum care where the percentage of women who had a timely postpartum care visit after giving birth, declined in 2017 and is below the 75th Medicaid percentile.
- For the initiation and engagement of alcohol or other drug treatment measure, the percentage of members newly diagnosed with alcohol or other drug dependences who initiated treatment within 14 days of the initial diagnosis and the percentage of members who continued their treatment both declined in 2017.

The table below is included in the 2017 Final Performance Report and displays performance results for each CCO in achieving benchmarks or improvement targets for each 2017 incentive metric.




## Quality Pool – Coordinated Care Organization Incentives

Disbursement of the coordinated care organization (CCO) quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures. Funds from the quality pool will be distributed on an annual basis, with the calendar year payment made by June 30th of the following year.

### *Pay for Performance*

This is the fifth year of Oregon's pay-for-performance program. The pay-for-performance model rewards coordinated care organizations (CCO) for the quality of care provided to Medicaid members. This model increasingly rewards CCOs for outcomes, rather than utilization of services, and is one of several key health system transformation mechanisms for achieving Oregon's vision for better health, better care and lower costs.

The Oregon Health Authority (OHA) made the fifth annual quality pool payments to CCOs in June 2017. To earn their full incentive payment, CCOs must meet benchmarks or improvement targets on at least 12 of the 16 measures and have at least 60% of their members enrolled in a patient-centered primary care home. The amount

a CCO can earn through the program is based on a percentage of their capitated payments each year. In 2017, the quality pool was more than $178 which is 4.25% of monthly payments.

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 three measures: Developmental screenings in the first 36 months of life; Effective contraceptive use among adult women; and Depression screening and follow-up.

Overall, all CCOs showed improvements in most measures, and 14 out of 16 CCOs earned 100% in their quality pool dollars.

**CCO Quality Pool – 2017**

| | Phase 1 distribution | | | Challenge pool | | Total | |
|---|---|---|---|---|---|---|---|
| CCO | Measures met, of 17 possible | Payment earned during Phase 1 * | Percent of quality pools earned | Challenge measures met | Challenge pool dollars earned | Total payment (Phase 1 + Challenge pool) | Total quality pool earned |
| Advanced Health | 10.7 | $3,072,442 | 70% | 3 | $53,406 | $3,125,847 | 71.3% |
| AllCare Health Plan | 12.7 | $9,248,658 | 100% | 3 | $134,678 | $9,383,336 | 101.5 % |
| Cascade Health Alliance | 10.7 | $2,455,669 | 70% | 2 | $30,832 | $2,486,500 | 70.9% |
| Columbia Pacific | 14.8 | $5,799,384 | 100% | 3 | $65,339 | $5,864,722 | 101.1 % |
| Eastern Oregon | 13.7 | $11,974,183 | 100% | 3 | $131,211 | $12,105,395 | 101.1 % |
| FamilyCare | 12.7 | $19,910,457 | 100% | 3 | $318,471 | $20,228,927 | 101.6 % |
| Health Share of Oregon | 13.7 | $43,141,732 | 100% | 3 | $573,419 | $43,715,150 | 101.3 % |
| Intercommunity Health Network | 12.6 | $12,428,525 | 100% | 3 | $144,858 | $12,573,383 | 101.2 % |
| Jackson Care Connect | 12.6 | $5,428,848 | 100% | 3 | $80,347 | $5,509,196 | 101.5 % |
| PacificSource – Central Oregon | 15.8 | $10,349,928 | 100% | 3 | $134,765 | $10,484,664 | 101.2 % |
| PacificSource – Gorge | 14.7 | $2,844,691 | 100% | 3 | $34,039 | $2,878,730 | 101.3 % |
| PrimaryHealth of Josephine County | 14.9 | $1,902,503 | 100% | 3 | $27,520 | $1,930,023 | 101.4 % |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Trillium | 13.6 | $18,906,370 | 100% | 3 | $239,853 | $19,146,222 | 101.3 % |
| Umpqua Health Alliance | 13.7 | $5,271,510 | 100% | 3 | $72,577 | $5,344,087 | 101.4 % |
| Willamette Valley Community Health | 12.8 | $18,368,465 | 100% | 3 | $263,973 | $18,632,439 | 101.4 % |
| Yamhill Community Care | 13.7 | $4,826,661 | 100% | 3 | $63,932 | $4,890,593 | 101.3 % |
| **Total** | **10.7** | **$175,930,026** | | | **$2,639,190** | **$178,299,214** | **71.3%** |
| * Quality pool distribution is based on number of measures met and CCO size (number of members). | | | | | | | |

# V. Appendices

## A. Quarterly Enrollment Reports

### 1. SEDS Reports

Reports are attached separately as Appendix A – Enrollment Reports. (Apr-Jun 2018, as posted for this period, is a preliminary report.)

### 2. State Reported Enrollment

| Enrollment | April 2018 | May 2018 | June 2018 |
|---|---|---|---|
| Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14 | 942,732 | 940,701 | 939,597 |
| Title XXI funded State Plan | 81,645 | 82,745 | 87,348 |
| 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 |
| | N/A | N/A | N/A |
| **Enrollment current as of** | **April 30, 2018** | **May 31, 2018** | **June 30, 2018** |

### 3. Actual and unduplicated enrollment

#### *Ever-enrolled Report*

| POPULATION | | | Total Number of Clients | Member months |
|---|---|---|---|---|
| **Expansion** | **Title XIX** | PLM children FPL > 170% | 10 | 16 |
| | | Pregnant women FPL > 170% | 2 | 2 |

| | | | | |
|---|---|---|---|---|
| | **Title XXI** | SCHIP FPL > 170% | 117,765 | 958,234 |
| **Optional** | **Title XIX** | PLM women FPL 133-170% | 53 | 76 |
| | **Title XXI** | SCHIP FPL < 170% | 82,499 | 575,405 |
| **Mandatory** | **Title XIX** | Other OHP Plus | 177,683 | 1,815,004 |
| | | MAGI adults/children | 922,120 | 8,477,602 |
| | | MAGI pregnant women | 25,747 | 130,123 |
| | | **Annual Total** | **1,325,879** | |

** Due to retroactive eligibility changes, the numbers should be considered preliminary*

### *OHP-eligible and Managed Care Enrollment*

| | | Coordinated Care | | | | Dental Care | Mental Health |
|---|---|---|---|---|---|---|---|
| **OHP eligibles*** | | **CCOA**** | **CCOB**** | **CCOE**** | **CCOG**** | **DCO** | **MHO** |
| July | 979,611 | 836,832 | 714 | 647 | 33,173 | 45,484 | 3,738 |
| August | 964,104 | 834,916 | 786 | 655 | 33,576 | 44,104 | 3,757 |
| September | 959,284 | 826,847 | 815 | 683 | 33,384 | 43,579 | 3,760 |
| October | 961,717 | 831,306 | 742 | 674 | 33,277 | 43,380 | 3,652 |
| November | 962,452 | 841,382 | 756 | 656 | 33,443 | 43,721 | 3,664 |
| December | 963,997 | 835,116 | 740 | 658 | 33,256 | 43,577 | 3,654 |
| January | 965,480 | 838,376 | 854 | 663 | 33,444 | 43,654 | 3,655 |
| February | 964,083 | 836,441 | 772 | 713 | 33,433 | 44,697 | 3,662 |
| March | 968,088 | 844,536 | 711 | 541 | 32,068 | 43,836 | 3,584 |
| April | 970,342 | 846,678 | 664 | 518 | 32,004 | 43,863 | 3,598 |
| May | 969,674 | 853,501 | 663 | 534 | 31,924 | 43,822 | 3,578 |
| June | 970,403 | 849,874 | 641 | 506 | 31,806 | 43,936 | 3,583 |
| **Annual Average** | **966,603** | **839,650** | **738** | **621** | **32,899** | **43,971** | **3,657** |
| | | **86.87%** | **0.08%** | **4.55%** | **0.38%** | **0.06%** | **3.40%** |

** 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; and CCOG: Mental and dental health*

## B. Complaints and Grievances

Reports are attached separately as Appendix B – Complaints and Grievances.

## C. Appeals and Hearings

Reports are attached separately as Appendix C – CCO Appeals and Hearings.

## D. Neutrality Reports

Reports are attached separately as Appendix D – Neutrality Reports.