Oregon Health Plan

Section 1115 Quarterly Report

1/1/2017 – 3/31/2017
Demonstration Year (DY): 15 (7/1/2016 – 6/30/2017)
Demonstration Quarter (DQ): 3/2017
Federal Fiscal Quarter (FQ): 2/2017

Oregon Health Authority

Oregon HEALTH PLAN

Table of contents

I. Introduction

A. Letter from the State Medicaid Director

From January through March 2017, the Oregon Health Authority (OHA) continued to move forward in meeting the goals of the Oregon Health Plan (OHP) demonstration.

- **Lever 1: Improving care coordination** – In this quarter, there were 651 recognized clinics in the state. As of November 2016, 90.6% of CCO members statewide were enrolled in a recognized PCPCH, which is a 77.44% increase in the proportion of members enrolled since 2012.
- **Lever 2: Implementing alternative payment methodologies (APMs)** –37.6% of all plan payments are non-fee-for-service (FFS). This is an increase from the previous quarter, in which 35.9% of plan payments were non-FFS. For calendar year (CY) 2016, 37.3% of plan payments were non-FFS.
- **Lever 3: Integrating physical, behavioral and oral health care** – Comparing measures for CY 2014 and the most recent reporting period:
    - Screening, Brief Intervention, Referral and Treatment (SBIRT) for Alcohol or Other Substance Misuse increased from 6.3% to 18.6%.
    - Follow-Up After Hospitalization for Mental Illness increased from 71.8% to 78.1%.
    - Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody has increased from 27.9% to 67.5%.
    - Screening for Clinical Depression and Follow-Up Plan increased from 27.9% to 37.4%.
    - Follow-Up Care for Children Initially Prescribed ADHD Medications increased from 52.3% to 63.6% for the initiation phase, and from 61.0% to 66.1% for the continuation and maintenance phase.
- **Lever 4: Increased efficiency in providing care** – Comparing measures for CY 2015 and the most recent reporting period (see Appendix E for details):
    - Emergency department visits per 1,000 member months increased from 43.1 to 47.0.
    - Developmental Screening in the First 36 Months of Life increased from 42.6% to 61.6%.
    - Adolescent Well-Care Visits increased from 32.0% to 41.6%.
    - Chronic obstructive pulmonary disease admissions per 100,000 member years decreased from from 411.9 to 408.8.
    - Adult asthma admissions per 100,000 member years decreased from 48.4 to 45.1.
    - Congestive heart failure admissions per 100,000 member years increased from 234.0 to 238.
- **Lever 5: Implementation of health-related flexible services –** The summative waiver evaluation will include flexible services to better understand how they are deterring higher-cost care. The evaluation will include both quantitative and qualitative methods, and will be available to OHA by the end of CY 2017.
- **Lever 6: Innovations through the Transformation Center** – This quarter, the CCO learning collaborative met twice and focused on applied behavior analysis (for autism and related disorders) and the Emergency Department Information Exchange/PreManage. 88% of respondents found the sessions valuable or very valuable to their work.

Lori Coyner, State Medicaid Director

B. Demonstration description

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

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

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

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

On July 5, 2012, the Centers for Medicare and Medicaid Services (CMS) approved the current demonstration, Oregon's **Health Care Transformation**, through June 30, 2017. Key features include:

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

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

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

- **Workforce:** To support the new model of care within CCOs, Oregon established in 2013 a loan repayment program for primary care physical, oral and behavioral health providers who agree to work in clinics that see a high percentage of Medicaid patients. To date, more than 50 providers have been provided loan repayment under this program. Oregon also agreed to complete training for 300 community health workers by 2015, and this was accomplished. As mandated by House Bill 3396 (2015 Regular Session), The Oregon Health Policy Board, through its Workforce Committee conducted further evaluation and research to determine how to best recruit and retain health care providers to practice in rural and medically underserved areas of the state. A report to the legislature was provided in November 2016. The OHA is continuing to implement the Legislature's statutory changes around incentives for health care professionals.

The primary goals of the Oregon demonstration are:

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

In December 2013, conforming amendments for the Affordable Care Act and the full implementation of the Tribal Uncompensated Care amendment to the 1115 Demonstration were approved.

In June 2014, the Hospital Transformation Performance Program (HTPP) was approved, and OHA and CMS concluded final negotiations regarding the measures included in the program in September 2014. This program offers hospitals incentive payments to support quality improvement.

In January 2017, the Tribal Uncompensated Care Program under the 11115 Demonstration was discontinued and the previously uncompensated services added to the covered benefits for members of Oregon's nine federally-recognized Tribes.

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II. Title

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III. Events affecting health care delivery

A. Overview of significant events across the state

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

Detail on impacts or interventions
Nothing to report this quarter.

B. Complaints and grievances

For this quarter, all CCOs reported using the updated complaint categories as reflected in the chart below. (Complaints received internally within OHA are reported in the narrative portion of this report.)

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

1. Access to providers and services
2. Interaction with provider or plan
3. Consumer rights

4. Clinical care
5. Quality of services
6. Client billing issues

CCO complaints

Table 2 – Complaints and grievances

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

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

Complaint or grievance type	Number reported
ACCESS TO PROVIDERS AND SERVICES	
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	472
b) Plan unresponsive, not available or difficult to contact for appointment or information.	26
c) Provider's office too far away, not convenient	26
d) Unable to schedule appointment in a timely manner.	95
e) Providers office closed to new patients	15
f) Referral or 2nd opinion denied/refused by provider.	55
g) Referral or 2nd opinion denied/refused by plan	24
h) Unable to be seen in a timely manner for urgent/ emergent care	5
i) Provider not available to give necessary care	47
j) Eligibility issues	73
k) Female or male provider preferred, but not available	4
l) NEMT not provided, late pick up resulting in missed appointment, problems with coordination of transportation services	893
m) Dismissed by provider as a result of past due billing issues	0
n) Dismissed by clinic as a result of past due billing issues	2
TOTAL:	**1,737**
INTERACTION WITH PROVIDER OR PLAN	
a) Provider rude or inappropriate comments or behavior	125
b) Plan rude or inappropriate comments or behavior	276
c) Provider explanation/instruction inadequate/incomplete	28
d) Plan explanation/instruction inadequate/incomplete	482
e) Wait too long in office before receiving care	175
f) Member not treated with respect and due consideration for his/her dignity & privacy	37
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available	34
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	1
i) Lack of coordination among providers	3
j) Wants to change providers; provider not a good fit	1
k) Member has difficulty understanding provider due to language or cultural barriers	28
l) Client dismissed by provider (member misbehavior, missed appointments, etc.)	34
m) Client dismissed by clinic (member misbehavior, missed appointments, etc.)	16
TOTAL	**1,240**
CONSUMER RIGHTS	
a) Provider's office has physical barrier(s), is not ADA compliant (preventing access from street level or to lavatory or to examination room or no special adaptations or doors)	18
b) Concern over confidentiality	22

Complaint or grievance type	Number reported
c) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group.	98
d) No choice of clinician, or clinician of choice not available.	17
e) Fraud and financial abuse (services billed not provided, service provided in two appointments that should have been provided in one.)	9
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health marital status, Medicaid/Medicare)	12
g) Complaint/appeal process not explained, lack of adequate or understandable NOA	3
h) Not informed of consumer rights	4
i) Denied member access to medical records (other than as restricted)	4
j) Did not respond to member's request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)	6
k) Advanced or Mental Health Directive not discussed or offered or followed	0
l) Restraint or seclusion used other than to assure member's immediate safety	0
TOTAL	**193**
QUALITY OF CARE	
a) Received appropriate care, but experienced adverse outcome, complications, misdiagnosis or concern related to provider care.	104
b) Testing/assessment insufficient, inadequate or omitted	33
c) Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider.	80
d) Member neglect or physical, mental, or psychological abuse	8
e) Provider office unsafe/unsanitary environment or equipment	54
f) Lack of appropriate individualized setting in treatment	4
TOTAL	**283**
QUALITY OF SERVICE	
a) Delay in receiving, or concern regarding quality of materials and supplies (DME) or dental	52
b) Lack of access to medical records or unable to make changes	7
c) Benefits not covered	51
TOTAL	**110**
CLIENT BILLING ISSUES	
a) Co-pays	5
b) Premiums	8
c) Billing OHP clients without approved waiver	298
TOTAL	**56**
Miscellaneous	-
Total	**3,930**
Total average CCO enrollment	865,701
Total rate per 1000 members	4.54

Attached separately is a summary of the statewide complaints and grievances reported by the CCOs in the six main categories. The chart includes the following:

- Summary totals per main category, per CCO
- Number of complaints pended per category, per CCO at the end of this quarterly reporting period
- Number of complaints resolved per category, per CCO at the end of this quarterly reporting period
- The range of number of complaints and grievances per category, per CCO in this quarterly reporting period. (range indicates the following: **lowest number** = lowest number of complaints received in the category; **highest number** = highest number of complaints received in the category.)

Trends related to complaints and grievances

This quarter, the statewide total complaints and grievances rate is 4.54 per 1,000 members[1]. This is a slight decrease from the previous quarter's rate (4.72 per 1,000 members).

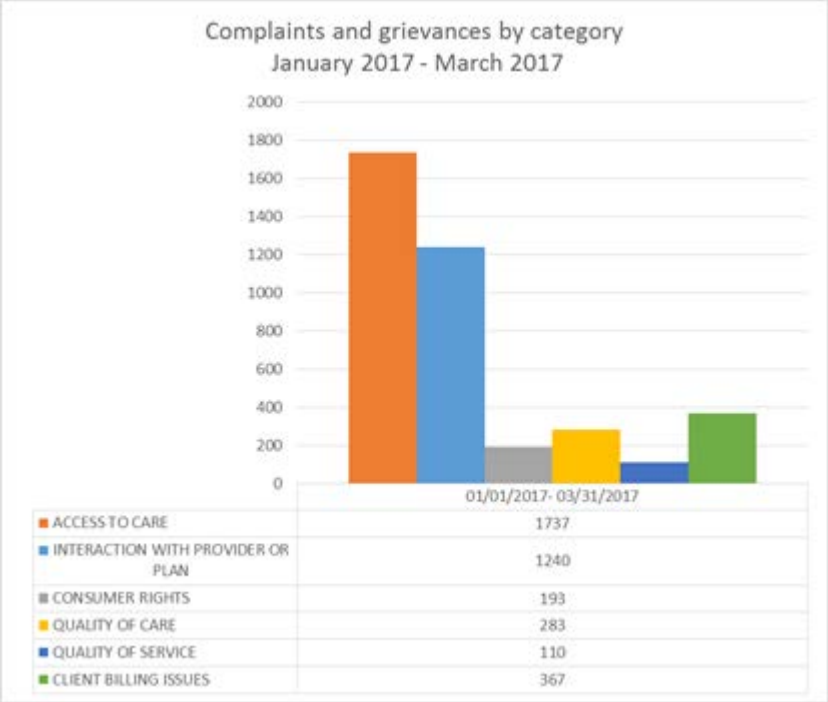
For total complaint rates among the individual 16 CCOs:

- The lowest rate was 1.06 per 1,000 members.
- The highest rate was 9.82 per 1,000 members. This is a decrease from last quarter, when the highest rate was 11.35 per 1,000 members.

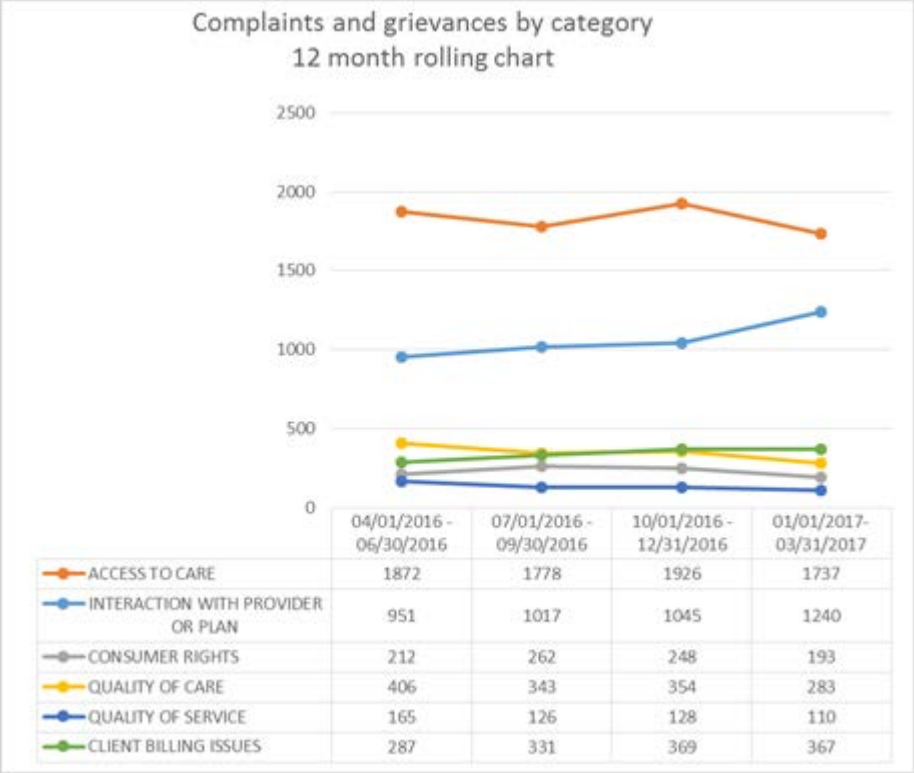
CCOs continue to standardize data collection among their contracted delegates to improve reporting of complaints. One CCO is implementing new case management software. Another CCO is creating a reference manual for staff to improve accuracy in complaint classification.

The Non-Emergency Medical Transportation (NEMT) complaints continue to be an issue; however, there was a slight decrease from the previous quarter. The CCOs and Health Systems Division staff continue to monitor issues with NEMT services.

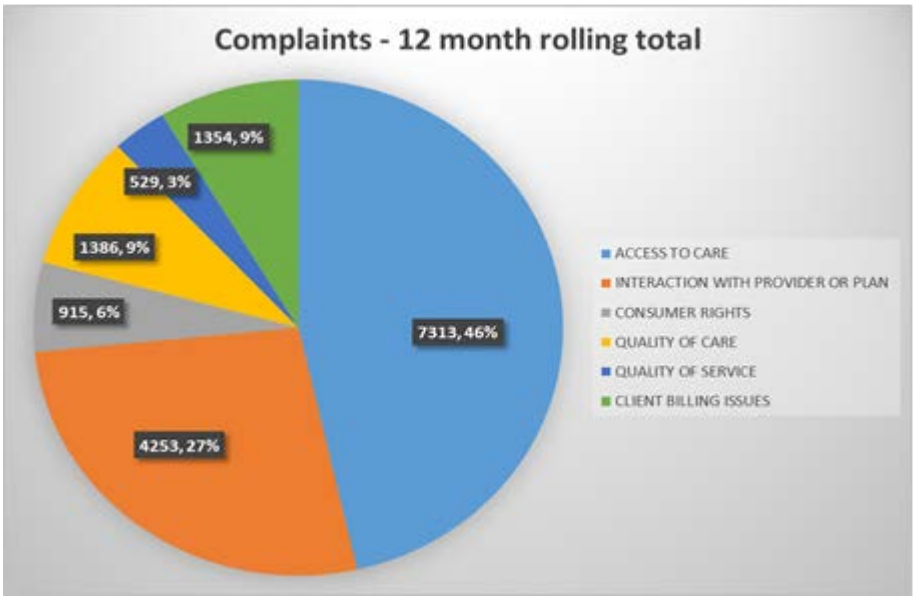
Access to Care, Interaction with Provider or Plan and Billing Issues categories show continued higher levels of complaints with provider offices as compared with previous quarters. This may be due in part to changes in how delegated contractors are reporting complaint data to the CCOs. CCOs reported they are working on improvements to their internal quality management processes to address these issues.



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



	04/01/2016 - 06/30/2016	07/01/2016 - 09/30/2016	10/01/2016 - 12/31/2016	01/01/2017- 03/31/2017
ACCESS TO CARE	1872	1778	1926	1737
INTERACTION WITH PROVIDER OR PLAN	951	1017	1045	1240
CONSUMER RIGHTS	212	262	248	193
QUALITY OF CARE	406	343	354	283
QUALITY OF SERVICE	165	126	128	110
CLIENT BILLING ISSUES	287	331	369	367



Interventions

The OHA staff is continuing to work on improving the reporting process with the current focus on improving how to report data to OHA.

Fee-for-service (FFS) complaints

No report this quarter.

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

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

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
a) Denial or limited authorization of a requested service.	30,102	1,177	18-194
b) Single PHP service area, denial to obtain services outside the PHP panel	225	12	0-6
c) Termination, suspension or reduction of previously authorized covered services	242	30	0-30
d) Failure to act within the timeframes provided in § 438.408(b)	5	0	-
e) Failure to provide services in a timely manner, as defined by the State	1	0	-
f) Denial of payment, at the time of any action affecting the claim.	18,504	412	0-162
Total	**49,079**	**1,631**	**18-392**
Number per 1000 members	**57**	**2**	**0.85 – 3.73**
Number overturned at plan level		**471**	**3-89**
Appeal decisions pending		**31**	**0-22**
Number of contested case hearings requested		**626**	**3-110**
Overturned prior to hearing		**188**	**0-43**
Overturn rate		**30.03%**	**0-61.11%**
Hearing decisions pending		**0**	**-**
Hearing requests per 1000 members		**0.72**	**0.25-1.58**

Contested case hearings

The following table[2] represents the contested case hearings that were processed during the quarter.

Plan Name	Total requests received	Average plan enrollment *	Per 1000 members
ALLCARE HEALTH PLAN, INC.	30	48,178	0.6227
CASCADE HEALTH ALLIANCE	10	16,164	0.6187
COLUMBIA PACIFIC CCO, LLC	9	23,400	0.3846
EASTERN OREGON CCO, LLC	18	46,718	0.3853
FAMILYCARE, CCO	108	113,262	0.9535
HEALTH SHARE OF OREGON	110	206,166	0.5336
INTERCOMMUNITY HEALTH NETWORK	36	51,678	0.6966
JACKSON CARE CONNECT	15	28,291	0.5302
PACIFICSOURCE COMM. SOLUTIONS	43	48,452	0.8875
PACIFICSOURCE COMM. SOLUTIONS - GORGE	3	12,237	0.2452
PRIMARYHEALTH JOSEPHINE CO CCO	6	9,997	0.6002
TRILLIUM COMM. HEALTH PLAN	55	85,263	0.6451
UMPQUA HEALTH ALLIANCE, DCIPA	40	25,877	1.5458
WESTERN OREGON ADVANCED HEALTH	20	19,231	1.0400
WILLAMETTE VALLEY COMM. HEALTH	109	93,851	1.1614
YAMHILL CO CARE ORGANIZATION	14	23,100	0.6061
ACCESS DENTAL PLAN, LLC		1,811	0.0000
ADVANTAGE DENTAL	3	21,253	0.1412
CAPITOL DENTAL CARE INC		13,313	0.0000

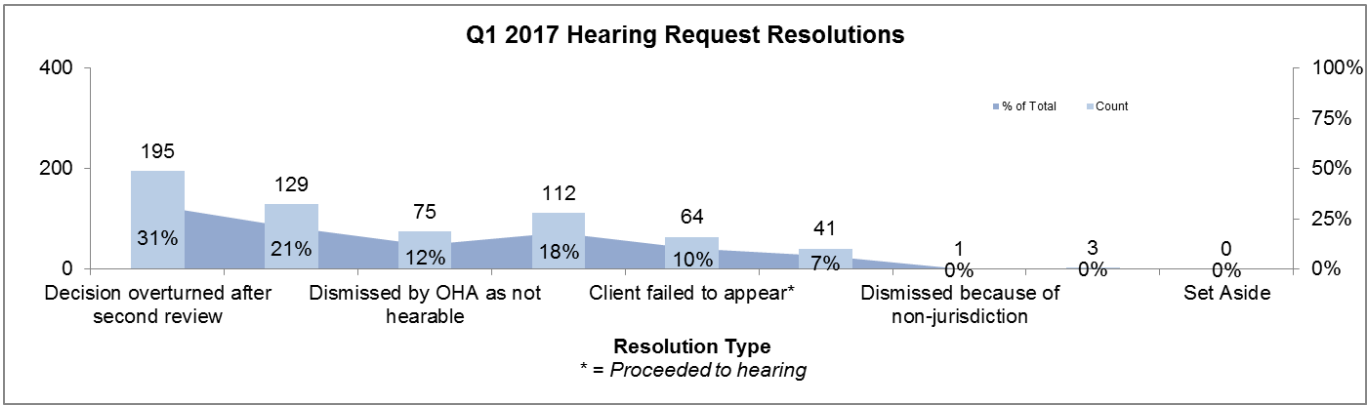
[2] Data Source: New_HearingLog.mdb; Data Extraction Date: 05/22/2017

Plan Name	Total requests received	Average plan enrollment *	Per 1000 members
CARE OREGON DENTAL		1,885	0.0000
FAMILY DENTAL CARE	1	1,790	0.5587
MANAGED DENTAL CARE OF OREGON		1,846	0.0000
ODS COMMUNITY HEALTH INC		6,806	0.0000
FFS	**24**	**286,436**	**0.0838**
Total	**654**	**1,187,005**	**0.5510**

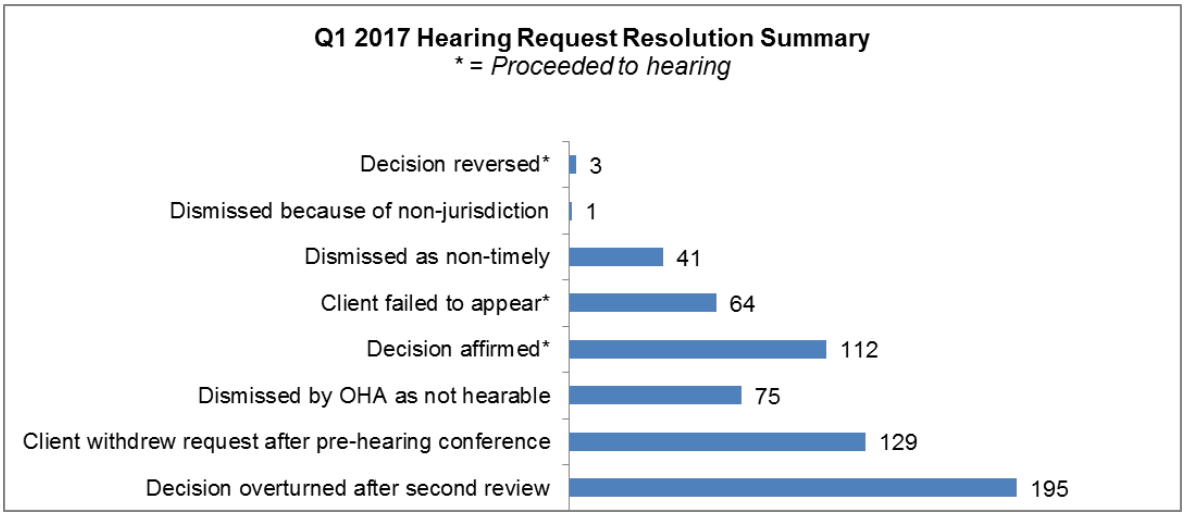
The following chart shows the outcomes of the hearings completed this quarter.

Outcome	Count	% of Total
Decision overturned after second review	195	31%
Client withdrew request after pre-hearing conference	129	21%
Dismissed by OHA as not hearable	75	12%
Decision affirmed	112	18%
Client failed to appear	64	10%
Dismissed as non-timely	41	7%
Dismissed because of non-jurisdiction	1	0%
Decision reversed	3	0%
Set aside	0	0%
Total outcomes	**620**	

Trends[3]



[3] Data Source: New_HearingLog.mdb & DSSURS; Data Extraction Date: 05/22/2017



Interventions

No report this quarter.

D. Implementation of 1% withhold

During this quarter, OHA analyzed encounter data received for completeness and accuracy for the subject months of June through August 2016. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

Future reports may contain the following information:

Table 3 – Summary

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

Metric	Frequency	
	Quarterly	Annually
Encounter data analysis ■ Spending in top 25 services by eligibility group and by CCO ■ To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well	X	X

E. Statewide workforce development

Traditional Health Workers

Table 4 - Traditional Health Workers (THW)

THW Program	Total number certified statewide		Number of approved training programs	
	Current Qtr.	Cumulative	Current Qtr.	Cumulative
Community Health Workers (CHW)	45	476	0	7
Personal Health Navigators (PHN)	0	6	0	1
Peer wellness Specialists	3	45	0	6
Other THW (Doulas)	5	37	0	1
Peer Support Specialists	165	1,338	1	23
TOTAL	**218**	**1,902**	**1**	**38**

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

Effective October 1, 2017, all Traditional Health Workers will be required to take basic oral health training in order to be certified (new and renewal).

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

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

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

The THW Commission members came to a consensus on the five areas that they would like to focus in the next three to five years. Participants explored variations of strategies and issues associated with each. The

following are the five strategic priorities that the participants identified as the most important to achieve in the next three to five years:

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

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

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

Health professional graduates participating in Medicaid

No report this quarter. OHA produces this data semi-annually in the appropriate quarterly reports.

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

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

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

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

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

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

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

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

G. Transformation Center

Patient-Centered Primary Care Home (PCPCH) Program

Revised PCPCH recognition criteria were implemented in January 2017. By the end of March, 495 clinics were recognized under the revised standards. This quarter seven of those clinics were awarded the highest 5 STAR designation, which requires a site visit for verification. The team plans to complete over 50 site visits to 5 STAR designation applicants in 2017.

Behavioral health integration learning and networking event

Initiated by a CCO request, the Transformation Center partnered with the Patient-Centered Primary Care Institute to convene a statewide event to identify and spread best practices for integrating physical and behavioral health services for persons with serious mental illnesses and substance use disorders. The "Sustaining Integrated Care for Persons with Serious Behavioral Health Conditions" event brought together 124 people representing physical health, behavioral health and payers. Evaluation respondents said the most helpful aspects were networking and discussing funding and metrics. Respondents indicated they planned to use what they learned about value-based payment models, peer support and behavioral health care for older adults, telehealth, patient engagement and patient registry related to health outcomes.

Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative's recommendations to the Oregon Health Policy Board were considered as part of the legislative development process for SB 934 sponsored by Senator Steiner Hayward. In March, a work group of the collaborative provided additional feedback, per the senator's request. Moving forward, the collaborative will continue to provide a forum for sharing and aligning primary care payment reform across Oregon.

Comprehensive Primary Care Plus (CPC+)

The Transformation Center managed the Medicaid fee-for-service application process for the federal CPC+ application. Following Oregon's selection as a CPC+ region, the center began supporting the Medicaid fee-for-service implementation.

Table 6 - Innovator Agents – Summary of promising practices

Innovator Agent learning experiences

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Learning collaborative activities

Summary of activities	No report this quarter.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Assisting and supporting CCOs with Transformation Plans

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Assist CCOs with target areas of local focus for improvement

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Communications with OHA

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Communications among Innovator Agents

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Community advisory council activities

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

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

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

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

Summary of activities	No report this quarter.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Information sharing with public

Summary of activities	See Transformation Center narrative for this quarter's activities.
Promising practices identified	No report this quarter.
Participating CCOs	16
Participating IAs	6

Table 7 - Innovator Agents – Measures of effectiveness

No data for this quarter. Other evaluation results from Transformation Center learning collaborative can be found in Section V, Table 9.

H. Legislative activities

The 2017 Legislative Session of the Oregon State Legislature began on February 1, 2017. Several bills were introduced that, if passed, could impact Oregon's Health System Transformation and coordinated care organizations (CCOs). Highlights include:

- House Bill 2122 – would modify requirements for second round of CCO contracting, requiring more transparency of CCO governing boards and increased utilization of alternative payment methodologies.
- Senate Bill 233 – would require increased transparency of financial information in global budget setting process and allow new review authority to the Department of Human Services.
- Senate Bill 558/House Bill 2726 – would provide coverage to all children regardless of citizenship status.

The other legislative priority for the Oregon Health Authority during the 2017 Session is addressing the nearly $1 billion budget shortfall caused by increased caseloads and decrease in federal matching funds for the Medicaid expansion population.

The 2017 Legislative Session must adjourn sine die on or before July 10, 2017.

I. Litigation status

No report this quarter.

J. Two-percent trend data

See Appendix C.

K. DSHP terms and status

See Appendix D.

IV. Status of Corrective Action Plans (CAPs)

Table 8 – Status of CAPs

Entity (CCO or MCO)	Columbia Pacific CCO
Purpose and type of CAP	To ensure the children's fidelity wraparound requirements are being met

Start date of CAP	3/3/2016
Action sought	Get CCO in line with contract requirements (Exhibit B, part 2, sections m and n
Progress during current quarter	OHA currently monitoring the CCO's CAP and have updates scheduled until CAP is completed
End date of CAP	9/30/2016
Comments	N/A

V. Evaluation activities and interim findings

In this quarter, the OHA Oral Health team published their first in-depth report on oral health data for Oregon's CCOs. Results indicated that there are certain counties in Oregon who have fewer dentists compared with the number of residents they serve, adult CCO members receive oral health services at lower rates than children, many members do not receive preventive dental services such as regular cleanings, fluoride treatments, and dental sealants, and when stratified by race and ethnicity, the data show variation between groups.

The Oral Health team continues to build on this work, and other reports and projects, to enhance coordination and collaboration across the agency to improve oral health for all Oregonians. Also this quarter, OHA continued monthly meetings with Oregon Health & Science University Center for Health Systems Effectiveness (OHSU CHSE) to summatively evaluate the 1115 waiver Demonstration. Finally work in the Sustainable Relationships for Community Health (SRCH) Program, Federally Qualified Health Center Alternative Payment Methodology Program (FQHC, APM), and Transformation Center continued.

Table 9 - Evaluation activities and interim findings

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

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes (PCPCH)

Interim findings:

- In this quarter, there were 651 recognized clinics in the state, surpassing Oregon's goal of 500 clinics by 2015. This represents approximately 60% of the estimated number of primary care clinics in Oregon.
- PCPCH enrollment is a CCO incentive metric. The statewide baseline (for 2012) for this measure is 51.8%. As of November 2016, 90.6% of CCO members statewide were enrolled in a recognized PCPCH, which is a 77.44% increase in the proportion of members enrolled since 2012. It is notable that CCOs have sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

Improvement activities:

Oregon's Patient-Centered Primary Care Institute (PCPCI) provides technical support and transformation resources to practices statewide, including learning collaborative opportunities. In the last quarter they have hosted four webinars:

1. Motivational Interviewing & Cardiac Health: Practical Applications (80 attendees)
2. PCPCH 2017 Q&A with the PCPCH Program Staff (87 attendees)

3. Nutrition Interventions for your Primary Care Setting (30 attendees)
4. Beyond Developmental Screening: Children Identified At-Risk (55 attendees)

Additionally, The Oregon Health Care Quality Corporation (Q Corp) launched a new initiative called the Clinician Academy. It was focused on pairing residents and new providers with seasoned providers to work on a community focused project for their region. The goal is to increase and enhance mentorship relationships, extend the health reach outside the clinic in a way that mirrors and supports community need, create community-minded providers who have practical skill sets in this work, and enable a broader, statewide integration and support network of interested providers who can support each other's work and goals beyond the Clinician Academy's lifespan. Recruitment for the Clinician Academy was completed in Q4 2016 and nine clinicians were enrolled in the program. A kick-off meeting was held in Q4 2016 and there are weekly project meetings. Final program meeting and report outs will occur in Q2 2017.

During this quarter a kickoff meeting was held in January. Project work was scoped with all participants. Planning, coaching and sign-ups for weekly check-ins during the program were completed. The eight-week Clinician Academy concluded in February. Participants have access to continued project support through the end of March 2017. Seven clinicians completed all the requirements for the program. Projects included depression with a focus on women's health, substance use disorder in pregnant women, pain management and geriatric nutrition.

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

Evaluation activities:

Oregon's coordinated care organizations

During this reporting period, OHA continued to provide updated metrics results to CCOs utilizing the automated metric reporting tool ("dashboard"), for periods covering September 2015 – August 2016, October 2015 – September 2016, and November 2015 – December 2016. Additional state performance measures were added to the dashboard: Diabetes LDL-C screening; Diabetes HbA1c testing; Follow-up after prescription for ADHD medication (continuation and maintenance phase); and Child and adolescent access to primary care providers (see Appendix E).

Hospital Transformation Performance Program

During this reporting period, OHA secured CMS approval for a fourth year of the Hospital Transformation Performance Program (HTPP). While CMS had previously indicated they would require significant changes to the program to approve an extension (and the Committee provided recommendations for new measures and a revised domain structure as such), CMS instead approved a one year extension of the current (i.e. Years 1 and 2) 11 measures. Whereas Years 1-3 of the HTPP spanned federal fiscal years, Year 4 of the HTPP will shift to calendar year (2017). The waiver provides flexibility to redesign the program upon expiration of the one-year extension.

During this reporting period, OHA finalized and posted Year 4 measure specifications and additional program documentation online (see Appendix E).

Federally Qualified Health Center Alternative Payment Methodology Program

In March of 2013, OHA launched the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) Program with three FQHCs. Since that time, five additional health centers began in late 2014, three more joined the program on July 1st 2015, and finally three more FQHCs joined on July 1st 2016. The FQHC APM Program provides an Advanced Payment and Care Model by paying per-member

per-month (PMPM) payments for each health center's (HC) attributed patient population, rather than the traditional PPS encounter rates. This allows practitioners to get off the treadmill of churning out office visits, and engage their communities in more patient-centered health strategies.

OHA tracks several metrics on a quarterly basis for APM FQHCs that are aligned with the CCO incentive measures to hold health centers accountable for the quality of care, and provide comparative analysis to their contracted CCOs performance. Quality Metric Reports are submitted on a quarterly basis (see interim findings below).

Certified Community Behavioral Health Clinics

Oregon was selected as one of eight demonstration states to pilot the Certified Community Behavioral Health Clinic (CCBHC) program. Oregon's two-year demonstration program is scheduled to "go-live" on April 1, 2017. Beginning in April, CCBHCs will be eligible to begin billing for allowable costs, identified as "demonstration services." OHA is refining internal processes to support a timely payment process as well as comprehensive data collection. OHA will continue to monitor compliance with state and federal standards, as well as provide ongoing technical assistance to CCBHCs as they work toward the April 1st project launch date.

Interim findings:

CCO financial reports

An internal analysis of the most recent financial reports available showed that 37.6% of all plan payments are non-fee-for-service (FFS). This is an increase from the previous quarter, in which 35.9% of plan payments were non-FFS; however, in looking at historical trends this is normal deviation. For the entire calendar year 2016, 37.3% of plan payments were non-FFS. In 2016, OHA held another round of Financial Reporting Workgroup meetings with CCOs to better standardize reporting and definitions resulting in more accurate reporting by CCOs. The revised Financial Reporting template is effective for 2017 reporting.

Federally Qualified Health Center Alternative Payment Methodology Program

We evaluated quarterly Quality Metric Reports for Q4 2016 in comparison with the 2015 benchmarks for CCO performance metrics. Fourteen health centers produced quality metric reports for Q4; although not all health centers reported on all 10 measures. In the table below, OHA analyzed the number of health centers meeting the CCO benchmarks. The FQHCs were able to surpass the CCO benchmark on colorectal cancer screenings, depression screenings with follow-up plan, blood pressure control, screenings for alcohol and drug use with referral to treatment, and tobacco use screenings with cessation therapy (strategies to quit).

Please note, the methodology for the FQHC quality metrics is different than the CCO quality metrics; therefore, they are not comparable.

Quality Metric	2015 CCO Benchmark	2016 APM FQHC Average	FQHCs Reporting in Q4 2016 (14 total)
Adolescent Well Child Check	62.0%	45.7%	8
Cervical Cancer Screening	71.0%	54.4%	10
Childhood Immunizations	82.0%	53.5%	12
Colorectal Cancer Screening	47.0%	47.6%	13
Depression Screening & Follow-up Plan	25.0%	55.4%	13
Diabetes Poor Control - HbA1c > 9% (lower is better)	34.0%	28.1%	13
Hypertension Controlled	64.0%	65.4%	13
SBIRT Received	12.0%	32.1%	10
Timeliness of Prenatal Care	90.0%	68.4%	9

Quality Metric	2015 CCO Benchmark	2016 APM FQHC Average	FQHCs Reporting in Q4 2016 (14 total)
Tobacco Screening & Cessation Therapy	50.9%	88.2%	14

Improvement activities:

Transformation Center

This quarter OHA continued implementing Comprehensive Primary Care Plus (CPC+), which launched January 1, 2017. An OHA CPC+ webpage was created and includes CPC+ resources for practices. A second webinar was held in February for CPC+ practices to share information about CPC+ in Oregon, including the quality and utilization measures selected by OHA.

The **Primary Care Payment Reform Collaborative**, required through Senate Bill 231, met in March to provide updates on primary care payment reform, hear from Oregon Senator Elizabeth Steiner Hayward about primary care legislative developments, and discuss next steps for the collaborative. The collaborative's recommendations to the Oregon Health Policy Board were considered as part of the legislative development process for SB 934 sponsored by Senator Steiner Hayward. A work group of the collaborative provided additional feedback to Senator Steiner Hayward on SB 934, per her request. Moving forward, the collaborative will continue to provide a forum for sharing and aligning primary care payment reform across Oregon.

During this quarter the Transformation Center continued to provide **support to four CCOs to develop value-based payments (VBPs)**.

1. Health Share of Oregon continued work with Bailit Health Purchasing, LLC, to develop VBP options for an integrated maternal health and substance use disorder project including: operational considerations, pros and cons of each model, and opportunities and challenges from the plan and provider perspective.
2. Western Oregon Advanced Health continued work with Lynnea Lindsey-Pengelly to develop quality and financial outcome metrics to measure performance of behavioral and physical health integration and provide recommendations for value-based contracting with insurers, including Medicare, to achieve full integration across payers.
3. Trillium Community Health Plan continued work with Dale Jarvis and Associates, LLC, to analyze potentially avoidable costs for members with severe mental illness; complete a return-on-investment analysis; suggest performance measures; develop value-based payment structures and options for each service type; transition payment models for each service type; and develop an implementation work plan.
4. Yamhill Community Care completed work with Dale Jarvis and Associates, LLC, to develop appropriate cost parameters to estimate per-member, per-month costs for different types of primary care practices for primary, secondary and tertiary prevention activities and complete a return-on-investment analysis to project potential savings for primary care clinics that implement high-impact initiatives.

Finally, work by two payers continued on **projects to advance value-based payment methods for integrated care** funded by grants from the Transformation Center. Both projects will be complete at the end of April 2017.

1. PacificSource Community Solutions is advancing integration of value-based payment methods across its Medicaid, Medicare and commercial lines of business to prepare to implement the payment models across provider networks starting in at least two practices in 2017. In this quarter, the project has focused on assessing current levels of clinical integration among five provider partners.

2. CareOregon has contracted with a consultant to evaluate pilot payment models to support behavioral health integration. Based on this evaluation, the payer will develop a sustainable value-based payment model to support behavioral and physical health integration that is capable of cross-regional and bi-directional implementation

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

Evaluation activities:

Oral health

The OHA Oral Health Team is in the early processes of developing an evaluation. Meetings are scheduled for this spring and summer to begin the development of a logic model, evaluation plan, and performance measures to define successes and identify areas of challenge. This action builds on the existing work that the oral health team has been doing over the last year to enhance coordination and collaboration across the agency (see improvement activities below).

Interim findings:

Oregon's coordinated care organizations

Five of the CCO incentive measures relate to physical and behavioral health care integration. Measure specifications for three measures (Screening, Brief Intervention and Referral to Treatment (SBIRT), Follow-Up After Hospitalization for Mental Illness, and Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody) changed in 2015. As a result, performance on these measures in CY 2014 and subsequent reporting periods is not comparable to performance in prior reporting periods.

The narrative below compares performance on these measures between CY 2014 and the 2015-2016 mid-year (July 2015-June 2016) the most recent reporting period.

- SBIRT for Alcohol or Other Substance Misuse increased from 6.3% in CY 2014 to 18.6% in 2015-2016 mid-year. The measure was above the 2016 benchmark target of 12%. The CY 2014 measure was rebased to include adolescents ages 12 to 17; however, they weren't officially part of the measure until CY 2015.
- Follow-Up After Hospitalization for Mental Illness increased from the 71.8% in CY 2014 to 78.1% in the 2015-2016 mid-year. The measure is just below the 79.9% 2014 CCO 90th percentile benchmark target. Beginning in the CY 2015 reporting period, the measure included follow-up services occurring on the same day of discharge.
- Mental, Physical, and Dental Health Assessment Within 60 Days for Children in DHS Custody has increased from 27.9% in CY 2014 to 67.5% in the 2015-2016 mid-year. The measure was below the 2016 benchmark target of 90%. Beginning in the CY 2015 reporting period, the measure included dental assessments.
- Screening for Clinical Depression and Follow-Up Plan increased from 27.9% in CY 2014 to 37.4% in CY 2015, and was above the target of 25.0% for CY2015; however, there is no 2015-2016 mid-year update, as this measure is only updated annually. The measure ranged from 0.5% to 62.8% across CCOs in CY 2015, with some of the variation likely due to challenges capturing data from electronic health records.
- Follow-Up Care for Children Initially Prescribed ADHD Medications increased from 52.3% in 2011 to 63.6% in the 2015-2016 mid-year for the initiation phase, which exceeds the CY 2016 benchmark target of 51%.The measure increased from 61.0% in 2011 to 66.1% in the 2015-2016 mid-year for continuation and maintenance phase, which exceeds the CY 2016 benchmark target of 63.0%. In the

2015-2016 mid-year the measure ranged from 56.1% to 66.7% across CCOs for initiation phase, and 54.3% to 91.7% across CCOs in the continuation and maintenance phase. Please note that this measure has been removed from the incentive measure set for 2015 given strong CCO performance (above the 90th percentile nationally), but OHA continues to monitor and report on the measure as part of the quality and access test.

Oral health in Oregon's CCOs

In March 2017, OHA released the first in-depth report on oral health data for Oregon's CCOs . There are 13 measures in this report, including quality measures (e.g., percentage of children receiving topical fluoride varnish), provider distribution and patient experience with the Oregon Health Plan. Key findings from the report include:

- Adult CCO members receive oral health services at lower rates than children. Only about one in three adults receive dental services in a given year, compared with a little more than half of children. Adults are also less likely to report having a regular dentist (57 percent of adults compared to 79 percent of children).
- Certain counties in Oregon have fewer dentists compared with the number of residents they serve, and only about two of every five dentists (41.5 percent) report seeing Medicaid patients. This situation could pose a challenge for members trying to access services.
- Many members do not receive preventive dental services such as regular cleanings, fluoride treatments, and dental sealants. Only one in five adults and just over half of children (50.1 percent) had a preventive service between July 2015 and June 2016. This finding is important, because dental diseases are largely preventable.
- When stratified by race and ethnicity, the data show variation between groups. Members who identify as Hawaiian/Pacific Islander consistently receive services at lower rates than other members. Members identifying as Asian American generally have higher rates of service use and follow-up.

Improvement activities:

Oral health

The Oral Health Team continues to build on the work completed through the State Innovation Model (SIM) that evaluated the effects of integrating funding for dental services into CCO's global budgets , in addition to the following three key SIM-funded reports produced for OHA by Health Management Associated (HMA):

- Oral Integration in Oregon: Environmental Scan & Recommendations. This report, published November 2016, includes an environmental scan of both local and national efforts toward oral health integration and included extensive interviews with state officials and their key partners to better understand transformation efforts. Key findings from the report include:
  a) The oral health status of Oregonians is improving, but further work remains.
  b) A limited oral health workforce continues to be a challenge
  c) Local oral health integration efforts are ahead of other states, but there is more to do including consensus on the definition of "integration".
  d) Some national models of oral health integration and local efforts for behavioral health integration can be applied.
  e) Potential innovative payment models could further oral health integration.
- Oral Health Toolkit: Resources for Supporting Oral health Integration in Oregon. This report, published November 2016, is a collection of resources to help the state, CCOs, and oral health and primary care providers and practice transformation leaders as they continue down the path of oral health integration. Topics and tools contained within this toolkit can serve as a framework for learning collaboratives facilitated by the transformation center, and may also serve as tools for practice change within CCOs and among providers.

- Oral Health Authority Oral Health Roadmap: Moving into the future. This report, published in December 2016, supports the development of the oral health strategic planning process to clarify a vision and goals, and to enhance coordination and collaboration across the agency .

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

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

Evaluation activities:

Evaluating Oregon's Medicaid waiver

In this quarter, OHA continued monthly meetings with OHSU Center for Health Systems Effectiveness (CHSE), the contractor for the summative evaluation. The summative evaluation will improve on the waiver midpoint evaluation and other preliminary efforts to assess the implementation and impacts of Oregon's Medicaid waiver: It will include data from all five years of the demonstration (with allowances for lag associated with some types of data).

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

Sustainable Relationships for Community Health (SRCH) Program

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

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

Interim findings:

Measures of efficient and effective care collected by OHA

The following measures of efficient and effective care improved in the 2015-2016 mid-year (see Appendix E for details):

- Emergency department visits per 1,000 member months increased from 43.1 per 1,000 member months in CY 2015 to 47.0 per 1,000 member months from December 2015-November 2016.
- Developmental Screening in the First 36 Months of Life increased from 42.6% in CY 2014 to 61.6% from December 2015 to November 2016, exceeding the CY 2016 benchmark of 50.0%.
- Adolescent Well-Care Visits increased from 32.0% in CY 2014 to 41.6% from December 2016 to November 2016.
- Potentially avoidable hospital admissions and complications for the December 2015 to November 2016 include:
    - Chronic obstructive pulmonary disease admission decreased from 411.9 per 100,000 member years in CY 2015 to 408.8 per 100,000 member years from December 2015 to November 2016.
    - Diabetes short-term complications increased from 140.9 per 100,000 member years in CY 2015 to 153.3 per 100,000 member years from December 2015 to November 2016.
    - Adult asthma decreased from 48.4 per 100,000 member years in CY 2015 to 45.1 per 100,000 member years from December 2015 to November 2016.
    - Congestive heart failure increased from 234.0 per 100,000 member years in CY 2015 to 238 100,000 member years from December of 2015 to November 2016.

SRCH Program

In January 2017, an interim evaluation showed that teams have made progress towards implementing closed-loop referrals and have advanced their partnerships. All teams have increased their performance on a series of teamwork indicators by 87% from the beginning of the grant year.

Improvement activities:

SRCH Program

Oregon Health & Science University Evaluation Core was brought on as the external evaluator for the SRCH 2016-2017 project, and ongoing evaluation activities took place with the SRCH grantees and OHA staff. Grantees delivered data reports for short term success measures to track progress on their tobacco, Chronic Disease Self-Management, Colorectal Cancer Screening and Diabetes Prevention Program referral system development.

Summary of Health Information Technology (HIT) initiatives

Health Information Technology Oversight Council

The Health Information Technology Oversight Council (HITOC) is tasked with setting goals and developing a strategic health information technology (HIT) plan for Oregon, overseeing implementation of the HIT plan, and monitoring progress with HIT goals. Supporting Medicaid goals is a core component of HITOC's work.

HITOC met in February and is currently revising its three year strategic plan, expected to be released in August 2017. Oregon's HIT strategic plan incorporates the needs of a broad range of stakeholders, including CCOs, providers, health systems, and payers. It will guide Oregon's implementation of HIT strategies, including those related to CCOs, Medicaid members, and providers over the next three years.

Health Information Technology Advisory Group

OHA convenes the Health Information Technology Advisory Group (HITAG), composed of CCO representatives to guide HIT activities that support CCOs.

In February 2017, OHA held a HITAG meeting to get CCOs' input on planning for the development of the Health Information Exchange (HIE) Onboarding Program and a governance model to support connection of HT systems.

Medicaid EHR Incentive Program

Through the CMS EHR Incentive 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 program's inception in 2011, 7,703 Oregon providers and 61 hospitals have received a total of $458.1 million in federal incentive payments ($300.5 million under the Medicare EHR Incentive Program and $157.6 under the Medicaid EHR Incentive Program, as of March 31, 2017).

- Since Program Year 2016 is the last year eligible providers can begin participation in the Medicaid EHR Incentive Program, OHA initiated significant outreach efforts this quarter to inform potential participants about the program. The program helped 221 providers who had never participated in the program submit attestations this quarter. An attestation is the first step in program participation, and begins the process by which providers are evaluated to see if they qualify for an incentive payment. That is an increase of 162 providers submitting attestations, compared to last quarter.
- In addition, compared to last quarter, there was an increase this quarter of 44 providers receiving incentive payments. The program also paid $9.6 million more in incentives to provider this quarter, as compared to last quarter.

Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP)

OMMUTAP provides technical support to providers who are participating in the Medicaid Electronic Health Records (EHR) Incentive Program. The program offers resources to help providers meaningfully use their EHRs and report CCO EHR-based metrics.

Between January and March 2017, an additional 240 providers at 70 clinics began participating in the program, bringing the total number of participating providers to 768 providers at 208 clinics. The technical assistance provided has supported these providers to meet meaningful use, improve workflow, and achieve interoperability of health information exchange to improve care coordination and service delivery.

EDIE/PreManage

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

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

PreManage is a companion to EDIE. PreManage brings real-time hospital event notifications from EDIE to health plans, CCOs, providers, and care coordinators. Users can choose patient demographics or particular patients to monitor, and when a patient in that demographic presents at an ED, the user will get a real-time notification. This helps CCO care coordinators follow up with appropriate referrals or re-engage a patient with primary care after an ED visit, or even enable care coordinators/providers to connect with a member during the ED visit to ensure the most appropriate care is being provided.
OHA is coordinating CCO use of PreManage for Medicaid. Many Medicaid providers are currently using PreManage to better manage their member populations and assist in the statewide reduction of ED utilizations, including:

- Three new CCOs went live on PreManage this quarter, for 14 total CCOs currently engaged. Twelve CCOs are active on the tool, two are in process, and two are in discussion. Eleven of the CCOs active on the tool have opted to expand their license to their key clinical practices (paying an additional PMPM through the CCO)
- Thirteen Assertive Community Treatment (ACT) teams are active on the tool and two are in process
- Oregon's Fee-for-Service contractor KEPRO is active
- All Dental Care Organizations (DCO) are engaged (3 are active on the tool and 3 are in process)
- Six Area Agency on Aging (AAA) and Aging & People with Disabilities (APD) sites are piloting PreManage

The Oregon Health Leadership Council (OHLC) is supporting EDIE/PreManage users through a learning collaborative tool and direct workflow support for up to 20 clinics.

The OHLC EDIE/PreManage learning website launched in January 2017 and has 246 members participating in the online learning collaborative. A Care Recommendation Resource section has been developed and shared on the site with members. It includes a guide, webinars, and technical toolkit. Weekly webinars are also available for site members to attend on various EDIE/PreManage topics.

- OHLC completed an evaluation of the use of EDIE within hospitals, including workflows, challenges, successes and improvements, or potential supports to maximize the value of the tool.

Provider Directory

The Provider Directory 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 Provider Directory addresses those issues by leveraging authoritative data sources to feed the Provider Directory and using data stewards to oversee management of the data to maintain both initial and long-term quality information.

The Provider Directory will benefit CCOs by supporting care coordination/health information exchange, administrative efficiencies, and serve as a resource for heath analytics in the following ways:

1) Having one place to go for accurate and complete provider data/reducing burden on providers and staff time spent on data maintenance activities
2) Enabling better care coordination for patients and ability to meet certain meaningful use objectives because the provider directory will supply complete information on providers and how to contact them
3) Improving the ability to calculate quality metrics that require detailed provider and practice information

OHA continues to meet with stakeholders bi-monthly via the Provider Directory Advisory Committee (PDAC) to provide input and oversight to OHA's development of this program. MiHIN was selected as the vendor for the Provider Directory in January 2017 through Oregon's prime vendor, Harris Corporation. The Provider Directory is to begin implementation in mid-2017 or early 2018.

Clinical Quality Metrics Registry

The Clinical Quality Metrics Registry (CQMR) will collect, aggregate, and provide clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. Initially, the CQMR will support the Medicaid EHR Incentive Program and the Coordinated Care Organization (CCO) incentive measures that are EHR-based. Over time, other quality reporting programs could use the CQMR as well.

The Michigan Health Information Network (MiHIN) was selected as the vendor for the CQMR in December 2016 through Oregon's prime vendor, Harris Corporation. The implementation date is still under discussion.

Common Credentialing

OHA is working with stakeholders to plan and implement a common credentialing program for Oregon health care practitioners, as mandated by Oregon law. It will include a web-based system to collect, store, and verify practitioner credentialing information, for use by credentialing organizations. It will streamline and centralize credentialing information to create efficiencies for an estimated 55,000 health care practitioners across Oregon and more than 300 credentialing organizations, including all Oregon health plans, CCOs, hospitals, health systems, dental care organizations, ambulatory surgical centers, and independent physician associations. The Common Credentialing Advisory Group provides stakeholder input and oversight to OHA's development of this program.

OHA signed vendor contracts in March 2017 and has begun implementation. The anticipated launch is in mid-2018.

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

Evaluation activities:

The summative waiver evaluation will include flexible services to better understand how they are deterring higher-cost care. Our contractor, CHSE, has formatted a detailed proposal for evaluating flexible services, which includes both quantitative and qualitative methods.

Interim findings:

CHSE, OHA's summative waiver evaluation contractor, will include findings about the effectiveness of flexible services in its final summative waiver evaluation report, which will be delivered to OHA by the end of CY 2017 (see Lever 5, Evaluation Activities, above). In addition, the contractor will provide recommendations for evaluating flexible services following the end of the 2012 – 2017 demonstration period.

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

Evaluation activities:

The Transformation Center's evaluation plan is aligned with the center's strategic plan initiatives. The center continues working in collaboration with Oregon Health and Science University to evaluate key activities.

Oregon Health & Science University completed the Transformation Center-funded **child psychiatry Project ECHO**. The project engaged 28 primary care providers from 17 clinics – most of them in rural areas, and all outside the Portland metro area. Each week for eight months (30 sessions), participants connected to a live session that included lectures and case reviews with child psychiatrists, pediatricians and a pharmacist. Topics included anxiety, depression, learning disabilities, trauma, medication management and other pediatric mental health issues. Selected evaluation results from participating clinicians include:

- Overall, 95% of participants reported that ECHO sessions provided some benefit or large benefit in increasing their confidence to treat pediatric patients with mental health disorders.
- The percentage of participants very comfortable or comfortable assessing and treating pediatric patients with mood and anxiety disorders increased from 39% to 79%.
- The percentage of participants very comfortable or comfortable medically treating pediatric patients with depression increased from 48% to 84%.
- Participants' familiarity with pediatric substance abuse resources in their community improved from 30% to 67%.
- Participants reported becoming much more comfortable prescribing children and adolescents medications for depression, hyperactivity and inattention, anxiety and insomnia.

Final reports for the Transformation Center's **Community Health Implementation Grants** to CCOs were due March 31, 2017. All CCOs made significant progress on their grant activities, supporting implementation of their community health improvement plan priorities. Completed projects included:

- A photo-voice project that used participatory photography and storytelling to authentically engage community members;
- Development of a curriculum and health literacy collateral, specifically with a train-the trainer curriculum and a media campaign, to increase the health literacy of transition-age youth;

- ASIST Suicide Prevention Trainings; and
- The creation of materials to highlight the importance of preventive oral health care and navigating Oregon Health Plan dental benefits.

Interim findings/ Improvement activities:

This quarter, the **CCO learning collaborative** met twice and focused on applied behavior analysis (for autism and related disorders) and the Emergency Department Information Exchange/PreManage. An average of 60 people attended each session. Of evaluation respondents, 88% found the sessions valuable or very valuable to their work. Respondents shared the most helpful aspects of the sessions were hearing about implementation strategies and challenges.

The third cohort of **Clinical Innovation Fellows** convened for three meetings, two online and one in person. On average, 88% of evaluation respondents rated the meetings as very valuable or valuable.

This quarter the Transformation Center has provided:

- **Targeted metrics technical assistance,** including Tobacco Cessation – One Rx for Change train-the-trainer training, with 16 participants representing CCOs, affiliated clinics and two staff from a tribal health organization; 100% of evaluation respondents indicated it was very valuable (80%) or valuable (20%) in supporting their work. Ninety-three percent indicated the training was effective in meeting the needs of their organization. The most helpful aspects were pharmacology information and resource sharing.
- **Support to CCO community advisory councils**, including "Meetings that Work" webinar – Nineteen people attended, and 60% of evaluation respondents (3 of 5) rated the session as valuable and effective for meeting their organization's needs. Suggestions for improvement include providing more advanced content; the Transformation Center will provide a follow-up webinar to address these needs.
- **Health equity consultations:** All 16 CCOs participated in a health equity consultation between May and November 2016. Overall, 119 of 144 participants completed evaluations (82.6% response rate). On a scale of 1–5, the majority of CCOs rated the overall value of the health equity consultation at 4.33 or higher. As for whether the health equity consultation was effective for meeting the needs of the CCO, the majority of CCOs rated the consultation at 4.25 or higher.
- A **statewide behavioral health integration learning and networking event**: Initiated by a CCO request, the Transformation Center collaborated with the Patient-Centered Primary Care Institute to convene a "Sustaining Integrated Care for Persons with Serious Behavioral Health Conditions" event. Attendees included 124 people representing physical health, behavioral health and payers. Evaluation respondents said the most helpful aspects were networking and discussing funding and metrics. Respondents indicated they planned to use what they learned about value-based payment models, peer support and behavioral health care for older adults, telehealth, patient engagement and patient registry related to health outcomes

VI. Public forums

Public comments received

Health Evidence Review Commission (HERC)

March 9, 2017:

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

HERC Value-based Benefits Subcommittee

February 2, 2017:

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

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

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

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

March 9, 2017:

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

In response to a committee member question on what this technology involved, Mr. Halaj described CES as an electrical device that stimulates cranial nerves. CES is indicated for depression, anxiety and insomnia. The same instrument is also used locally for pain. In response to another question, Mr. Halaj indicated that

CES is not covered by most insurers, which he argued is due to pharmaceutical company pressure, rather than lack of evidence of effectiveness. He answered a final question from the committee by saying that that there are several billing codes used for this technology.

HERC Evidence-based Guidelines Subcommittee

February 2, 2017:

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

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

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

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

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

Dr. David Sibell, an OHSU pain medicine physician and member of the Spine Intervention Society, presented articles and described them by saying that transforaminal epidural steroid injections have clinical and statistical effectiveness in the treatment of radiculopathy when using the appropriate technique. Using other forms of the procedure and giving the injections for other indications is not effective. Failing to pay

attention to pain as a variable for a treatment whose primary effect is pain relief is inappropriate. He said safety has improved over the last decade, eliminating the risks of arterial injection by using imaging guidance.

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

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

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

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

Medicaid Advisory Committee

The committee did not receive any formal public comment in January, February or March 2017.

Oregon Health Policy Board

The board did not receive any formal public comment in January, February or March 2017.

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

Transition plan finalized and approved by CMS in 2015.

VIII. Appendices

Appendix A. Quarterly enrollment reports

1. SEDS reports

Attached separately.

2. State reported enrollment tables

Enrollment	January 2017	February 2017	March 2017
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	958,855	954,852	979,399
Title XXI funded State Plan	65,427	66,247	68,898
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH Funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A

Enrollment current as of	January 31, 2017	February 28, 2017	March 31, 2017

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Expansion	**Title 19**	PLM Children FPL > 170%	22	57	-90.91%	-236.36%
		Pregnant Women FPL > 170%	9	26	-44.44%	-211.11%
	Title 21	SCHIP FPL > 170	69,597	185,773	10.34%	69.68%
Optional	**Title 19**	PLM Women FPL 133-170%	251	703	-21.51%	-170.12%
	Title 21	SCHIP FPL < 170%	51,766	133,820	-8.90%	-36.60%
Mandatory	**Title 19**	Other OHP Plus	160,897	450,436	-0.66%	-4.66%
		MAGI Adults/Children	771,636	2,094,780	-3.58%	-8.21%
		MAGI Pregnant Women	16,554	39,822	-2.43%	-21.20%
		QUARTER TOTALS	1,070,732			

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

OHP eligibles and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
January	956,790	810,242	745	709	35,014	47,018	3,921
February	953,384	810,669	890	749	34,437	45,862	3,806
March	978,379	829,396	954	720	34,615	46,250	3,820
Quarter Average	962,851	816,769	863	726	34,689	46,377	3,849
		84.83%	0.09%	0.08%	3.60%	4.82%	0.40%

**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; CCOG: Mental and Dental*

Appendix B. Neutrality reports

1. Budget monitoring spreadsheet

Attached separately.

2. CHIP allotment neutrality monitoring spreadsheet

Attached separately.

Appendix C. Two-percent trend reduction tracking

Attached separately.

Appendix D. DSHP tracking

Attached separately.

Appendix E. Oregon Measures Matrix

Attached separately. In this period, OHA continued reporting on the 2016 coordinated care organization (CCO) and state performance measures and continued measure development and validation work. This quarterly report continues to include the final 2013, 2014, and 2015 results for the 18 CCO incentive measures and 33 quality and access test measures, and provides data for a new rolling 12-month window (December 2015 – November 2016) for a subset of measures for which data are available.

Also in this reporting period, OHA secured CMS approval for a fourth year of the Hospital Transformation Performance Program (HTPP). Preliminary Year 3 data for the program are presented in Addendum 2.

CCO incentive metrics updates

CCO reporting

- During this reporting period, OHA continued to provide updated metrics results to CCOs utilizing the automated metric reporting tool ("dashboard"), for periods covering September 2015 – August 2016, October 2015 – September 2016, and November 2015 – December 2016.
- Additional state performance measures were added to the dashboard: Diabetes LDL-C screening; Diabetes HbA1c testing; Follow-up after prescription for ADHD medication (continuation and maintenance phase); and Child and adolescent access to primary care providers.

Measure validation updates

OHA has contracted with the Oregon Health Care Quality Corporation (Q Corp) to independently calculate and conduct a multi-directional validation process on the 33 quality and access test measures. This has been an ongoing process, with Q Corp calculating and validating the 2011 baseline, calendar years 2013, 2014 and 2015, the "dry run" period (July 2012 – June 2013), and the first and second and third years of the test (DY 12, 13 and 14).

The following table shows the status of validation of the 22 measures computed using administrative claims data for each measurement period.

Time Period	Baseline	Dry Run	CY 2013	Year 1 Test	CY 2014	Year 2 Test	CY 2015	Year 3 Test
Measures Signed Off (as of 9/30/15)	22	22	22	22	21	TBD	-	-
Measures Signed Off (as of 12/31/15)	22	22	22	22	22	13	-	-
Measures Signed Off (as of 3/31/16)	22	22	22	22	22	21*	-	-
Measures Signed Off (as of 6/30/16)	22	22	22	22	22	21*	-	-

Time Period	Baseline	Dry Run	CY 2013	Year 1 Test	CY 2014	Year 2 Test	CY 2015	Year 3 Test
Measures Signed Off (as of 9/30/16)	22	22	22	22	22	21*	17	-
Measures Signed Off (as of 12/31/16)	22	22	22	22	22	21*	17	11
Measures Signed Off (as of 3/31/17)	22	22	22	22	22	21*	17**	14
Total Measures	22	22	22	22	22	22	22	22

** OHA specifications for Plan All-Cause Readmission (NQF 1768) did not conform to HEDIS 2015. OHA agreed to update specifications for the CY 2015 measurement period, but elected not to rerun and validate for the Year 2 Test Period.*

***OHA and Q Corp mutually agreed to suspend validation of CY 2015 data once Year 3 Test data became available.*

Hospital metrics updates

During this reporting period, OHA secured CMS approval for a fourth year of the Hospital Transformation Performance Program (HTPP). CMS approved a one year extension of the current (i.e., Years 1 and 2) 11 measures. Whereas Years 1-3 of the HTPP spanned federal fiscal years, Year 4 of the HTPP will shift to calendar year (2017). The waiver provides flexibility to redesign the program upon expiration of the one-year extension.

During this reporting period, OHA finalized and posted Year 4 measure specifications and additional program documentation online.

Hospital reporting

- Hospitals continued to validate Year 3 data for Emergency Department Information Exchange (EDIE) measure with the CMT, the contractor with whom OHA contracts to run this measure.
- In this quarter hospitals also received individual-level data and progress reports on the Follow-up after hospitalization for mental illness measure, with data through the fourth quarter of HTPP Year 3.
- On March 31, the Oregon Association of Hospitals and Health Systems (OAHHS), submitted full Year 3 data to OHA for all measures except EDIE, Follow-up after hospitalization, CAUTI, and CLABSI.

Committee and technical advisory workgroup updates

The **CCO Metrics & Scoring Committee** held three regular meetings during this reporting period:

- In January, the Committee selected a new CCO incentive measure for 2018 with the intent of addressing disparities: Emergency department utilization among members with severe and persistent mental illness. The Committee received expert testimony in support of their efforts to develop a health equity measure.
- At its February meeting, the Committee heard informational presentations on behavioral health (one of the identified “areas of the interest” for 2018 measure selection/development) and discussed alternate patient experience measures.
- The Committee’s March meeting focused on oral health (another 2018 area of interest), including a presentation on a new report which includes CCO data for more than a dozen oral health measures. The Committee received expert testimony expressing concern with the idea of requiring dental risk assessment codes in an incentive measure.

Meeting materials are available online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.

The **CCO Metrics Technical Advisory Group (CCO TAG)** met monthly this quarter. The primary focus of these meetings was to provide recommendations to the Committee for the 2018 measure set in response to suggestions received from a stakeholder survey. The CCO TAG also formed a workgroup to develop EHR-based SBIRT measure specifications. Meeting materials are available online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Technical-Advisory-Group.aspx.

The **Hospital Performance Metrics Advisory Committee** held one brief phone meeting this quarter (in March) for a formal update following CMS approval of HTPP Year 4, and to discuss next steps moving forward. At this meeting, the Committee received expert testimony raising concerns about changes to the EDIE (Emergency Department Information Exchange) measure in Year 4, and about the voluntary opioid prescribing in the ED measure. Meeting materials are available online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Performance-Metrics.aspx.

The Committee plans to meet in July to review the Year 3 report (to be published in June).

The **Hospital Metrics Technical Advisory Group (Hospital TAG)** held one regular meeting during this reporting period (in February) to review and discuss Year 3 data submission processes and final details of Year 4 program structure. In addition, OHA staff hosted an "office hour" in March to answer any HTPP-related questions. Meeting materials are available at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Metrics-Technical-Advisory-Group.aspx.

HTPP Measures Matrix

This matrix is available in the Measures and Benchmarks Table online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Baseline-Data.aspx.

HTPP measures

Attached separately. This quarterly report includes preliminary (unvalidated) data from HTPP Year 3 (October 2015 – September 2016).

Appendix F: Uncompensated Care Program

The UCCP program ended on January 12, 2017. Previously uncompensated services are continuing to be provided to tribal members as compensated services.