Oregon Health Plan

Section 1115 Quarterly Report

1/1/2018 – 3/31/2018
Demonstration Year (DY): 16 (7/1/2017 – 6/30/2018)
Demonstration Quarter (DQ): 3/2018
Federal Fiscal Quarter (FQ): 2/2018

Oregon Health Authority

Oregon HEALTH PLAN

Table of contents

I. Introduction

A. Letter from the State Medicaid Director

The Oregon Health Authority (OHA) is moving forward in meeting the goals of the Oregon Health Plan demonstration. As you will find detailed in the full report, OHA and coordinated care organizations (CCO) are making strides in health system transformation "levers" as identified in the waiver agreement and accountability plan. Highlights from the report include the following.

Lever 1: Improving care coordination
OHA continues to improve care coordination through collaborative partnerships, innovative programs, and system support.

On March 1, 2018 OHA approved a new Tribal Consultation and Urban Indian Health Program Confer Policy. The new policy applies to OHA and all its divisions, programs, services, projects, activities, and employees and shall serve as a guide for the tribes to participate in OHA policy development to the greatest extent allowable under federal and state law.

Lever 2: Implementing alternative payment methodologies
Among other initiatives for alternative payment methodologies, OHA works toward this goal through primary care payment reform and the Advanced Payment and Care Model (APCM).

The Primary Care Payment Reform Collaborative, which is advising and assisting OHA in developing the Primary Care Transformation Initiative, has started drafting an initiative implementation strategy to present to the Oregon Health Policy Board. The purpose of the initiative is to increase investment in primary care, improve reimbursement methods, and align primary care reimbursement by purchasers of care.

Also, OHA is collaborating with Oregon Health and Sciences University's Office of Rural Health as more Rural Health Centers express interest in the APCM, advance their practices to meet Patient-Centered Primary Care Home standards, and prepare for a population-based reimbursement structure.

Lever 3: Integrating physical, behavioral and oral health care
Behavioral, physical, and oral health integration is also moving forward as OHA works to increase and equip the behavioral health workforce and battle the opioid epidemic across health sectors.

OHA has contracted with the University of Colorado's Eugene S. Farley Health Policy Center to address the shortage of behavioral health providers and develop core competencies for an integrated workforce. The center will conduct an assessment of the behavioral health workforce, including licensed and unlicensed providers.

The Oregon State Legislature passed a bill that requires all prescribers of controlled substances, including dentists, to register with the Prescription Drug Monitoring Program, and the 2018 Statewide Performance Improvement Project on Opioid Safety focuses on aligning chronic opioid use with state and national Centers for Disease Control and Prevention standards.

Lever 4: Increased efficiency in providing care

Oregon Health Authority

OHA's Office of Equity and Inclusion (OEI) and Public Health Division continue working on administrative simplification and effective models of care that incorporate community-based and public health resources.

OEI is working to expand Regional Health Equity Coalitions (RHEC) into additional counties and to tribes in Oregon, particularly Eastern Oregon. Currently there are four RHECs serving nine Oregon counties. Their work covers a wide range of underserved communities in urban, rural, and frontier regions with communities of color as a leading priority, and they focus on a broad range of priorities to impact the many social determinants of health that influence communities' wellness.

Two Sustainable Relationships for Community Health (SRCH) program grantee consortia started their year-long projects in January 2018. Prior SRCH grantees met their goals of implementing closed-loop referrals and building sustainable relationships between CCOs, public health agencies, and community partners in five local communities in Oregon. With continued refinement and improvement of the SRCH model, we expect to see similar results from the current grantee cohort.

Lever 5: Implementation of health-related flexible services

OHA continues work to provide greater communication and clarity around tracking and reporting on the use of health-related services and outcomes, while OHA's Office of Equity and Inclusion works to build the Traditional Health Workers (THW) and Health Care Interpreters (HCI) workforce.

In January, the THW Commission requested that OHA implement measures to remedy existing and future barriers to utilization of THWs. As a result, OHA has implemented the commission's recommendations into the CCO 2.0 policy options; this will ultimately inform and shape the CCO contract in 2020. As of March, OHA has certified over 2,600 THWs and approved 36 trainings and continuing education programs.

The HCI program sets competency criteria, approves HCI training programs, and qualifies and certifies spoken and sign language HCIs. The HCI Registry currently has over 500 trained, qualified, and certified spoken and sign language HCIs. This number includes about 62 HCIs who completed the Center for Medicare and Medicaid Innovation State Innovation Model grant.

Lever 6: Innovations through the Transformation Center

OHA's Transformation Center continues to advance peer-to-peer learning and the spread of best practices and innovation through many initiatives, including its Innovation Café and Technical Quality Strategies Workplan Group.

The 2018 Innovation Café will focus on childhood health. The call for projects received 35 submissions, with most projects focusing on cross-sector partnerships affecting the social determinants of early childhood health.

Also, CCOs submitted their first Technical Quality Strategy (TQS) plans, which replace the CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables, and the Transformation Center has developed a TQS Workplan Group to develop an ongoing process that assures the work of the CCOs is accurately represented.

OHA continues to invest in health system transformation, and we look forward to improving health outcomes and health care in Oregon by working with our partners and stakeholders to meet demonstration goals.

David Simnitt, State Medicaid Director

B. Demonstration description

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

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

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

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

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

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

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

- Extension of the Hospital Transformation Performance Program through June 30, 2018, at which point hospital performance payments will transition to CCOs;

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

C. State contacts

Demonstration and Quarterly and Annual Reports

Jennifer R. Smith, Medicaid Policy Coordinator
503-945-9717 phone
503-945-5872 fax

State Plan

Jesse Anderson, State Plan Manager
503-945-6958 phone
503-945-5872 fax

Coordinated Care Organizations

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

Quality Assurance and Improvement

Vacant

For mail delivery, use the following address

Oregon Health Authority
Health Policy and Analytics
500 Summer Street NE, E54
Salem, OR 97301-1077

II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 10/1/2017 – 12/31/2017
Demonstration Year (DY): 16
Demonstration Quarter (DQ): 2/2018

III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan eligibility

In November 2017, Oregon moved a substantial Oregon Eligibility (ONE) system enhancement into production which included an automated process by which: client case data is verified via electronic verification sources; eligibility is evaluated; and eligibility determinations are made with minimal action required from staff or clients. Oregon refers to this functionality as automated renewal. The first round of automated renewals was initiated in December 2017, targeting cases with a renewal date of February 2018, and they have continued each month since then. The first round of automated renewals resulted in:

- A final eligibility determination without further verification from the member in 47.7% of cases;
- The need for additional verification documentation from the member to complete eligibility determination in 46% of cases; and
- Only 6.3% of cases where applications were not able to be processed through automated renewal, and a pre-populated renewal notice was sent to the member.

This process has served to minimize manual workload on staff, lessen the paperwork burden for many renewing clients, reduce administrative mailing costs, and reduce the number of members who experience lapses in coverage due to late renewal responses.

2. Coordinated care organization enrollment

The Oregon Health Authority (OHA) successfully transitioned to the Oregon Eligibility (ONE) system and made significant advances in reducing the fee-for-service population. OHA continues to ensure eligible Oregon Health Plan members are appropriately enrolled in coordinated care organizations (CCO). While new member enrollment is an automatic process in the Medicaid Management Information System (MMIS), OHA's quality control measures verify member demographics to make sure members who can be enrolled in a CCO, are enrolled. During this quarter, MMIS enrollment system logic was implemented to enroll all members, not including members with exemptions, into the highest CCO level. OHA staff and partners are meeting monthly to work through any issues that may arise during this transitional period.

B. Benefits

The Pharmacy and Therapeutics Committee developed new or revised prior authorization criteria for the following drugs: Inhaled medications for asthma and chronic obstructive pulmonary disease (COPD); biologics for autoimmune conditions; VMAT2 inhibitors; PCSK-9 inhibitors; bone metabolism drugs; Luxturna; Keveyis; anti-Parkinson's agents; and drugs for atopic dermatitis. There were several agents recommended to be made preferred on the Preferred Drug List changes for this quarter including Tacrolimus and Pimecrolimus.

On January 1, 2018, the new Prioritized List was implemented, including interim modifications to address changes in evidence, medical technology, and practice guidelines. These changes are described here.

On January 5, 2018, additional interim modifications related to certain medications were made; these are described here.

C. Access to care (annual reporting)

D. Quality of care (annual reporting)

E. Complaints, grievances, and hearings

CCO and FFS complaints

The information provided is a compilation of data from 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. One CCO closed January 31, 2018 and reported data for the first month of 2018 only. The reporting period covers the quarter beginning January 1, 2018 through March 3, 2018.

Trends

	Apr – Jun, 2017	Jul – Sep, 2017	Oct – Dec, 2017	Jan – Mar, 2018
Total complaints received	4,225	4,157	4,995*	5,537*
Total average enrollment	882,453	855,569	1,106,876*	1,179,176*
Rate per 1,000 members	4.78	4.71	4.51*	4.70*
* FFS data is included in the totals beginning in October 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports.				

Barriers

CCOs report the access-to-care category continues to receive the highest number of complaints, with non-emergency medical transportation (NEMT) showing the most complaints. While the overall access-to-care category had a slight decrease, the interaction-with-provider/plan category shows an increase as CCOs are improving how they report data in appropriate categories. A shift of Oregon Health Plan (OHP) members to other CCOs due to the closing of FamilyCare, Inc. may attribute, in part, to overall increases. FFS data continues to show the highest number of complaints in the quality-of-service category, followed by the billing.

Interventions

Some CCOs are providing additional education to provider staff, resulting in a reduction in the number of complaints reported at provider offices. One CCO is considering NEMT site visits to monitor conditions. Another CCO continues to work with a consultant to improve NEMT services. One CCO reports a reduced number of complaints in two specific categories directly related to increased education and communication with provider offices. In addition, one CCO has developed a method for providers to temporarily pause assignments of members to their clinics to allow better coordination of services.

OHP Member Services reports 643 complaints from members who have FFS coverage and an additional 548 records identified as complaints received from members enrolled in CCOs. In addition to the complaint calls, Member Services took 2,679 calls from members asking for a variety of information (e.g. coverage information, CCO enrollment, ID card requests, etc.).

Statewide rolling 12-month totals

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

Complaint category	Apr – Jun, 2017	Jul – Sep, 2017	Oct – Dec, 2017	Jan – Mar, 2018
Access to care	1,759	1,719	2,343	2213
Client billing issues	310	334	393	457
Consumer rights	239	215	205	230
Interaction with provider or plan	1,329	1,293	1,374	1682
Quality of care	416	422	313	466
Quality of service	124	131	293	439
Other	48	43	74	50
Grand Total	**4,225**	**4,157**	**4,995***	**5,537***
* FFS data is included in the totals beginning in October 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports.				

Related data

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

CCO and FFS appeals and hearings

CCO Notices of Action – Adverse Benefit Determination

The following table lists the total number of notices of action – adverse benefit determination (NOA-ABD) issued by coordinated care organizations (CCO) this quarter. The total number of NOA-ABDs are listed by NOA reason.

Notice of Action – Adverse Benefit Determination (NOA-ABD) reason	Total issued
a) Denial or limited authorization of a requested service.	36,229
b) Single PHP service area, denial to obtain services outside the PHP panel	228
c) Termination, suspension, or reduction of previously authorized covered services	304
d) Failure to act within the timeframes provided in § 438.408(b)	12
e) Failure to provide services in a timely manner, as defined by the State	0
f) Denial of payment, at the time of any action affecting the claim.	15,087
Total	**50,992**
Number per 1000 members	46

CCO Appeals

The following table shows the total number of appeals received by CCOs during the quarter. Federal managed care rule changes went into effect for Oregon on January 1, 2018, and OHP members are now required to exhaust their appeal rights at the CCO level before a contested case hearing can be requested at the state level. The table below has been revised to reflect only CCO appeal information. CCOs report a higher number of requests for appeals this quarter in both dental services and benefits not covered. Some CCOs report they provide targeted provider education and peer-to-peer consultation to reduce the number of appeals. Some CCOs say staff work with members to assist them in finding services they need, or to find alternative covered options. CCO staff also assist members in understanding the legal aspects of appeals and hearings and the OHP Prioritized List of Health Services.

CCO Appeals	Requests	Range
a) Denial or limited authorization of a requested service.	1,279	14-231
b) Single PHP service area, denial to obtain services outside the PHP panel	6	0-5
c) Termination, suspension, or reduction of previously authorized covered services	2	0-1
d) Failure to act within the timeframes provided in § 438.408(b)	0	0
e) Failure to provide services in a timely manner, as defined by the State	0	0
f) Denial of payment, at the time of any action affecting the claim.	320	0-101
Total	**1,607**	
Number per 1000 members	1.73	
Number overturned at plan level	495	
Appeals decisions pending	51	
Overturn rate at plan level	30.8%	

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 16 CCOs, seven dental care organizations (DCO) and fee-for-service (FFS). One CCO closed January 31, 2018 and reported data for the first month of 2018 only. During every quarter, there is an overlap between processed cases and cases received (e.g. Cases processed and resolved in this quarter may have been received last quarter.).

The Oregon Health Authority (OHA) received 447 hearing requests related to the denial of medical services which include non-emergency medical transportation (NEMT) services. Of those received, 425 were for CCO-enrolled members, two were for DCO-enrolled members, and 20 were for FFS members.

OHA processed and resolved 592 cases. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. There were 92 cases approved prior to hearing where the CCO overturned the appeal resolution. Members withdrew from 95 cases after an informal conference with an OHA hearing representative, and OHA dismissed 228 cases that were determined not hearable. Of the 147 cases that went to hearing, the administrative law judge: upheld the OHA or CCO decision in 75 cases; reversed the decision in five cases; and dismissed 67 cases for members' failure to appear. Thirty cases were dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

There was an increase in the cases determined not hearable due to a federal rule change effective January 1, 2018: OHP members must exhaust their appeal rights at the CCO level and receive notice of appeal resolution (NOAR) before they can request a contested case hearing at the state level. Requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

Outcomes of Contested Case Hearings

Outcomes	Count	% of Total
Decision overturned prior to contested case hearing	92	16%
Client withdrew request after pre-hearing conference	95	16%
Dismissed by OHA as not hearable	228	39%

Decision affirmed*	75	13%
Client failed to appear*	67	11%
Dismissed as non-timely	30	5%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	5	1%
Set Aside	0	0%
Total	**592**	
**Resolution after an administrative hearing*		

Related data

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

F. CCO activities

1. New plans

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

2. Provider networks

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

3. Rate certifications

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

OHA amended and finalized 2018 capitation rates for CCOs and submitted for approval to the Centers for Medicare and Medicaid Services in March 2018.

4. Enrollment/disenrollment

FamilyCare, Inc. left Oregon's coordinated care organization (CCO) market effective January 31, 2018. The agency's partnerships with CCOs in FamilyCare's service area—HealthShare of Oregon, Willamette Valley

Community Health and Yamhill Community Care—helped successfully transition FamilyCare's 113,000 Oregon Health Plan members.

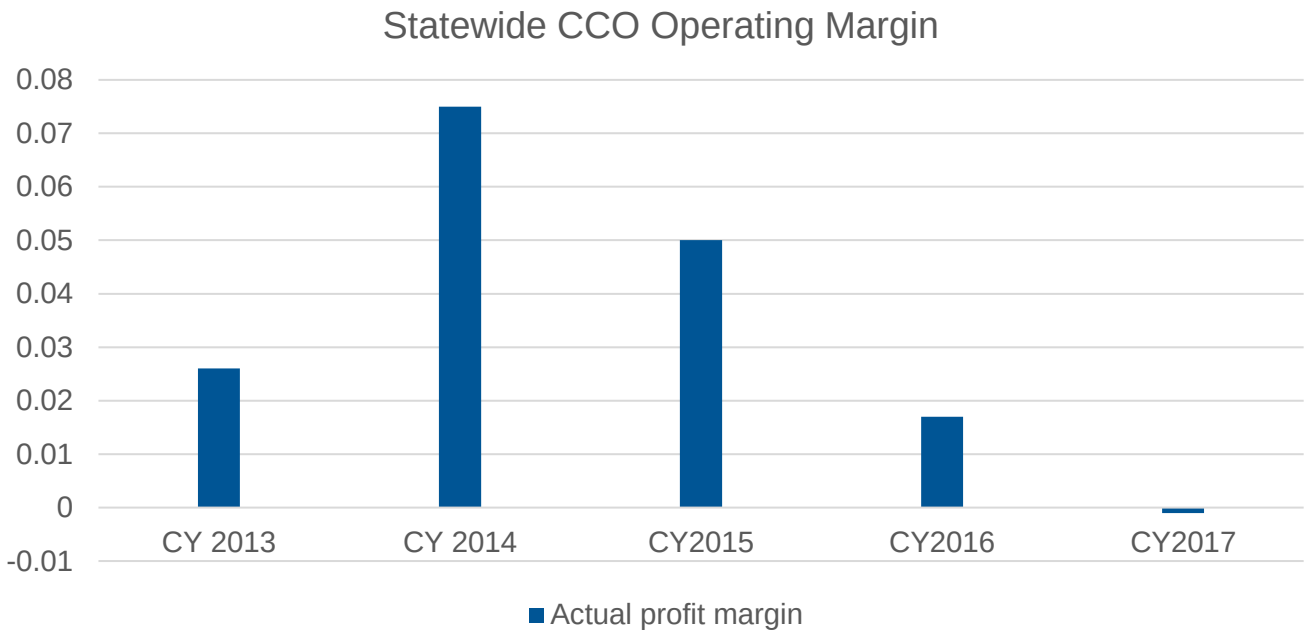
Enrollment data is listed in the actual and unduplicated enrollment table in Appendix A.

5. Contract compliance

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

6. Relevant financial performance

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



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

Also as of December 31, 2017, all CCOs meet the net worth requirement, ranging in net assets from $203 to $1,060 per-member per-month (PMPM), averaging $541 PMPM for the state.

7. Corrective action plans

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

8. One percent (1%) withhold

During this quarter, the Oregon Health Authority's Health Systems Division analyzed encounter data received for completeness and accuracy for the subject months of June through October of 2017. All coordinated care organizations (CCO) met the administrative performance standard for all subject months and no 1% withholds occurred.

9. Other significant activities

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

G. Health Information Technology

Oregon's coordinated care organizations are directed to use health information technology (HIT) to link services with core providers. They are also expected to achieve minimum standards in foundational areas of HIT and develop their own goals for the transformational areas of HIT use.

HIT Commons

HIT Commons is a public-private partnership to coordinate investments in health information technology (HIT), leverage funding opportunities, and advance health information exchange across the state. HIT Commons will focus initially on: continuing the spread and adoption of Emergency Department Information Exchange (EDIE) and PreManage, two web-based communication tools that provide real-time information to reduce emergency department utilization and improve care coordination and care management; and launching a statewide subscription for the Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative. The Oregon Health Authority and the Oregon Health Leadership Council, with the assistance of an interim governance advisory group, completed a business plan and appointed an initial Governance Board in 2017.

The HIT Commons Governance Board began meeting in January 2018, and met again in March 2018. Initial work has focused on approving EDIE/PDMP project steering committees, reviewing and updating key policies, and developing a stakeholder communications plan.

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 continues implementation of Oregon's HIT strategic plan, which incorporates the needs of a broad range of stakeholders including coordinated care organizations, providers, health systems, and payers. HITOC met once during this quarter, in February.

Oregon Prescription Drug Monitoring Program Integration Initiative

The Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative, administered by the Oregon Health Authority's Public Health Division, connects the Emergency Department Information Exchange (EDIE),

health information exchanges, and other health information technology (HIT) systems to Oregon's PDMP, which includes prescription fill information on controlled substances.

The Oregon PDMP Integration Initiative began in the summer of 2017 and is in phase one of adoption. With phase one, EDIE notifications can include PDMP data when certain triggers are met. This new feature is being rolled out hospital-by-hospital and can only be implemented by hospitals who have integrated EDIE alerts into their electronic health records (EHR) systems. (Some hospitals receive EDIE notifications via fax or secure printer.)

Phase two is anticipated to launch this summer and will include a statewide subscription for the Oregon PDMP Integration Initiative under the HIT Commons, supporting Oregon prescribers and pharmacists who connect their EHRs or other HIT to the PDMP Gateway to access integrated PDMP data in their electronic workflow. As of March 31, 2018:

- Fifteen hospitals across Oregon receive PDMP data as part of their EDIE alert. (Emergency department physicians at Asante Rogue Regional Medical Center stated that having the PDMP data in their EDIE notifications has been one of the most valuable tools provided to them since EDIE itself.)
- Grants for rural hospitals to integrate PDMP Gateway into their EHRs are available through the Oregon Association of Hospitals Research and Education Foundation. Grants may be used for hospital integration costs related to EDIE and/or PDMP Gateway.

H. Metrics development

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

Activities related to CCO metrics measurement

According to Oregon's Senate Bill 440, the publicly funded health plans such as Medicaid, Public Employees Benefit Board and others should align their quality metrics by selecting from a common menu set of quality measures. SB440, created the Health Plan Quality Metrics Committee (HPQMC) and specified that the current coordinated care organization (CCO) Metrics and Scoring Committee (MSC) would become a subcommittee that informs the larger committee. However, the MSC continues to select the specific incentive measures and benchmarks for CCOs. Because of this new relationship, many of the activities were brought jointly before both the MSC and the HPQMC to form a common knowledge of activities related to CCO quality measurement. During this quarter, the HPQMC continued their work to develop a common menu set of quality and health outcome measures to be used in Oregon that are coordinated, evidence-based and focused on a long-term vision.

Activities related to metrics development

During this quarter, there were two main activities pertaining to the development of new measures: the initial Health Aspects of Kindergarten Readiness Technical Workgroup meeting; and work toward developing an evidence-based obesity measure.

The Health Aspects of Kindergarten Readiness Technical Workgroup had its first meeting in March. This group will focus on the health aspects/health system's role in kindergarten readiness with the ultimate goal of creating a cross-sector measure of shared accountability. In its early stages the work group plans to examine the unique

role the health system can play in preparing children for school, with the aim of creating a measure that the MSC could select as an incentive measure for the coordinated care organizations.

The Oregon Health Authority's metrics team is working with physicians from the Public Health Division and the Health Evidence Review Commission to summarize the latest evidence and public health risk for obesity. The committee will convene a work group that will identify how to transition from the current screening metric (weight assessment and counseling for nutrition and physical education for children and adolescents, National Quality Forum measure 0024) toward a measure that will include evidence-based, effective treatments. The first meeting in scheduled to occur May 31, 2018.

Hospital Transformation Performance Program

During this quarter, the Oregon Health Authority (OHA) began collecting data from hospitals for the measurement period January 1 – December 31, 2017, the last program year. Five of the 11 Hospital Transformation Performance Program measures were submitted to OHA by March 31, 2018. These are:

- Emergency department (ED) revisits for high utilizers;
- Adverse drug events due to opioids;
- Excessive anticoagulation with Warfarin;
- Hypoglycemia in inpatients receiving insulin; and
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening in the ED.

All measures will be finalized and incentive payments, based upon meeting measure improvement targets or benchmarks, will be distributed to hospitals in the next quarter.

As the measurement program wraps up, many hospitals continue to express support for future hospital incentive metric programs. Some measures have been well accepted in the hospitals and supported local measurement and workflows that would not otherwise have happened without the state's hospital incentive program.

Evaluation Activities

2012-2017 Demonstration Waiver Evaluation

The Oregon Health Authority (OHA) continued and concluded contract activities for the Summative Evaluation with Oregon Health and Science University's (OHSU) Center for Health System Effectiveness. During this quarter, key findings and recommendations from the final Summative Evaluation were shared with stakeholders including OHA's Transformation Center, the Oregon Health Policy Board, and Medicaid and OHA leadership. These findings and recommendations are being used in many aspects of OHA's future work related to the coordinated care organizations.

2017-2022 Demonstration Waiver Evaluation

The evaluation plan for the 2017-2022 waiver evaluation was approved by the Centers for Medicare and Medicaid Services during this quarter.

I. Budget neutrality

The Oregon Health Authority (OHA) provides two budget-neutrality reports: Oregon Health Plan Section 1115 Medicaid Demonstration Budget Neutrality report and Oregon's Children's Health Insurance Program (CHIP) Title XXI Allotment report. There are no significant current issues to address in these reports. With the approval

of the CHIP allotment for Federal Fiscal Year 2018, OHA is projected to run out of CHIP allotment in July 2018.

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

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

- House Bill 4018 (Implementation: contract-related provisions, immediately; the remainder of the bill, January 1, 2019) –
    - Establishes meeting requirements for governing bodies of coordinated care organizations (CCO);
    - Modifies composition of a CCO's governing body;
    - Requires a CCO to spend a portion of earnings above specified threshold on services designed to address health disparities and social determinants of health consistent with federal terms and conditions under Section 1115 of the Social Security Act;
    - Modifies composition of a CCO's governing body specific to financial risk entities; and
    - Codifies, in statute, provisions related to contract nonrenewal and compliance requirements.
- Senate Bill 1549 – Ensures that individuals in the Oregon State Hospital (OSH) may maintain medical assistance eligibility until: 12 months after the individual is admitted to OSH or upon eligibility recertification, whichever is earlier. Additionally, if medical assistance was terminated for an individual while in OSH, they may reapply for medical assistance up to 120 days prior to release, with benefits going into effect on the date of discharge.
- House Bill 4005 – While this bill does not impact Medicaid directly, it does:
    - Require prescription drug manufacturers to report, on an annual basis, information on prices of prescription drugs and costs associated with developing and marketing prescription drugs;
    - Authorize the state to impose civil penalties on manufacturers for failing to comply with reporting requirements;
    - Requires health insurers that offer prescription drug benefits to report specified information about prescription drug prices and impact of prescription drug prices on premium rates;
    - Requires the state to conduct an annual public hearing on prescription drug prices and related information reported by manufacturers; and
    - Establishes the Task Force on the Fair Pricing of Prescription Drugs.

K. Litigation status

Lawsuits and legal actions

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

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

L. Public forums

Health Evidence Review Commission

The Health Evidence Review Commission (HERC) reviews clinical evidence in order to prioritize health spending and guide the Oregon Health Authority in making benefit-related decisions for its health plans. HERC promotes evidence-based medical practice statewide. Public comment from HERC meetings is listed below.

January 5, 2018

Testimony for this meeting is related to the reconsideration of the prioritization of two drugs to treat Duchenne muscular dystrophy: deflazacort (Emflaza) and eteplirsen (Exondys 51).

Meganne Leach, PNP, Doernbecher Children's Hospital, Oregon Health and Sciences University
Ms. Leach testified she is in support of covering eteplirsen. She thanked the Commission for potentially removing the low-prioritization of these drugs and allowing treatment. This is an exciting time as more information about the efficacy of the drug is forthcoming.

January 18, 2018

Testimony for this meeting related to the inclusion of the use of fractional exhaled nitric oxide (FeNO) for the management of asthma on the funded asthma line.

Debby Ham, MD, Circassia Pharmaceutics
Dr. Ham testified about exacerbation findings in the Agency for Healthcare Research and Quality (AHRQ) review saying they are hard to tease out, being composite outcomes, including unscheduled visits to the doctor, emergency room visits, hospitalizations, and adding additional therapy. She also said the AHRQ document was the most recent review and included data through April of 2017, encompassing the largest body of evidence for FeNo.

Dan Bues, Circassia Pharmaceutics
Mr. Bues testified that 39 other states do not distinguish between coverage for diagnostics and disease management and he urged the Commission to follow their example. He said Medicare reimbursement is $20.52 and stated that Medicaid is always less, probably around $13-15. He said some payers cap usage at four times per year.

Paul Blomberg, Circassia Pharmaceutics
Mr. Blomberg testified about the number of devices in the state, totaling 14. The biggest users are allergists and pulmonologists.

March 8, 2018

Testimony for this meeting related to scoping statements for services HERC was considering developing coverage guidances on.

Dr. Rick Pittman, MD, a vascular surgeon

Dr. Pittman declared no conflicts of interest. He stated he is passionate about the topic of *Intermittent Pneumatic Compression Devices of the Treatment of Lymphedema* and would like to be more involved. He said he would recommend separating upper and lower extremity lymphedema because they are two separate diseases with different patient populations. He also said patient education is important; teaching patients how to care for themselves is critical in treatment of this disease.

Cat Livingston, MD, MPH, HERC Associate Medical Director

Dr. Livingston said HERC uses ad hoc experts for the coverage guidance process and invited Dr. Pittman to apply when the topic is discussed. Dr. Pittman gave his information to staff.

Helen Christians, OT, Oregon Burn and Wound Center

Ms. Christians declared no conflicts of interest. She has 30 years of experience working with patients with chronic venous insufficiency and lymphedema. She stressed the need for continued therapy for the lifelong disease and the need for patient education on how to care for themselves. She talked about alternatives to compression sock levels: 20/30 weight rather than 30/40 weight. Dr. Livingston asked Ms. Christians to work with staff by email to help address this issue, and staff supplied contact information.

Craig Gonzales, EndoGastric Solutions

Mr. Gonzales testified he wanted to ensure the scope statement for Newer Interventions for GERD (gastro-esophageal reflux disease) was looking at the TIP (transoral incisionless fundoplication) 2.0 procedure, not the original procedure approved in 2007. He requested that patient satisfaction be added as an important outcome to the scope. He also asked if the scope could help tease out which patents are the best candidates for the interventions. Dr. Livingston said HERC could consider adding severity of symptoms but it may be too large a conversation to add patient satisfaction.

HERC Value-based Benefits Subcommittee

January 18, 2018

Testimony for this meeting related to the review of the prioritization of the drug eteplirsen (Exondys 51) to treat Duchenne muscular dystrophy.

Jonathan Eames, Consultant

On behalf of Genetech, Mr. Eames addressed Guideline Note 95 (GN95) regarding the treatment of primary progressive multiple sclerosis. He said GN95 was appropriate until March 28, 2017 when the Food and Drug Administration (FDA) approved Ocrevus for primary progressive multiple sclerosis (PPMS). PPMS accounts for approximately 15% of MS cases. All other Medicaid programs are covering Ocrevus for PPMS, as well as commercial payers, to his knowledge. He is aware of providers who have requested that HERC review this in the past year. He wants to ensure that this issue is placed on the HERC agenda and GN95 is updated. HERC Director, Darren Coffman, reported that the State's Pharmacy & Therapeutics Committee recently reviewed Ocrevus. He noted that a related process on the placement of certain pharmaceuticals on the Prioritized List is currently under review.

March 8, 2018

Testimony for this meeting related to the inclusion of the use of fractional exhaled nitric oxide (FeNO) for the management of asthma on the funded asthma line.

Dan Bues, Circassia Pharmaceutics
Mr. Bues gave a market update indicating that Regence Blue Cross Blue Shield has reviewed FeNO and now covers the test for diagnosis and management. Washington Medicaid removed prior authorization for FeNO and now covers the test for diagnosis and management, as did Oklahoma Medicaid. Bues noted that currently 40 state Medicaid programs have approved FeNO testing for diagnosis and management; two other states are reviewing the test.

Debby Hamm, MD, Circassia Pharmaceutics
Dr. Hamm testified that the strength of evidence (SOE) in the AHRQ report on FeNO was high for reducing exacerbation, defined in some cases as reduced emergency department visits or hospitalization. The report showed reduced use of oral steroids with FeNO included in the management algorithm when data was pooled for adults and kids. The Cochrane Review of pediatric data showed reduced use of oral steroids. Secondary outcomes had severe imprecision and low SOE in the AHRQ report. She noted that there is a clinically significant reduction in exacerbations – they are an important independent risk factor of having worse asthma outcomes. The hospitalization outcome had imprecise SOE, mainly because hospitalization is a rare event for asthma. The HERC quality of evidence statement takes into account harms, health equity, and outcomes in specific subgroups. The National Institute for Health and Clinical Excellence and Cochrane both say that FeNO can be helpful in the management of specific groups of patients, such as patients still symptomatic with inhaled corticosteroid (ICS) therapy. The underling pathology of asthma is inflammation, which is what FeNO measures. The type of inflammation measured by FeNO occurs in only half of asthma patients. FeNO can help distinguish if the patient has the type of inflammation that ICS can help.

Hamm noted that asthmatics are a vulnerable patient population, and FeNO helps give concrete data on their disease process which is helpful in uncovering lack of adherence with medications. AHRQ defined utilization as a high priority issue to determine how to use FeNO clinically. This AHRQ report should be out in the next year. All large asthma networks doing research on management are using FeNO to define disease subpopulations. Biologics are increasingly coming on the market for the treatment of asthma, and FeNO should be helpful in determining who should get these.

HERC Evidence-based Guidelines Subcommittee

February 1, 2018

Testimony for this meeting is related to a draft coverage guidance on urine drug testing.

Tony Howell, LCSW, Linn County Alcohol and Drug Program
Mr. Howell said setting arbitrary limits on urine drug screens is going to hurt people in certain circumstances. For example, people who are homeless may have severe addiction, and there is no residential treatment available. The county treats them in an outpatient setting. He said having frequent testing encourages them to stay abstinent by speaking to their "better angels." He said that this screening needs to be random and frequent. For some, having urine testing may be critical for getting their children back. He cited the American Society of Addiction Medicine (ASAM) policy which recommends the frequency and test type be determined by the provider, not the plan. For cost savings he recommended looking at definitive tests that come in without presumptive tests. His plan gets $10-15 per test. If there is a need for more expensive testing, the county pays the cost.

Heather Jefferis, MA, Executive Director, Oregon Prevention Education and Recovery Association (OPERA)

Ms. Jefferis distributed written testimony from Tanya Pruitt from the Milestone Family Recovery Center and expressed concerns about removing clinician freedom in applying a very important test to a fragile treatment system that struggles with having appropriate resources to meet patient needs. These restrictions would limit the tools available. She said it would be important to have evidence. She knows that housing is important and in many cases housing programs require drug testing. Patients undergoing treatment and needing housing cannot pay for their own testing. She said the tests can be done in conjunction with motivational interviewing and cognitive behavioral therapy to help people talk about their substance use disorder in a healthy way and to reduce stigma and create an opportunity to get them into recovery.

Chris Wig, BA, MS, CADC I, QMHA, Program Director, Emergence Behavioral Therapies

Mr. Wig stated the clients he treats are participants in the Lane County Drug Court and Veteran's Court. He expressed concern about the limits on frequency. He said that the testing is medically appropriate and compared it to blood glucose testing for patients with diabetes. He said that treatment can often be changed based on the results of a urine test. Some treatments may not be appropriate for a patient still using substances since they lack the insight to make changes. He acknowledged the cost concerns but said he doesn't believe the proposed changes would result in as much cost savings as hoped for. He said a colleague showed him a bill for $800-$1200 for a urinalysis from a pain specialist. He said Oregon Health Plan (OHP) reimbursed that claim and this should be totally illegal and that no one here is asking for that. The tests his agency uses are reimbursed at a rate of about $20. In certain cases they do more extensive testing, with the cost going to the agency. He said the standards and practices manual for drug court requires at least two urinalysis screens per week. Limiting the number reimbursable through OHP wouldn't reduce the amount of drug testing but would cause his agency to need to pay for those tests. Currently the money that would be used for this is being used to address social determinants of health. He provided additional materials from the director of Emergence.

Jay Wurscher, Alcohol and Drug Services Coordinator, Office of Child Welfare Programs, Oregon Department of Human Services

Mr. Wurscher said 65 percent of the approximately 7,500 children in foster care on a given day are there because of parental substance use disorders. As Child Welfare works to reunite families, it is necessary to have accurate information for the court to use in making decisions. To have timely and accurate information they require gas chromatography/mass spectrometry confirmation tests rather than presumptive tests. He said the treatment centers his program works with tests in a way to give as much clarity and depth as possible, as this is to the benefit of children and parents. Otherwise there is a ripple effect far beyond the child and the family.

HERC Health Technology Assessment Subcommittee

March 1, 2018

Karen Heller, MS, CGC, Myriad Genetics

Ms. Heller testified on the scope statement for the topic of being considered for coverage guidance development. She asked whether the scope would include germline tests as well as tumor tissue tests. The scope was clarified to only include tests of tumor tissue. The title of the coverage guidance was changed to "FDA-approved Next Generation Sequencing Tests for Tumors of Diverse Histology" and interventions section was edited to clarify that this includes circulating cell-free DNA.

Ms. Heller also offered public testimony on the draft coverage guidance being developed for Gene Expression Profiling for Breast Cancer. She referred to the Sestak 2017 publication which predicted distant recurrence for both node-positive and node-negative breast cancer patients.

Medicaid Advisory Committee

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

January 24, 2018

The committee discussed health-related services and social determinants of health policy work. There was no public comment or testimony.

March 28, 2018

The committee discussed implementation and use of MAC's social determinants of health recommendations, and the committee heard the following informational presentations: An OHP member shared their Medicaid experience; the principal investigator for Accountable Health Communities, Oregon presented on the Accountable Health Communities project in Oregon and how coordinated care organizations (CCO) are engaged; legislative representatives from both the Oregon Department of Human Services (DHS) and OHA gave a Medicaid update and legislative recap.

Samantha Shepard, MA, Executive Director, CCO Oregon

Ms. Shepard submitted testimony from CCO Oregon's Social Determinants of Health Workgroup. CCO Oregon's letter emphasized: 1) the need for additional guidance on best practices/how to do this work effectively; 2) possible funding sources for this work within the CCO model; 3) the importance of streamlining screening and data collection; 4) the importance of partnerships between local CCOs' community providers and partners to best address the unique needs of the members in a given community and leverage existing work.

Brandy Charlan, Medicaid member from Klamath Falls

Ms. Charlan shared her experience and ideas she has for addressing Medicaid member needs. She appreciates having coverage for her and her children (as of Medicaid expansion). She highlighted challenges such as accessing health care services in Klamath Falls, enrollment difficulties, provider availability and wait times. She also shared challenges she has faced related to unstable housing and stress and encouraged the MAC and the State to look at housing security programs.

Metrics and Scoring Committee

The Metrics and Scoring Committee was established by the Oregon legislature to recommend outcomes and quality measures for coordinated care organizations (CCO).

January 19, 2018

The committee heard an update and overview of the process to develop new five-year contracts between the CCO and the Oregon Health Authority (CCO 2.0). They also received an overview of OHA's structure in terms of where metric units are located in the agency, supports offered to the Committee and CCOs related to metrics work, and links with quality improvement. There was no public comment or testimony.

February 16, 2018

The committee heard a presentation from OHA's metrics team on the CCO incentive metrics. CCO performance was broken down by year, race/ethnicity, utilization, and geography. The committee also heard a presentation on the key findings and recommendations from the 2012-2017 Summative Waiver Evaluation. There was no public comment or testimony.

March 16, 2018

This meeting focused on electronic health records (EHR) programs and measure sets and included an updates on the Clinical Quality Metrics Registry which is scheduled to go live in December. A panel of three guests provided their perspective on their biggest EHR measure challenges, success stories with EHR, and their experience with EHR measures. There was no public comment or testimony.

Oregon Health Policy Board

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

January 16, 2018

This meeting focused on OHA leadership changes, the 2012-2017 Summative Waiver Evaluation, and policy analysis related to: sustainable cost growth; value-base payments; social determinants of health; health equity; and behavioral health. The board also reviewed and voted to approve the High Cost Drugs Committee Charter, approved new members of the Healthcare Workforce Committee, and approved the Healthcare Workforce Needs Assessment report. There was no public comment or testimony.

February 6, 2018

The board heard a legislative briefing including an in-depth look at particular bills of interest to the OHPB and several OHA updates: the new Oregon State Hospital Superintendent, Dolly Matteucci steps in in mid-March, member transitions from FamilyCare, Inc. coordinated care organization (CCO) are on track, and federal legislation regarding the Children's Health Insurance Program and community health centers are also on track. There was no public comment or testimony.

March 6, 2018

The board meeting included an organizational and legislative update from OHA leadership, OHPB committee updates, an overview of OHA's Transformation Center and the work they do to support health system transformation, and a CCO 2.0 workplan presentation. There was no public comment or testimony.

IV. Progress toward demonstration goals

A. Improvement strategies

To meet the goals of the three-part aim, Oregon's coordinated care model and fee-for-service delivery systems rely on six key levers to generate savings and quality improvements and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that the Oregon Health Authority

will take in the form of the stimuli and supports described below, they comprise a roadmap for achieving Oregon's vision for better health, better care and lower costs.

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes.
- Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes.
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care.
- 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.
- Lever 5: Implementation of health-related services aimed at improving care delivery, enrollee health, and lowering costs.
- 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 Oregon Health Authority's Transformation Center

2017-2022 Demonstration Waiver

During this quarter, the Oregon Health Authority received approval from the Centers for Medicare and Medicaid Services on the 2017-2022 Waiver Evaluation Design 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

Certified Community Behavioral Health Clinics

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

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

In addition, OHA is required to report on 21 CCBHC specific metrics (nine led by clinics and 12 led by OHA), develop and monitor a prospective payment system, and monitor CCBHCs for compliance with program requirements. CCBHCs must meet numerous federal requirements, such as the ability to directly provide

outpatient mental health and SUD services to the full age range, regardless of payer. There are also nine Oregon CCBHC Standards, which enhance or expand on the federal requirements.

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

Patient-Centered Primary Care Homes

Patient-Centered Primary Care Homes (PCPCH) program staff conducted 16 site visits to primary care clinics. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address identified barriers. Program staff provide each clinic a written report summarizing the site visit.

As of March 30, 2018, 639 clinics were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Forty-four PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model. These clinics are located in both rural and urban areas.

Tribal Care Coordination

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

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

Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes

Comprehensive Primary Care Plus

Modifications to the Medicaid Management Information System (MMIS) are underway to calculate performance-based incentive payments to all participating clinics. Of the 154 Oregon Comprehensive Primary

Care Plus (CPC+) practices, 145 have contracts with the Oregon Health Authority (OHA) for Medicaid fee-for-service (FFS) members.

Care management fee payments for all participating practices are continuing. Track-two clinics have validated 2017 claims for codes relating to appointments for new and existing patients. OHA is moving a portion of anticipated FFS revenue for those specific services to prospective payment. The portion of the prospective alternative payment methodology (APM) payment aligns with the percentage selected by the practice for the Centers for Medicare and Medicaid Services APM payment. Track-two practices will receive the prospective APM payment in a lump sum and subsequent claims will be reduced by the corresponding amount.

The Oregon CPC+ payers meet monthly with a facilitator to discuss opportunities for coordination and alignment to support CPC+ practices. This quarter the group discussed technical assistance, payment alignment and options for data aggregation. HealthInsight/Q Corp has been selected as the Oregon CPC+ data aggregator.

Advanced Payment and Care Model

The Advanced Payment & Care Model (APCM) continues to expand and develop toward value-based payment, rather than simply an alternative to Prospective Payment System (PPS) reimbursements. Clinics will submit quarterly Quality Metrics Reports on seven established quality measures, and participating community health clinics have agreed to place a portion of their Medicaid revenue at risk when they are unable to meet the quality metric targets for four of the seven established quality measures for four consecutive quarters. After four consecutive quarters in which the clinic fails to meet the quality target for four or more measures, the clinic will be placed on a performance improvement plan that is expected to align methodologies with coordinated care organization improvement target-setting (Minnesota Method). Failure to meet the improvement target for an additional four quarters will result in a per-member per-month rate reduction. This model is expected to go live with the submission of Quality Metric Reports in late-October 2018. The Oregon Health Authority will continue to conduct annual payment reconciliation to ensure participating clinics are reimbursed at least what would have been paid through traditional PPS reimbursements.

Two additional Federally Qualified Health Centers and two additional rural health clinics (RHC) are expected to join the APCM in July 2018. Along with state collaboration with the Oregon Primary Care Association (OPCA) for onboarding activities, the collaborative has begun working with the Oregon Health and Science University's Office of Rural Health (ORH) as more RHCs express interest, advance their practices to meet Patient-Centered Primary Care Home standards, and prepare for a population-based reimbursement structure. The OPCA and ORH are discussing how to offer similar learning collaborative events relative to advancing primary care for Oregon RHCs.

Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative is a legislatively mandated multi-stakeholder group that is tasked with advising and assisting the Oregon Health Authority as it develops the Primary Care Transformation Initiative. The purpose of the initiative is to increase investment in primary care, improve reimbursement methods, and align primary care reimbursement by purchasers of care. The collaborative has started drafting an initiative implementation strategy that will be presented to the Oregon Health Policy Board.

Value-Based Payment Innovations and Technical Assistance

The Transformation Center is working with national value-based payment (VBP) experts at Bailit Health to develop a VBP Roadmap, which will set VBP targets for coordinated care organizations (CCO). The VBP Roadmap is a required deliverable in Oregon's 1115 waiver. CCOs are an integral partner in the development of the roadmap, and the Oregon Health Authority (OHA) has established a CCO VBP Roadmap workgroup to advise OHA on definitions, targets, and measurement methods. The CCO workgroup met in February and March.

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

Behavioral Health Collaborative Implementation

The Behavioral Health Collaborative (BHC) was a group of 50 stakeholders that met in 2016-2017 and submitted recommendations to the Oregon Health Authority (OHA) on how to improve the behavioral health system. Using the coordinated care model that integrates behavioral health with physical and oral health, the BHC envisions a system that:

- Is coordinated, seamless, and treats the whole person;
- Puts the individual and their support system at the center of care;
- Is accountable for all aspects of an individual's care;
- Is focused on early intervention, health promotion, and prevention; and
- Is community-focused.

OHA continues to work with stakeholders to implement the recommendations of the BHC.

Collaboration

OHA will pilot one Regional Behavioral Health Collaborative (RBHC) in the Portland metro area. This RBHC will require coordinated care organizations (CCO), community mental health programs, local public health authorities, tribes, and other key system partners including: hospitals; schools; and corrections, to collaborate and focus on behavioral health priorities within local communities. This is intended to build on existing innovations and collaborations. The Transformation Center will be providing technical assistance and facilitation for this pilot.

Risk Sharing

OHA has convened a stakeholder group to address CCO sharing risk for the Oregon State Hospital. The group has developed concepts for risk sharing for the waitlist population and is vetting with additional stakeholders and CCOs. The group has begun discussion of risk sharing for the civil commitment population.

Workforce

Workforce is a critical issue for behavioral health. Not only does Oregon have a shortage of qualified behavioral health providers, but there is high turnover. OHA has contracted with the University of Colorado's Eugene S. Farley Health Policy Center to conduct an assessment of the behavioral health workforce, including licensed and unlicensed providers. The assessment will be complete by January 31, 2019 with a recruitment and retention plan complete by March 30, 2019.

Core Competencies

Preparing the behavioral health workforce to work in integrated health settings requires an update of competencies. As a first step, OHA is consulting with the University of Colorado's Eugene S. Farley Health Policy Center to develop core competencies for an integrated workforce.

Standardized assessments

OHA has identified a suicide risk assessment, has consulted with states that have adopted the assessment, and is currently soliciting feedback from stakeholders and partners on adoption. The next steps will include an implementation plan with training for providers.

Health Information Technology

OHA has completed a survey of behavioral health providers' electronic health records and health information technology needs, with preliminary recommendations. A small group of behavioral health providers is being convened to further investigate the findings and the preliminary recommendations. A report will be published and a plan based on the recommendations will be implemented.

Data

OHA convened stakeholders to form a data workgroup.

Roadmap to Oral Health

Oregon has continued efforts to improve integrated oral health care for Medicaid recipients. This quarter's Oregon Health Authority (OHA) activities include the following.

- The Transformation Center (TC) offered technical assistance to help coordinated care organizations (CCO) envision and implement more integrated oral health throughout their systems of care.
- The TC conducted a needs assessment to determine focus areas, and found a range of needs, from increasing basic education for members about the importance of preventive care to improving health information exchange.
- Two Quality Health Outcomes Committee (QHOC) meetings featured oral health integration. QHOC brings together clinical leadership from Oregon's CCOs to coordinate and lead quality improvement efforts supporting implementation of innovative health care practices. The state dental director and a government affairs director from one of Oregon's dental care organizations co-presented about the importance of oral health to overall health and gave an overview of possible integration activities, and the Transformation Center organized a learning collaborative highlighting particular efforts that CCOs were making to integrate oral health in primary care and primary care in dental offices.
- Beginning January 1, 2018, OHA increased fee-for-service rates by 10 percent for specified diagnostic and preventive services and 30 percent for specified oral surgical codes with the goal of attracting additional providers and increasing access to dental care.
- OHA's Health Systems Division, in collaboration with OHA's Public Health Division, Prescription Drug Monitoring Program (PDMP), Oregon Health and Sciences University's (OHSU) School of Dentistry and the Oregon Opioid Initiative, presented a brochure and guidelines regarding dental opioid prescribing in Oregon to dental care organizations, CCOs, internal OHA partners, Oregon College of Emergency Physicians, Board of Dentistry, Board of Pharmacy, OHSU's School of Dentistry, and the Oregon Dental Association.

In addition, the legislature passed House Bill 4143, which will now require all prescribers of controlled substances, including dentists, to register with the PDMP.

Statewide Performance Improvement Project

The Oregon Health Authority (OHA) Statewide Performance Improvement Project (PIP) on Opioid Safety was adopted in July 2014 for calendar-year performance monitoring for all 16 coordinated care organizations (CCO) to adopt. Overall PIP project management is conducted through OHA's External Quality Review Organization, HealthInsight Assure, in accordance with the 2012 Centers for Medicare and Medicaid Services' PIP Protocol. For calendar year 2018, the PIP will focus on moving the chronic opioid use to alignment with state and national Centers for Disease Control and Prevention guidelines.

Project metric

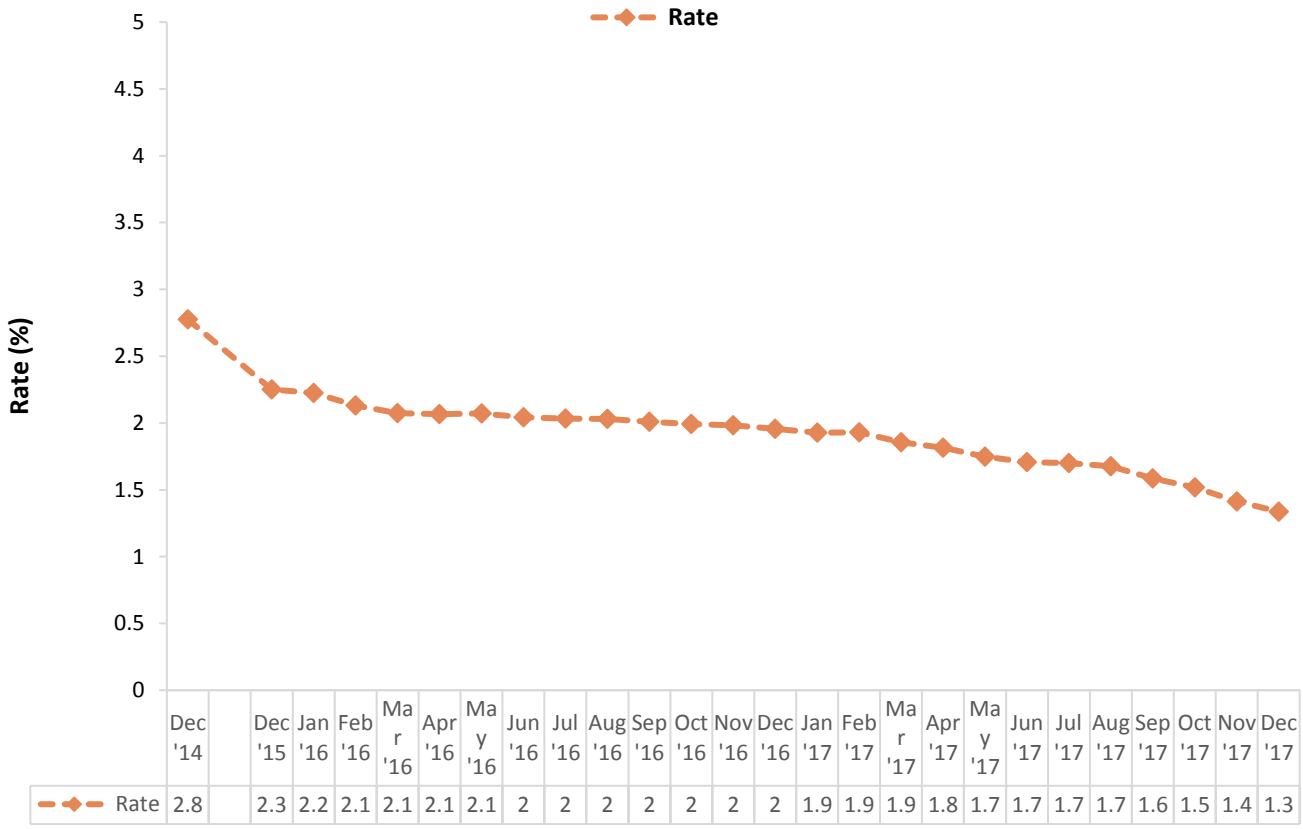
The project metric is the percentage of Oregon Health Plan (OHP) enrollees aged 12 years and older who filled prescriptions for opioid pain relievers of at least ≥ 120 mg morphine equivalent dose (MED) on at least one day and the percentage of enrollees with at least ≥ 90 mg MED on at least one day during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

Outcomes

For detailed interventions and data analysis please review the recently released Oregon Health Authority Managed Care: 2017 External Quality Review Annual Report.

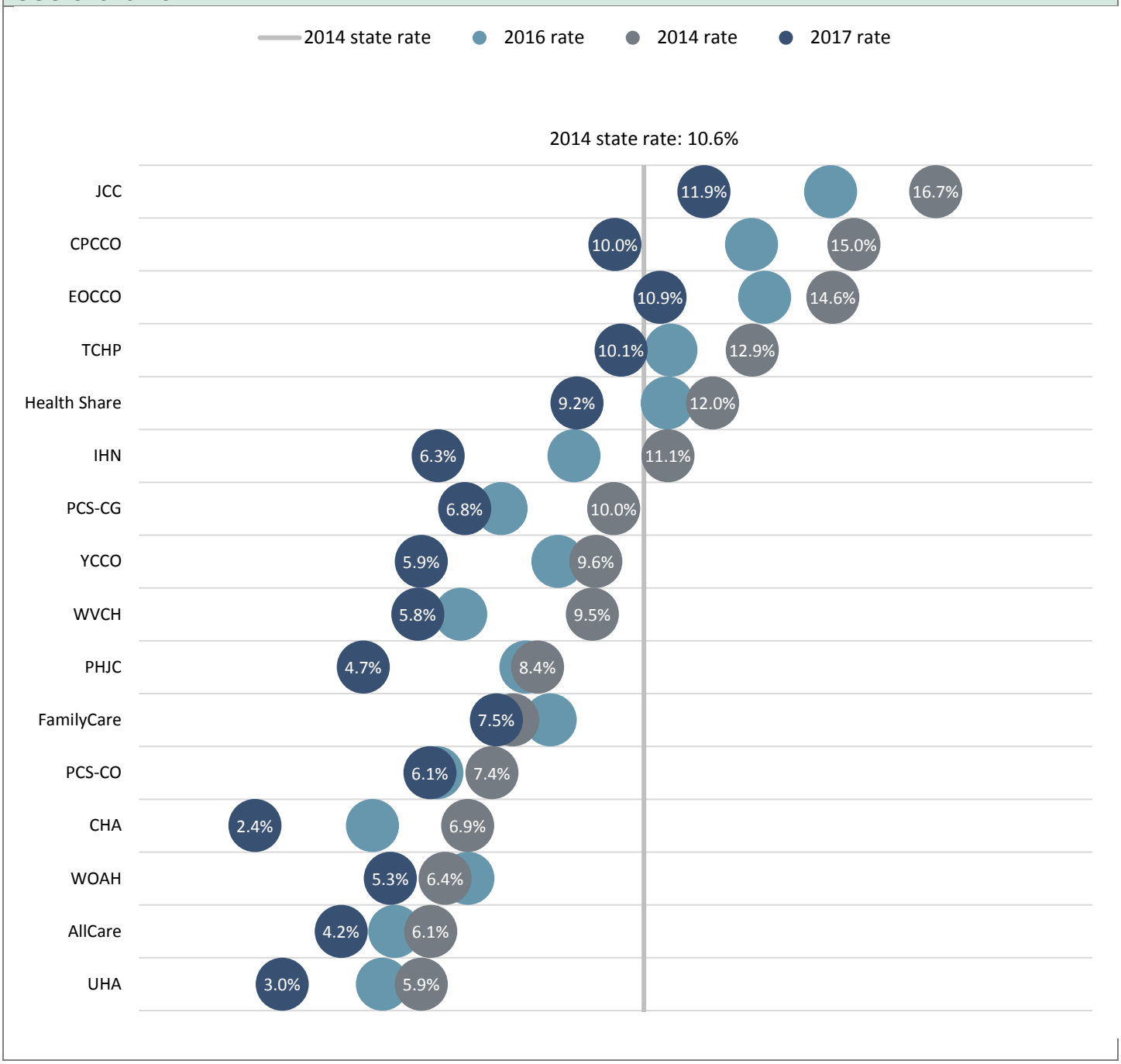
A few key charts showing the progress to date are shown below. Decreased prescribing across ≥ 90 and ≥ 120 MED are seen across all CCOs. While the results are promising, continued monitoring and progress to ensure safety, quality of care and evidence based treatment adoptions will occur into 2018.

The percentage of OHP enrollees age 12 years and older who filled prescriptions for opioid pain relievers of ≥ 120 Morphine Milligram Equivalent (MME) for at least one day during the measurement period.



	Dec '14		Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr '17	May '17	Jun '17	Jul '17	Aug '17	Sep '17	Oct '17	Nov '17	Dec '17
Rate	2.8		2.3	2.2	2.1	2.1	2.1	2.1	2	2	2	2	2	2	2	1.9	1.9	1.9	1.8	1.7	1.7	1.7	1.7	1.6	1.5	1.4	1.3

Figure 10. The percentage of OHP enrollees age 12 years and older who filled prescriptions for opioid pain relievers of ≥ 120 MME for at least one day during the measurement period according to CCO over time.



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

Innovator Agents

During this quarter, coordinated care organizations (CCO) submitted their first Technical Quality Strategy (TQS) plans, which replace the CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables. Innovator agents acted as conduits between the Transformation Center and CCOs to

review plans and provide technical assistance as needed. In addition, innovator agents provided feedback to the Transformation Center on questions or suggestions about how to improve the form and/or the process. As a result, the Transformation Center has developed a TQS Workplan Group that includes two innovator agents and designated representatives from the CCOs to work collaboratively to develop an ongoing process that assures the work of the CCOs is accurately represented.

As CCO 2.0 begins to roll out, innovator agents were included in the early planning stages of community engagement. In their unique role of being embedded in the communities, innovator agents are able to assist with key community connections and provide information about how best to share information within each unique setting. As CCO 2.0 planning continues, innovator agents will continue to help with planning and community engagement.

Regional Health Equity Coalitions

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

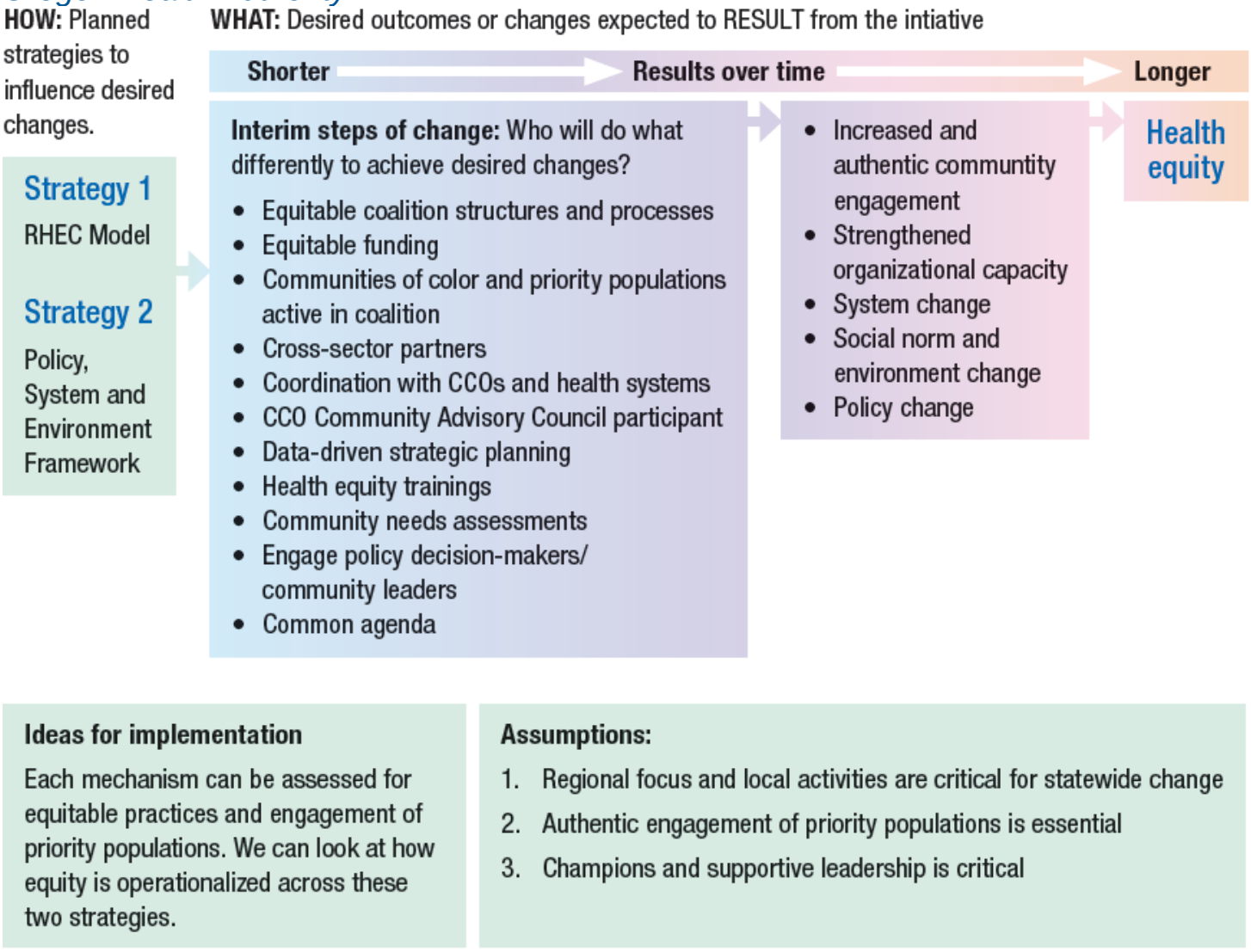
In 2011, the Oregon Health Authority (OHA) established RHECs to support local, community-driven, culturally-specific activities to reduce disparities and address social determinants of health. Once funded, the coalitions selected the region and populations they would focus their work on. Each RHEC conducted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

The RHEC Model

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

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

A recent study published in Health Affairs highlighted the potential positive impacts some activities are having on addressing health disparities among Medicaid populations, namely among Black/African American and American Indian populations. RHECs are mentioned as part of Oregon's multipronged approach in healthcare transformation to address health inequities, stated as showing signs of early success, and stated as a potential model for other states.

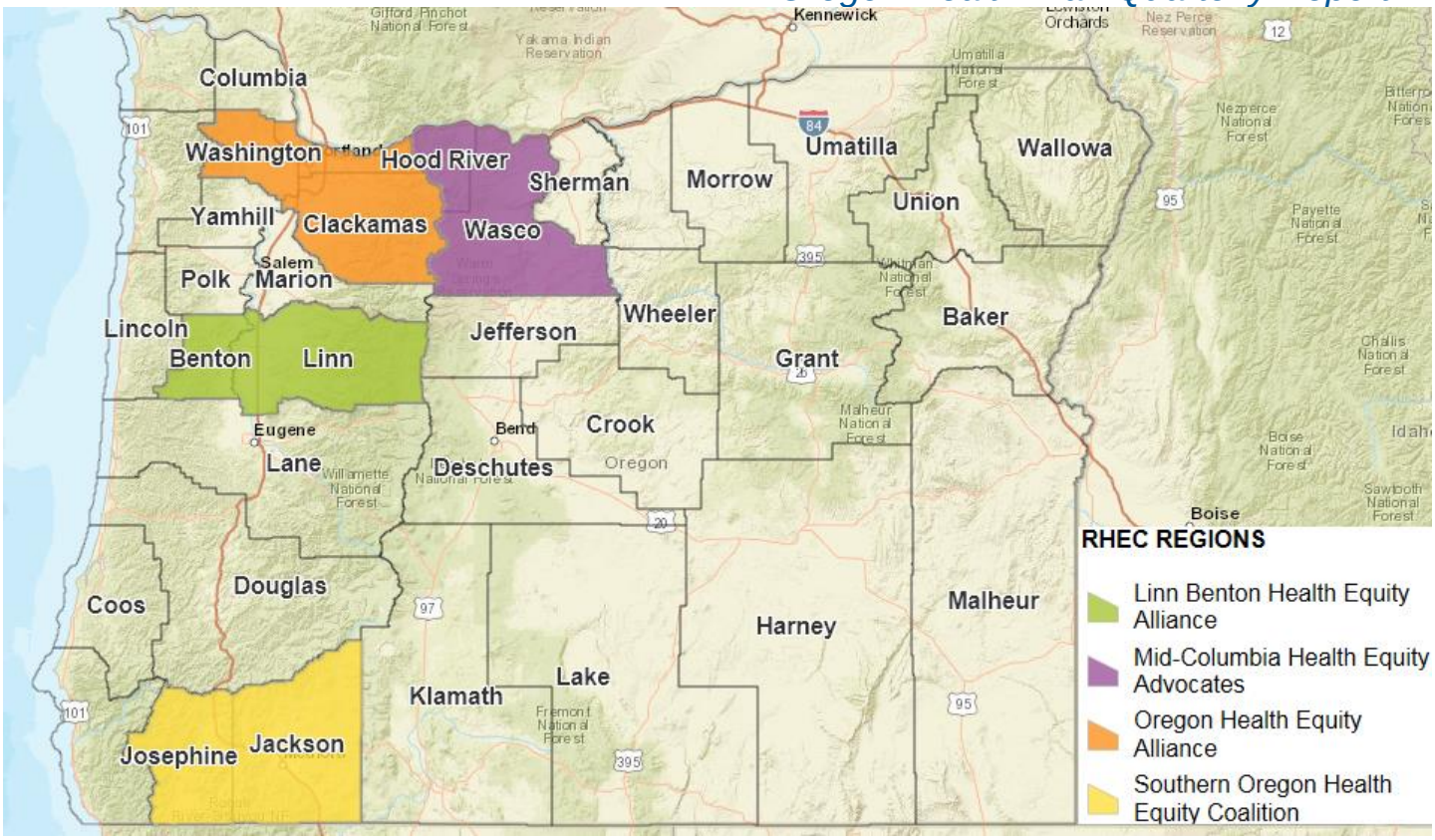


Regional Health Equity Coalitions Strategy Map

Current RHECs and Priority Areas

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

OHA's Office of Equity and Inclusion is working to expand RHECs into additional counties and to tribes in Oregon, particularly Eastern Oregon. Due to the demographic and geographic diversity of the state, additional RHECs would need to be developed. The primary barrier to accomplish this expansion is the need for additional funding.



Oregon's Regional Health Equity Coalitions

The coalitions focus on a broad range of priorities to impact the many social determinants of health that influence communities' wellness. Priority areas include: behavioral health; built environment (increase places where people can walk or exercise); breastfeeding; corrections and criminal justice reform; cultural competence; data systems; dental/oral health; disability; education; elder rights; employment; food insecurity; health care; health communications; higher education; housing; immigration; language access; nutrition and physical activity; self-management programs; tobacco use disparities; traditional health workers; transportation; workforce development; worksite wellness; and youth rights.

Outcomes

The RHECs aim to promote health equity by addressing the root causes of inequities through the social determinants of health. Resources to conduct a larger collective impact assessment or contribution analysis are lacking. However, the RHECs collect data on an ongoing basis to measure progress on short-term and intermediate outcomes that have theoretical and/or empirical links to health equity. In this way, they can see where and how they are making progress towards meeting the large overarching goal of health equity for all. Based on 2017 data, below are examples of accomplishments in the five outcome areas that RHECs collect data on.

RHEC Evaluation Outcome Areas	Examples
Increased and Authentic Community Engagement	One coalition created two countywide Health Equity Assessment Reports focused on race/ethnicity and LGBTQ issues using county and state data. This coalition held community conversations for people to share real life experiences related to a variety of issues: educational attainment, teen pregnancy, oral health,

	cultural responsiveness and other issues captured in the quantitative reports. They also collected stories to guide the priority areas to be included in their strategic plan and used a multicultural storytelling methodology to ask community members what factors contribute to health in their communities.
Strengthened Organizational Capacity	A coalition hosted an implicit bias training series in various counties in their region. The training series provided participants with strategies to minimize implicit bias in personal and professional contexts. Over 100 local professionals and community members attended workshops. Several others have expressed interest in future trainings. Opportunities to be aware of and explore one's own implicit biases means that interactions between organizations and community members can progress toward more respectful and culturally appropriate exchanges.
System Change	One coalition partnered with their regional CCO's Health Equity Task Force to interview community members about their experiences accessing health services across three counties. They produced a video and a report, which they presented to the CCO. This resulted in an assessment of the utilization barriers of healthcare interpreter services in the region. The CCO then contracted with the RHEC to provide their medical providers with additional training around healthcare interpreter usage. Providing health care interpreter services ultimately means that patients and their families know more about their health and healthcare choices. The result is better health outcomes for individuals and cost savings for health systems.
Social Norm and Environment Change	Another coalition sponsored a three-part series in partnership with their local chapter of the National Association for the Advancement of Colored People (NAACP). This event increased the capacity and reach of their partner organizations, and fostered community engagement around the issue of structural racism among community members. The event also strengthened the involvement of local stakeholders and policymakers with this population and issue.
Policy Change	Another coalition has made incredible progress on policy change for health equity at the state level by developing criteria and a policy process for meaningful participation of members at every stage of the legislative process. Overall, this RHEC has created a unified, clear and intentional policy agenda that has influenced healthcare in Oregon. The RHEC's policy committee develops, analyzes and informs local and state policy. Members receive education and training around policies and the political process to build capacity. The policy committee engages with legislative representatives, community members and leaders, and the media to provide education around health equity issues.

Sustainable Relationships for Community Health program

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

Activities

Two SRCH Program grantee consortia: Yamhill CCO and Klamath County Public Health, started their year-long projects in January 2018. The SRCH teams convened at their initial site visits in January and at the first SRCH institute in February. The teams are working on building closed-loop referral systems to colorectal cancer screening, chronic disease self-management, and the national diabetes prevention program. The teams mapped their local systems, defined the various roles of partners, identified their aims, drivers, and activities, and developed their work-plans. They will convene again in May to continue working on collaborative activities.

Progress and findings

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

Trends, Successes or Issues

As described in the last section, the prior SRCH grants were successful in meeting their aims of implementing closed-loop referrals and building sustainable relationships between CCOs, public health agencies, and community partners in five local communities in Oregon. With continued refinement and improvement of the SRCH model, we expect to see similar results from the current grantee cohort.

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

Health-related services

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

Oregon Health Authority

OHA is continuing to work to provide greater communication and clarity around tracking and reporting on the use of HRS and outcomes associated with flexible services. This includes analyzing evidence of impact on health outcomes of HRS spending on kindergarten readiness and traditional health workers.

Cultural Competency Continuing Education

The Oregon Health Authority's (OHA) Office of Equity and Inclusion (OEI) provides resources and support for improving cultural competence of regulated health care professionals in Oregon. OEI established an advisory committee to develop/update criteria to approve Cultural Competence Continuing Education (CCCE) opportunities, and OEI maintains a list of OHA-approved training opportunities for providers.

Beginning in July 2017, 23 health care professional boards report to OEI every two years on CCCE participation amongst regulated health care professionals. Boards report:

- The number of regulated health care professionals (their members) who completed CCCE;
- The number of audited members who completed CCCE from the OHA-approved list;
- Whether the board requires members to participate in CCCE; and
- The level of reporting each board requires of members related to participation in CCCE.

Boards may also adopt rules to require members to participate in OHA-approved CCCE training in addition to, or instead of, any other CE board requirement. OHA will begin reporting this information back to the Oregon Legislative Assembly in August 2018.

Traditional Health Workers

The purpose of the Traditional Health Worker (THW) program is to help THWs in Oregon become trained and certified to meet current standards, diversify the health care workforce, provide high-quality and culturally competent care to our increasingly diverse populations and ultimately promote health equity. The THW program works to promote the roles, engagements, and utilization of the THW workforce, which includes Community Health Workers, Peer Wellness Specialists, Patient Health Navigators, Peer Support Specialists, and Doulas.

The program, in partnership health systems, stakeholders, and community based organizations, strives to ensure that THWs are uniquely positioned to work with communities to identify and address the underlying causes of health problems. Key focal areas for the THW program include pursuing strategies to integrate THWs into the coordinated care organizations (CCO), advancing community engagement opportunities, and developing and implementing ongoing revisions to the THW scope in the context of health system transformation.

The Oregon Health Authority's (OHA) Office of Equity and Inclusion (OEI) continues to support the training and certification of THWs by:

- Enrolling certified workers on the state registry;
- Approving quality training programs; and
- Developing processes and procedures to facilitate seamless integration of the THW workforce in the health system.

The state certification process requires successful completion of approved training, a background check, and continuing education to maintain certification. As of March 2018, OHA has certified a total of 2,641 THWs and approved 36 trainings and continuing education programs.

Certified Traditional Health Workers

	Statewide certifications		
	Sub-type	**Current Qtr.**	**Cumulative**
Community Health Workers (CHW)		59	547
Personal Health Navigators (PHN)		0	9
Peer Wellness Specialists (PWS)	Adult Addictions	2	10
	Adult Mental Health	18	63
	Family Support	0	1
Doulas		7	42
Peer Support Specialists (PSS)	Adult Addictions	60	1,276
	Adult Mental Health	85	496
	Family Support	24	107
	Youth Support	20	90
TOTAL		**275**	**2,641**

Traditional Health Worker Certification

	Number of approved training programs	
	Current Qtr.	**Cumulative**
Community Health Workers (CHW)	2	10
Personal Health Navigators (PHN)	0	0
Peer Wellness Specialists (PWS)	1	5
Doulas	1	1
Peer Support Specialists (PSS)	1	26
TOTAL	**5**	**42**

Traditional Health Worker Commission

The THW Commission promotes the THW workforce in Oregon's health care delivery system to achieve the state's triple-aim goals; advise and make recommendations to OHA on the development, implementation, and sustainability of the THW program; and ensure the program is responsive to consumer and community health needs while delivering high-quality and culturally competent care.

In January 2018, the THW Commission proposed and requested the OHA to implement the measures outlined below in order to remedy existing and future barriers to utilization of THWs:

- Mandate CCOs to consult with the THW Commission to develop a process to integrate best practices for THW member services;
- Designate a liaison from each CCO as a central contact to ensure ongoing fidelity;
- Work with the THW Commission to build a THW workforce that can sufficiently serve its members by using existing THW service providers and increasing capacity to fill service gaps;
- Encourage CCOs to incorporate alternative payment methods to establish sustainable service payment rates for THW services; and
- Encourage CCOs to include THWs in the development of Community Health Needs Assessments and Community Health Improvement Plans.

Oregon Health Authority

During this quarter, the THW program coordinator continued to provide a series of presentations to THW training program participants. Presentations focused on certification, Medicaid enrollment, and the public registry process. In addition, OEI staff and the THW Commission developed presentations for CCO Oregon's 2018 Winter Conference which focused on ways to improve the integration and utilization of THWs in health systems. In February, OEI staff and the THW Commission developed presentations for CCOs' Community Advisory Councils focusing on providing technical assistance on best practices and the most effective ways of integrating THWs in health care systems.

Health Care Interpreters

The Oregon Health Authority's (OHA) Health Care Interpreters (HCI) program enhances Oregon's health system transformation goals. Evidence suggests that persons with limited English proficiency, or who communicate in sign language, were often unable to interact effectively with health care providers, were excluded from health care services, experienced delays or denials of health care services, or received health care services based on inaccurate or incomplete information. As a result, the Health Care Interpreters (HCI) program was implemented to set competency criteria, approve HCI training programs, and qualify and certify spoken and sign language HCIs. The HCI recognition process includes 60 hours of training and state HCI Registry enrollment. The HCI Registry currently has over 500 trained, qualified, and certified spoken and sign language HCIs. This number includes about 62 HCIs who completed the Center for Medicare and Medicaid Innovation State Innovation Model grant sponsored HCI training.

OHA is currently initiating activities to help address emerging gaps in the workforce development mission of the HCI program, including: an HCI community advisory council retreat, changes to existing HCI laws, and training and testing for HCIs.

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

Developing Equity Leadership through Training and Action

Developing Equity Leadership through Training and Action (DELTA) is a comprehensive leadership training initiative for building and strengthening capacity of Oregon's public health and healthcare systems in health equity and diversity development. A cohort of 25 individuals representing community leaders, policy makers, administrators and clinicians are recruited each year from communities of color, the Oregon Health Authority, hospitals and health systems, and coordinated care organizations for participation in the program. DELTA includes training, project work to implement Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards), coaching/mentorship, and application of skills. DELTA goals include the following.

- Sustain funding through a blended model of grants and sponsoring partnerships.
- Build the capacity and commitment of Oregon's health leaders to eliminate health disparities.
- Develop collaborative approaches and partnerships to promote health equity across Oregon's health promoting systems.
- Inspire leaders to act individually and collectively as proactive change agents to address significant challenges and barriers to achieving optimal health outcomes for all Oregonians.

- Apply the skills they acquire from the training to facilitate the development and institutionalization of health equity and inclusion strategies in their organizational settings.

DELTA's fifth cohort began in October 2017, and will continue through April 2018. Twenty-three individuals from diverse population demography and sectors were selected through an application process in October 2017 to form the fifth cohort, and their training includes 44 hours of classroom training and nine in-person meetings in various locations throughout the state to expose participants to a range of communities (based on the social determinants of health). Each participant also submitted a project proposal that drives and institutionalizes best practices that promote health equity and inclusion in their organization.

Transformation Center activities

The Transformation Center continues to offer coordinated care organizations (CCO) and clinics technical assistance in key strategic areas.

Behavioral health integration

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

The Oregon Health Authority launched a six-month project building on the Behavioral Health Collaborative to develop an aligned vision for the future of behavioral health in Oregon, provide clarity on the biggest challenges, and establish a clear action plan to address those challenges. By the end of the project, the state and the largest regional behavioral health system (Portland metro area) will be prepared to implement a meaningful regional behavioral health collaborative including aligned goals and metrics.

Population Health

Community Advisory Councils

In preparation for the annual Community Advisory Council (CAC) leader event in April, staff and consultants conducted 22 key informant interviews with CAC members, including Oregon Health Plan members, CAC chairs and CAC coordinators. The Transformation Center also held a webinar for CAC members focused on traditional health workers and continues to convene CAC leaders for monthly calls focused on member recruitment and engagement.

Community Health Assessment and Community Health Improvement Plans

Three one-day Community Health Assessment/ Community Health Improvement Plan (CHA/CHP) development trainings were held in Eastern Oregon. Thirty-one CCO, local public health, and hospital representatives participated, and 100% of evaluation respondents considered the training valuable. The curriculum is grounded in the Mobilizing for Action through Partnership and Planning framework, with the focus on collaboration to meet collective CHA/CHP requirements for CCOs, hospitals and local public health authorities. Three more communities have requested trainings, which are being planned for April and May.

CCO incentive metrics technical assistance

Adolescent well-care visits

The Transformation Center is providing TA to increase adolescent well-care visits for young adults 18–21 years old, as this group has the lowest use of these key preventive health visits. One webinar was held about Health Hack, a curriculum for navigating the health system. A contractor facilitated a thought leader meeting and is developing a lesson plan to pilot test at Portland Community College.

Childhood immunization rates

Four additional CCOs are participating in technical assistance for childhood immunization rates. TA includes evidence-based quality improvement activities to identify root causes of low immunization rates and prioritize CCO-level, clinic-level, and/or community-level interventions

Controlling high blood pressure

The Transformation Center is developing technical assistance to support the controlling high blood pressure metric and has created a Million Hearts® resources catalog. Resources are organized by audience (clinicians, health systems, patients, policy makers, etc.).

Effective contraceptive use

After individual consultation calls about increasing effective contraceptive use, 12 CCOs requested follow-up technical assistance. Projects include provider trainings, train-the-trainer curriculums, patient education materials and workflow improvement.

The Transformation Center began a six-webinar series focused on youth sexual health. Presenters include public health and CCO staff. Sixty-five people attended the first webinar.

Emergency department use among members with mental illness

Seven CCOs will participate in peer-learning consultation calls focused on the CCO incentive metric focused on emergency department use among members with mental illness. The facilitated calls will focus on quality improvement or opportunities for innovative care coordination and transitions of care. All participating CCOs will receive 20 hours of follow-up TA.

Tobacco Cessation

The Transformation Center held a webinar on how to use quit line data for tobacco cessation quality improvement work. A contractor is also developing a provider-focused e-module to provide training in the Five As and brief intervention, as well cessation counseling during pregnancy. The training will include no-cost CMEs and will be available summer 2018.

Cross-cutting supports

Innovation Café: Strategies for Improving Children's Health

Registration is open for the 2018 Innovation Café, which will focus on childhood health. The goal of this event is to spread innovation and best practices to improve CCO performance. The call for projects received 35 submissions, with most projects focusing on cross-sector partnerships affecting the social determinants of early childhood health.

Transformation and Quality Strategy technical assistance

CCOs submitted their first Transformation and Quality Strategies, which replace the Transformation Plan and Quality Assessment and Performance Improvement deliverables. This streamlined approach aims to move health transformation by providing CCOs an opportunity to align their transformation and quality work. Transformation Center staff are coordinating the review and feedback process.

Transformation Plans

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

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The Transformation Center facilitated one statewide CCO learning collaborative session this quarter, which focused on oral health integration.

Early childhood health coordination

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

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

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

2. State reported enrollment table

Enrollment	January 2018	February 2018	March 2018
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	939,837	937,443	941,936
Title XXI funded State Plan	81,543	81,395	81,715
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A
	N/A	N/A	N/A
Enrollment current as of	January 31, 2018	February 28, 2018	March 31, 2018

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	Percent change from previous quarter	Percent change from same quarter of previous year
Expansion	**Title 19**	PLM Children FPL > 170%	0	0	0.00%	0.00%
		Pregnant Women FPL > 170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL > 170	90,449	241,304	0.99%	23.05%
Optional	**Title 19**	PLM Women FPL 133-170%	1	3	-200.00%	-25000.00%
	Title 21	SCHIP FPL < 170%	50,255	130,570	0.28%	-3.01%
Mandatory	**Title 19**	Other OHP Plus	156,524	438,927	0.20%	-2.79%
		MAGI Adults/Children	731,234	1,998,952	-1.48%	-5.53%
		MAGI Pregnant Women	13,208	30,090	-3.74%	-25.33%
		QUARTER TOTALS	**1,041,671**			

OHP eligible and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
October	965,480	838,376	854	43,654	3,655	663	33,444
November	964,083	836,441	772	44,697	3,662	713	33,433
December	968,116	844,536	711	43,836	3,584	541	32,068
Quarter average	965,893	840,489	742	44,267	3,634	627	32,751
		87.02%	0.08%	4.58%	0.38%	0.06%	3.39%

**Total OHP Eligibles include: GA, ACA expansion, CX Families, 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*

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

Reports are attached separately as Appendix D – Neutrality Reports.