Oregon Health Plan

Section 1115 Quarterly Report

01/1/2019 – 03/31/2019
Demonstration Year (DY): 17 (7/1/2018 – 6/30/2019)
Demonstration Quarter (DQ): 3/2019
Federal Fiscal Quarter (FQ): 2/2019

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I. Introduction

A. Letter from Oregon's Deputy State Medicaid Director

The Oregon Health Authority (OHA) is continuing its momentum in advancing the goals of the renewed Oregon Health Plan (OHP) demonstration. As you will find detailed in this report, OHA and coordinated care organizations (CCO) are making strides in Health System Transformation (HST) "levers" as identified in the waiver agreement and accountability plan. Highlights from the report include the following:

Lever 1: Improving care coordination

OHA continues to improve care coordination through Patient-Centered Primary Care Homes (PCPCH) which are part of Oregon's efforts to fulfill a vision of better health, better care and lower costs for all Oregonians. Four additional clinics became PCPCHs this quarter, for a total of 636 PCPCH clinics in the state.

Among the key milestones for this reporting quarter, the Oregon Rural Health Practice Network has partnered with OHA to participate in a learning collaborative to provide support and increase tier levels for PCPCHs.

Lever 2: Implementing alternative payment methodologies

OHA continues advancing the use of value-based payments (VBP) through several programs including the VBP Roadmap for CCOs. During 2018, the Transformation Center worked with stakeholders and national VBP experts to develop the Roadmap. The Roadmap was approved by the Oregon Health Policy Board (OHPB) and released along with a technical guidance report intended to provide valuable tools for communicating and educating CCOs on upcoming VBP requirements. By 2024, at least 70 percent of each CCO's provider payments will be in the form of VBP Alternative Payment Model (APM).

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

Oregon is maintaining core tenets of the existing Coordinated Care Model through oral integration efforts that includes the adoption of new administrative rules which expands telehealth to include Medicaid tele-dentistry services, allowing dental clinicians to provide expanded access to oral health in rural areas and reducing geographic disparities in access and outcomes.

Tele-dentistry uses telehealth technology to link dental clinicians in the community with dentists in local offices, facilitating access to the full dental team and comprehensive dental care.

Lever 4: Increased efficiency in providing care

While innovator agents continue to connect OHA and CCOs to achieve the goals of Health System Transformation, Oregon has partnered with the Sustainable Relationships for Community Health (SRCH) program to bring together various organizations and sectors within the community. Through these efforts, Oregon will create sustainable, effective relationships between community partners to improve access, quality and cost of preventative chronic disease self-management services.

The current SRCH successes include two Leadership Institute cohorts with 13 public health organizations and one tribal health partner participant. Cohort attendees build upon existing relationships, communicate the importance of collaboration, and co-develop shared goals, measurable outcomes and specific actions with partners to implement system change.

Lever 5: Implementation of health-related services

OHA upholds its commitment to promote CCOs' use of health-related services (HRS) by continually working to revise Oregon Administrative Rules, revising CCO contracts, upholding financial reporting standards, and developing additional guidance to assist CCOs as they implement HRS. As an additional help, OHA published guidance for CCOs to provide technical assistance on alignment with HRS rules.

Lever 6: Innovations through the Transformation Center

CCOs continue to seek technical assistance through the Transformation Center and are receiving valuable support of their work through workgroups, statewide behavioral health collaboratives, and community health improvement trainings. Current trainings include tobacco cessation, developmental screening webinars, and reducing emergency department use among members with mental illness.

The Transformation Center is the hub of innovation and quality improvement for Oregon's health system transformation to achieve better health, better care, and lower costs for all.

Lori Coyner, 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. Fifteen 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 (OHP) members. During the previous five-year demonstration, which ended on June 30, 2017, Oregon sought to demonstrate the effectiveness of delivery system improvements under health system transformation.

In January 2017, CMS approved an extension to Oregon's 1115 Medicaid Demonstration waiver to continue and enhance Oregon's health system transformation initially approved in 2012. Moving forward, Oregon will continue to utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care.

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 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 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:

- 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;
- Offering incentive payments to Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus providers for enhanced fee-for-service delivery of care to Medicaid recipients; and
- Establishing minimum requirements for CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 1/1/2019 – 3/31/2019
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III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan eligibility

The Oregon Health Plan (OHP) Processing Center experienced substantial backlogs of work and phone wait times during the reporting period. Aggressive steps taken to address these areas included additional staff recruitment and training to assist with workload. Process improvement strategies were deployed to address ongoing business processes and ease existing queues of work.

The small uptick in Title XIX and Title XXI enrollment, as outlined in Appendix A, may be partially due to the efforts to complete determinations on the backlog of applications.

2. Coordinated care organization enrollment

OHA implemented an opt-out enrollment option for dually eligible Medicaid/Medicare members who were previously enrolled through an opt-in model. Implementation is occurring in three regional phases between January and July 2019. For this reporting period, OHA has observed a steady decrease in CCO**E** (mental health) and CCO**G** (mental and oral health) enrollments accompanied by an increase in CCO**A** (physical, mental, and oral health) enrollment.

Additionally, OHA partnered with the Department of Human Services (DHS) in the creation of training and resource materials about CCOs with the intent of raising awareness and empowering DHS eligibility staff who process Medicaid, CHIP, and dually eligible member enrollments.

For related data see Appendix A – Enrollment Reports, which is attached separately.

B. Benefits

The Pharmacy &Therapeutic (P&T) Committee developed new or revised prior authorization criteria for the following drugs: lofexidine, buprenorphine and buprenorphine/naloxine, cannabidiol, stiripentol, thrombocytopenia agents, influenza antivirals, biologics for autoimmune conditions, GLP-1 receptor agonists, hydroxyprogesterone caproate, benzodiazepines, hereditary angioedema, and GnRH modifiers. The committee also added the following drugs to the preferred drug list: sofosbuvir/velpatasvir authorized generic, eltrombopag, romiplostim, Bydureon, Victoza, vitamin D solution, Berinert, and Haegarda.

The Health Evidence Review Commission made interim modifications to address changes in evidence, medical technology, and practice guidelines.

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 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. The reporting period covers the quarter beginning January 1 through March 31, 2019.

Trends

	Apr – Jun, 2018	Jul – Sep, 2018	Oct – Dec, 2018	Jan – Mar, 2019
Total complaints received	5,882	5,917	5,839	5,683
Total average enrollment	1,217,091	1,185,394	1,180,577	1,190,032
Rate per 1,000 members	4.83	4.99	4.95	4.78
* 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

CCO complaints decreased by 2.67 percent overall during this reporting period. The access-to-care category continues to receive the highest number of complaints, although the data reveals a 16.2 percent decrease from the previous quarter. The Interaction with Provider/Plan category increased by 9.4 percent this reporting period, with client billing issues showing a 39.9 percent increase from the previous quarter. FFS data continues to show the highest number of complaints in the quality-of-service category, followed by access-to-care.

Interventions

During this quarter, CCOs continue to provide regular training to internal customer service representatives to ensure all complaints are reported appropriately. This has resulted in an increase in the number of complaints reported in some areas due to increased awareness to record all complaints. Some CCOs report completion of internal projects which improve the recording of complaints and allows staff to look deeper into root causes.

CCOs report following up by establishing processes which reduce the number of complaints in specific areas. CCOs report they are continuing to see improvements in areas where they have established committees to review issues monthly that go beyond the grievance area. Some CCOs continue to add additional staff specifically to improve communication between the provider offices and members. CCOs report they are seeing improvements in areas where continuous outreach and education with provider offices and clinics are practiced. This can result in a temporary increase in the number of complaints as the provider and clinical staff learn more about what should be recorded. CCOs report they are continuing to work bi-weekly and monthly with NEMT providers and are seeing the number of NEMT complaints decreased by almost 19 percent overall from the previous quarter.

Oregon Health Plan (OHP) Member Services reports 636 complaints during this quarter from members with fee-for-service coverage. OHP Member Services reported an additional 423 records identified as complaints received from members enrolled in CCOs. In addition to the complaint calls, Member Services took 1,325 calls from members asking for a variety of information, such as coverage, CCO enrollment, and ID cards.

Statewide rolling 12-month totals

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

Complaint category	Apr – Jun, 2018	Jul – Sep, 2018	Oct – Dec, 2018	Jan – Mar, 2019
Access to care	3,076	3,491	3,422	2,865
Client billing issues	394	299	373	522
Consumer rights	220	195	207	221
Interaction with provider or plan	1,283	1,103	1,082	1,184
Quality of care	526	476	417	443
Quality of service	345	305	338	420
Other	38	48	0	28
Grand Total	**5,882**	**5,917**	**5,839**	**5,683**
* 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 determinations (NOABD) issued by coordinated care organizations (CCO) this quarter. The total number of NOABDs are listed by NOA reason. For the current quarter CCOs report pharmacy, specialty care and outpatient care categories as having the highest numbers of NOABDs issued. CCOs report continued training for providers, including readability training for writing denial letters, and improving communications between offices and providers to improve customer service to members.

Notice of Action – Adverse Benefit Determination (NOA-ABD) reason	Total issued
a) Denial or limited authorization of a requested service.	32,590
b) Single PHP service area, denial to obtain services outside the PHP panel	112
c) Termination, suspension, or reduction of previously authorized covered services	144

Notice of Action – Adverse Benefit Determination (NOA-ABD) reason	Total issued
d) Failure to act within the timeframes provided in § 438.408(b)	36
e) Failure to provide services in a timely manner, as defined by the State	288
f) Denial of payment, at the time of any action affecting the claim.	22,935
Total	**56,105**
Number per 1000 members	64

CCO Appeals

The following table shows the total number of appeals received by CCOs during the quarter. There was a slight increase from the previous quarter, with a slight decrease in the number of appeals overturned at the plan level. CCOs reported that specialty care and pharmacy continue to show the highest numbers of appeals. CCOs continue to work with members to assist with finding services needed or seeking alternative covered options.

The table below has been revised to reflect only CCO appeal information. CCOs reported that specialty care and outpatient services had a higher number of requests for appeal. CCOs report they provide education and training to their staff as well as provider staff to increase knowledge about covered benefits. Some CCOs report they have made internal changes to assist providers with access to medical consultations to help reduce the number of denials. CCOs continue to work with members to assist them in finding services they need or finding alternative covered options.

CCO Appeals	Requests
a) Denial or limited authorization of a requested service.	1,281
b) Single PHP service area, denial to obtain services outside the PHP panel	8
c) Termination, suspension, or reduction of previously authorized covered services	8
d) Failure to act within the timeframes provided in § 438.408(b)	1
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.	363
Total	**1,661**
Number per 1000 members	1.89
Number overturned at plan level	514
Appeals decisions pending	12
Overturn rate at plan level	30.94%

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 15 coordinated care organizations (CCO), six dental care organizations (DCO) and fee-for-service (FFS). It is important to note that FFS members may be enrolled in a DCO for dental services.

The Oregon Health Authority (OHA) received 470 hearing requests related to the denial of medical, dental, and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 446 were for CCO-enrolled members, 2 were members enrolled with a DCO, and 22 were from FFS members. During this reporting period, 457* cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. There were 34 cases approved prior to

hearing where OHA overturned their denial or the CCO overturned their appeal resolution. Members withdrew from 27 cases after an informal conference with an OHA hearing representative. OHA dismissed 355 cases that were determined to be not hearable.

Of the not-hearable cases, 312 were forwarded to their respective CCOs to process as an appeal. OHP members must first exhaust their appeal rights at the CCO level and receive a notice of appeal resolution (NOAR) before they can request a contested case hearing at the State level. Hearing requests received by OHA prior to the appeal being exhausted are dismissed as not hearable.

Of the 39 cases that went to hearing, the administrative law judge upheld the OHA or CCO decision in 21 cases and dismissed 18 cases for the member's failure-to-appear. Two cases were dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

**In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in October of 2018 may be cases OHA received as far back as August of 2018.*

Outcomes of Contested Case Hearings Processed

Outcomes	Count	% of Total
Decision overturned prior to contested case hearing	34	7%
Client withdrew request after pre-hearing conference	27	6%
Dismissed by OHA as not hearable	355	78%
Decision affirmed*	21	5%
Client failed to appear*	18	4%
Dismissed as non-timely	2	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	0	0%
Set Aside	0	0%
Total	**457**	
**Resolution after an administrative hearing*		

Related data

Reports are attached separately as Appendix C – CCO Contested Case 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

There were no relevant changes in provider networks for physical health, oral health, or behavioral health during this reporting period.

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 Oregon Health Plan (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.

During the current reporting period, OHA posted Hepatitis C and Applied Behavioral Analysis (ABA) Risk Corridor templates and instructions for 2018 and 2019. Additional communications related to the Hospital Reimbursement Adjustments (HRA) and dual eligible recoupment were sent to CCOs.

OHA met with CCOs during the February Rates workgroup to discuss the CY 2018 Exhibit L submission, as well as the 2019 CCO Quality Pool update. Meeting topics also included ABA, Hepatitis-C, and Cover All Kids risk corridor templates and data. In February 2019, OHA provided CCOs with individual data files for review. In addition, OHA communicated to CCOs the various submission dates and deadlines related to template submissions and risk corridors.

4. Enrollment/disenrollment

There are no significant changes in member enrollment or disenrollment.

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

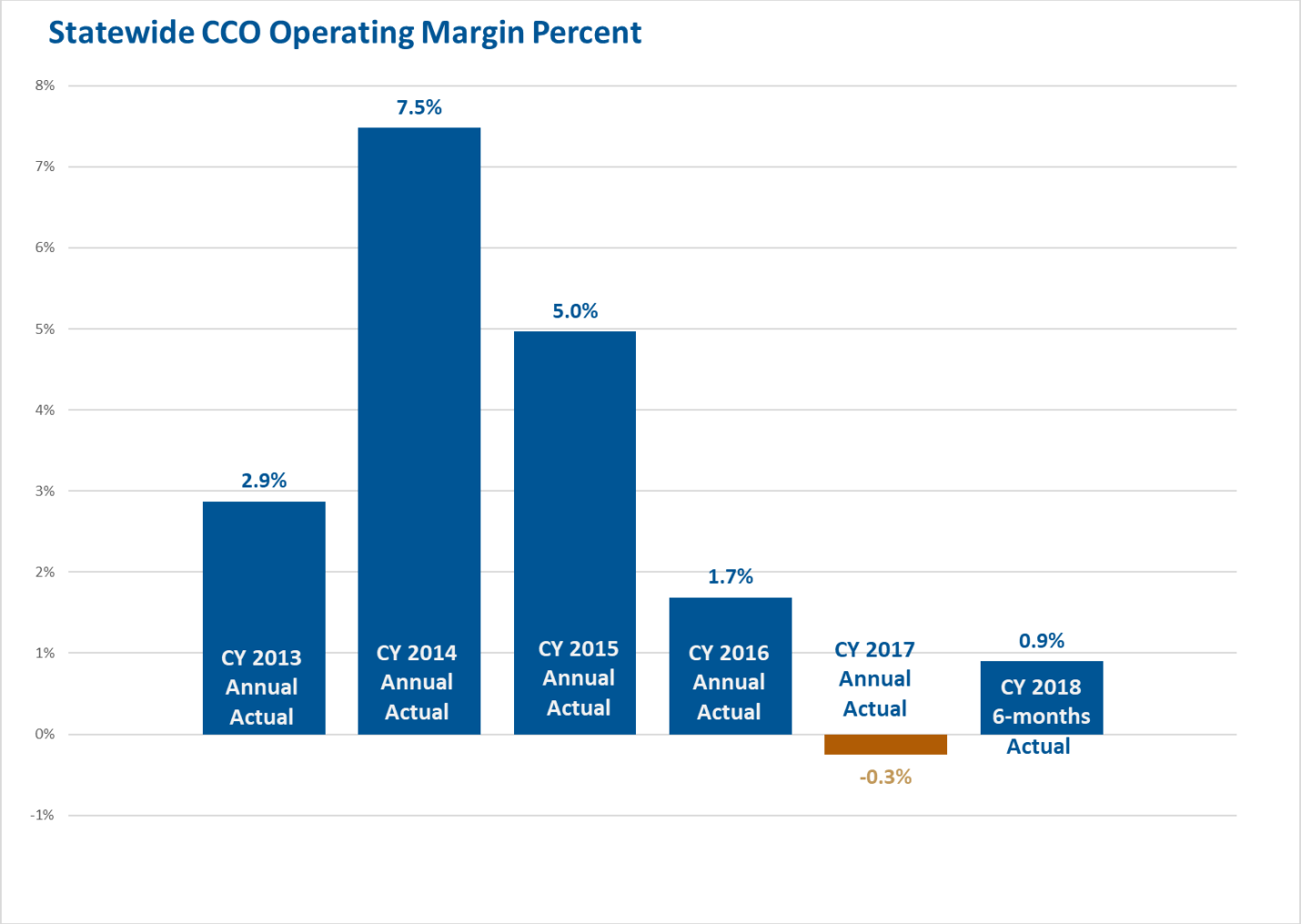
5. Contract compliance

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

6. Relevant financial performance

Data reported is for the nine months ending September 30, 2018.

The statewide coordinated care organization (CCO) operating margin was at 1.3 percent compared to -0.3 percent for the year ending December 31, 2017. For reference, the capitation rates include a one percent profit margin. CCO operating margins returned to a slightly profitable status after trending downward during the previous three-year period.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services CCOs provides to its members, including medical, behavioral, dental, health-related services, reinsurance premiums, recoveries, and other adjustments, as a percentage of total revenue. The MSR for all CCOs in aggregate was 91.3 percent. Administrative services accounted for 7.3 percent of total CCO revenue, leaving 1.3 percent as operating margin.

All CCOs met or exceeded the 85 percent target for MSR, a key indicator for medical loss ratio (MLR). Half of the CCOs had MSRs above 90 percent.

As of September 30, 2018, all CCOs met net worth requirements. Net assets of the CCOs ranged from a low of $218 per member (Willamette Valley Community Health, LLC) to a high of $1,250 per member (Intercommunity Health Network), averaging $463 per member for the state.

7. Corrective action plans

This reporting period, Advanced Health CCO exceeded the five percent threshold for adjudication, and was subsequently placed on a corrective action plan to be completed by March 31, 2019. The corrective action plan for Advanced Health will be monitored to ensure that all encounter data is submitted within 45 days from the date of adjudication. While this monitoring is a normal part of the encounter data submission and review process, enhanced monitoring will be in place through July 2019 to ensure resolution of past issues.

8. One percent (1%) withhold

During this quarter, OHA analyzed encounter data received for completeness and accuracy for the subject months of June 2018 through August 2018. All coordinated care organizations (CCO) met the administrative performance standard for all subject months and no 1% withholds occurred.

9. Other significant activities

There are no other significant activities to report for this quarter.

G. Health Information Technology

Oregon's coordinated care organizations (CCO) 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.

Medicaid Electronic Health Records Incentive Program

Through the Electronic Health Records (EHR) Incentive program (also known as the Promoting Interoperability program), eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT).

Since 2011, when the Medicaid EHR Incentive Program began, 3,818 Oregon providers and 60 hospitals have received over $199.9 million in federal incentive payments under the program (as of March 31, 2019). During the reporting period, 286 Oregon providers received $2.4 million in Medicaid EHR incentive payments. To promote continued participation and success in the program, Medicaid EHR Incentive program staff hosted an informational webinar to present updates and requirements to 77 attendees. The Medicaid EHR Incentive program sunsets at the end of 2021.

Oregon Medicaid Meaningful Use Technical Assistance Program

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

Since the program's launch in 2016, a total of 1,588 providers across 374 clinics have enrolled (as of March 31, 2019). For this reporting period, 93 providers across 69 clinics received technical assistance, bringing the total number of providers to 1,207. OMMUTAP will sunset in May 2019.

HIT Commons

Health Information Technology (HIT) Commons is a public-private partnership to coordinate investments in HIT technology, leverage funding opportunities, and advance health information exchange (HIE) across the state. HIT Commons continues its focus on promoting adoption of its two web-based communications tools:

- The **Emergency Department Information Exchange** (EDIE) is a collaboration between the Oregon Health Leadership Council (OHLC), the Oregon Health Authority (OHA) and other partners including hospitals, health plans, CCOs and Emergency Department physicians. Patient information is

automatically sent to EDIE in real time when patients visit an Emergency Department. Patient care history, known providers, and care coordination information are returned to EDIE users.

- **PreManage** – Web-based software that provides real-time notifications to subscribers when their patient/member has a hospital event.

EDIE and PreManage provide real-time information to reduce emergency department utilization, improve care coordination, manage care, and serve as the platform for the Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative. OHA and the OHLC, 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 met twice during the reporting period. The Board approved two new members, including one community-at-large member, and directed staff to begin exploration and conceptual development of a statewide social determinants of health (SDoH) network.

Emergency Department Information Exchange and PreManage

The Emergency Department Information Exchange (EDIE) collects emergency department (ED) and inpatient Admit Discharge Transfer (ADT) data from hospitals and pushes notifications back to the ED in real time. EDIE provides notification containing patient ED visit, care team (primary care, behavioral health, etc.), and care guideline information. PreManage is a companion software tool to EDIE. PreManage brings the same real-time hospital event notifications (ED and inpatient ADT data) to those outside of the hospital system, such as health plans, CCOs, providers, and care coordinators. EDIE and PreManage are used statewide, with adoption of PreManage growing rapidly.

A 2019 Technical Assistance calendar has been created for distribution, with the first of a six-part series held to support basic, intermediate, and advanced use of the platform for primary care and behavioral health clinics. As of February, hospitals who receive EDIE notifications via fax receive a Physician Order for Life Saving Treatment (POLST) as a printout with EDIE notifications.

Oregon Prescription Drug Monitoring Program Integration Initiative

The Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative connects EDIE, HIE, and other HIT systems to Oregon's PDMP, which includes prescription fill information on controlled substances. This initiative aligns with broader state and federal efforts to increase the use of PDMPs to reduce inappropriate prescriptions, improve patient outcomes, and promote more informed prescribing practices.

Since the initiative began, PDMP data through integration is now available to nearly 6,000 prescribers, 87 health care entities (including hospital EDs), and two retail pharmacies.

Clinical Quality Metrics Registry

Oregon's Clinical Quality Metrics Registry (CQMR) collect, aggregate, and provide clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting.

The CQMR went live January 2019 for Medicaid EHR Incentive program/Promoting Interoperability users to submit electronic clinical quality measures (eCQMs). In February 2019, CQMR went live with the option to report eCQMs to CMS for the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+) for 2018. OHA continues to engage with stakeholders through a subject matter expert

workgroup and other outreach to prepare CCOs to use the CQMR for 2019 reporting, with pilots ahead of the reporting deadlines.

During the reporting period, training materials and webinars were provided to help users learn to onboard and use CQMR. In addition, ongoing technical assistance is offered through a contract with Oregon Health & Science University (OHSU) to help clinics prepare for patient-level eCQM reporting.

H. Metrics development

The Oregon Health Authority (OHA) continued reporting on the 2018 coordinated care organization (CCO) and state performance measures in monthly dashboards. Measure development and validation work was ongoing during the quarter in preparation for finalizing calendar year 2018 performance measure incentives for payment in June 2019. Throughout this quarter, OHA continued to engage stakeholders in the measurement strategy through public committees and workgroups including the Metrics and Scoring Committee and the Metrics Technical Advisory Workgroup. Both meet monthly.

Health Plan Quality Metrics Committee

The Health Plan Quality Metrics Committee (HPQMC) was established under Oregon's Senate Bill 440, which mandated publicly funded health plans, such as Medicaid and the Public Employees Benefit Board to align quality metrics using a common menu set of quality measures. SB 440 specified that the Metrics and Scoring Committee (MSC) would become a subcommittee that informs the larger committee. The MSC continues to select the specific incentive measure and benchmarks for the coordinated care organizations (CCO).

During this reporting period, the HPQMC reviewed measure recommendations for the 2020 measure menu and hosted presentations from stakeholders, with MSC presenting committee recommendations. HPQMC presented a health equity measure which promotes equitable language access to health services through the tracking of interpreter services and utilization of certified and qualified health interpreters.

Metrics and Scoring Committee

The Metrics and Scoring Committee (MSC) continues to meet monthly.

At the January meeting, the chairs of MSC presented the Committee's recommendations to HPQMC as related to the 2020 quality measures menu and measure development. The Committee recommended that the HPQMC:

- Endorse the health aspects of the Kindergarten Readiness multi-year, four-part metric set;
- Endorse development of a CCO-level attestation measure on social-emotional health, and essential elements of the kindergarten readiness measurement strategy;
- Endorse move from measure development work focused specifically on food insecurity to boarder social determinants of health;
- Explore expanding HPQMC measures menu to include benchmarks related to suicide, flu immunizations and substance use disorders.

At the February meeting, OHA's Director of Quality Improvements gave a presentation on the central role of metrics in quality improvement efforts, and where the CCO Quality Incentive program fits with other quality improvement efforts by the agency and CCOs. The Committee began reviewing all 19 current incentive

measure sets. Measures reviewed this quarter include: Adolescent well-care visits, timely postpartum care visits, patient centered primary care home enrollment, and initiation and engagement in drug and alcohol treatment.

At the March meeting, the Committee received updates on the development of an evidence-based obesity measure and the State Health Improvement Plan priorities. Measures related to oral health, kindergarten readiness, weight-assessment, nutrition, and activity counseling were reviewed.

Health Aspects of Kindergarten Readiness Technical Workgroup

The Health Aspects of Kindergarten Readiness Technical Workgroup (HAKRTW) presented its final measurement strategy proposal to HPQMC, in partnership with the chairs of he Metrics and Scoring committee. The proposals purpose is to drive health system behavior change, investments, and cross-sector efforts that contribute to improved kindergarten readiness.

Implementation steps over the next few years recommended by the workgroup, include:

- Adopt two metrics now for the 2020 CCO incentive measure set:
  - Well-child visits for children 3-6 years old
  - Preventive dental visits for children 1-5 years old
- Adopt a CCO-level attestation metric focused on children's social-emotional health once specifications are finalized (i.e. for the 2021 or 2022 CCO incentive measure set).
- Replace the existing developmental screening metric with a new follow-up to developmental screening metric in 2022 or 2023.

To achieve its intended impact and realize its transformative potential, the workgroup strongly believes that this proposal must be implemented as a package.

Health Equity Measurement Workgroup

During this quarter, the Health Equity Measurement Workgroup focused exclusively on the development of a new measure to be used as a health equity measure for coordinated care organizations. The goal is to achieve meaningful access to health care services for all CCO members through quality communication, language access services, and delivery of culturally responsible care. Proportion of visits with spoken and sign language interpreters will be measured. Final approval for the measure will be determined in May 2019 by the HPQMC. If passed, the measure will be eligible for selection as a CCO incentive measure by the Metrics and Scoring committee.

Evidence-Based Obesity Metric Workgroup

The Evidence-Based Obesity Metric Workgroup finalized its recommendations August 2018. The recommended measure contains two parts: A focus on investments in multisector interventions, and a measure of body mass index documentation, referral, and intervention.

During this quarter, part one, referred to as the multi-sector interventions (MSI), was presented to the Metrics and Scoring Committee Technical Advisory Group, along with MCS for feedback. The purpose of MSI is to slow the increase of obesity. MSI's must reach ≥10% of the CCO member population and address disparities through community engagement and partnerships and evidence-based interventions. Part one is anticipated to begin in 2021.

Part two, referred to as body mass index (BMI), also began meeting during this quarter. Part two evaluates the technical feasibility for reporting population BMI from electronic health records. Part two is anticipated to begin in 2023.

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.

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

There are no legislative activities to report for this quarter.

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 no new pending actions, lawsuits or legal actions for this reporting period.

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

L. Public forums

Health Evidence Review Commission

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

January 17, 2019

Testimony for this meeting related to the Coverage Guidance on Temporary Mechanical Circulatory Support with Impella Devices being recommended by the Evidence-based Guidelines Subcommittee.

Erin Hanussak, Impella Heart Patient

Ms. Hanussak testified that she was an Impella heart patient who was invited to the HERC meeting by Abiomed. She lives in Roseburg, Oregon and had an Impella implanted after a virus attached her heart. She was hospitalized for 31 days. The Impella allowed her heart to rest and recover, and she does not need a transplant.

Dr. Eric Kirker, Providence Heart Institute Cardiac Surgeon

Dr. Kirker is a cardiac surgeon and Senior Medical Director at Providence Heart Institute of Oregon. He reported that he implants Impella devices and has no financial disclosures otherwise. He claims that Impella is a

new and disruptive technology. He discussed the benefits of Impella including relieving cardiac effort, when compared to ECMO, particularly in patients with cardiogenic shock and high lactate levels. He also indicated LVAD or transplant patients experience a reduction in sternotomies with Impella. The 3.5 and 5.0 models have no studies and are completely different from the 2.5 model.

Erik Schulwolf, Foly Hoag LLP Attorney
Mr. Schulwolf specializes in healthcare reimbursement matters. He represented Abiomed, manufacturer of the Impella devices, at the meeting. He recommended aligning coverage with other payers, the FDA, and clinical society guidelines. He expressed concern that the result of this unusually restrictive coverage policy that is currently recommended would leave Medicaid patients in Oregon receiving a level of care inferior to other patients. He recommended changes that were submitted in Abiomed's January 10th comment letter.

Dr. Jacob Abraham, Providence St. Vincent Medical Center, Medical Director
Dr. Abraham is the medical director at the Providence Center for Advanced Heart Disease. He stated a conflict of interest as being a scientific consultant to Abiomed and he has received travel support to attend research conferences not sponsored by the industry. The requirement that two advanced heart-failure and transplant cardiologists must agree that the Impella should be used as a bridge to transplant or LVAD has some operational challenges since there are only three of them in the entire state right now. Further, he addressed the evidence (or lack of) in the use of Impella for cardiogenic shock, as noted by others. Shock is a notoriously difficult state to lend itself to scientific study because shock is a spectrum. Intervention timing is important for outcomes. Lastly, Impella allows for reduction of left ventricular wall stress.

Dr. Abraham noted that, at his Medical Center, cardiogenic patients are managed effectively. His concern is patients outside Providence in cardiogenic shock. Being asked to weigh in on whether that patient is a candidate for an LVAD or transplant is very challenging. It involves many factors including physiology of their heart, social status, wait time, etc. The default answer would be to go ahead and install an Implella, even as a bridge to decision. There are also other cardiac procedures that may be bridged to; for example: in patients with congenital heart defects. His recommendation would be to specify that it doesn't need to be an in-person consultation and he might go as far as to strike the consultation requirement.

It was clarified that interventional cardiologists around the state have been implanting Impella devices. The Providence Center has implanted 234 devices since 2016, about 20 percent involving Medicaid patients. Implanting for high-risk PCI is less common indication.

Dr. Todd Caulfield, Providence St. Vincent, Chief of Medical Staff
Dr. Caulfield is also an interventional cardiologist for Providence. He disclosed no financial relationship to Abiomed or any other manufacturer. He thanked appointed ad hoc expert Dr. Crispin Davies for stating that this technology represents the standard of care for elective PCI. Instead of performing a CABG and hoping that the patient survived, they are now able to manage these patients well in the cath lab. He asked that the Commission look very closely at the O'Neal paper, particularly at the discussion sections on the intention-to-treat analysis as well as the per-protocol population. This is a small trial that will not tell you about a mortality benefit over the balloon pump. What it is looking to do is bundle adverse outcomes together and see if there is a benefit. There are strong trends there that will play out the longer you follow the patients. There will be less expense due to less repeat procedures. Secondly, he wants to make sure the guideline covers the acute STEMI patient. There isn't time for a consultation on transplant/LVAD candidacy before implanting an Impella in these cases.

Further testimony at this meeting related to a proposal developed with HERC's Chronic Pain Task Force (CPTF) over seven meetings from September 2017 to December 2018. The proposal would involve the creation of a new line in the funded region of the Prioritized List that would provide the coverage of treatments for five currently nonfunded conditions involving complex pain syndromes including fibromyalgia. The new line would have to be created as part of the biennial review process so would not go into effect until January 1, 2020 if approved by HERC. New covered treatments under the proposal would include cognitive behavioral therapy, acupuncture, health and behavior assessment, physical/occupational therapy, pain education, yoga, mindfulness-based stress reduction, massage, supervised exercise, and intensive interdisciplinary rehab (if available). Additionally, patients would receive all FDA-approved non-opioid medications such as Tylenol, NSAIDS, duloxetine, pregabalin, antidepressants, etc. Medications would be paired with active therapy, including psychotherapy. Fibromyalgia patients on long-term opioid therapy counter to Prioritized List coverage would be provided with a taper using shared decision-making between patient and doctor. Opioids below a 90 MME would be allowed for the other conditions.

Kristen Garity
She declared no affiliations and no conflicts. She said risk benefit analysis can turn out to be wrong. Tapers should be reversible and there should be an appeal process for patients who try all of the alternatives and none of them make a difference. She mentioned that we have to stop making individual decisions based on population level data.

Amara M., Oregon Pain Action Group Volunteer
As the CPTF and HERC revisits the language of the back and spine guidelines with the taper paragraph she would like to formally request the taper portion of the back and spine lines be re-evaluated.

March 14, 2019

Testimony for this meeting related to the proposal developed with HERC's Chronic Pain Task Force as described above.

Sarah Rohrs
She declared no conflicts of interest. She testified about her husband's intractable pain and the forced-taper he is currently undergoing. She talked about illicit drug overdoses and how tapering chronic pain patients does not affect that statistic.

Shelley Latin, Attorney
She declared no conflicts of interest. She said that forced taper decisions should remain in the hands of doctors and never legislated by regulation. She said the composition of the Chronic Pain Task Force was biased towards wanting to reach a particular outcome, ignoring the mountain of public testimony, including Dr. Beth Darnall's offer of her Empower study. She said the issue is too important to wait another two years. She said there is no reason to limit opioid prescriptions while adding alternative services.

Cherry Amabisca
She declared no conflicts of interest. She said over the last 15 years she has taken care of five friends and family members who have complex medical conditions who are also on opioids. She questioned the task force's use of evidence when recommending a force-taper to zero. She said there is no evidence that any of the 154 Oregonians who died of prescription opioid overdoses in 2017 included any Medicaid patients, nor evidence

that alternative treatments work. She said you will do harm to chronic pain patients who also have anxiety if you force them to choose between their pain medications and benzodiazepines.

Amara M.
She declared no conflicts of interest She said she is the co-founder of the Oregon Pain Action Group and Alliance for the Treatment of Intractable Pain. She testified about being abandoned as a pain patient and her experience with Guideline Note 60 implementation. She expressed her frustration with the Back Lines Reconfiguration Task Force process.

Allan Chino, Clinical Psychologist
Dr. Chino served two terms on the Oregon Pain Management Commission, is past-president of the American Academy of Clinical Psychology and former director of the Psychological Association. He declared no conflicts of interest. He urged the Commission to reject mandatory forced-tapers and to embrace individual, patient-centered treatment plans. He further urged the members to read Dr. Sean Mackey's submitted testimony letter.

Joseph Gramer
He declared no conflicts of interest. He is a Salem resident and is disabled with chronic pain. He said his quality of life is now compromised by a forced taper of pain medicine that was already within the CDC dosage guidelines and that had been effective for years.

Wendy Sinclair, Founder of the Oregon Pain Action Group
She also works with the Alliance for the Treatment of Intractable Pain. She commented about the back and neck guideline note stated that when it was passed the public was not given an opportunity to comment or research the evidence. She testified about her personal experience with chronic pain and opioid medication. Sinclair said she submitted the full version of Sean Mackey's letter to the Commission today.

Note: Coffman clarified that all of the meetings prior to the decisions on the back and neck guideline were open to the public, as are all of the Commission's meetings.

Sandy Anderson, State of Oregon Employee
She declared no conflicts of interest. She said she has been a chronic pain patient for the last 25 years and receives benefit from opioid medication, well under the CDC MME suggested guideline. She said she thinks ending opioid coverage would put many more people on disability or cause suicides.

Richard Ashby
He is a chronic pain patient who declared no conflicts of interest. He is on a forced-taper. He stated he has tried all the alternative treatment his insurance will pay for to no effect. He said people are talking about getting street drugs and committing suicide.

Ginevra Lipton, Frida Center Medical Director
Dr. Lipton specializes in treating fibromyalgia. She is a fibromyalgia patient herself and declared no conflicts of interest. She applauded the Commission's efforts to make fibromyalgia a covered condition along with expanding access to alternative and complementary care. She said she agrees that opioids are imperfect tools to manage chronic pain but until we have better tools, imperfect tools are better than nothing. She also expressed concern with the number of alternative and complementary care providers who will accept OHP.

Steven Hicks

He declared no conflicts of interest. He said he is evidence of how the opioid epidemic has greatly diminished his life and the life of his family. Since he has been force-tapered off opioids, his family's responsibilities to care for him have greatly increased. He expressed how difficult it is to be completely dependent on others for his care. He said he is here representing others who are too hurt to come to the meeting.

HERC Value-based Benefits Subcommittee

The HERC's Value-based Benefits Subcommittee (VbBS) reviews all potential changes to the Prioritized List and is comprised of both commission members and other provider and stakeholder representatives. Interim modifications to the Prioritized List of Services are initially forwarded for consideration to the VbBS, which will often require at least two meetings to first hear the request and then have staff collect the necessary information to decide on an action. The Commission's decisions are always based on what is best for the entire OHP population, and not on one individual case.

January 17, 2019

Testimony for this meeting related to the proposal developed with HERC's Chronic Pain Task Force as described above.

Amara M.

As an advocate of the Oregon Pain Action Group, she testified that she has chronic back pain due to a back injury. She feels this proposal is cruel and unusual punishment. Policies like these are creating pain refugees. Affects children of whose parents are affected by this proposed policy.

Kristin McGarity

She testified that she has interstitial cystitis, a condition that doctors used to think that opioids did not treat. However, high dose opioids are now known to help. Unidirectional tapers do not allow re-evaluation of the risk/benefit analysis. This proposal needs a clear appeal process. Doctors are not perfect. One doctor makes a bad call, and you are tapered for life. The resources reviewed by the task force and VbBS are all from one viewpoint. Chronic pain is more than pain that continues beyond tissue healing. Some things just don't heal. Policy does not account for new evidence, or for new understanding of disease. Stop making individual decisions from population-based data.

Cherry Amabisca

She said that CCOs are right about increased costs in this proposal. It is big increases in costs for alternate therapies to reduce a small amount of opioids that are being prescribed for this population. She is concerned about conflict of interest for members of task force due to more patients coming into their practice or grants or other funding they might receive. She said, according to Dr. Hedberg, there are 144 prescription opioid deaths in Oregon (Medicaid plus all other payers). The opioid crisis peaked and is coming down. Why are you punishing patients? She objects to tapering off opioids for back conditions. Her experience is that CCOs are not enforcing opioid tapers for back conditions.

Wendy Sinclair, Oregon Pain Action Group Founder

She said if the intent of the Commission is only adding services, then there is no need for the paragraph on opioid tapering because this is taking away treatment for some patients. She is concerned for patients with fibromyalgia because people are getting letters from Medicaid that their doctors are getting instructed to taper

them off opioids. Decisions of HERC have unintended consequences—feeds into environment that is shaming chronic pain patients. There is an absolute need for individualized medical care that allows doctors to give appropriate medical care. Each patient is unique. Don't dictate how doctors practice medicine. She does not agree with the statement that opioids are harmful for fibromyalgia because many fibromyalgia patients are greatly benefiting from opioids. Patients don't take opioids when not effective.

Jacqueline Connor
She is a patient with fibromyalgia and spine conditions. She spent years resisting opioid therapy and not able to work. She started opioids 15 years ago, which allowed her to work and care for herself. When CDC opioid prescribing guidelines came out, her doctor tapered her dose by 80 percent in 10 days. She has not been able to work and has very limited functionality since the taper. She thinks blanket statements saying opioids don't work are wrong. It interferes with doctors' ability to treat patients. She said there was an Oregon law passed in 2006 to control Sudafed, but meth related deaths are higher than ever. Taking the Sudafed medication away did not help. Chronic shortage in mental health care is another concern.

Carolyn Concia, Geriatric Nurse Practitioner
She is concerned about patients getting off opiates using forced tapers, and being forced to say they are drug addicts. She recommends adding an ethicist on the Commission.

March 14, 2019
Testimony for this meeting is related to a proposal developed with HERC's Chronic Pain Task Force as described above.

Dr. Tracy Muday
She testified as a member of the Chronic Pain Task Force. She said the CPTF recommendation has been modified through the committee process. The goal was to add therapies to reduce the risk of harms. The evidence of benefit of these therapies are low, and there are unintended consequences of harm with reprioritizing these conditions. There is misunderstanding of the aims and scope of the process, among the public and even the task force members. Thoughtful, well intentioned people have pointed out the potential of harms of the current proposal. These harms outweigh the benefits of the therapies, which themselves have low evidence.

Kelly Howard
She testified as a chronic pain patient. This process has been very difficult for patients to determine what is going on, and to understand the language used. Adding the alternative treatments under discussion is a great idea, but they are generally not very helpful. She is concerned about removing opioid therapies and is baffled by VbBS attitude toward scientific literature. Evidence is low to very low for the therapies proposed to be added, but adding options is beneficial. However, evidence of opioid benefit, which is higher quality, was discounted. She acknowledged that there are not studies on opioids for longer than three months. She is concerned about the ethics of tapering all chronic pain patients from their opioids. She feels that there is a lot of prejudice and bigotry about pain patients on opioids being "addicts." There is a difference between physiologic dependence and addiction.

Shelley Latin
She testified about concerns that the CPTF was "one-sided" and did not contain objective views about the best treatments for chronic pain patients. She feels that there should never be forced tapers but should be a medical

decision between a doctor and patient. She said there has been a mountain of testimony about prominent pain physicians that tapers are harmful, including the testimony of Beth Darnell. She went to the Stanford pain program personally. She feels that the alternative treatments are not a replacement for opioids, which is supported by evidence. There is also inadequate infrastructure to provide these alternative treatments across the state, particularly places such as eastern Oregon. She would like consideration of Dr. Darnell's offer to be included in her EMPOWER study.

Larry Gordon
He testified that Beth Darnell was an excellent addition to the committee and that he agreed with the previous testimony (Note: Beth Darnell was an invited presenter, not a CPTF member). He is concerned that no one is on any of the task force/committees that represents the chronic pain community. His wife is an example of the unintended consequences of forced tapering. Her family physician was afraid of the CDC guidelines and losing his license, so he abandoned her and sent her to another physician who did not know her. She is disabled and in chronic pain. She was sent to a pain specialist, who tapered her off her opioids. This was devastating to her and she wanted to commit suicide. The Department of Health and Human Services did a report on the CDC guidelines, and stated that these guidelines were not to be used for local jurisdictions to write laws or mandates. He said this policy will result in chronic pain patients being abandoned by their doctors. The doctors treating these patients should not be at risk for losing their license. He asked the Committee to consider mitigating the unintended consequences.

HERC Evidence-based Guidelines Subcommittee

The HERC Evidence-based Guidelines Subcommittee, elected in September 2014, is one of three subcommittees created under the HERC. EbGS looks at evidence-based guidelines on the evaluation and management of low back pain.

February 7, 2019

Testimony for this meeting related to the initiation of the process to update HERC's 2015 Coverage Guidance on Planned Out-of-hospital Births.

Silke Akerson, Director of the Oregon Midwifery Council
Ms. Akerson expressed frustration to hear discussion of data which includes unattended out-of-hospital births. She compared it to reviewing data around setting bones, where the data includes bones set by untrained family members. Family members aren't attendants but account for some of the deaths. She would like this fact acknowledged. She said this is the case in the Oregon biorecords data as well as the Snowden study. They account for five deaths in six years in the Oregon data. This is also the case in the Grunebaum studies (Editor's note: One of the Grunebaums studies is limited to births with attendants who have licensure). She would love to be able to know whether there is a variable harm to newborns, but it is hard to conclude based on faulty evidence.

Akerson said the Oregon Health Authority had some self-identified quality problems in the 2012-2013 data in Oregon. In 2015-2017, since quality program began, the perinatal mortality rate for attended out-of-hospital birth (including community midwives) is 0.72 per thousand, very different from what is being presented.

Even though there aren't the studies that meet HERC requirements about breastfeeding, the MANA stats study shows a 98 percent breastfeeding rate at six weeks.

Finally, there is some misunderstanding of misattribution bias in states other than Oregon. Those other states aren't tracking pre-planned out-of-hospital births that end up being transferred to hospitals. She's heard it said that this makes the mortality rate look lower than it actually is for planned out-of-hospital births. However, her understanding is that misattribution bias actually works in reverse; the majority of deaths in the Oregon dataset actually occur before transfer. What we are missing is a large denominator of births that transferred in non-emergent transfers. There are a high number of transfers that are low-risk transfers. We're missing the high number of people who transfer for an epidural.

She expressed empathy for the subcommittee trying to draw conclusions from such poor data. But it is frustrating to see that the data that is reviewed includes bad outcomes from unattended births.

HERC Health Technology Assessment Subcommittee

The HERC Health Technology Assessment Subcommittee develops medical technology assessments where technology assessments from trusted sources do not exist or require the consideration of additional evidence. Medical Technology Assessments include a new search of the current peer-reviewed research on the topic. HERC coverage guidance may be based on evidence-based guidelines developed by HTAS.

February 21, 2019

There was no public testimony for this meeting.

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 23, 2019

There was no public testimony for this meeting.

March 20, 2019

There was no public testimony for this meeting

Metrics and Scoring Committee

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

January 18, 2019

There was no public testimony for this meeting.

February 15, 2019

Samantha Shepherd, Executive Director of CCO Oregon

She provided public comment on behalf of CCO Oregon regarding social determinants of health, health equity, behavioral health and dental health. She gave recommendations for the the Health Plan quality Metrics, and the Metrics and Scoring Committee to consider for CCO 2.0 metric decisions.

March 15, 2019

Samantha Shepherd, Executive Director of CCO Oregon
She provided public comment regarding potential changes to the dental sealant measure.

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 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

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 June 30, 2019. Oregon is one of eight states participating in the program, which emphasizes access to quality outpatient behavioral health services by meeting criteria grouped into six program areas:

1. Staffing;
2. Availability and accessibility of services;
3. Care coordination;

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

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

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

For this demonstration period, Oregon continued to pay a daily rate to participating clinics, using the selected the Prospective Payment System (PPS) model. 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. Among the key milestones for this quarter:

- State-led metrics for Demo year 1 (April 2017- March 2018) validated & submitted to SAMHSA
- All on-site compliance visits were completed with OHA
- All progress reports were submitted to national evaluator

Patient-Centered Primary Care Homes

Patient-Centered Primary Care Homes (PCPCH) program staff conducted 37 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.

Four additional clinics became PCPCHs this quarter, for a total of 636 PCPCH clinics in the state. This is approximately three-quarters of all primary care practices in Oregon. Thirty-eight of those clinics have been designated as 5-STAR, the highest tier in the PCPCH model.

The Transformation Center has partnered with the Oregon Rural Health Practice Network (ORPRN) on a tele-learning series to assist coordinated care organizations (CCO) to add PCPCHs to their networks and provide support to already recognized PCPCHs to increase their tier level. Thirteen clinics have signed up to participate in the learning collaborative series.

Tribal Care Coordination

The State of Oregon and the nine Federally-recognized Tribes are the first in the nation to advance tribal care coordination through the Federal Medical Assistance Percentage (FMAP) Savings and Reinvestment Program. This program allows the state to claim 100 percent federal match for services that would otherwise be paid at the normal federal/state Medicaid recipient match rate for AI/AN services received outside of an IHS or tribal 638 facility. To be eligible for 100 percent federal match, the care received outside of the IHS/tribal facility must be requested and coordinated by the IHS/tribal facility.

The claiming of 100 percent federal match is made possible by updated CMS guidance contained in State Health Official Letter SHO #16-002 (2/26/16). The disbursement of these savings to the tribes is allowed per Governor Brown's letter to the tribes on 9/7/16.

Services eligible for this program include any covered Medicaid services. These services are typically covered at 100 percent FMAP when provided at IHS/tribal facilities, but updated guidance allows 100 percent funding for services outside of IHS/tribal facilities if the care is coordinated by the IHS/tribal facility. The state then claims the enhanced federal match, subtracts a small administrative fee, and returns the difference to the IHS/tribal health program that coordinated the care.

To further assist in efforts to expand coordination of care for tribal members, the Oregon Health Authority has contracted with Care Oregon to provide care coordination services for the roughly 17,000 AI/AN populations enrolled in the Oregon Health Plan who are fee-for-service (FFS) patients. Care Oregon's model of care coordination was led and developed by the tribes during discussions taking place in 2016. The tribes requested establishment of a program that focused on culturally-responsive health care and considered the unique nature of the AI/AN health care delivery system. During the first 11 months of the program, 766 members enrolled in the program, and 1,336 calls were received by Care Oregon's call center. Of the 766 members, 140 tribal members were enrolled in one of Oregon's nine federally recognized tribes; 346 individuals were enrolled in an out-of-state tribe. Care Oregon reports high rates of member satisfaction with the program, which has been renewed for a second year.

During the current quarter, OHA collaborated with tribal representatives on a proposal for Oregon's nine federally-recognized tribes announcing their intent to form an Indian Managed Care Entity. This proposal is still currently in the planning phase and efforts are expected to continue through 2019 to design and execute a plan to create one or more Indian Managed Care Entities that will assist in the coordination of health care for tribal members.

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

Comprehensive Primary Care Plus

Of the 156 Oregon Comprehensive Primary Care Plus (CPC+) practices, 145 have contracts with the Oregon Health Authority (OHA) for Medicaid fee-for-service members. The Oregon CPC+ payers meet monthly with a facilitator to discuss opportunities for coordination and alignment to support CPC+ practices.

Oregon was selected as a CPC+ region and began implementation January 1, 2017. The Transformation Center manages the Medicaid fee-for-service implementation. Per-member, per-month care management fees are a key component of the CPC+ payment model. In 2018 OHA launched the second key component, a performance-

based incentive payment that is paid based on practice performance on quality and utilization metrics. In 2018 each practice that submitted data received an average of $12,500.

The Oregon CPC+ payers continue to have monthly facilitated meetings to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers have selected the existing HealthInsight Oregon Reporting Portal for data aggregation. Custom CPC+ reports are in development for addition to the portal for availability to practices.

Value-Based Payment Innovations and Technical Assistance

During the current quarter, the Transformation Center worked with stakeholders and national value-based payment (VBP) experts to release the final VBP Roadmap for CCOs, along with a technical guidance report. The CCO VBP Roadmap is a required deliverable of Oregon's 1115 waiver and, beginning 2020, will include annual and five-year statewide VBP policies for CCO five-year contracts.

By 2024, at least 70 percent of each CCO's provider payments will be in the form of a VBP in the Refreshed Health Care Payment Learning and Action Networks (LAN) Alternative Payment Models Framework Category 2C (Pay for Performance) or higher, and at least 25 percent of the CCO's provider payments should include downside risk (fall within LAN Category 3B or higher).

As part of their responsibility towards achieving VBP targets, CCOs must develop new or expanded VBPs in five care delivery areas: hospital care, maternity health care, children's health care, behavioral health care, and oral health care. In addition to these targets, CCOs will also be required to make monthly infrastructure and operations payments (LAN Category 2A) to all their patient-centered primary care homes.

Primary Care Payment Reform Collaborative

OHA convenes the Primary Care Payment Reform Collaborative, a multi-stakeholder advisory group tasked with assisting OHA with the development and implementation of a Primary Care Transformation Initiative. Central to the initiative is a primary care payment model emphasizing paying for quality of care rather than quantity, as well as integrating behavioral health and addressing social determinants of health. The collaborative finalized its 2018 progress report on the initiative, which was delivered to the Oregon Legislature and Oregon Health Policy Board in January 2019. This year the collaborative will focus its work on implementation of the initiative. Four work groups support this work: metrics, evaluation, implementation and technical assistance.

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

- Governance and finance
- Standards of care and competencies
- Workforce

- Peer-delivered services
- Data and outcomes
- Health information technology and exchange

The workgroups for the above areas of focus convened between January and March of 2019. They recommended system changes that OHA can implement to attain the BHC's overarching goal: creating a coordinated, seamless health care system that treats each individual as a whole person and not a collection of problems and diagnoses.

Roadmap to Oral Health

The Oregon Health Authority (OHA) has taken additional steps during this quarter to achieve oral health integration. These include:

- Adoption of new administrative rules which expands telehealth to include Medicaid tele-dentistry services, allowing dental clinicians to provide expanded services in underserved areas of the state.
- A new CCO incentive metric regarding oral health examinations for adults with diabetes will encourage CCOs to align the work of dental and primary care providers.

Statewide Performance Improvement Plan

The Oregon Health Authority's (OHA) contract with CCOs, as negotiated with the Centers for Medicare and Medicaid Services (CMS) requires CCOs to conduct three performance improvement projects (PIPs) and one focus study that target improving care in at least four of seven quality improvement areas.

The Oregon Statewide Performance Improvement Project on Opioid Safety: Reducing Prescribing of High Morphine Equivalent Doses "High Dose Statewide PIP" is currently closed and OHA is working on getting the re-measurement period complete with CCO reporting and external quality review.

For the current quarter, the statewide PIP, based upon calendar year (CY) 2019-2021, is in the design phase. OHA and CCOs selected the topic of opioid prescriptions in acute situations. Measure specifications have been developed with report writing for baseline data for CY 2018 underway. The measure is currently defined as:

Percent of patients with at least one opioid prescription in one year, who have no opioids prescribed in the prior six months, among patients in the population by days' supply (i.e., ≤3, 4–7, 8–13, and ≥14).

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, the Oregon Health Authority's (OHA) innovator agents collaborated with coordinated care organizations (CCO), community partners, and Community Advisory Councils (CACs) as they develop their new Community Health Assessments and Community Health Improvement Plans. Innovator agents have made connections for technical assistance, participated in planning committees, and clarified Oregon Administrative Rules. Innovator agents have acted as conduits for information to Community Advisory Councils and CCOs as the Oregon Health Authority (OHA) plans for CCO 2.0. They have been assisting with community forums to gather feedback and provide information, have been available to CCOs to provide clarification as questions arise and have continued to give updates to CACs.

Oregon Health Authority

As CCO 2.0 continues, innovator agents assisted with gathering feedback and input for OHA about proposed policies from CCOs, Community Advisory Committees (CACs) and communities until public comment closed in November. They have continued to provide information to these same partners about the CCO 2.0 application process, dates for deliverables and important policy updates.

Most CCOs, CACs and communities are in the process of developing Community Health Assessments and Community Health Improvement Plans. Innovator agents have led and participated in community planning meetings, provided information and feedback, and have assisted with connecting CCOs and communities to technical assistance.

CCOs completed and submitted their second Transformation Quality Strategy in March. Innovator agents assisted by participating in workgroups, connecting with CCOs, and providing technical assistance and feedback to CCOs on their plans.

Public Health Modernization

There are no public health modernization updates for Jan-Mar 2019.

Sustainable Relationships for Community Health program

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

To build leadership and staff capacity prior to receiving the SRCH grant funding, OHA developed and recruited participants from thirteen local public health organizations and one tribal health organization for the SRCH Leadership Institute. The two-day cohort engaged local public health, tribal health and behavioral health partners in building relationships, identifying project and policy opportunities, and building core capacities for health systems transformation. This quarter, the second SRCH Leadership Institute convened in January 2019 where participants learned techniques and tools to drive large-scale systems change and enhance and sustain community health partnerships. Participants developed value propositions and a 90-day action plan including the identification of strategic health system partners to invite to a second convening.

Progress and findings

All cohort co-designed sustainable health systems change that improve health outcomes, promote equity and contain costs. This work included co-developing a shared goal, measurable outcomes and specific actions with partners. All SRCH Leadership Institute teams learned techniques that are critical to establishing, nurturing and sustaining partner relationships to improve health outcomes. To accommodate schedule conflicts, OHA-PHD staff also facilitated two individual convenings for local public health organizations and their partners to increase participation.

Trends, Successes or Issues

During the two SRCH Leadership Institute cohorts, 13 local public health organizations and one tribal health partner participated. The OHA Public Health Division plans to release the 2019-2020 Request for Grant Funding, for another cohort, in Spring 2019. SRCH is designed to align with OHA's agency-wide goals, public health modernization, and is an actionable strategy that can be used to meet the triple aim of health systems transformation.

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

Health-related services

Coordinated care organizations (CCO) receive a global payment for each enrolled member, which provides CCOs the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. During this reporting period OHA staff reviewed CCOs' 2018 HRS policies and developed guidance specific to each CCO on how to align with Oregon Administrative Rules. CCOs will have the opportunity to update their policies going forward. OHA will review each policy again following the 2019 HRS policy submission deadline. The Oregon Rural Practice-based Research Network (ORPRN) began interviews with CCOs to better understand the landscape of HRS and support the development of technical assistance to CCOs. ORPRN will also interview clinic and health system partners on HRS spending from their perspectives and will hold a CCO convening based on the results of the interviews.

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

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 staffs the Regional Behavioral Health Collaborative (RBHC), which OHA launched in November 2018 to further the work of the statewide Behavioral Health Collaborative (BHC). The RBHC is a partnership with behavioral health leaders and stakeholders in the Portland tri-county area to improve behavioral health outcomes through collective action across organizations responsible for behavioral health. The initial focus of the RBHC are peer-delivered services and substance use disorder activities that can make an impact in 12–24 months. Three topic-specific work groups — communities of color, youth and families, and medical community collaboration — are identifying goals, strategies, implementation plans and measures of success for the first year of the RBHC.

Population Health

Community Advisory Councils

The Transformation Center continues to provide targeted supports to CCO community advisory councils (CACs) for CAC member recruitment and engagement. During the quarter, the Transformation Center hosted its annual CCO Community Advisory Counsel conference with 130 participants in attendance, representing 15 CCOs and 33 of the 37 CACs. All evaluation respondents noted value received in support of their work.

Children's Health Complexity

The Transformation Center launched technical assistance guidance for CCOs using children's health complexity data. The data is provided by OHA's Office of Health Analytics in partnership with the Oregon Pediatric Improvement Partnership (OPIP). Support includes 10 hours for each CCO to work with OPIP, as well as technical assistance to OHA in the use of data to enhance care coordination for the fee-for-service Medicaid population. During the quarter assistance was provided to five CCOs.

Community Health Training

The Transformation Center staff held one CCO Community Health Improvement Plan (CHP) training in January. Seven CCOs have now received the training, which focuses on best practices in community health assessments and CHP development.

CCO incentive metrics technical assistance

Tobacco Dependency

The OHA Transformation Center and Health Promotion and Chronic Disease Section of the Public Health Division offered a community of practice and webinar series focused on treating tobacco dependence in behavioral health settings. Presenters were from the University of Colorado, School of Medicine. Four community of practice sessions and four webinars were completed this quarter, with participants representing 16 organizations. The webinar sessions are open to the larger behavioral health community and are recorded to expand the reach for each topic.

Developmental Screening and Follow-Up

A contractor developed and facilitated four webinars with accompanying tip sheets, guides and supplementary materials. The materials covered strategies for CCOs to support primary care providers in improving follow-up to developmental screening. Twenty-four people attended.

Effective Contraceptive Use

The Transformation Center pilot tested and disseminated a CCO-customizable metrics brief to support clinic staff in understanding and documenting the effective contraceptive use measure. The center also held a webinar for CCO staff to describe the implementation of policy expanding the scope of pharmacists to directly prescribe hormonal contraception in Oregon.

Emergency Department Use Among Members with Mental Illness

The Transformation Center staff launched two virtual learning collaborative series on reducing emergency department visits among members with mental illness (four sessions each):

- Systems improvement for populations experiencing mental illness – for CCO staff
- Behavioral and physical health integration: lessons from the field – for clinicians, clinic staff, and community partners

The Oregon Rural Practice-based Research Network is leading this work.

Timeliness of Postpartum Care

The Transformation Center launched a spring online learning series for CCOs, tribes, clinics and partners on the timeliness of postpartum care CCO incentive metric. All evaluation respondents rated the first webinar as valuable or very valuable. Future webinars will include peer sharing.

Cross-cutting supports

Transformation and Quality Strategy Technical Assistance and Review

The Transformation Center held four webinars for CCO staff to review updates and requirements for the 2019 Transformation and Quality Strategy (TQS). CCOs submitted their TQS' in March, and center staff are coordinating OHA review. Submissions included over 200 unique CCO-led projects or programs to address the 12 required TQS components.

Patient-Centered Counseling Training

The Transformation Center held seven patient-centered counseling trainings for Medicaid providers. Over 200 people attended. Examples drew from CCO metric-related topics, and evidence-based health communication models included motivational interviewing, the FRAMES model and Five As for tobacco cessation counseling. No-cost continuing medical education credits were available. Evaluation results were extremely positive, with 100 percent of respondents indicating the training was valuable to their work and effective for meeting their needs.

Innovation Café: Strategies for Improving Children's Health

The 2019 Innovation Café will focus on sharing innovation and best practices to address social determinants of health (specifically housing, trauma, early learning/early childhood education, and food insecurity). The planning committee received 51 project proposals and selected 46 to be presented.

Early Childhood Health Coordination

Transformation Center staff facilitated three meetings with partners about an Oregon oversample for the 2020 National Survey of Children's Health. Staff also continued to coordinate with Early Learning Division staff regarding connection and collaboration between health care partners and early learning hubs, with a focus on the 2019 Innovation Café and planning for collaboration supports when the new CCO contracts go into effect.

Transformation in Action Newsletter

The Transformation Center released the first *Transformation in Action* newsletter. Its goal is to feature stories about CCOs' innovative work, highlight evidence-based practices, and celebrate successes. The first issue focused on tobacco cessation and community health workers. Nearly 300 people have subscribed.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Reports are attached separately as Appendix A – Enrollment Reports. (Jan-Mar 2019), as posted for this period, is a preliminary report.)

2. State reported enrollment table

Enrollment	January 2019	February 2019	March 2019
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	940,874	942,414	949,990
Title XXI funded State Plan	88,216	88,830	90,291
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, 2019	February 28, 2019	March 31, 2019

3. Actual and unduplicated enrollment

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	49,985	126,410	-20.54%	-80.95%
Optional	**Title 19**	PLM Women FPL 133-170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL < 170%	97,007	249,702	11.27%	48.19%
Mandatory	**Title 19**	Other OHP Plus	156,703	440,043	-0.13%	0.11%
		MAGI Adults/Children	734,955	2,021,416	0.06%	0.51%
		MAGI Pregnant Women	11,384	26,346	-3.03%	-16.02%
		QUARTER TOTALS	**1,050,034**			

OHP eligible and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
January	982,802	853,926	574	511	33,129	42,429	1,183
February	979,097	856,682	670	490	32,781	43,194	1,283
March	985,909	857,483	582	475	32,593	43,719	1,285
Quarter average	982,603	856,030	609	492	32,834	43,114	1,250
		87.12%	0.06%	0.05%	3.34%	4.39%	0.13%

**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.