Oregon Health Plan

Section 1115 Quarterly Report

7/1/2017 – 9/30/2017
Demonstration Year (DY): 16 (7/1/2017 – 6/30/2018)
Demonstration Quarter (DQ): 1/2018
Federal Fiscal Quarter (FQ): 4/2017

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I. Introduction

A. Letter from the State Medicaid Director

As we begin the 2017-2022 1115 Medicaid Waiver renewal period, I am pleased to tell you the Oregon Health Authority (OHA) continues to move forward in meeting the goals of the Oregon Health Plan (OHP) demonstration. As you will find detailed in the full report, OHA and coordinated care organization (CCO) activities continue to press toward achieving 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 continued to improve care coordination through the Patient-Centered Primary Care Home (PCPCH) program and the federal Certified Community Behavioral Health Clinic (CCBHC) project.

  The PCPCH program launched a "Transformation in Practice" webinar series in September to provide in-depth technical assistance on featured PCPCH measures from their peers and OHA staff. Also, the Transformation Center began planning efforts to offer technical assistance to help CCOs add PCPCHs to their network and provide support to recognized PCPCHs.

  The CCBHC demonstration will lead to improved access, increased integration and improved outcomes for OHP members. OHA is focusing on compliance monitoring to ensure quality standards are met and working with CCBHCs to ensure accurate data submission. OHA will also provide technical assistance to clinics so they can effectively use data to improve outcomes.

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

  OHA continues working toward value-based payments (VBPs) through several programs including the Federally Qualified Health Center (FQHC) Advanced Payment and Care Model (APM) and Comprehensive Primary Care Plus (CPC+) programs. For the FQHC APM, OHA, participating health centers and the Oregon Primary Care Association worked together to establish an accountability plan and standardize quarterly reporting on eight Uniform Data Systems (UDS) quality measures. OHA also continued implementing the CPC+ program, providing a webpage of resources for practices as well as technical assistance to providers on reporting metrics and meeting quality measures.

  OHA has engaged national VBP experts at Bailit Health to consult with OHA on developing a VBP roadmap, which will identify VBP targets for CCOs. Also, the Center for Health Care Strategies is providing technical support to OHA for contract language and stakeholder engagement.

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

  OHA is making strides toward integrating behavioral, physical and oral health. Regional Behavioral Health Collaboratives (RBHCs) are being established to bring key partners and stakeholders together to review state and local needs assessments, reports, and data in order to focus on regional behavioral health priorities. Managers from OHA's dental program participated in the Center for Health Care Strategies' 2017 State Oral Health Leadership Institute; their work illuminated the role dental

prescribers play in the opioid epidemic. Also, the Metrics and Scoring Committee considered two additional oral health measures for the 2018 incentive measure set.

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

  While innovator agents continue to connect OHA and the CCOs to achieve the goals of health system transformation, OHA's Public Health and Health Systems divisions connect to advance the Sustainable Relationships for Community Health (SRCH) grant program. The program aligns with OHA's agency-wide goals and public health modernization. As an actionable strategy to meet the triple aim of health systems transformation, SRCH brings together CCOs, local public health authorities and community-based organizations to work together towards improved health outcomes. The Oregon Health and Sciences University's SRCH grantee cohort evaluation was completed in September and showed that all teams have made significant progress on their initiatives and were successful in meeting their goals.

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

  OHA is currently working to revise Oregon Administrative Rules, revise CCO contracts and financial reporting standards, and develop additional guidance to assist CCOs as they implement the revised definition of health-related services. The summative evaluation completed by Oregon Health & Science University's Center for Health System Effectiveness (CHSE) showed that CCOs provided a wide variety of flexible services, including services to individual members, groups of members, and services available to members and other people in the community. Based on their experiences, most CCOs believed that flexible services were effective at improving outcomes and reducing costs

  CCOs have expressed the need for greater communication and clarity around tracking and reporting on the use of health-related services and outcomes associated with flexible services. OHA is working toward more complete, consistent data to evaluate the effects of health-related services. We are in the process of revising financial reports, and moving forward OHA will provide technical assistance to CCOs.

  OHA is exploring mechanisms to account for quality and efficiency outcomes, resulting from increased investments in health-related services, in rate development. Specifically, the state has proposed to develop capitation rates with a profit margin that varies by CCO based on efficiency and quality measurement. Oregon is further exploring this concept due to some potential concerns with implementation feasibility.

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

  Peer-to-peer learning, the spread of best practices and innovation continue through OHA's Transformation Center. This quarter the Transformation Center began working to support a new CCO incentive metric focused on emergency department use among members with mental illness, coordinated a partnership among OHA, CCOs and the Oregon School Activities Association to create a comparison of the adolescent well-care visit and pre-participation physical evaluation, and completed a 10-part webinar series for CCOs and clinics to increase effective contraceptive use.

  The Transformation Center continues to support CCOs through technical assistance, health equity consultations, and support through the Technical Assistance Bank.

This report marks the beginning of OHA's 1115 demonstration waiver renewal for OHP. As OHA continues to invest in health system transformation, we look forward to improving health outcomes and health care in Oregon by working with our partners and stakeholders to meet the goals of the demonstration while accomplishing the targeted changes included in the extended waiver.

David Simnitt, Interim State Medicaid Director

B. Demonstration description

In July 2012, CMS approved an amendment and extension related to Oregon's 1115 Medicaid Demonstration waiver that transformed Oregon's health care delivery system to one of coordinated care. Sixteen Coordinated Care Organizations (CCOs) – which geographically cover the entire state – now deliver physical, oral and behavioral health services to approximately 90 percent of 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, through June 2022, to continue and enhance Oregon's health system transformation. Moving forward, Oregon will continue to utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

Under the demonstration, Oregon strives to promote waiver objectives by:

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

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

- Enhance Oregon's Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve;
- 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;
- 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

- Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

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

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

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 7/1/2017 – 9/30/2017
Demonstration Year (DY): 16 – Quarter 1
Demonstration Quarter (DQ): 1/2018
Federal Fiscal Quarter (FQ): 4/2017

III. Overview of the current quarter

A. Enrollment progress

The Oregon Health Authority's enrollment strategies have remained consistent with previous reporting periods, although Oregon Health Plan (OHP) eligibility determination is transitioning to the Department of Human Services (with OHA's single state agency oversight). There are no significant changes in eligibility and CCO-enrollment numbers.

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

B. Benefits

The Oregon Pharmacy and Therapeutics Committee developed new or revised prior authorization (PA) criteria for the following drugs: Hepatitis C Direct-acting antivirals, Ocular Vascular Endothelial Growth Factors and Proton Pump Inhibitors, Long-acting Opioid Analgesics, Short-acting Opioid Analgesics, Opioid Analgesics (removed PA), Drugs for Duchenne Muscular Dystrophy and Biologics for Autoimmune Conditions Nusinersen. The committee also added the following drugs to the preferred drug list: Gabapentin tablets, Ranitidine (150mg and 300mg tablets), Famotidine (20mg and 40mg tablet), Irbesartan and Valsartan.

C. Access to care

Oregon Access Monitoring Review Plan

OHA submitted the Access Monitoring Review Plan (AMRP) in October 2016 to monitor fee-for-service access-to-care. Oregon has spent this reporting period operationalizing the primary monitoring activities identified in the plan by building a dashboard that incorporates quarterly utilization rates for the required service categories and quarterly beneficiary complaint rates. The primary monitoring functions are also able to hone in on specific regions of the state to compare access in those areas to the statewide baseline and threshold. The data within the dashboard is updated through September 30, 2017. Testing and updates to the dashboard continue to take place, and additional plans to add county level detail are being designed.

OHA is continuing work with the nine federally recognized tribes through formal Tribal Consultation and additional meetings to better incorporate their feedback into the plan. In Oregon, approximately 50% of tribal

Oregon Health Plan members have chosen not to enroll in managed care plans. Oregon intends to update the AMRP with an additional public comment period and re-submit the plan to CMS by June 2019.

D. Complaints, grievances, and hearings

Complaints and grievances

Coordinated care organizations complaints and grievances

The information provided is a compilation of data from the 16 coordinated care organizations (CCOs). The data reported covers the quarter beginning 07/01/2017 and ending 09/30/2017.

Trends

	Oct – Dec, 2016	Jan – Mar, 2017	Apr – Jun, 2017	Jul – Sep, 2017
Total complaints received	4,070	3,930	4,225	4,157
Total average CCO enrollment	862,040	865,701	882,453	855,569
Rate per 1,000 members	4.72	4.54	4.78	4.71

- Total rate per 1000 members statewide this quarter in all categories is 4.71. The previous quarter was 4.78 rate per 1000 members.
- Rates per 1000 members among the individual 16 CCOs show the lowest rate per 1000 members for one CCO was .74 and the highest was 9.46 for another CCO. The numbers show a decrease from last quarter, when the highest rate was 10.48 rate per 1000 members.
- Interaction with Provider or Plan categories showed a decrease overall to 1293 complaints this quarter from the 1329 high over the last four quarters. The Billing Issues category showed the highest amount over the last four quarters at 334 complaints.

There is continued effort across the CCOs to standardize data collection among their contracted delegates to improve reporting of complaints.

Barriers

- The Non-Emergency Transportation (NEMT) complaints continue to be an issue. Some CCOs are reporting they are continuing to take steps to resolve the high number of complaints by meeting regularly with NEMT providers to resolve issues.
- Increase in Quality of Care complaints category over the last 12 months. Exploration with CCOs to determine the data increase and subsequently the development of mitigation plans.

Interventions

Some CCOs report they began using new data collection software that will improve their reporting of complaints. One CCO reported hiring new staff to specifically work on reducing the number of grievances overall. Several CCOs indicate they are providing training and coaching on an individual provider basis when a complaint is received.

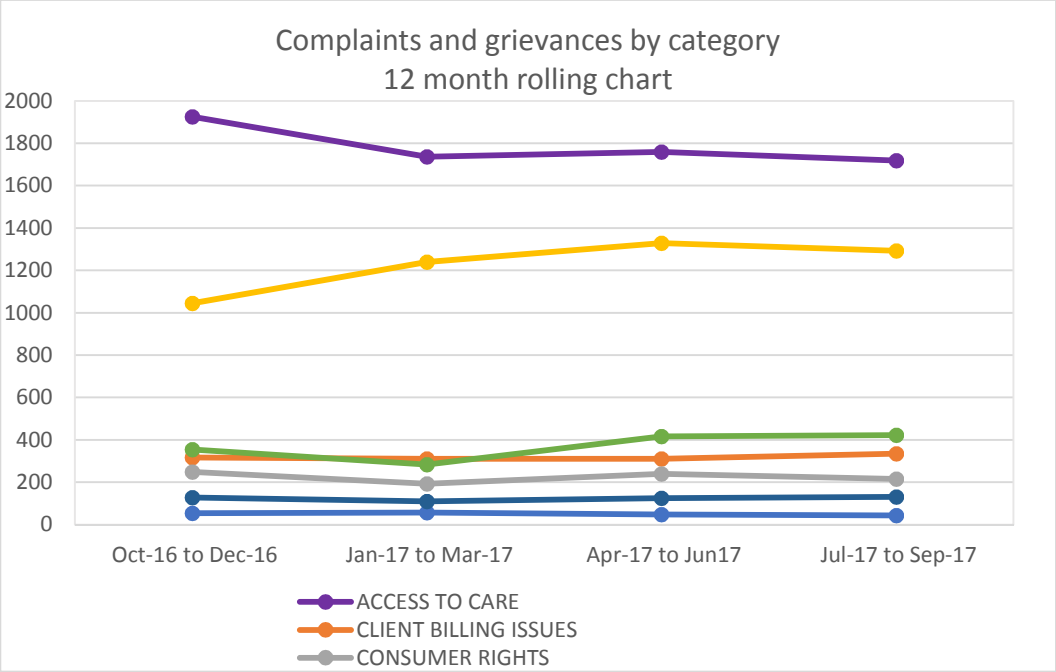
Related data

For related data see Appendix B: Complaints and grievances, which is attached separately

Statewide rolling 12-month totals

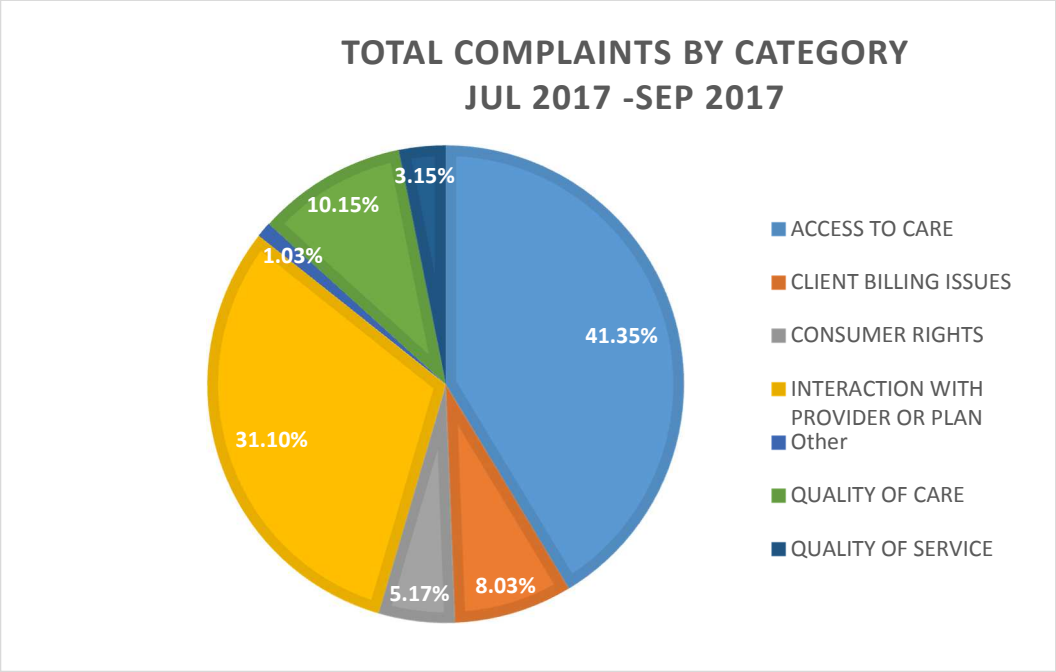
This chart includes the total of all complaints reported statewide by the 16 CCOs for the quarter.

Complaint category	Oct – Dec, 2016	Jan – Mar, 2017	Apr – Jun, 2017	Jul – Sep, 2017
Access to care	1,926	1,737	1,759	1,719
Client billing issues	316	311	310	334
Consumer rights	248	193	239	215
Interaction with provider or plan	1,045	1,240	1,329	1,293
Quality of care	354	283	416	422
Quality of service	128	110	124	131
Other	53	56	48	43
Grand Total	**4,070**	**3,930**	**4,225**	**4,157**



CCO summary

This chart shows the distribution of this quarter's complaints data amongst the six complaints categories. The percentage reflects the percent of total reported for the quarter.



Fee-for-service complaints and grievances

OHA's Client Services Unit began logging complaints into the Medicaid Management Information System (MMIS). The first full quarter of data-entry has occurred, and additional work will be conducted to analyze the data to ensure accuracy and data reporting capabilities for fee-for-service.

CCO and FFS appeals and hearings

OHA received 703 hearing requests related to the denial of medical services. The number of hearings requested for CCO-enrolled and fee-for-service clients were 668 and 35, respectively. The top three issues for hearings were surgery denials (192 requested hearings), referral denials (135 requested hearings) and prescription denials with (115 requested hearings).

Of all hearing requests, 237 were approved after a second review (original decisions overturned). There were 188 hearings where the member withdrew their hearing request after an informal conference with an OHA hearings representative. Seventy-eight cases were dismissed as not hearable due to provider error. There were 171 cases that went to hearing, and the administrative law judge: upheld the OHA or CCO decision in 89 cases, reversed the OHA or CCO decision in three, and dismissed for members' failure to appear in 79. Thirty-five hearing requests were dismissed due to a member requesting the hearing after the allowable 45 days without good cause for the late request.

For related data see Appendix C: CCO appeals and hearings, which is attached separately.

E. Coordinated care organization activities

1. New plans

There are no new plans serving the Medicaid population.

2. Provider networks

AllCare transitioned 1,450 members from Jackson County Mental Health to Options for Southern Oregon for mental and behavioral health services. There was no significant increase in behavioral health crisis, emergency department visits for behavioral health conditions, hospitalizations for mental health, behavioral health crisis in provider offices, or grievances for adults, or youth, during the transition period. Jackson County Mental Health continues to provide crisis services for AllCare members.

Cascade Health Alliance (CHA) has dissolved their contract with Advantage Dental and Capitol Dental and is now contracting directly with individual dental providers within their service area. CHA had approximately 17,148 members with dental benefits in the third quarter. CHA's Quality Management department will continue to conduct regular audits of all providers, including dental. Additionally, CHA is closely monitoring any member grievances and appeals related to this change in dental network.

3. Rate certifications

Oregon's 16 CCOs contract with the state to manage and deliver health care to Oregonians that are eligible for Oregon Health Plan (OHP) benefits. The Oregon Health Authority (OHA) pays a per-member per-month capitation to CCOs to manage OHP members' physical, behavioral and oral health care. The average rate increase among Oregon's CCOs is 3.3 percent. As part of its federal waiver with the Centers for Medicare & Medicaid Services (CMS), Oregon has pledged to contain rate increases to 3.4 percent per year or less.

Oregon's rate development takes into account several factors, including differences in regional costs, population disease risk and hospital reimbursement. The state contracts with Optumas, an actuarial consulting firm, to assist in the rate development, and capitation rates have been certified by Optumas as actuarially sound. OHA gives CCOs an opportunity to review the rates before they are submitted to CMS. The agency also works with the CCOs and the actuary to ensure that the methodology behind the rate setting is rigorous, equitable and compliant with federal requirements.

4. Enrollment/disenrollment

There were no significant changes in CCO-enrollment. Enrollment data is listed in the actual and unduplicated enrollment table in Appendix A.

5. Corrective action plans

For encounter data from the CCOs, there are no open corrective action plans.

6. One-percent (1%) withhold

The Oregon Health Authority's Health Systems Division (HSD) analyzed encounter data received for completeness and accuracy for the subject months of December 2016 through February 2017. All CCOs met the administrative performance standard for all subject months and no one-percent withholds occurred.

7. Other significant activities

As part of the contract process, each CCO was required to develop a transformation plan geared specifically to the needs of the community it serves. Transformation plans demonstrate how the organization will work to improve health outcomes, increase member satisfaction and reduce overall costs. During this quarter, CCOs submitted their most recent transformation plan progress reports, which described progress toward meeting

benchmarks (to be achieved by December 31, 2017) in eight focus areas. Projects and benchmarks were designed by each CCO to further their transformation work.

F. Health Information Technology

Health Information Technology Oversight Council

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

HITOC met in August and approved an update to its three-year strategic plan. Oregon's HIT strategic plan incorporates the needs of a broad range of stakeholders, including coordinated care organizations (CCOs), providers, health systems, and payers and will guide Oregon's implementation of HIT strategies, including those related to CCOs, Medicaid members, and providers over the next three years. The plan includes an updated focus on spreading health information exchange, supporting the HIT needed for alternative payment models, and exploring the role of HIT in addressing the social determinants of health. The strategic plan also includes support to pursue the public-private HIT governance partnership described in the waiver, and work is now underway to complete planning activities and launch the new effort, the HIT Commons, by January 2018.

Health Information Technology Advisory Group

The Oregon Health Authority (OHA) convenes the Health Information Technology Advisory Group (HITAG), composed of CCO representatives, to guide HIT activities that support CCOs. HITAG also provides a forum for CCOs to share information and ideas with each other. In July, HITAG and HIT/Health Information Exchange Community and Organizational Panel (HCOP) held a joint meeting to discuss next steps for HIT, behavioral health, and social determinants of health. HITAG met in September to discuss strategies for HIT supports for member engagement and CCO involvement in the upcoming HIT Commons.

Medicaid EHR Incentive Program

Through the Centers for Medicare and Medicaid Services (CMS) Electronic Health Records (EHR) Incentive Programs, eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). An increase in the number of providers using CEHRT helps promote better health outcomes for Oregonians by increasing access to and use of vital health information at the point of care. Since the program's inception in 2011, 7,874 Oregon providers and 61 hospitals have received a total of $494 million in federal incentive payments ($328 million under the Medicare EHR Incentive Program and $166 million under the Medicaid EHR Incentive Program, as of September 30, 2017). Between July and September 2017, 242 Oregon providers received nearly $3 million in Medicaid EHR incentive payments.

Program year 2016 participation yielded 2,157 attestations, 703 of which were from providers who had never participated in the program. This is an increase of over 600 attestations from 2015.

In May 2017, CMS approved naturopathic physicians and pediatric optometrists to be eligible professionals for Medicaid. A total of 107 naturopathic physicians and four pediatric optometrists submitted an attestation for program year 2016, which was the last year to begin participation.

Oregon Medicaid Meaningful Use Technical Assistance Program

The Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) provides technical support to Medicaid physicians, nurse practitioners, dentists, and physician assistants in certain circumstances. The program offers resources to help providers meaningfully use their EHRs and report CCO EHR-based metrics.

An additional 74 providers at 33 clinics began participating in the program, bringing the total number of participating providers to 1,385 providers at 310 clinics. Technical assistance has supported these providers in meeting meaningful use, improving workflow, mitigating privacy and security risks, and achieving interoperability of health information exchange to improve care coordination and service delivery.

Emergency Department Information Exchange/PreManage

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

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

OHA is coordinating CCO use of PreManage for Medicaid. Many Medicaid providers are currently using PreManage to better manage their member populations and assist in the statewide reduction of ED utilizations.

- Fifteen of 16 CCOs are now receiving hospital event notifications. Thirteen are receiving notifications through PreManage and two are accessing notifications through their health information exchange. Twelve of the CCOs with PreManage have opted to expand their license to their key clinical practices.
- Thirteen Assertive Community Treatment (ACT) teams are live on PreManage and two are in process.
- Oregon's fee-for-service care coordination contractors (KEPRO and CareOregon) are live.
- All dental care organizations are engaged (six are live on PreManage and three are in process).
- Six Department of Human Services' Area Agency on Aging (AAA) and Aging & People with Disabilities (APD) sites are piloting PreManage and will roll-out statewide starting in November 2017.

Provider Directory

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

The provider directory will benefit CCOs by supporting care coordination, health information exchange and administrative efficiencies. The directory will also serve as a resource for heath analytics because it:

- Provides one place to go for accurate and complete provider data, which will reduce the burden on providers and the staff time spent on data maintenance activities.
- Enables better care coordination for patients and the ability to meet certain meaningful use objectives because it supplies complete information on providers and how to contact them.
- Improves the ability to calculate quality metrics that require detailed provider and practice information

OHA continues to meet with stakeholders via the Provider Directory Advisory Committee to provide input and oversight to OHA's development of this program. The provider directory will begin implementation in late 2018.

Clinical Quality Metrics Registry

The Clinical Quality Metrics Registry (CQMR) will collect, aggregate and provide clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. Initially, the CQMR will support the Medicaid EHR Incentive Program and the CCO incentive measures that are EHR-based. Over time, other quality reporting programs could use the CQMR as well. The CQMR is expected to go live in late 2018. OHA is exploring options for Oregon providers to use the CQMR to submit quality data to CMS for the Medicare Merit-based Incentive Payment System and the Comprehensive Primary Care Plus program.

Common Credentialing

OHA is working with stakeholders to plan and implement a common credentialing program for Oregon health care practitioners. OHA is working with vendors on system configuration and the development of program policies. Marketing and outreach efforts will commence in March 2018 and will be operational on September 4, 2018. The program is mandated by Oregon law and will include a web-based system to collect, store, and verify practitioner credentialing information for use by credentialing organizations. It will streamline and centralize credentialing information to create efficiencies for an estimated 55,000 health care practitioners across Oregon and more than 300 credentialing organizations, including all Oregon health plans, CCOs, hospitals, health systems, dental care organizations, ambulatory surgical centers, and independent physician associations. The Common Credentialing Advisory Group provides stakeholder input and oversight to OHA's development of this program.

Health Information Exchange Onboarding Program

The Health Information Exchange (HIE) Onboarding Program will help connect key Medicaid providers to community-based HIEs that provide meaningful HIE opportunities and play a vital role for Medicaid in their communities. OHA may contract with one or more community-based HIEs. HIEs will onboard priority physical, oral, and behavioral health Medicaid providers according to a work plan developed in consultation with Medicaid partners. Oregon anticipates awarding the contract(s) early in 2018.

Behavioral Health Information Technology Scan

OHA is in the midst of a behavioral health HIT scan, including stakeholder interviews and an online survey, which was released in May 2017. The survey collects information from behavioral health entities across the state regarding HIT and HIE use, needs, challenges, and priorities. Stakeholder interviews are underway to gather additional context. The report is anticipated to be final in early 2018.

G. Metrics development

Oregon's coordinated care organizations

The Oregon Health Authority (OHA) began reporting on the 2017 coordinated care organization (CCO) and state performance measures, completed the benchmark setting process for 2018 with the Metrics and Scoring Committee, and continued measure development and validation work.

The 2018 incentive metrics benchmarks, improvement targets and annual floors were identified for all 17 chosen incentive metrics. In addition, two major activities occurred during this reporting period:

1. OHA helped CCOs prepare for the 2018 measurement year for the newly introduced measures, including the disparity metric: *Emergency Department use by people with mental illness*, a measure that emphasizes management of physical health conditions for people with severe and persistent mental illness.
2. OHA made considerable efforts towards the development of future measures, for those measures that were not fully developed, for placement on the 2018 measure list.

Activities in preparation for CCO 2018 incentive measures

A metric was adopted as a disparity measure to improve physical health of members with persistent mental illness. Work on this measure will be supported by increased adoption of PreManage, a tool that brings real-time hospital notifications to CCOs and care coordinators. All 59 Oregon hospitals contribute admit, discharge, and transfer data (both emergency department and inpatient data) to the Emergency Department Information Exchange (EDIE), which serves as the data infrastructure for PreManage. CCOs, health plans, and providers can subscribe to PreManage to access the hospital event data and better manage their populations who are high utilizers of hospital services. During this quarter, OHA explored the possibility of using this software tool to alert primary care physicians when members with mental illness visit the emergency department.

OHA joined a Maternal and Infant Health Care Quality Innovation Acceleration Program to work on the development of a defined set of provider characteristics for the metric: *Effective Contraceptive Use*. The incentive metric is a home-grown measure based on published literature and input from subject-matter experts. This innovation acceleration project is meant to identify the service-delivery structures associated with high-quality care so that a value-based payment model can be tested once a spectrum of quality can be identified for contraceptive services.

Activities related to CCO metrics development

OHA continued to study the implications of moving from a claims-based incentive metrics list to including several electronic health record based quality metrics. For this reason, OHA launched a pilot project to study the ease or difficulty of collecting a three-part metric for Screening, Brief Intervention and Referral to Treatment (SBIRT) measures in CCOs. The work plan for this pilot study was developed to test reporting from several different electronic health care software types.

The challenge pool of incentive metrics for 2018 are child-related because of the strong developmental interests of the Metrics and Scoring Committee. The group identified a future need to have a health-based measure of kindergarten-readiness. OHA set about developing a work plan that included, as a preliminary task, identifying questions with potential for inclusion in the annual Consumer Assessment of Healthcare Providers and Systems

(CAHPS) survey of Medicaid members in both English and Spanish. Since it was the desire to have national standardized data for comparison, The National Survey of Children's Health (NSCH), Section G was selected as a source for items to be included in Oregon's 2018 CAHPS survey, but it contained far too many questions for the CAHPS survey. A Delphi-like method of professional consensus was chosen to narrow the items down into a handful of questions.

Approximately 75 experts from both health-medical and educational-developmental fields were included in this process. They ranked the importance of NSCH, Section G items for kindergarten-readiness. Item analysis was conducted from ratings in a CAHPS survey based upon importance for inclusion in the CAHPS state survey and importance to the construct of kindergarten-readiness. Five items were identified based on results. Findings were summarized over the entire group as well as between medical and educational participants to determine if endorsement of items differed between expert groups. While there was quite a bit of variation across the entire section of questions, both groups had consensus for the top five questions, which were selected for the 2018 CAHPS survey. The five items chosen for inclusion in 2018 are:

- How often does this child play well with others?
- When he or she is paying attention, how often can this child follow instructions to complete a simple task?
- In the past two months, were you ever asked to keep your child home from any child care or preschool because of their behavior?
- How often does this child lose control of his or her temper when things do not go his or her way?
- Compared to other children his or her age, how much difficulty does this child have making or keeping friends?

The survey is answered by parents with children from birth to five years for both English and Spanish respondents to determine how answers might inform a new kindergarten-readiness metric for CCOs in future years.

H. Budget neutrality

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.

Because Congress has not provided new funding for CHIP for Federal Fiscal Year (FFY) 2018, OHA is projected to run out of CHIP allotment in December 2018. Governor Kate Brown has directed the agency to continue to provide CHIP coverage in anticipation that Congress will act. OHA is projecting the state will receive its FFY 2018 allotment in December 2017.

For related data see Appendix D: Neutrality reports which is attached separately.

I. Legislative activities

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

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

Other 2017 legislation impacting Oregon's Medicaid program included:

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

J. Public forums

Health Evidence Review Commission

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

September 28, 2017

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

Jenn McNary, a Duchenne advocate and mother of two children with DMD, ages 15 and 18

Ms. McNary said her older son is able to complete most of his activities of daily life (ADLs). She urged the Commission to take time to make the right decision and to ask questions of her and other advocacy groups.

She said the drug is not experimental. The Food and Drug Administration (FDA) accelerated approval exists to provide access to drugs with biomarker evidence that is reasonably likely to provide benefit. It is not considered experimental therapy by law, as stated by the Department of Health and Human Services. She testified that the medication is about preserving muscle so patients have a better outcome. She said if she were able, she would prioritize ultra-rare fatal childhood diseases at the top of the list and everything else below and likened Exondys 51 to a "parachute" for children with DMD.

In responding to member questions she said the following:

- She was persistent in getting her sons into drug trials and has helped other families do the same; unfortunately, the Oregon families are not eligible for trials.
- She would love to provide HERC the patient-reported outcomes not seen in the Pharmacy and Therapeutics Committee report.
- The drug works on muscle that is still present and is required for the lifetime of a patient and there are no known side-effects.
- In Oregon there are two patients receiving the medication and three more that are eligible and need it.

Jamie Saukko, a mother of a 2-year old with DMD
Ms. Saukko's child is not eligible for the trials but is in desperate need of the drug. She said we are wasting valuable time as her son loses muscles.

Hannah Cain, a Duchenne advocate and mother of a 6-year old with DMD
Ms. Cain is not a carrier; there was a spontaneous gene-mutation which caused her son's disease. She said the FDA approves medicine on the fast-track to fulfill an unmet medical need with promising therapy. "This is usurping the FDA process. What is on the line for you is money, what's on the line for us is a lot greater. We don't have time." She added she feels a win is the patient not getting worse while they are waiting for a cure we hope is on the horizon.

Mike Donabedian, Sarepta Pharmaceuticals
Mr. Donabedian said that during their review, the Pharmacy and Therapeutics Committee removed the age requirement which had restricted the drug to those over five years of age and removed the requirement for ambulatory status before voting to send the topic to HERC for potential placement below the funding line. He asked how they can both improve access to the drug while sending it off to be placed on an unfunded line. No explanation was given at the July Pharmacy and Therapeutics Committee meeting. He strenuously requested discussion be halted at this meeting until that question can be answered.

Lisa Borland, Sarepta Pharmaceuticals
Ms. Borland described the accelerated approval pathway for both drugs. She emphatically stated the drugs are not experimental, FDA approval is not conditional and prioritization on line 660 circumvents the FDA's intent.

HERC Value-based Benefits Subcommittee

August 10, 2017

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

Lisa Borland, Sarepta Pharmaceuticals
Ms. Borland indicated that she was attending the meeting to answer any questions about Exondys 51. Exondys 51 was approved by the FDA for a very specific subset of patients with Duchenne muscular dystrophy (DMD) (13%, representing about 1,000 patients across the US). Exondys 51 gained approval through the accelerated approval pathway to allow medications to come out for rare conditions.

Jamie Saukko, a mother of a 2-year old with DMD

On behalf of her son with DMD from Eugene, Ms. Saukko said her son desperately needs Exondys 51. She said DMD is a fatal diagnosis with no treatment other than Exondys 51. His condition is deteriorating daily, and he needs to be on this medication before further damage is done. This drug will help her son and others produce dystrophin, as clinical trials showed improvement in dystrophin level. It will not change the eventual end, but will improve function for some time. Ms. Saukko thinks the medication should be covered, regardless of age and ability to walk. Everyone who qualifies should have access to this drug.

Jim Rickards, MD, from MODA Health

Dr. Rickards said the role of the HERC in reviewing medical evidence of medication effectiveness of marginal or no clinical benefit is important. Paying for these high cost drugs reduces ability to fund other things. He reviewed the lack of clinical efficacy for Exondys 51. As a steward of Medicaid dollars, MODA recommends that HERC review these drugs and place them on appropriate non-funded lines.

Billy Ellsworth, a patient with DMD

Billy is a patient with DMD from Pittsburg. He has been receiving Exondys 51 since 2011 and feels it has helped maintain his strength and ability to walk and be independent. He is sad at the thought of not getting this drug and losing his independence. He sees other boys with DMD who are much worse than he is. He feels the drug is effective and helps him continue to walk. He asked that HERC please support coverage of this drug.

Terri Ellsworth, Billy's mother

Billy is 16½ and has been receiving this drug for six years. Their family flew across the country to testify because of their strong feeling that the drug is effective. Ms. Ellsworth testified about what other parents go through in caring for their sons with DMD. Billy can do most ADLs himself. Ms. Ellsworth does not feel that Billy is an outlier. Prior to starting Exondys 51 he was an extreme toe walker, a sign of the end of the ability to ambulate. He is now able to walk with improved toe walking. She said a little dystrophin is better than no dystrophin for clinical impact. She feels this drug has a significant impact on patients and families. This is a rare disease and all drugs for rare diseases are expensive. This drug is FDA approved. Medicaid did approve Exondys 51 in Oregon. She requested that DMD experts be sought out for future discussions.

September 28, 2017

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

Dr. Erika Finanger, a pediatric neurologist from OHSU

Dr. Finanger provided some information about an ongoing trail of eteplirsen. This ongoing study (N=75) is a 48-week trial of eteplirsen with control patients who are DMD patients with other exon-skipping mutations (not exon-51), but who are thought to be generally clinically similar to the exon-51 patients in terms of standard of care therapy. Finanger said her clinical experience is that her patients on eteplirsen are not losing ability to ambulate, unlike similar untreated patients. She noted that eteplirsen went through an established FDA approval process. She agrees on the need for further study on the effectiveness of eteplirsen. She did note that the researchers need to use surrogate outcome in the eteplirsen studies as finding other outcomes takes a very long time and is likely not feasible. In regard to deflazacort, she agreed it has a significant cost difference compared to prednisone. She has patients on both types of steroids. She notes that a small increase in weight gain can have a very significant impact in her patients. If there is large weight gain with prednisone, she changes to

deflazacort. Patients need to be on steroids for significant clinical benefit, and if they cannot tolerate prednisone, they need effective alternatives.

Jenn McNary, a Duchenne advocate and mother of two children with DMD, ages 15 and 18
Ms. McNary's two sons were in the eteplirsen trials. One son participated in an eteplirsen study while still ambulatory at 16. Her second son, 19, who was not ambulatory in the study, has had some muscular improvement and does not require ventilation assistance. Slowing the disease down has been very significant for their family. Interviews from families were recorded at an FDA hearing and she urged the VbBS/HERC members to review these interviews. Ms. McNary noted that, in regards to the question about what level of dystrophin is clinically significant, patients with exon-45 skipping DMD have higher levels of dystrophin and have milder disease progression and walk two years longer than DMD patients with exon-51 mutations. These exon-45 mutation patients have dystrophin levels that are similar to eteplirsen results for exon-51 patients.

Mike Donabedian, Sarepta Pharmaceuticals
Mr. Donabedian said the meeting materials contain inaccuracies. He said there are estimated to be three-to-four patients with exon-51 skipping on OHP. (This was noted in the Pharmacy and Therapeutics report and previously verbally corrected by HERC staff.) Other drugs are still in clinical development and are anticipated to treat approximately six-to-eight additional types of patients. He also stated that the VbBS limit of three minutes of testimony does not meet the criteria of "meaningful engagement." When asked about critical access programs, he said there is a critical access program available on a case-by-case basis. He would not comment on whether the three-to-four OHP patients would be eligible for such a critical access program through his company. He also could not comment about the availability of the drug through ongoing clinical trials.

Lisa Borland, Sarepta Pharmaceuticals
Ms. Borland said FDA approval of eteplirsen is not conditional, it is full and final. However, if no data is brought back to the FDA showing clinical efficacy in four-to-five years, approval will be withdrawn. She discussed the accelerated approval pathway at the FDA. Eteplirsen was approved by the FDA based on dystrophin levels as a surrogate endpoint were considered reasonably likely to impact clinical outcomes. There is evidence in medical literature that slightly higher dystrophin levels can prolong time to loss of ambulation (different mutations other than exon-51 skipping resulting in higher dystrophin levels). Eteplirsen is the only FDA approved treatment that targets the underlying cause of DMD. When asked about any other drug that has an automatic removal of approval without confirmatory study, Borland replied that the FDA requirement for confirmatory study is not unique to eteplirsen. When asked about any dose response difference between the 30 and 50 mg/kg doses, Borland answered that no difference was seen in dystrophen levels at 30 and 50 mg/kg.

Jamie Saukko, a mother of a 2-year old with DMD
Ms. Saukko said this is the only medication to treat her son. No clinical trials are available to her son. She feels that treating her son at two would result in a more significant improvement due to lack of muscle harm to date. She has not seen DMD patients walking as long as the eteplirsen patients she has heard about. Her brother and her uncle had DMD and died in their early 20s. She also testified in support of coverage for deflazacort—her son is too young for steroids, but she thinks patients should have drug choices if needed.

Hannah Cain, a Duchenne advocate and mother of a 6-year old with DMD
Ms. Cain said her son was just diagnosed last month at age six. She is battling for the right to an FDA-approved drug for her son. Her son will have progressive symptoms, and these will have a great impact on her family.

eteplirsen can improve his quality of life and extend his life. She also noted that, based on expert opinion, deflazacort is superior to prednisone.

HERC Evidence-based Guidelines Subcommittee

September 7, 2017

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

David Sibell, MD, professor at the OHSU Comprehensive Pain Center

Dr. Sibell said he agrees that patients in the Journal of the American Medical Association (JAMA) study did not appear to benefit from this procedure. However, he said the patient selection and surgical technique in the study were not optimal. For instance, they used smaller needles, no image guidance and only a single diagnostic medial branch block with a less stringent threshold.

Janna Friedly, MD, appointed expert

Dr. Friedly said she agreed with Sibell's assessment. The challenge is that the clinical experience does not match the results in the controlled trials. She said that this study highlights that the use of the procedural technique in clinical practice may not reflect the identified best practices both in terms of patient selection and in terms of the technique itself.

Sandy Christensen, MD, assistant professor at the OHSU Comprehensive Pain Center

Dr. Christensen said there is a high-quality study underway at Johns Hopkins University. She suggested the subcommittee wait for the results of this study, expected in about a year.

HERC Health Technology Assessment Subcommittee

June 15, 2017

The testimony for this meeting related to a draft coverage guidance on gene expression profiling for prostate cancer.

Melissa Wood, Genomic Health (maker of Oncotype DX)

Ms. Wood provided public testimony stating that the Medicare criteria have been recently expanded to include intermediate-risk patients. She said it is fascinating that the focus is on clinical utility, as they have trials ongoing. She said they have recent trials underway with the Veteran's Administration and Kaiser Permanente. She said that she would like to bring this evidence when it is available. She also expects guidelines to change in the coming year. She said the Oncotype DX test for breast cancer is unique since it provides predictive results as well as prognostic data. She said it is more difficult to run tests on archived tissue because of the smaller amount of tissue available in prostate cancer. She said these tests have the potential to reduce overtreatment.

Som Saha, MD, MPH, Health Technology Assessment Subcommittee member

Dr. Saha said he would be convinced to revisit the topic if there were a study that showed that people who got the test were more likely to enter active surveillance.

Wally Shaffer, MD, HERC member

Dr. Shaffer asked Ms. Wood whether Medicare coverage was contingent on a registry for all three tests being discussed. Wood said that the registry was at least for Prolaris and Oncotype DX.

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 OHA.

September 27, 2017

Agenda items:

- Agency Medicaid updates
- Office of Equity and Inclusion background and social determinants of health and equity
- Oregon Health Policy Board Action Plan for Health
- Social determinants of health and CCOs

Karen Wheeler, Business Development Associate, Greater Oregon Behavioral Health (GOBHI)

GOBHI has a set of staff people working on the social determinants of health. Ms. Wheeler spends much of her time working on housing. She recommended using simple language to spread the message on social determinants of health with stakeholders. GOBHI uses language like "health begins where we live, work, learn and play." Ms. Wheeler offered the MAC a resource from the Robert Wood Johnson Foundation called "A New Way to Talk about Social Determinants of Health." It's also important to form partnerships with non-medical partners. The medical community cannot do this work alone.

Metrics and Scoring Committee

The Metrics and Scoring Committee was established by the legislature to recommend outcomes and quality measures for CCOs.

July 21, 2017

Maggie Bennington-Davis, MD, Chief Medical Officer, Health Share of Oregon

In a letter to the committee dated July 19, 2017, Dr. Bennington-Davis encourages the committee not to adopt a body-mass index (BMI) screening and counseling electronic health records (EHR) metric in 2018.

Ken Carlson, MD, FAAP, Pediatrician, Childhood Health Associates of Salem and Board Member of Oregon Pediatric Society

In an email to the committee dated July 20, 2017, Dr. Carlson encourages the committee to drop the age of effective contraceptive use from 18 to 15 for women.

Colleen Reuland, MS, Director, Oregon Pediatric Improvement Partnership and Member of the Health Plan Quality Metrics Committee

Ms. Reuland expressed concern about changing the age range of the developmental screening metric up to age five, noting that this was outside of the work done in creating the measure. (She was the developer.) She

encouraged use of term “health-aspects of kindergarten-readiness” to avoid confusion with a more global measure.

Chandra Elser, Quality Improvement Analyst, Health Share of Oregon
Ms. Elser addressed the committee in regards to the cadence of electronic health record (EHR) based measures. She encourages the committee to hold off on implementing the EHR-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure until 2019.

Sara Love, ND, Policy Director, CCO Oregon
Encouraged adoption of an oral health metric.

Jeremiah Rigsby, JD, Public Policy and Regulatory Affairs Director, Care Oregon
Mr. Rigsby expressed concerns about “re-basing” measures for childhood immunizations and timing of his clinics responses

August 18, 2017

Deanna Watson, Umpqua Community Health Clinic
Ms. Watson expressed concern over why adolescent well-child visits were low because of Job Corps encounters not qualifying.

September 15, 2017

Maggie Bennington-Davis, MD, Chief Medical Officer, Health Share of Oregon
In a letter to the committee dated September 12, 2017, Dr. Bennington-Davis expressed concern over lowering the age of effective contraceptive use to 15, as discussed during July’s Metrics and Scoring Committee meeting, and proposed the committee delay adding 15-17 year olds to this metric.

Kristin Dillon, MD, Chair, Health Plan Quality and Metrics Committee
Dr. Dillon discussed the shared goals and developing relationship between the Health Plan Quality Metrics Committee for all public payers and the Metrics and Scoring Committee.

Oregon Health Policy Board

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

July 11, 2017

John Mullin, Oregon Law Center
Mr. Mullin praised programs and advocacy for House Bill 2391. Potential referral of HB 2391 was the main focus of his testimony, and he is interested in OHA budget and spending on this bill. He reached out to the Legislative Fiscal Office (LFO) about a public airing and tracking on the bill.

August 1, 2017

John Mullin, Oregon Law Center

Mr. Mullin encouraged DHS engagement, briefly gave an overview of the progress DHS has made, specifically with in-home care services. He also praised different programs between DHS and OHA (Cover All Kids, etc.).

Art Suchorzewski, FamilyCare, Inc.

Mr. Suchorzewski commented regarding CCO rates and methodology. He summarized the 2018 Rates Development Report. Rates are shown to be higher for FamilyCare Health than internally, which is an issue. He requested that OHPB look into the data. He discussed FamilyCare Health's reduction of $26M due to primary care investments, which internally provides a savings, but he requested that OHPB look into that data as well. He stated the 2018 quarterly legislative report shows FamilyCare Inc. as an outlier because it is a private entity, and he requested that the board look into the packet FamilyCare Inc. sent to the board.

Bill Murray, FamilyCare, Inc.

Mr. Murray commented regarding CCO rates and methodology and discussed data accuracies with rate development. He also repeated Mr. Suchorzewski's testimony.

September 12, 2017

Jim Slater, Care Oregon

Mr. Slater commented regarding pharmacy policy development. He stated Pharmacy Class Collaborative as a space where pharmacy could inform on the outside, and he advised Coordinator Care Oregon to create a similar space.

John Mullin, Oregon Law Center

Mr. Mullin commented regarding OHA administration and referendum 301. He discussed his hope for DHS, DCBS, and OHA to work together. He expressed concern about the 301 referendum, not as a political statement, but he wants clear understanding about signatures, spending, short-term before and at the end of legislative session. He understands caution by agencies and has reached out to LFO. Also, he is concerned about the gap between OHA and stakeholders; stakeholders are not getting important information from OHA.

Post-Award Forum

Introduction

On June 28, 2017, the Oregon Health Authority (OHA) hosted a post-award forum in partnership with the Medicaid Advisory Committee (MAC) monthly meeting, to gather perceptions, feedback and input on the progress of Oregon's 1115 Medicaid Waiver Demonstration renewed in January 2017. The 2017 Medicaid waiver demonstration reinforces and expands Oregon's commitment to:

- Integrate physical, behavioral and oral health care.
- Address social determinants of health and health equity.
- Pay for value, hold down costs, and invest in health-related services.
- Continue to expand the coordinated care model.

The feedback gathered through the public forum is being used to ensure the waiver goals and approved changes are being implemented with the input and interest of Oregonians. Input gathered through the forum is included in OHA's 1115 Waiver Quarterly Report to the Centers for Medicare and Medicaid Services (CMS), as is required by the state's agreement with CMS.

Quick Statistics

The post-award forum was open to statewide public participation. To ensure the widest possible participation from all parts of the state, OHA set up numerous ways in which people could participate in the meeting and submit feedback on the progress of the demonstration.

- All Oregonians were invited to participate. Email blasts and public meeting notices, as well as announcements through OHA's website, social media, and newsletters were disseminated widely more than sixty days in advance of the meeting.
- The post-award forum was held in conjunction with the monthly MAC meeting at the Oregon State Library, 250 Winter Street NE in Salem, OR.
- In addition to participating in person, the post-award forum could also be listened to by phone or through an online webinar.
- Oregonians were encouraged to give oral testimony at the end of the post-award forum, submit questions through the online webinar and answer a survey questionnaire following the forum.
- For 30 days following the post-award forum, Oregonians were able to submit feedback and comments using an online survey posted to the OHA website. OHA also accepted written testimony through mail or email.

Forum Goals and Feedback

The goals of the post award forum included providing an overview of the approved 1115 Medicaid waiver and progress on targeted changes supporting waiver goals; obtaining the public's feedback about the demonstration's progress; and providing an opportunity to submit comments and questions. A total of 60 people attended the post award forum, in person or via webinar. OHA received minimal comments and questions about the demonstration progress. In general, the questions and comments received were supportive of the progress made under the demonstration renewal.

An account of feedback gathered from the post-award forum and online survey are summarized below.

Summary of Post Award Forum Comments

Category	Comment or Question
Targeted waiver change: Hospital Transformation Performance Program (HTPP)	Wanted to understand more about the program and how hospitals are measuring health outcomes
Targeted waiver change: Hospital Transformation Performance Program (HTPP)	Do hospitals allow their patients to weigh in on the metrics or are patient perspectives and satisfaction measured?
Targeted waiver change: value based payment	What is the timeline to develop the value-based payment roadmap?
Enrollment	Wanted to understand the enrollment process for coordinated care organizations (CCO) and how a member can switch from one CCO to another

Enrollment	Do members in fee-for-service receive choice counseling before being enrolled into a CCO?
Contracting	Do CCOs have a contract that includes requirements found in the 1115 Medicaid waiver?
Waiver and State Plan Amendment public process	It would be good to allow for more input in the State Plan Amendment Process. What are the upcoming SPAs?
Targeted waiver change: health-related services	CCOs may be reluctant to use health-related services, as defined in the waiver. What incentives are we providing to them?
System Reform	Convoluted policies in the medical system make the system more expensive than it needs to be. Wouldn't a single payer plan without so many restrictions be less expensive?
System Reform	Wouldn't a single payer plan with everyone in one risk pool be more cost effective?
Third Party Liability	Oregon has a program in place to utilize employer sponsored insurance for Medicaid recipients, but it is voluntary.
Targeted waiver change: health-related services	Healthcare should refer to eating health and exercising on a regular basis. Medical care is having access to the services of doctors and other medical providers. There should be a distinction between the two concepts.
Targeted waiver change: health-related services	Does the Oregon Health Plan reimburse for health-related services for fee for service members?
Targeted waiver change: value based payment	Will the value-based payment work have a significant impact on durable medical equipment (DME) and DME providers?
Eligibility and enrollment	I lost OHP coverage when I turned 65. Why can't low income seniors stay on OHP when they turn
Services	Commented on the coverage of Hepatitis C. Wanted to know about the waiver and the amount of money available for Hepatitis C treatment. Also discussed the high rates of HIV infection in Oregon and suggested HIV should be included as a metric for CCOs.

Sustainable rate of growth	The biggest opportunity to slow the growth of health care costs is increased coordination of care for members who have Medicare and Medicaid, and/or those who use services coordinated by DHS for nursing homes or in-home services. This population needs more focus to see better integration and reduce confusion and fragmentation.
CCO successes	It has been great to see improved access to care and reduced emergency room use, more preventive services and regular care to improve chronic health management.
CCO challenges since implementation	Partial CCO enrollment is very confusing and we should try to increase coordinated care. Medicare and Medicaid members have not received good choice counseling about how to best integrate their care.
Continued priorities for CCOs	It is important to continue to prioritize the following to improve delivery of care through CCOs: • Increase adoption of patient-centered primary care homes • Address health disparities and social determinants of health • Increase use of traditional health workers • Integrate physical, behavioral, and oral health care
Targeted waiver change: health-related services	Valuable to know CCOs have been investing in health-related services to address housing transitions for high need members and looking forward to seeing how opportunities grow to include food insecurity, domestic violence and other issues.
Advancing health system transformation	There are various opportunities to increase investments in building capacity to offer supportive housing and services, support building or running housing for homeless or those in transition, linkage to those with mental health or other needs critical for success.
Targeted waiver change: dual eligible passive enrollment	To ensure a smooth transition to CCOs for dual-eligible members through the passive enrollment change, it will be important to improve Aging and Disabilities and AAA staff capabilities to explain Medicare and Medicaid choices, alignment and benefits of coordinated care. AAA staff often rush to get new members a Part D plan without explaining how an aligned MA or special needs plan can work with the Medicaid plan and make

	navigating health care easier. There should be an emphasis on member education about the change and options before the enrollment change starts.
Advancing health system transformation	OHA should add metrics for CCOs to improve health outcomes for elderly or disabled. Currently, there are no metrics that focus on things like fall prevention in the elderly even though this is a predictor of health and life expectancy for seniors. OHA should have education focused on fall prevention. Additionally, OHA should have metrics that help measure how CCOs are preventing young people with disabilities from developing chronic conditions as they age.

IV. Progress toward demonstration goals

Improvement strategies

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

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

2012-2017 Demonstration Waiver Evaluation

OHA continued contract activities for the summative evaluation with Oregon Health Sciences University's (OHSU) Center for Health System Effectiveness (CHSE). The summative evaluation analysis plan was presented in draft form and OHA staff provided feedback on the representation of quantitative findings in visual formats. The summative evaluation is expected to improve on the waiver midpoint evaluation and will use a relevant comparison group to study the implementation and impacts of Oregon's Medicaid waiver. It will include data from several years of the demonstration (with allowances for lag associated with some types of data). In addition, OHA expects the contractor will use Medicaid members from Washington State and "weighted" Oregon commercial plan members as comparison groups, enabling the contractor to rigorously estimate the effect of the waiver on health care spending, quality, access and other key outcomes. The contractor will also synthesize findings from other evaluations of prior OHA and CCO transformation activities. It is expected that the summative evaluation findings will provide actionable recommendations for advancing Medicaid transformation beyond this waiver period. The contractor will deliver the final report of findings to the Centers for Medicare and Medicaid Services (CMS) and OHA by the end of 2017. As a result of data reporting lags and time for analysis, the final report will not include all five years of data from the waiver under evaluation.

2017-2022 Demonstration Waiver

OHA responded to CMS comments on the 2017-2022 Waiver Evaluation Design Plan which included further refinement of measures and specificity in four areas of hypothesis testing: behavioral health integration, oral health integration, health related services impact and dual-eligible (members with both Medicare and Medicaid) care delivery efficiencies under CCO enrollment. OHA is working closely to further refine the evaluation design for the 2017-2022 waiver renewal period.

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

Patient-Centered Primary Care Homes

The Patient-Centered Primary Care Homes (PCPCH) program staff conducted 39 site visits to primary care clinics to provide customized technical assistance on PCPCH model implementation. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address identified barriers. Program staff provide each clinic a written report summarizing the site visit.

In September, the program launched a "Transformation in Practice" webinar series. During the webinars, program staff provide in-depth technical assistance on featured PCPCH measures. In addition, staff from a recognized PCPCH describe how they have implemented the measure to transform their practice. Three webinars are scheduled for the fall, and more will be added in 2018. Planned webinar topics include: clinical quality improvement, complex care coordination and care plans and referrals, access and continuity.

The Transformation Center also plans to offer technical assistance to help CCOs add PCPCHs to their network and provide support to already recognized PCPCHs. Initial planning work began this quarter and two needs assessments calls are scheduled in November.

At the end of this reporting period, 618 clinics were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Twenty-seven PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model. These clinics are located in both rural and urban areas. Two health care clinics with unique care delivery models were designated as 5 STAR: a behavioral health clinic with integrated primary care and a school-based health center.

PCPCH recognition is based on a self-attestation model with a relatively low administrative burden for clinics. The fidelity of a self-attestation model relies on a strong verification procedure. The PCPCH program has contracted with 11 new clinical transformation consultants (CTCs) to conduct site visits to clinics and provide peer-to-peer technical assistance to providers. The CTCs are primary care providers with extensive experience implementing the PCPCH model. Seventy-six site visits have been verified in 2017.

PCPCH enrollment is an incentive metric for CCOs. The statewide baseline for this measure was 51.8% in 2012. As of December 2016, 88.8% of CCO members were enrolled in a PCPCH. It is notable that CCOs have sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

Over 150 PCPCHs are participating in the Centers for Medicare and Medicaid Innovation Comprehensive Primary Care Plus payment model. These PCPCHs receive technical assistance on providing proactive, coordinated, population-based care, and have the opportunity for regional and national learning and networking opportunities.

Certified Community Behavioral Health Clinics

Oregon was selected as a demonstration state for the federal Certified Community Behavioral Health Clinic (CCBHC) project. Oregon started the two-year demonstration in April 2017. This demonstration will lead to improved access, increased integration and improved outcomes. This quarter has focused on compliance monitoring to assure that clinics continue to adhere to the quality standards for CCBHCs. Three of the 12 CCBHCs have had onsite reviews for compliance, and the project director has quarterly phone conferences with each CCBHC to discuss compliance issues.

Data collection is an important aspect of the demonstration. Although official data reporting is not required until the end of the demonstration, OHA has required two data submissions from the programs to assess their ability to submit the data. Data submission has improved and OHA will continue to work with providers to produce complete data reports. OHA will also provide technical assistance to improve data reporting and to use data to improve outcomes.

The CCBHCs receive a Prospective Payment System (PPS) rate. This is accomplished by direct payments from OHA for Medicaid fee-for-service (FFS) individuals and a wrap-around payment reconciliation process for individuals enrolled in a CCO. CCBHCs have just started submitting requests for wrap-around payments. Early problems with processing these payments have been recognized and solutions have been implemented.

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

Hospital Transformation Performance Program

OHA calculated and shared official year four improvement targets with each hospital involved in the Hospital Transformation Performance Program (HTPP), OHA's hospital incentive measure program. OHA completed

conversations with stakeholders regarding the final year of reporting for the HTPP and worked with the Hospital Performance Metrics Advisory Committee and Hospital Technical Advisory Workgroup on the potential for measure recommendation and selection that might be used in the future by CCOs to represent hospital services in a full continuum of care spectrum.

Federally Qualified Health Center and Rural Health Center Payment Methodology (Advanced Payment and Care Model)

The Advanced Payment and Care Model (APM) added two additional Federally Qualified Health Centers (FQHCs) to the program in July 2017, bringing the overall total of participating organizations to 14 FQHCs and one Rural Health Center (RHC). Three more FQHCs and one RHC are currently engaging in onboarding activities for a potential July 2018 transition to the APM.

In July 2017, the Oregon Health Authority (OHA), participating health centers, and the Oregon Primary Care Association reached agreement on an updated accountability plan establishing that health centers must report quarterly on eight Uniform Data Systems (UDS) quality measures. The group also agreed that failure to reach the UDS average on at least four of the measures within the reporting period will result in the development of a performance improvement plan. Additionally, health centers report Care STEPs, which were formerly known as Touches (non-billable enabling type services that address social determinants of health), on a quarterly basis. Part of the new accountability plan establishes that attributed Oregon Health Plan (OHP) members who were not engaged through a billable office visit or Care STEP over the prior 24 months will be dis-enrolled from the health center and no longer generate per-member per-month payments for the health center.

Comprehensive Primary Care Plus

Comprehensive Primary Care Plus (CPC+) launched on January 1, 2017. OHA continued implementing CPC+ and created a CPC+ webpage which includes resources for practices. Of the 154 Oregon CPC+ practices, 126 have contracts with OHA for Medicaid fee-for-service members. As of September 20, 2017, 56 practices have received per-member per-month care management fees for a total of nearly $240,000, year-to-date.

The Oregon CPC+ payers contracted with a facilitator to organize monthly meetings for the payers to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. During this quarter, the Oregon CPC+ payer group has discussed technical assistance, payment alignment and data aggregation.

Value-based payment innovations and technical assistance

The Transformation Center has engaged national value-based payment (VBP) experts at Bailit Health to consult with OHA on developing a VBP roadmap, which will identify VBP targets for CCOs. Once the roadmap is complete, the Transformation Center will make technical assistance available to CCOs through Bailit Health and other consultants.

In addition, OHA is participating in the Centers for Medicare and Medicaid Innovation VBP Innovation Accelerator Program (IAP) which funds the Center for Health Care Strategies (CHCS) and other technical assistance organizations to work with OHA to further VBP activities. As part of the IAP, CHCS is providing technical support to OHA in the form of an environmental scan of other states' VBP contract language as well as technical support for stakeholder engagement. This includes support around how to leverage the Transformation Center to engage, educate and support CCOs on the new VBP standards.

Statewide Performance Improvement Project

The OHA Statewide Performance Improvement Project (PIP) on Opioid Safety was adopted in July 2014 for calendar year performance monitoring for all 16 coordinated care organizations (CCOs) to adopt. Overall PIP project management is conducted through OHA's External Quality Review Organization (EQRO), HealthInsight Assure, in accordance with the 2012 CMS PIP Protocol.

The EQRO met with CCOs during September - October 2017, to discuss the progress of their Statewide PIPs and to provide feedback on report documentation. In addition to a general overview of their project, CCOs were asked to discuss their efforts in meeting the Oregon Health Plan (OHP) January 1, 2018, opioid coverage deadline (no chronic opioids for members with back and spine pain diagnoses).

Project metric

The project metric is the percentage of OHP enrollees aged 12 years and older who filled prescriptions for opioid pain relievers of at least ≥ 120 mg morphine equivalent dose (MED) on at least one day and the percentage of enrollees with at least ≥ 90 mg MED on at least one day during the measurement year.

Outcomes

The number of members who received at least one opioid prescription during the measurement year (study denominator) has decreased significantly since baseline (calendar year 2014) at both the state as well as individual CCO level.

High Dose, All Age group Comparison

High dose: ≥ 120 MED, all ages: ≥ 12 years old

CCO	Baseline CY 2014	Aug-2016 thru Jul-2017	*% Change Decrease*
ALLCARE_HEALTH_PLAN	6.1%	4.9%	***1.2%***
CASCADE_HEALTH_ALLIANCE	6.9%	3.6%	***3.3%***
COLUMBIA_PACIFIC	15.0%	11.3%	***3.7%***
EASTERN_OREGON	14.6%	12.1%	***2.4%***
FAMILYCARE	7.8%	7.8%	***0.0%***
HEALTH_SHARE_OF_OREGON	12.0%	10.3%	***1.7%***
INTERCOMMUNITY_HLTH_NETWK	11.1%	7.6%	***3.5%***
JACKSON_CARE_CONNECT	16.7%	13.3%	***3.4%***
PACIFICSOURCE_CENTRAL	7.4%	6.0%	***1.4%***
PACIFICSOURCE_GORGE	10.0%	7.7%	***2.3%***
PRIMARYHEALTH_JOSEPHINE	8.4%	6.4%	***1.9%***
TRILLIUM_COMM_HEALTH_PLAN	12.9%	11.0%	***1.9%***
UMPQUA_HEALTH_ALLIANCE	5.9%	4.3%	***1.6%***
WESTERN_OR_ADVANCED_HLTH	6.4%	5.4%	***1.0%***
WILLAMETTE_VAL_COMM_HLTH	9.5%	6.6%	***3.0%***

YAMHILL_COMM_CARE_ORG	9.6%	7.4%	***2.2%***
FFS	9.8%	7.6%	***2.2%***
Statewide Average	10.0%	7.9%	***2.2%***

Interventions

1. **Prior authorization and pharmacy hard/soft stops**: All CCOs have implemented prior authorization and pharmacy hard-stop interventions. With the exception of the PacificSource Community Solution CCOs (Columbia Gorge and Central Oregon), which are implementing graduated pharmacy hard stops through May 2018, CCOs have established pharmacy thresholds of 90 mg MED.

2. **Tapering plans**: All CCOs have implemented interventions requiring the use of tapering plans for members on long-term high dosages of opioids.

3. **Provision of alternative treatment service options**: Many CCOs had collected data that could demonstrate increased utilization of alternative treatment services, especially chiropractic and acupuncture services.

4. **Distribution of high-opioid user lists or dashboards to providers**: Providers in the community found patient level reports helpful in identifying patients who need alternatives to high-dose opioids. The greater impact of these reports has been when individual or clinic training and support is provided, along with the distribution of the reports.

5. **Provider and member education**: All CCOs co-sponsored or conducted "Pain Summits," which included presentations to both providers and community members and X-waiver training. CCOs reported that these events were well-attended and received positive feedback.

6. **Improved medication-assisted treatment (MAT) access and availability of naloxone**: All CCOs have worked to increase the number of X-waivered providers in their areas. Most CCOs have developed their own opioid treatment programs, or partnered with existing programs. CCOs have also conducted or co-sponsored pharmacist training on prescribing naloxone.

7. **Collaboration with other CCOs**: In 2016, four southern Oregon CCOs (AllCare, Jackson Care Connect, Primary Health of Josephine County and Western Oregon Advanced Health) decided that the opioid problem could be better addressed through collaborative regional efforts and began developing standardized tools and processes. In 2017, two other CCOs joined the collaborative's community media campaign. In Multnomah County, two CCOs (Health Share and FamilyCare) are participating in the Tri-County Opioid Safety Coalition workgroups and interventions; with significant efforts in developing close to real time data monitoring of key indicators.

Behavioral Health Collaborative Implementation

In the summer of 2016, OHA convened the Behavioral Health Collaborative to develop a set of recommendations to move the behavioral health system to a coordinated care model, fully integrating

behavioral health with physical and oral health. Much of this work is still in process and OHA is developing guidance and timelines. The Transformation Center will provide technical assistance.

In order to integrate behavioral health with physical and oral health, systems and stakeholders need to come together in local communities to have a collective impact. This will take place through Regional Behavioral Health Collaboratives (RBHC) for each geographic service area. RBHCs will build on existing local structures and must include CCOs, community mental health programs, local public health authorities and the tribes. To truly impact behavioral health at the community level, other key partners will need to be engaged. These partners may include schools, corrections, hospitals, emergency departments, first responders, child welfare, and any other stakeholders that encounter individuals with behavioral health concerns.

Each region will:

- Convene to review relevant state and local needs assessments, reports, data and other information.
- Select three priority areas to focus on over the next two years.
- Develop an action plan that describes the specific behavioral health outcome goals, the strategies that will be employed to achieve the outcomes, and how progress will be measured.

Meanwhile, various stakeholder workgroups are meeting to start recommending systemic reforms to the behavioral health system. They are developing recommendations regarding standards of care and competencies, workforce, peer-delivered services, data, health information technology, and parity.

Oral Health Roadmap

OHA continues to work to advance CCO integration of oral health and improve oral health outcomes for Medicaid members. Key activities during this quarter include OHA's: dental program, Public Health Division and Metrics and Scoring Committee.

OHA's dental director and Medicaid fee-for-service dental program manager are participants in the Center for Health Care Strategies' 2017 State Oral Health Leadership Institute. The team has selected to work on a state-specific project during the program that addresses dental opioid prescribing in Oregon. The project's goals are to:

1. Promote responsible, consistent, and compassionate dental prescribing guidelines for opioids.
2. Increase registration and usage of the Prescription Drug Monitoring Program by Oregon dentists.

They created a presentation and educational materials that illuminate the role that dental prescribers play in the opioid problem. These include dental prescribing guidelines, available on the Oregon Opioid Prescribing Guidelines Task Force website, and presentations that have been given to multiple groups, including the CCOs' Quality Health Outcomes Committee and other CCO groups. This work will continue beyond 2017.

OHA Public Health's Oral Health Unit conducted a webinar for CCOs on Tuesday, September 19th focused on the mandatory certification program for local school dental sealant programs and the dental sealant metric. Participants learned more about the dental sealant metric and how CCOs are involved in the certification program. The webinar was recorded and is posted online at www.healthoregon.org/sealantcert.

The Metrics and Scoring Committee considered adding two additional oral health measures to the 2018 incentive measure set: preventive service utilization for adults and dental care for adults with diabetes. Although

neither was ultimately selected for the 2018 measure set, both measures are now on the Committee's on-deck list for future measurement years.

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

Sustainable Relationships for Community Health program

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

Five Sustainable Relationships for Community Health (SRCH) Program 2016-2017 grantee consortia completed their year-long projects in June 2017. Three of the teams and several representatives from CCOs that have not yet participated in a SRCH grant convened again for a SRCH Institute in late June to further their progress on implementing the Diabetes Prevention Program (DPP). 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. OHA worked to establish goals and work-plans for three CCOs who will continue to receive funding for implementing DPP through June 2018 as part of the National Association of Chronic Disease Directors' *Promoting Medicaid Delivery Models for the National Diabetes Prevention Program through Managed Care Organizations and/or Accountable Care Organizations* grant.

OHA staff from the Public Health Division and the Health Systems Division take part in monthly check-ins with the National Association of Chronic Disease Directors (NACDD) to provide updates and identify areas of technical assistance for SRCH grantees (CCOs, local public health authorities and DPP provider organizations). SRCH grantees funded to work on the NACDD grant are building partnerships with seven DPP provider organizations to contract with and enroll 435 CCO members into a DPP. These SRCH grantees implemented strategies for patient and provider engagement for the National Diabetes Prevention Program (NDPP). SRCH grantees have met with seven clinic providers in Multnomah, Washington and Clackamas Counties to review the NDPP program and promote referrals to the NDPP programs. Outreach materials for NDPP were created and distributed to patients and providers, including CCO member-facing materials translated into other languages (Spanish, Chinese and Vietnamese). During this reporting period, OHA also received the final evaluation of the SRCH grantee cohort, and began planning for the next grantee cohort.

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

As described above, the SRCH grants were successful in meeting their aims of implementing closed-loop referrals, and building sustainable relationships between CCOs, public health agencies and community partners in five local communities in Oregon. The third cohort of SRCH grantees is being planned and will commence in December 2017.

Innovator Agents

Innovator agents help coordinated care organizations (CCOs) and the Oregon Health Authority (OHA) work together to achieve the goals of health system transformation: better care, better health and lower costs. Agents serve as a single point-of-contact between CCOs and OHA, providing an effective and immediate line of communication, allowing streamlined reporting and reducing the duplication of requests and information.

CCO transformation plans establish the foundation for OHA's partnership with CCOs to achieve Oregon's health system goals. Plans also encourage continuous quality improvement, recognizing that transformation is a continuous process and that a CCO's transformation plan will and should evolve over time. As part of the contract process, each CCO was required to develop a transformation plan geared specifically to the needs of the community it serves. Plans demonstrate how the organization will work to improve health outcomes, increase member satisfaction and reduce overall costs.

Innovator agents participated in several transformation plans, community assessment and state health improvement plan activities, including:

- Discussions, webinars and phone conferences regarding the CCOs' community health improvement plans (CHPs), community health assessments (CHAs) and transformation plans. Agents also reviewed and researched questions related to CHPs and CHAs.
- Oral, behavioral, and physical health collaborative community and steering committee meetings to address ongoing successes and challenges related to the Quality Incentive Metrics, CHAs, CHPs and transformation plans.
- Early Learning Hub activities within different communities. Early Learning Hubs are part of the Oregon Department of Education's Early Learning Division. Sixteen regional Early Learning Hubs connect cross-sector partners to work together to create local systems that are aligned, coordinated and family-centered. Their goal is to connect families to resources to receive the support they need to become healthy, stable and attached, while children receive the early learning experiences they need to thrive.
- Regional Health Equity Coalitions: collaborative, community-driven, cross-sector groups organized regionally to identify policy, system and environmental solutions that increase health equity for underserved and underrepresented communities experiencing health disparities.
- Planning meetings as communities began developing their CHAs.
- Community surveys to develop a complete view of the Community Health Needs Assessment (CHA) and tie it to transformation plan activities.
- CCO transformation plan reviews and follow up regarding clarification on reporting requirements.
- Transformation and Quality Strategy plan development at the state level. The Transformation and Quality Strategy will replace the CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables. This approach provides CCOs with an opportunity to internally coordinate and align all of their transformation and quality work.

Innovator agents continue to participate in ongoing activities to support transformation, improvement and quality. The team's future plans include developing new Transformation Plan reporting and contractual requirements, continuing work with CHP activities, applying CHA outcomes to new and existing initiatives, and continuing work on the Pathways model linking to other examples throughout the state.

Community advisory council activities

Each CCO has at least one community advisory council where Oregon Health Plan (OHP) members can share their voice about health within their communities. CCO Community Advisory Councils (CACs) give members the opportunity to talk about their experiences in accessing care to help find solutions to improving access and make recommendations for how to improve health care quality and services in their community.

Innovator agents continued to provide support for CACs. As CACs begin the process of developing new CHAs and CHPs, agents will continue to provide support and connections to technical assistance. This quarter, agents:

- Provided support and consultation in ongoing recruitment activities to increase and solidify consumer and stakeholder voices on the CAC.
- Assisted with understanding of timelines for updates and requirements.
- Reviewed new CHA activities (development of initiatives with refined needs assessments).
- Reviewed CCO initiatives for inclusion/updates to current CHPs.
- Assisted in gathering qualitative data on identified CCO initiatives (smoking cessation, diabetes, etc.).
- Participated and provided OHA updates to local CACs.
- Continued to work with CCOs and their respective CACs to gauge the impact of health system transformation on community health needs, and actively participate in the implementation of the CACs.
- Engaged CACs in conversations and webinars related to learning opportunities.

Communication and information-sharing with CCOs

Innovator agents met with staff from various areas of OHA to gather updated information for CCOs. This included staff from the Health Systems Division, Health Analytics, Transformation Center, and the Public Health Division. Agents also:

- Attended the Quality and Health Outcomes Committee and shared information with CCOs.
- Worked with OHA's Transformation Center staff on engagement of CCO and community advisory council (CAC) partners in upcoming webinars and technical assistance.
- Provided assistance with community partners and members regarding eligibility.
- Engaged in CCO/Transformation Center discussions related to Technical Assistance Bank opportunities, planning and next steps. The Technical Assistance Bank is a Transformation Center resource that provides support to CCOs and CACs.
- Supported and collected information for the Early Learning Hub Legislative Report, including early learning requests for Hub- and CCO-related stories and efforts for the state-wide report and legislative requests for additional information from CCOs.
- Provided clarification of the Ombudsman's role and the Disability Services Advisory Council as it relates to non-emergent medical transportation and other reports (appeals and grievances).

The team, in partnership with CCOs, community stakeholders, the Transformation Center and other OHA divisions and state agencies, continues to address social determinants of health and health disparities, build and participate in statewide learning and community collaborations and gather and disseminate coordinated care model innovations locally, regionally and nationally.

Communication and information-sharing with Oregon stakeholders

Innovator agents participated in the following activities, community work and projects in an effort to share information with the public and stakeholders towards health improvement. Innovator agents:

- Worked with stakeholders engaged in health equity, school health and high school graduation focus areas to improve systems and make connections for community and CCO resources.
- Facilitated steering committees exploring next community health assessment (CHA) work between hospital systems, CCOs, federally-qualified health centers (FQHCs), public and mental health and other agencies interested in guiding the CHA work.
- Participated in community collaboratives where ONE application assisters discussed systems issues and specific community-related projects.
- Provided Health System Transformation 101 presentations to community partners.
- Engaged with local FQHCs on how to innovate, how to recognize innovation and how to create buy-in to innovative work at clinics.
- Met with Regional Solutions staff to engage in and understand overlapping work as it relates to upcoming CHAs. Regional Solutions is the Governor's approach to community and economic development; it recognizes the unique needs of each Oregon region and the importance of working locally to identify priorities, solve problems and seize opportunities to get projects done.
- Connected with local stakeholders on assessment, housing and equity work.
- Shared the Pathways model and use of the Clinical Research Administration (CLARA) data system in other regions for potential alignment.

The team anticipates continuing to work with schools and health equity partners, provide OHA updates to CACs and community groups as requested and available, address enrollment and eligibility questions as needed, and identify concerns and provide updates within Oregon communities.

Services to coordinated care organizations

Innovator agents provided information and researched questions around fee-for-service (FFS) versus CCO enrollment and application processing. Ongoing questions around FFS and CCO enrollment will require further communication moving forward. Agents also provided support with the memorandum of understanding and CCO connections to the Department of Human Services (DHS) Aging and People with Disabilities (APD) office.

The team continues to support OHA's Home CCO Enrollment initiative and research the potential advantages to including explanation of benefits for Medicaid members to view on the Web App. Home CCO enrollment is designed to keep people enrolled in their home CCO while they receive temporary behavioral health treatment in another area. Agents also continue to work with CCOs on non-emergent medical transportation to increase access and efficient contracting with transportation brokerages.

Rapid-cycle stakeholder feedback

Innovator agents worked with local Regional Health Equity Coalitions to assemble data to review, discuss and plan for health disparities as related to incentive metrics, worked with OHA's assigned CCO account

representative to resolve concerns shared by Oregon Health Plan (OHP) members and community partners and participated in collaborative webinars with OHA's regional outreach coordinators (ROCs). Agents also supported CCOs in the various areas of community health, including kindergarten-readiness, sports physicals in coordination with well-child visits and connection to the Department of Education's Early Learning Hubs.

Agents plan to continue reviewing disparity data as part of ongoing discussions in communities and within CCOs and work with CCO account representatives to identify process improvements for CCOs and clarify policy questions as they arise.

Learning experiences

Innovator agents received training and information in the areas of social determinants of health, opioid use, poverty, quality metrics, housing initiatives and programs, smoking cessation, and behavioral health integration. Agents regularly share this information at CCO board-of-director meetings, community advisory council (CAC) meetings and regional advisory committees. Agents also participated in a day-long curriculum review of technical assistance they plan to provide to communities to update their CHPs and CHAs. Agents gave feedback on how the technical assistance could best meet the needs of the CCOs and their communities.

Ongoing and future learning opportunities for Innovator Agents include:

- Supporting the Transformation Center by providing Mobilizing for Action through Planning and Partnerships (MAPP) development training to CCOs, CACs and communities as they develop their new CHPs and CHAs.
- Participating in training for the new Transformation and Quality Strategy document.
- Linking work with Project Access Now Pathways model for data collection/aggregation.
- Ongoing conference calls and the annual meeting with the American Public Health Association.

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

Health-related Services Background

In 2012, under a renewal to its 1115 waiver, Oregon began the process of transforming its Medicaid delivery system by establishing coordinated care organizations (CCOs). CCOs receive an integrated global payment for each member, which provides CCOs with the flexibility to offer health-related services to improve the health of Oregon's Medicaid population. Under the 1115 Medicaid demonstration waiver for 2017-2022, OHA has continued its commitment to promote CCOs' use of health-related services. The 2017-2022 waiver changed the definition of health-related services to include flexible services and community benefit initiatives and states that a health-related service must meet the requirements for activities that improve health care quality, as defined in 45 CFR 158.150, or expenditures related to health information technology and meaningful use requirements to improve health care quality, as defined in 45 CFR 158.151.

The Oregon Health Authority (OHA) is currently working to revise Oregon Administrative Rules, CCO contracts and financial reporting standards, and develop additional guidance to address the challenges outlined by the 2012 waiver evaluation findings and to assist CCOs as they implement the revised definition of health-related services using the requirements under 45 CFR 158.150 and 45 CFR 158.151. Beginning with the 2018

CCO contract, CCOs will be required to report financial information for health-related services using the revised definition.

2012-2017 Waiver Evaluation of Flexible Services

The 2012 waiver required Oregon to evaluate whether CCOs' use of flexible services has deterred high-cost care. OHA contracted with Oregon Health and Science University's Center for Health System Effectiveness (CHSE) to conduct the summative evaluation. CHSE planned to analyze the relationship between CCOs' spending on flexible services (as reported in CCOs' financial reports to OHA) and changes in specific measures of CCOs' health care spending and quality. To assess the usefulness of financial report data for analysis, and to collect qualitative information about CCOs' use of flexible services, CHSE carried out interviews with staff identified as key informants by all 16 CCOs.

The 2012-2017 waiver evaluation showed that CCOs provided a wide variety of flexible services, including services to individual members, groups of members, and services available to members and other people in the community. The flexible services offered by individual CCOs reflected their varying vision for flexible service use (e.g., one CCO provided flexible services aimed at reducing the use of high-cost health care services in the short term), and in many cases their flexible service policies were directed by stakeholder input. Based on their experiences, most CCOs believed that flexible services were effective at improving outcomes and reducing costs.

Challenges Identified in 2012-2017 Waiver Evaluation

CCOs' 2014 and 2015 financial reports did not fully capture many services that met the definition of flexible services. As described above, CCOs' quarterly financial reports include a subsection that identifies a CCO's spending on flexible services and number of members who received flexible services by category. CCOs often omitted the following services from this section in their 2014 and 2015 reports: community-level services; care coordination and disease management; services provided using funding sources outside global budgets; and services not tied to medical diagnoses or services with billing codes.

CCOs are just beginning to provide flexible services as defined in state administrative rules that were developed in late 2015. After receiving the new administrative rules and guidance, CCOs needed time to develop their policies, train providers and implement their flexible services programs. As a result, CCOs spent relatively little on individual-level flexible services in 2014 and 2015. Most interviewees reported that CCOs increased flexible services from 2015 to 2016 or planned to increase spending from 2016 to 2017.

CCOs vary widely in their capacity to track and report on flexible services. Several CCOs lack systems for tracking and reporting on members' use of flexible services and outcomes associated with flexible services. At this point, most CCOs say data needed to evaluate the effect of flexible services on health care use and spending are unavailable. Interviewees said more widespread use of flexible services over a longer timeframe is needed to confidently evaluate these effects. In addition, several interviewees highlighted the challenge of demonstrating that flexible services cause decreases in spending or improvements in health outcomes. Despite some of these challenges, some CCOs have started to evaluate flexible services impact on health care spending, outcomes, and patient satisfaction.

Conclusions from CCO Interviews

CCOs need greater communication and clarity regarding definition, reporting and rate-setting. Even after OHA provided new administrative rules and guidance on flexible services, confusion about the definition of flexible services resulted in inconsistent reporting of flexible services spending across CCOs. Examples include reporting of community-level services, care coordination and disease management programs and services with billing codes. In addition, CCOs indicated confusion about how flexible services fit into the rate-setting process. OHA is currently revising state administrative rules and developing guidance to assist the CCOs in revising their policies to align with the updated definition of health-related services included in the 2017 waiver.

A tension exists between flexibility and achieving the State's desired outcomes. CCOs described different "visions" for flexible services, ranging from short-term services to avoid high-cost health care use, to helping members develop a healthy habit, to community investments. Consistent with CCOs' broad flexibility to implement reforms, these different visions may reflect CCOs' responses to the diverse needs of their members and communities. OHA may need to provide CCOs with greater guidance and clearer expectations if it intends for CCOs to use flexible services for specific purposes. As mentioned above, OHA is currently revising state administrative rules to include specificity about the criteria that must be met to offer health-related services.

A need exists for complete and consistent data about flexible services, with awareness of the burden for CCOs. Financial reports provide an incomplete picture of flexible services, and only a minority of CCOs have begun to link data about flexible services and member outcomes at an individual level. More complete, consistent, and granular data will be needed to gain an accurate picture of flexible services and begin to evaluate their effects. OHA is revising the financial reports to ensure that all health-related services can be captured and reported. Moving forward, OHA will provide technical assistance to CCOs as they begin to increase their investments in health-related services and evaluate the impact on their spending and population.

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

Collaborative Governance and Finance Committee

Transformation Center staff coordinate the Behavioral Health Governance and Finance Committee, which reports to the Oregon Health Policy Board. The committee is developing action plans for implementing the Behavioral Health Collaborative's recommendations for behavioral health governance (regional single points of shared accountability) and funding and payment. This quarter's activities included the following.

- The committee developed a four-phased process:
    1. By June 2018, letters of intent will be submitted from geographic regions to convene key system partners to review needs assessments and select local priorities;
    2. By October 2018, community-based priorities will be identified;
    3. By mid-2019, an action plan will be complete and timeline for reporting set, and
    4. Also by mid-2019, regular progress reports will be submitted.
- The committee established a subgroup on risk sharing with the Oregon State Hospital.
- A consultant recorded webinars on organizational models for single points of shared accountability and behavioral health funding and payment.

Applied behavior analysis learning collaborative

The Transformation Center hosted a webinar to introduce CCOs, educators, Department of Human Services' staff and stakeholders to the theory and practice of applied behavior analysis, a therapy for children with autism. Nearly 50 people attended.

Project ECHO

The Oregon Rural Practice-based Research Network is managing the Oregon ECHO Network, a hub to offer tele-mentoring clinics for primary care providers on a variety of clinical and quality topics. ECHO launched its first medication-assisted treatment during this quarter.

CCO incentive metrics technical assistance

Adolescent well-care visits

Initiated by a CCO request, the Transformation Center coordinated a partnership among OHA, CCOs and the Oregon School Activities Association to create a comparison of the adolescent well-care visit and pre-participation physical evaluation. The Transformation Center also started exploring ways to provide technical assistance to increase adolescent well-care visits for young adults 18–21 years old; this group has the lowest use of these key preventive health visits.

Effective contraceptive use

The Transformation Center completed a 10-part webinar series for CCOs and clinics working to increase effective contraceptive use (ECU). Every CCO region participated in at least one webinar (average of six webinars per CCO region), and 133 people attended at least one webinar or watched a recording. Additionally, the Center began planning more in-depth technical assistance around this metric for the state's CCOs.

The Center also surveyed CCOs to identify which electronic health records lack sufficient builds and workflows for capturing and reporting ECU data. Twelve CCOs responded. Many different EHRs are being used across the state with varying capacity within clinics to create the custom builds needed.

Emergency department use among members with mental illness

The Transformation Center began its work to support a new CCO incentive metric focused on emergency department use among members with mental illness. The Center held two needs assessment calls and has started planning technical assistance. Currently webinars are planned for addressing metric specifications, identifying primary drivers of emergency department utilization, examples of multi-system care coordination, and innovations for managing patient pain.

Tobacco cessation

The Transformation Center partnered with Multnomah County Health Department to deliver a webinar focused on smoking cessation treatment for pregnant women. Twenty-five people attended, and 100% of evaluation respondents rated the webinar as valuable.

Childhood immunizations

In September, this technical assistance opportunity was opened up to the CCOs who didn't participate in the last fiscal year. Six CCOs requested the assistance, bringing the total participants to 12 of the state's 16 CCOs.

The Transformation Center also published a story about one CCO's success in improving childhood immunization rates by 14 percentage points through a root-cause analysis technical assistance project delivered in 2016.

Cross-cutting supports

Good Ideas Bank

The Transformation Center created the Good Ideas Bank: a database, data-entry process and reporting mechanisms to capture and share data about emerging and tested CCO, system, clinical and other health and health care innovations.

Transformation Plan analysis

CCOs submitted their most recent Transformation Plan progress reports, which described progress toward meeting benchmarks (to be achieved by December 31, 2017) in eight focus areas. Projects and benchmarks were designed by each CCO to further their transformation work.

The largest number of CCOs (11 of 16) had met the benchmarks they set in alternative payment methods, while integration of care was the area still in progress by the most CCOs (14 of 16). Reported integration challenges included recruiting behaviorists, coordination between behavioral health and primary care providers, and coordination between primary care providers and dentists.

Community Advisory Council activities

The Transformation Center continues to convene community advisory council (CAC) leaders for monthly calls focused on member recruitment and engagement. This quarter member recruitment materials (printed cards, posters and a web page) were finalized for assisting partners recruit Oregon Health Plan members to CACs. The Transformation Center partnered with the state Women, Infants and Children (WIC) program to distribute fliers to all WIC coordinators to post in their lobbies. PCPCH program site visitors are also distributing fliers to clinics.

Community health assessments and community health improvement plans

Consultants developed a curriculum for a one-day community health assessment/community health improvement plan (CHA/CHP) development training. The training is intended for CCOs, local public health authorities (LPHAs) and hospitals, with potential to also include local mental health authorities. The curriculum is grounded in the Mobilizing for Action through Partnership and Planning (MAPP) framework, with the focus on collaboration among CCOs, LPHAs and hospitals for a combined CHA to meet the CHA/CHP requirements of all three organizations. The training is now available for CCOs upon request.

Annual CHP progress reports from CCOs included the following themes:

- Improved coordination with early learning partners and a focus on children and youth health
- Behavioral health focused initiatives that emphasize improvements in integration
- Mental health first-aid training (for youth and adults) and initiatives to reduce suicides
- Training for adverse childhood experiences and trauma-informed care across sectors
- Emphasis on making connections to address the social determinants of health through community initiatives and training
- Access to food and physical activity among children and adults to curb the rise of obesity

- Motivational interviewing training
- Training and employing community health workers in various healthcare settings
- Telemedicine pilots, including behavioral and oral health initiatives

Many CCOs noted challenges with accessing data to identify health disparities. OHA's Public Health Division and Transformation Center have created a list of potential data sets for community health indicators.

V. Appendices

A. Enrollment reports

1. SEDS reports

Reports are attached separately as Appendix A – Enrollment Reports DY16 Q1 (July-Sept 2017, as posted at this link, is a preliminary report.)

2. State reported enrollment tables

Enrollment	July 2017	August 2017	September 2017
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	975,616	957,059	949,992
Title XXI funded State Plan	75,321	76,595	77,835
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A
Enrollment current as of	July 31, 2017	August 31, 2017	September 30, 2017

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%	10	16	-60.00%	-480.00%
		Pregnant Women FPL > 170%	2	2	-350.00%	-850.00%
	Title 21	SCHIP FPL > 170	86,604	228,105	10.13%	40.27%
Optional	**Title 19**	PLM Women FPL 133-170%	51	63	-349.02%	-696.08%
	Title 21	SCHIP FPL < 170%	53,355	130,984	-2.44%	-23.73%
Mandatory	**Title 19**	Other OHP Plus	157,750	447,057	-2.12%	-4.19%
		MAGI Adults/Children	765,346	2,082,070	-2.09%	-8.51%

POPULATION			Total Number of Clients	Member Months	Percent change from previous quarter	Percent change from same quarter of previous year
		MAGI Pregnant Women	15,083	34,044	-7.40%	-28.47%
		QUARTER TOTALS	1,078,201			

OHP eligible and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
July	979,611	836,832	714	45,484	3,738	647	33,173
August	964,104	834,916	786	44,104	3,757	655	33,576
September	959,284	826,847	815	43,579	3,760	683	33,384
Average	967,666	832,865	772	44,389	3,752	662	33,378
		86.07%	0.08%	4.59%	0.39%	0.07%	3.45%

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

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

B. Complaints and grievances

Reports are attached separately as Appendix B – Complaints and Grievances DY16 Q1

C. CCO appeals and hearings

Reports are attached separately as Appendix C – CCO Appeals and Hearings DY16 Q1.

D. Neutrality reports

OHA provides two budget-neutrality reports: OHP Section 1115 Demonstration (Expenditures) and OHP Title XXI Allotment. Reports are attached separately as Appendix D – Neutrality Reports DY16 Q1.