Oregon Health Plan

Section 1115 Quarterly Report

7/1/2018 – 9/30/2018
Demonstration Year (DY): 17 (7/1/2018 – 6/30/2019)
Demonstration Quarter (DQ): 1/2019
Federal Fiscal Quarter (FQ): 4/2018

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I. Introduction

A. Letter from Oregon's Deputy State Medicaid Director

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

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

Three-quarters of all primary care practices in Oregon are certified Patient-Centered Primary Care Homes (PCPCH), and 52 of those clinics have been designated as 5 STAR, the highest tier in the PCPCH model. Over 900,000 CCO members (87% of the total CCO population) receive care at a PCPCH.

The Transformation Center has paired with the Oregon Rural Health Practice Network (ORPRN) on a tele-learning series to assist CCOs to add PCPCHs to their networks and provide support to already recognized PCPCHs to increase their tier level.

OHA has also contracted with CareOregon to provide care coordination services for tribal fee-for-service members. This contract will provide a way to reach approximately 51% of American Indian/Alaska Native (AI/AN) members, that would not otherwise have care coordination services made available to them.

Lever 2: Implementing alternative payment methodologies
Among other initiatives for alternative payment methodologies, OHA works toward this goal through metrics tracking, performance improvement, and collaborative policy development.

OHA is developing a clinical quality metrics registry that practices can use to submit quality data to Oregon Comprehensive Primary Care Plus (CPC+) payers and the Centers for Medicare and Medicaid Services (CMS). The state will use the registry data to help produce information on utilization, cost, and performance.

OHA, the Oregon Primary Care Association (OPCA), and participating Federally-Qualified Health Centers (FQHC) and Rural Health Centers (RHC) formed a collaborative workgroup focused on operationalizing the transition from an alternative payment methodology (APM) to value-based payments (VBP). Their approach includes a performance improvement plan (PIP) for CCOs who fail to reach average performance.

The Transformation Center completed an extensive period of public engagement to collect feedback on proposed VBP policies. The final CCO VBP Roadmap is on schedule to be released in January 2019, and it will be a valuable tool to communicate with and educate CCOs on VBP requirements.

Lever 3: Integrating physical, behavioral, and oral health care
OHA is working to equip the behavioral health workforce and increase integration across health sectors.

Oregon Health Authority

OHA is consulting with the Eugene S. Farley Jr., Health Policy Center from the University of Colorado to thoroughly assess Oregon's behavioral health care workforce and develop core competencies for behavioral health providers working in integrated behavioral health ambulatory settings. The center will identify gaps in workforce capacity and draft recommendations. The assessment will inform a recruitment and retention plan for the behavioral health workforce.

Lever 4: Increased efficiency in providing care

OHA's Public Health Division continues working on administrative simplification and effective models of care that incorporate community-based and public health resources.

The Oregon Legislature's public health modernization investment is allowing counties to partner with each other and share staff resources, so they can better prepare for and respond to communicable disease threats. The 2017 investment helped fund communicable disease control efforts at eight regions of local public health authorities and is improving health equity by identifying and engaging populations disproportionately affected by communicable diseases.

The Sustainable Relationships for Community Health (SRCH) met goals of implementing closed-loop referrals and building sustainable relationships between CCOs, public health agencies, and community partners in five local communities in Oregon.

Lever 5: Implementation of health-related services

OHA continues its commitment to promote CCOs' use of health-related services (HRS) to achieve the triple aim of better health, better care, and lower costs for all Oregonians.

OHA requires CCOs to have HRS policies that include how members, communities, and primary care teams are engaged in the use of HRS; policies are reviewed annually. OHA has developed processes for providing feedback to individual CCOs about reported spending that does not fit the parameters of HRS, and for publishing a deidentified report for all CCOs to learn from.

Lever 6: Innovations through the Transformation Center

OHA's Transformation Center continues to advance peer-to-peer learning and the spread of best practices and innovation through technical assistance and Medicaid provider learning opportunities.

The Transformation Center is:

- Supporting a Portland tri-county Regional Behavioral Health Collaborative (RBHC) to improve behavioral health outcomes through collaboration and collective action across organizations;
- Continuing with technical assistance projects on behavioral health integration, topics of which include integrating behavioral health into pediatrics and implementing a plan for an embedded behaviorist model; and
- Planning patient-centered counseling training sessions for Medicaid providers. Evidence-based health communication models will include motivational interviewing, the FRAMES Model: Feedback, Responsibility, Advice, Menu Options, Empathy, and Self-Efficacy and Five A's: Ask, Advise, Assess, Assist, and Arrange for tobacco cessation counseling.

Dana Hittle, Interim Deputy State Medicaid Director

B. Demonstration description

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

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

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

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

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

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

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

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

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

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II. Title

Oregon Health Plan

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III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan eligibility

A large enhancement of the ONE eligibility system in September 2018 has helped to ensure compliance to federal requirements, improve the accuracy of systematic determinations, and add efficiencies to staff processes and applicants' experience. Verify Lawful Presence (VLP) functionality was enhanced to implement systematic verification of immigration status at several steps and to satisfy VLP version 37 requirements. Prior to this, the system only verified step one through the VLP version 33 interface, and if further verification checks were required, they were performed manually by staff.

Additionally, the September enhancement includes functionality to appropriately count or exclude income received by children and tax dependents in determinations for themselves and their household members. This enhancement includes the ability to appropriately determine the countability of a child or tax dependent's Social Security Benefits, alleviating the need to produce and review manual reports to ensure accurate determinations.

2. Coordinated care organization enrollment

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

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

B. Benefits

The Pharmacy and Therapeutics Committee developed new or revised prior authorization criteria for the following drugs: Oral Cystic Fibrosis Modulators; SGLT-2 Inhibitors; Asthma Biologics; Radicava®; Antiepileptics; Sedatives; Pulmonary Arterial Hypertension; Attention Deficit Hyperactivity Disorder; CGRP Antagonists; Palynziq™; Hepatitis C Direct-acting Antivirals; Benzodiazepines; and Botulinum Toxins.

The committee also added the following drugs to the preferred drug list: Vraylar®; Aristada® Initio™; Invega® Sustenna® and Trinza® syringes; Perseris™; Zenpep®; clindamycin phosphate cream with applicator; clindamycin phosphate vaginal suppositories; and metronidazole gel.

The Health Evidence Review Commission has made interim modifications to address changes in evidence, medical technology, and practice guidelines. Detailed changes are described in the Interim Modifications letter.

C. Access to care (annual reporting)

D. Quality of care (annual reporting)

E. Complaints, grievances, and hearings

CCO and FFS complaints

The information provided is a compilation of data from 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. One CCO closed January 31, 2018 and reported data for the first month of 2018 only. The reporting period covers the quarter beginning July 1 through September 30, 2018.

Trends

	Oct – Dec, 2017	Jan – Mar, 2018	Apr – Jun, 2018	Jul – Sep, 2018
Total complaints received	4,995*	5,537	5,882	5,917
Total average enrollment	1,106,876*	1,179,176	1,217,091	1,185,394
Rate per 1,000 members	4.51*	4.70	4.83	4.99
* FFS data is included in the totals beginning in October 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports.				

Barriers

CCOs report the access-to-care category continues to receive the highest number of complaints. The access-to-care category increased 13.5% from the previous quarter, with non-emergency medical transportation (NEMT) receiving the most complaints in the access-to-care category. There were slight decreases in all other categories this quarter. FFS data continues to show the highest number of complaints in the quality-of-service category, followed by access-to-care.

Interventions

During this quarter CCOs report they are continuing to provide regular training to internal staff to ensure all complaints are resolved and reported appropriately. One CCO reports they trained internal customer service staff on using tone, empathy, compassion, and general scripting when answering member calls to ensure they provide excellent service to members. CCOs report they are working in various ways to reduce the number of complaints from specific providers, such as NEMT brokerages. Some CCOs are meeting bi-weekly and monthly with NEMT providers and are beginning to see improvements. One CCO uses a Peer Review Committee and is seeing improvements in the number of complaints. CCOs are continuing to provide education to members to ensure they provide the correct insurance information at the time of service, or when they incorrectly receive an initial billing.

Oregon Health Plan (OHP) Member Services reports 444 complaints from members who have fee-for-service coverage for the July – September 2018 quarter. OHP Member Services reported an additional 356 records identified as complaints received from members enrolled in CCOs. In addition to the complaint calls, Member Services took 1,538 calls from members asking for a variety of information, such as coverage, CCO enrollment, and ID cards.

Statewide rolling 12-month totals

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

Complaint category	Oct – Dec, 2017	Jan – Mar, 2018	Apr – Jun, 2018	Jul – Sep, 2018
Access to care	2,343	2,213	3,076	3,491
Client billing issues	393	457	394	299
Consumer rights	205	230	220	195
Interaction with provider or plan	1,374	1,682	1,283	1,103
Quality of care	313	466	526	476
Quality of service	293	439	345	305
Other	74	50	38	48
Grand Total	**4,995***	**5,537**	**5,882**	**5,917**
* FFS data is included in the totals beginning in October 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports.				

Related data

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

CCO and FFS appeals and hearings

CCO Notices of Action – Adverse Benefit Determination

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

Notice of Action – Adverse Benefit Determination (NOA-ABD) reason	Total issued
a) Denial or limited authorization of a requested service.	28,584
b) Single PHP service area, denial to obtain services outside the PHP panel	182
c) Termination, suspension, or reduction of previously authorized covered services	107
d) Failure to act within the timeframes provided in § 438.408(b)	36
e) Failure to provide services in a timely manner, as defined by the State	182
f) Denial of payment, at the time of any action affecting the claim.	17,116
Total	**46,207**
Number per 1000 members	53

CCO Appeals

The following table shows the total number of appeals received by CCOs during the quarter. Federal managed care rule changes went into effect for Oregon on January 1, 2018, and OHP members are now required to exhaust their appeal rights at the CCO level before a contested case hearing can be requested at the state level. The table below has been revised to reflect only CCO appeal information. CCOs reported that specialty care and outpatient services had a higher number of requests for appeal. CCOs report they provide education and training to their staff as well as provider staff to increase knowledge about covered benefits. Some CCOs report they have made internal changes to assist providers with access to medical consultations to help reduce the number of denials. CCOs continue to work with members to assist them in finding services they need or finding alternative covered options.

CCO Appeals	Requests
a) Denial or limited authorization of a requested service.	1,152
b) Single PHP service area, denial to obtain services outside the PHP panel	5
c) Termination, suspension, or reduction of previously authorized covered services	8
d) Failure to act within the timeframes provided in § 438.408(b)	5
e) Failure to provide services in a timely manner, as defined by the State	0
f) Denial of payment, at the time of any action affecting the claim.	335
Total	**1,505**
Number per 1000 members	1.72
Number overturned at plan level	456
Appeals decisions pending	8
Overturn rate at plan level	30.29%

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 15 CCOs, seven dental care organizations (DCO) and fee-for-service (FFS). During every quarter, there is an overlap between processed cases and cases received (e.g. Cases processed and resolved in this quarter may have been received last quarter.).

The Oregon Health Authority (OHA) received 436 hearing requests related to the denial of medical services, which include non-emergency medical transportation (NEMT). Of those received, 418 were for CCO-enrolled members, and 18 were for FFS members.

OHA processed and resolved 451 cases. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. There were 22 cases approved prior to hearing where the CCO overturned the appeal resolution. Members withdrew from 34 cases after an informal conference with an OHA hearing representative, and OHA dismissed 326 cases that were determined not hearable. Of the 66 cases that went to hearing, the administrative law judge: upheld the OHA or CCO decision in 45 cases; reversed the decision in one case; and dismissed 20 cases for members' failure to appear. Two cases were dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request, and one case was dismissed due to non-jurisdiction.

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

Outcomes of Contested Case Hearings Processed

Outcomes	Count	% of Total
Decision overturned prior to contested case hearing	22	5%
Client withdrew request after pre-hearing conference	34	8%
Dismissed by OHA as not hearable	326	72%

Decision affirmed*	45	10%
Client failed to appear*	20	4%
Dismissed as non-timely	2	0%
Dismissed because of non-jurisdiction	1	0%
Decision reversed*	1	0%
Set Aside	0	0%
Total	**451**	
**Resolution after an administrative hearing*		

Related data

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

F. CCO activities

1. New plans

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

2. Provider networks

New dental plan contracts for HealthShare of Oregon, one of Oregon's coordinated care organizations (CCO), are effective as of October 1, 2018. HealthShare, is committed to move toward full care integration and to improve access and care to its 320,000 Oregon Health Plan (OHP) members. In May, HealthShare released a request for application (RFA) to its nine contracted dental plans to evaluate which were best aligned with those commitments. On June 20, 2018, after RFAs were reviewed and evaluated, HealthShare's Board of Directors selected five of the nine dental plans for continued partnerships. Contracts for the four dental plans not selected were terminated on September 30, 2018.

Throughout this transition, HealthShare's top priority is to maintain members' relationships with their dental providers whenever possible. HealthShare reported the following member transition data.

- Members with no dental plan change (already enrolled with the five continuing dental plans) – 185,000
- Members whose dental plan changed:
    - With the option to continue seeing the same dentist regardless of plan change – 78,543
    - Whose providers could not be identified through claims data – 2,605
    - Who have not been receiving dental services – 54,400.

In response to the Oregon Health Authority's (OHA) request for additional information on the 54,400 members identified as not receiving dental services, HealthShare provided the following statement:

> *As you may know, many members do not access their dental benefits for a variety of reasons, and those members are the ones referred to as "not receiving services". Included in that number are also individuals who only received community-based services or non-routine emergency services (examples include sealants in a school setting, Tooth Taxi services, etc.). Those encounters would not fit our definition of a relationship with a primary dental provider or a dental home. Because these members are*

not currently receiving dental care, we do not see a change in their dental plan as a disruption of a care relationship.

Eastern Oregon Coordinated Care Organization (EOCCO) is ending its contract with Capitol Dental effective October 1, 2018. EOCCO will continue to contract with Advantage Dental and ODS Dental to deliver oral health services to members.

3. Rate certifications

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

In July, OHA met with CCOs on several occasions to discuss base data policy, risk corridor updates, upcoming benefit changes, and risk score updates. Discussions included a revised base data policy with a proposed addition related to the value-based payment and an exhibit itemizing the impact of the diagnosis-related group (DRG) in-patient adjustment by hospital. OHA and CCOs also discussed the impact of the policy decisions by rate group for each region.

Recently passed legislation (2018 House Bill 4018) requires OHA to provide each CCO with notice of proposed changes to the terms and conditions of the CCO contract for the next benefit period. Notice is to be provided no later than 134 days prior to the end of a benefit period. In August, OHA delivered the rate exhibits, policies, and models related to calendar year 2019 CCO draft capitation rates for CCO review. The notice allows each CCO the opportunity to make an informed business decision whether to continue participation in the program for the upcoming year. There are currently no CCOs that opted out of their 2019 contracts.

4. Enrollment/disenrollment

There are no significant changes in member enrollment or disenrollment.

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

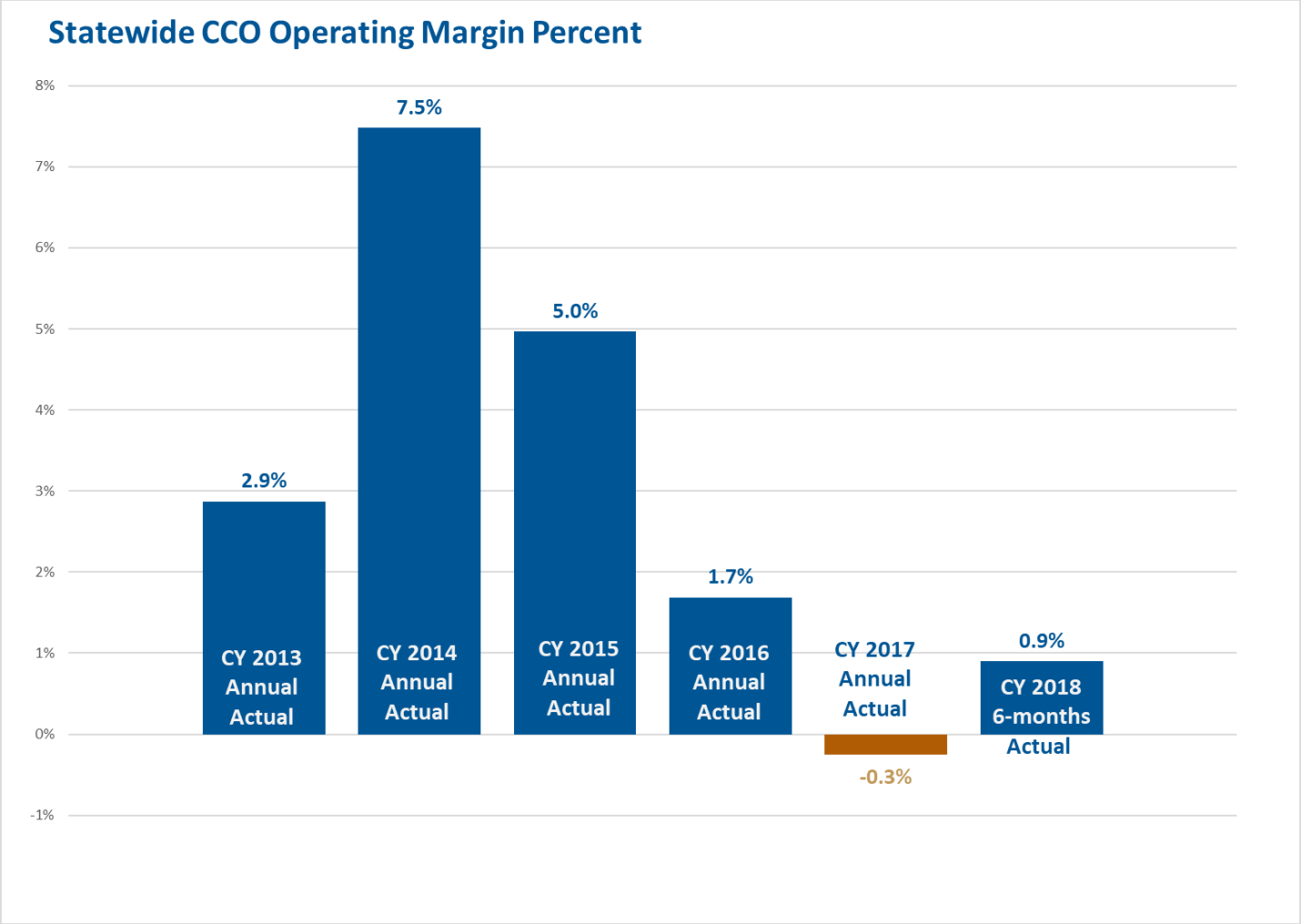
5. Contract compliance

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

6. Relevant financial performance

Data reported is for the six months ending June 30, 2018.

The statewide coordinated care organization (CCO) operating margin was at 0.9% compared to -0.3% for the year ended December 31, 2017. For reference, the capitation rates include a 1% profit margin and 0.5% risk contingency. CCO operating margins returned to a slightly profitable status after trending downward during the previous three-year period.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental, and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. The MSR for all CCOs in aggregate was 91.5%. Administrative services accounted for 7.6% of total CCO revenue, leaving 0.9% as operating margin.

All CCOs (excluding Family Care, which left the market early in 2018) met or exceeded the 85% target for MSR, a key indicator for medical loss ratio (MLR). Half of the CCOs had MSRs above 90%.

As of June 30, 2018, all CCOs meet their net worth requirement. Net Assets of the CCOs ranged from a low of $201 per member (Willamette Valley Community Health, LLC) to a high of $1,129 per member (Intercommunity Health Network), averaging $560 per member for the state.

7. Corrective action plans

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

8. One percent (1%) withhold

During this quarter, the Oregon Health Authority's Health Systems Division analyzed encounter data received for completeness and accuracy for the subject months of December 2017 through February 2018. All coordinated care organizations (CCO) met the administrative performance standard for all subject months and no 1% withholds occurred.

9. Other significant activities

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

G. Health Information Technology

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

Medicaid Electronic Health Records Incentive Program

Through the Centers for Medicare and Medicaid Services (CMS) Electronic Health Records (EHR) Incentive Programs (also known as the Promoting Interoperability Programs), eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). Increasing the number of providers adopting, implementing, upgrading, or meaningfully using CEHRT helps promote better health outcomes for Oregonians by increasing access to and use of vital health information at the point of care. Since the Medicaid program's inception in 2011, 3,795 Oregon providers and 60 hospitals have received over $192 million in federal incentive payments under the Medicaid EHR Incentive Program (as of September 30, 2018). Between July and September 2018, 490 Oregon providers and three hospitals received $4.2 million in Medicaid EHR incentive payments. To promote continued participation and success in the program, Medicaid EHR Incentive Program staff hosted an informational webinar to present updates and requirements to 116 attendees. The program sunsets in 2021.

Oregon Medicaid Meaningful Use Technical Assistance Program

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

Since the program's launch in 2016, a total of 1,471 providers across 342 clinics have enrolled (as of September 30, 2018). Between July and September 2018, 125 providers across 57 clinics received technical assistance bringing the total number of providers to 1,135. The program will sunset in 2019.

Behavioral Health

Oregon Health Authority (OHA) conducted a Behavioral Health, health information technology (HIT) scan, including an online survey and in-depth interviews. The scan collected information from behavioral health entities across the state regarding HIT and health information exchange (HIE) use, needs, challenges, and priorities. The online survey was sent to all Oregon agencies operating at least one state-licensed behavioral health program, reaching a total of 874 programs. Almost half (48%) of the agencies responded, representing 60% of state-licensed behavioral health programs. The respondents showed strong engagement with the survey, with 75% agreeing to be contacted for follow-up. Highlights from the survey include:

- Of responding agencies, 76% are using electronic health records (EHR);
- Financial cost is a top barrier to EHR use for both agencies with and without an EHR; and

- Though some agencies are exchanging patient information via electronic means, the most commonly used methods of information exchange are fax, secure email, and paper.

OHA also completed 12 in-depth interviews with survey respondents. The interviews provided rich, detailed information, further shedding light on the HIT/HIE successes and challenges experienced by behavioral health agencies. A draft report, which will be a resource for statewide HIT/HIE efforts within behavioral health, was released to the Health Information Technology Oversight Council (HITOC) and other stakeholders in December 2017. OHA is finalizing further analyses of both the survey and interview data which will be included as Report appendices.

At HITOCs request, OHA is convening a Behavioral Health HIT Workgroup that is reviewing and providing feedback on the report recommendations and priorities. The workgroup is informing the prioritization of recommended strategies for supporting the behavioral health system's current HIT/HIE needs, which will be presented to HITOC in December and included as an addendum to the report. OHA will release a final report by the end of 2018.

HIT Commons

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

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

Network of Networks

The planned Network of Networks is a critical part of the Health Information Technology Oversight Council's (HITOC) strategy for statewide health information exchange (HIE) to support care coordination, population health, patient engagement, and value-based payment models. In its mature form, the Network of Networks may include: coordinating and convening key stakeholders; identifying and implementing needed infrastructure to facilitate exchange; ensuring interoperability; ensuring privacy and security practices; providing neutral issue resolution; and monitoring environmental, technical, and regulatory changes and adapting as needed. It will not include a state-run HIE.

In June 2018, after further study of the current Oregon HIE environment, HITOC chartered two workgroups to develop the Network of Networks concept: a technical definitions group and an advisory group.

The technical definitions group met in July and August and drafted core definitions for the advisory group's use. It also explored some complex core concepts, providing valuable advice that will help guide the advisory group's work.

Oregon Health Authority

The Oregon Health Authority (OHA) expects the advisory group to convene in Winter 2018. It will make recommendations to HITOC about key next steps after analyzing approaches and their relative merits in terms of effort, impact, and cost.

HITOC anticipates that the HIT Commons, Oregon's public-private partnership for accelerating HIT, will lead the Network of Networks initiative beginning in 2019.

Oregon Prescription Drug Monitoring Program Integration Initiative

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

The Oregon PDMP Integration Initiative went live in 2017 with Phase I, which consisted of working with Oregon hospitals who had electronic health record- (EHR) integrated EDIE notifications to include PDMP data when certain triggers were met. The new feature had to be rolled out hospital-by-hospital to ensure compliance with state PDMP permission regulations and was only implementable by hospitals with integrated EDIE alerts in their EHRs (some hospitals receive EDIE notifications via fax or secure printer).

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

- PDMP data through integration is now available through:
    - EDIE alerts in 26 hospitals, reaching 600+ prescribers;
    - Two EHR and two HIE integrations, reaching an additional 100+ prescribers; and
    - Two pharmacy integrations, reaching approximately 240 pharmacists.
- Reliance eHealth Collaborative and InterCommunity Health Network's (IHN) Regional Health Information Collaborative (RHIC) are in the process of rolling out implementation to their members.
- In the last year, there has been a 134% increase in the total number of queries submitted through Integration, EDIE and web browser.
- Queries through integration now exceed queries through web browser.
- Grants for rural hospitals to integrate PDMP Gateway into their EHRs are available through the Oregon Association of Hospitals Research and Education Foundation. Grants may be used for hospital integration costs related to EDIE and/or PDMP Gateway solution.

Clinical Quality Metrics Registry

Oregon's Clinical Quality Metrics Registry (CQMR) will collect, aggregate, and provide clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. Initially, the CQMR will be used for electronic clinical quality measures (eCQMs) for the Medicaid EHR Incentive Program and coordinated care organization (CCO) incentive metrics. Participants in those programs will also have the option to use the CQMR for reporting eCQMs to the Centers for Medicare and Medicaid Services (CMS) for the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+) program. Over

time, other quality reporting programs could use the CQMR as well, which will support OHA's goal of streamlining and aligning quality metric reporting requirements and reducing provider burden.

The CQMR is in its implementation phase, which began with a kick-off in December 2017 with Peraton and Michigan Health Information Network (MiHIN), OHA's prime vendor and subcontractor, respectively. OHA has continued to engage stakeholders in a subject matter expert workgroup in addition to outreach with other stakeholder groups. Program work in preparation for implementation includes work on communications, legal agreements, and contracting for technical assistance to clinics focused on patient-level eCQM reporting.

The CQMR is expected to go live in January 2019. Contingency plans are in place and have been communicated to stakeholders to avoid disruptions in reporting.

H. Metrics development

The Oregon Health Authority continued reporting on the 2017 coordinated care organization and state performance measures in monthly dashboards and continued measure development and validation work. Throughout this quarter, the Oregon Health Authority (OHA) continued to engage stakeholders in the measurement strategy through public committees and workgroups including the Metrics and Scoring Committee and the Metrics Technical Advisory Workgroup. Both meet monthly.

Health Plan Quality Metrics Committee

According to Oregon's 2017 Senate Bill 440 (SB 440), the publicly funded health plans such as Medicaid, Public Employees Benefit Board and others should align their quality metrics by selecting from a common menu set of quality measures. SB 440 created the Health Plan Quality Metrics Committee (HPQMC) and specified that the Metrics and Scoring Committee (MSC) would become a subcommittee that informs the larger committee. The MSC continues to select the specific incentive measure and benchmarks for the coordinated care organizations (CCO). The HPQMC finalized the 2019 measures and it includes 51 measures and 20 developmental measures.

Metrics and Scoring Committee

The Metrics and Scoring Committee (MSC) continued to meet monthly. At the July meeting, the committee received an update on the CCO 2.0 process and took an in-depth look at two measures under consideration for the 2019 measure set (smoking cessation and substance use disorder measures). The committee also worked on finalizing the 2019 measure set. At the August meeting, the committee selected the 2019 challenge pool measures. They also began selecting the 2019 benchmarks and improvement target floors. At the September meeting they completed selecting the 2019 benchmarks and improvement target floors. They also received an update on the Health Aspects of Kindergarten Readiness Technical Workgroup.

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

Related data

Reports are attached separately as Appendix E – CCO Incentive Measures, 2019.

Health Aspects of Kindergarten Readiness Technical Workgroup

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

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

The workgroup has been meeting monthly since April and had three meetings during this quarter. At the July meeting the workgroup discussed potential "near ready" metrics that address workgroup priority areas. At the August meeting the workgroup discussed "new" metrics and summarized "near ready" and "ready" metrics that could be implemented. At the September meeting, the workgroup discussed its measurement strategy and using a combination of ready, near ready and new metrics that could be phased in over time.

Evidence-Based Obesity Metric Workgroup

This workgroup convened for the first time in May. The group would like to recommend a measure that goes beyond clinical intervention at the primary care level and includes a multi-component, cross-sector approach. The workgroup met in July to summarize the work done during phase one and discussed plans for work to be completed during phases two and three. This group will reconvene in November.

I. Budget neutrality

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

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

There are no legislative activities to report for this quarter.

The 2018 Session of the Oregon Legislative Assembly adjourned Saturday, March 3, 2018. Significant legislation impacting Oregon's Medicaid program that passed during the 2018 session are:

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

- Requires a CCO to spend a portion of net income or reserves on services designed to address health disparities and social determinants of health consistent with federal terms and conditions of the Oregon Health Authority's (OHA) 1115 Medicaid Demonstration Waiver;
- Modifies composition of a CCO's governing body specific to financial risk entities; and
- Codifies, in statute, provisions related to contract nonrenewal and compliance requirements.

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

K. Litigation status

Lawsuits and legal actions

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

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

L. Public forums

Health Evidence Review Commission

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

August 9, 2018

Testimony for this meeting related to a proposal by HERC's Chronic Pain Task Force that was developed over six meetings from September 2017 to June 2018. The proposal would involve the creation of a new line in the funded region of the Prioritized List that would provide the coverage of treatments for five currently non-funded conditions involving complex pain syndromes, including fibromyalgia. The new line would have to be created

as part of the biennial review process, and if approved by HERC would not go into effect until January 1, 2020. New covered treatments under the proposal would include cognitive behavioral therapy, acupuncture, health and behavior assessment, physical/occupational therapy, pain education, yoga, mindfulness-based stress reduction, massage, supervised exercise, and intensive interdisciplinary rehab (if available). Additionally, patients would receive all Federal Drug Administration- (FDA) approved non-opioid medications such as Tylenol, NSAIDS, duloxetine, pregabalin, antidepressants, etc. Medications would be paired with active therapy, including psychotherapy. The new line would be tied to Guideline Note 60 restricting opioid use, as there is evidence of harms in the use of opioids for chronic pain. Patients on long-term opioid therapy would be required to taper within a year after the taper is begun.

Tim Harless, chronic pain patient and advocate
Mr. Harless, who was cut off opioids by the Veterans' Administration shared his life story and medical history.

Karen Yeargain, LPN, public health nurse and chronic pain patient
Ms. Yeargain shared her personal and professional experience with chronic pain in Oregon. She strongly urged the Commission to not take away the option for opioids for chronic pain patients who are stable.

Valorie Hawk, Coalition of 50 State Pain Advocacy Groups (C-50)
Ms. Hawk shared her experiences with Washington State's taper policy, which includes a grandfather clause.

HERC Value-based Benefits Subcommittee

August 9, 2018
Testimony for this meeting related a proposal by the Health Evidence Review Commission's (HERC) Chronic Pain Task Force. This was the initial presentation of this proposal to the standing HERC subcommittee.

Carolyn Concion, NP
Ms. Concion testified that patients are stabilized on opioids for years, then providers taper medications, frequently involuntarily. She said patients are also rejected by providers due to their chronic pain.

Bob Twillman, PhD, Executive Director, Academy of Integrated Pain Management
Dr. Twillman testified in support of moving chronic pain above the current funding line but opposes forcing opioid tapers. He requested that the subcommittee look at outcomes for chronic back pain patients tapered off opioids: functionality, suicides, mental health issues, etc. He noted that improved function is a criterion for the first 90 days of opioids in the opioid guideline, but improved function is not considered after 90 days. He feels that the opioid guideline needs criteria for pausing, stopping, or reversing tapers.

Karen Yeargain, LPN, public health nurse and chronic pain patient
Ms. Yeargain testified that it is not diverted prescription drugs that are causing overdose problems, but rather street drugs. Oregon has decreased prescribing of opioids and is seeing increased suicides, but no increase in street drugs in chronic pain patients. Opioids increase functionality.

Ginevra Liptan, MD, Internal Medicine
Dr. Liptan, an internal medicine physician with a focus on fibromyalgia, testified, noting that she is also a chronic pain patient. Opioids are imperfect. She agreed that the HERC should cover fibromyalgia and noted that

Oregon is the only state without Medicaid funding for fibromyalgia care. She requested that the commission add tools that are helpful but do not take away the tool that has been helpful (opioids).

Allan Chino, PhD, ABPP, Clinical Health Psychologist and Pain Specialist

Dr. Chino testified about the need to move fibromyalgia above the line and have tools to help these patients. He noted that outcomes are superior when a range of treatment options are available, including opioids. Decisions should be based on individual patients. He noted that he has never seen hyperalgesia in his practice.

Karl Probst, Veterans' Administration patient

Mr. Probst testified about the new Veterans' Administration policy that requested patients get off opioids. Patients are offered suboxone instead. He feels that he has a better quality of life though opioids.

Patrick Starnes, Independent candidate for Oregon Governor

Mr. Starnes asked the committee not to lump addicts with chronic pain sufferers. He stated that the commission needs more pain patient representation on the Task Force.

Steven Hix, chronic pain patient

Mr. Hix shared he is very frightened about what is happening locally and nationally with opioids. He has tried all the proposed modalities without success. Hydrotherapy was the most successful. He notes that it is very easy to lose hope and become depressed. The most vulnerable people in this country are suffering. Taking away people's medicine will not magically make their pain go away. This is a matter of human decency. There is a huge problem when one is labeled as a drug seeker. Health care insurance is a huge expense.

Helen Turner, Clinical Nurse Specialist

Ms. Turner cares for children with chronic pain and testified that opioids help children go to school and have improved quality of life. Evidence for opioids is messy at best and does not apply to all patients. She is trying to get as many kids off opioids as she can.

Amanda Siebe, Complex Regional Pain Syndrome patient

Ms. Siebe brought in boxes of medical records, which include her treatment with all types of modalities. Only methadone helps her pain. Taking away opioids drives patients to suicide and street drugs. This takes away hope and functionality, giving nothing in exchange. Less than 3% of patients on opioids become addicted.

BJ Cavnor, Executive Director, One in Four Chronic Health

Mr. Cavnor shared concerns about restrictions on opioids in the guideline note. Pain patients are not addicts. Chronic pain patients are stigmatized. The Prescription Drug Monitoring Program (PDMP) database monitors drugs. Patients and providers should decide the best treatment strategy between them. This is a reactive policy at the state and national level and does not help the overall opioid crisis.

Julia (no last name given)

Julia testified that this conversation was not public knowledge. She has tried all non-opioid medications, procedures, and modalities; none work other than opioids. [Note: all meetings of the Chronic Pain Task Force were open to the public and 28-days advanced notice was given on HERC's website and to their ~5,000 person listserv.]

Written Testimony

In addition to verbal testimony provided at the meeting, there was a large volume of written public testimony on the subject. A summary of main themes of the topics include:

- Alternative therapies are not adequate or do not work.
- Benefits of long-term opioid therapy: improved function, ability to work and care for self or family.
- Harms of involuntary taper from long-term opioid therapy: reduced function and ability to work; increased pain; increased risk of suicide; and increased use of illicit opioids or other drugs.
- Patients on chronic opioids are not addicts.
- The proposed taper policy is an overreaction to a few bad patients or doctors or illegal drug users.
- Stories of bad experiences with forced tapers.
- Opioid tapers should be decided between doctors and patients, not payers.
- This discriminates against low-income/Oregon Health Plan (OHP) patients.

When given this summary, a committee member asked how staff would respond to the argument that this might discriminate against people on OHP. Staff said the Prioritized List already does not allow them access to acupuncture or access to certain drugs or therapy, which someone on a Blue Cross/Blue Shield would have access to. In some ways, this change would bring more equity to OHP members. Technically, opioids and other prescription drugs are ancillary services and are not covered by the Prioritized List, but opioids are typically not prior authorized and still get prescribed and provided since diagnosis codes are not included on prescriptions.

HERC Evidence-based Guidelines Subcommittee

July 12, 2018

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

Kelley Story, MS, CADCIII, Director of Residential Programs for Samaritan Health Services

Ms. Story said that residential programs need to meet regulatory requirements including testing for regular tests. They face mandates that can be in direct conflict. She said that presumptive results aren't sufficient—there is no other chronic disease for which we would accept presumptive results. In addition, she said that there is evidence that frequent testing improves outcomes. The subcommittee discussed false positives, but there are also concerns about false negatives. The standard panel used by her organization uses definitive tests for 12 substances. In addition, many patients are using fentanyl, which is not well-detected by presumptive tests, without being aware of it. She told several stories about the value provided by urine drug testing, including cases where the Department of Human Services intervened based on a presumptive test when definitive testing later came back negative. She expressed concern about patients who are elderly or pregnant who may require additional testing.

Evidence-based Guidelines Subcommittee Chair responded:

Saying this is a challenging topic, and the subcommittee recognizes the importance of the problem. However, the subcommittee is also concerned about the high level of spending on these tests. He said it seems unlikely to him that a person would need 36 definitive tests per year. In addition, Mental Health Parity requires that the limits are adopted as "soft limits."

September 6, 2018

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

Tony Howell, LCSW, Linn County

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

HERC Health Technology Assessment Subcommittee

September 27, 2018

Testimony for this meeting related to a draft coverage guidance on Federal Drug Administration- (FDA) approved next generation sequencing (NGS) tests for tumors of diverse histology. At the end of this meeting the development of the coverage guidance was tabled until further evidence anticipated from randomized controlled trials are completed, which may be available as early as 2019.

James L. Gajewski, MD, MACP, President, Oregon Society of Medical Oncology

Dr. Gajewski spoke first. He declared no conflicts of interest and referenced his participation in a 2013 Health Evidence Review Commission (HERC) workgroup related to a guideline note on cancer treatment at the end of life. He said that the Affordable Care Act requires that cancer treatment access be without regard to the impact of the therapy on the length of survival, quality of life, and disability. He also said that the current HERC guidelines require access to care defined by national guidelines, *which we interpret as American Society of Clinical Oncology (ASCO), National Comprehensive Cancer Network (NCCN), American Society of Hematology (ASH), and American Society for Blood and Marrow Transplantation (ASBMT),* as well as access for patients with rare tumors to best available therapy when the provider needs to consult other outside physicians. He said that as a clinical hematologist stem-cell transplanter, NGS is very important in bone marrow failure states to separate aplastic anemia from mild dysplasia or to decide when to give immunosuppressive therapy or take patients to transplant. Secondly, for some patients who are "watch-and-wait" with mild dysplasia, repeated NGS can detect mutations which might help him decide to transplant earlier. For his long-term transplant survivors, NGS helps make decisions about preemptive cellular with a donor lymphocyte transplant prior to an all-out relapse. There are a lot of issues with the statistics. He said it's difficult to do large trials. Often the decisions are based on understanding of cancer biology and the mutations. The addition of new mutations predicts a worsening cancer prognosis.

Gajewski said that clinical trials are covered under the Oregon cancer guideline. Staff clarified that the trial drugs are not covered but supportive care necessary to access the clinical trial (such as hospitalization) is covered.

Cindy Langhorne, Lung Cancer Program Director, Caring Ambassadors Program, Inc.

Ms. Langhorne said her organization receives pharmaceutical support but none from FoundationOne. She began her career and advocacy as the founding member of the Lung Cancer Alliance. She is also co-leader of the Lung Cancer Action Network, a coalition of 24 organizations advocating for detecting, treating, and curing the

disease. She said cancer is not seen as a single disease and that most new treatments now target specific biomarkers. These targeted therapies are improving outcomes in patients with that biomarker. Still, next generation sequencing is often seen as an 'extra service' by patients and their providers. Twenty years ago, survival was 12 months. Now stage-four patients are living longer and longer. She told the story of a colleague who was diagnosed in 2011 and is thriving. On behalf of half-a-million people living with lung cancer in the U.S., she encouraged HERC to reconsider the recommendation. All patients deserve the same access to care.

The Health Technology Assessment Subcommittee Chair clarified that many of the biomarkers for non-small cell lung cancer are already covered under the Oregon Health Plan, but with tests focused on specific targetable mutations.

Anne Murray, Lobbyist, Bristol-Myers Squibb Co.
Ms. Murray testified about a letter submitted by email. She wanted to ensure it had been received by members and provided copies.

Rocky Dallum, JD, Partner, Tonkon Torp, LLP
Mr. Dallum said he represents Quest, Oregon Bio, and National Bio. He said that the issues are covered in the letters which have been submitted previously and provided copies.

Julia Elvin, MD, PhD, Anatomic and Molecular Pathologist, Foundation Medicine
Dr. Elvin said that this complicated and rapidly-evolving area of laboratory medicine is critical for patients making difficult choices and to hopefully live better and longer with their disease. Foundation Medicine disagrees with the recommendation, which uses outdated studies and disregards the conclusions of the FDA and Centers for Medicare and Medicaid Services (CMS), based on their review of 280 relevant articles as well as extensive validation from our analytic information from tumor samples. As a pathologist she said the understanding of cancer subtypes has been fueled by understanding of the molecular drivers. This is giving physicians a more complete picture of each patient's disease and may reveal targeted treatments and eligibility for mutation-matched clinical trials. Possibly more importantly, comprehensive molecular characterization will demonstrate the lack of mutations in relevant pathways, and thus the lack of probable therapeutic benefit for certain treatments that were approved only in a particular tumor subtype.

Dr. Elvin recommended that the subcommittee recommend coverage for the test. Patients most impacted by coverage denial are the most vulnerable and will further reinforce disparities in cancer outcomes and clinical trial enrollment of lower socioeconomic groups. Regarding clinical utility, she said her organization disagreed with the characterization that the FDA and CMS conflated clinical utility with proven effectiveness of targeted therapies. She said they specifically focused on clinical utility and whether the molecular profiling can help guide physicians in decision-making. NGS testing is part of standard care for many advanced cancers rather than an empiric or scattershot approach. NCCN guidelines have been evolving due to NGS technology and have changed their guidelines for many cancers. She asked the subcommittee whether they truly believed that the patient was going to get a less effective or less safe therapy if an NGS-based profile informs it. She said the answer is no. She said profiling can predict how a patient's disease will behave and what interventions may or may not be successful. This is like the move from gram-stain analysis in infectious disease to routine antibiotic resistance testing.

Charles Koyias, MD, Medical and Scientific Affairs Manager, Roche Diagnostics

Dr. Koyias believes personalized care will continue transforming lives and improving patient outcomes. He expressed concern by the approach taken. Specifically, he asked why the Health Technology Assessment Subcommittee (HTAS) asserts that adequate coverage exists for targeted therapies when individual mutations are analyzed, yet no evidence exists for the use of NGS. Analytic and clinical validity have been well-established. NGS-based tests cited in the HTAS review have undergone rigorous review with the FDA and have been approved as elements that are essential to the use of a targeted therapy in a particular indication. CMS' coverage and analysis group reviewed over 280 peer-reviewed studies on the evidence supporting clinical utility for these tests. The use of NGS tests is supported in NCCN guidelines for patients with lung, melanoma, ovarian and prostate cancers. He said the College of American Pathologists (CAP), the International Association for the Study of Lung Cancer (ISALC), and the Association for Molecular Pathology (AMP) updated their guidelines for the selection of patients with targeted tyrosine-kyrine inhibitor therapies. He referenced evidence showing that survival of patients receiving a targeted therapy is significantly longer than patients with no mutation. The HTAS must take all this into account before finalizing a negative recommendation. He said ignoring evidence not reviewed under the HTAS methodology threatens patient access to these tests but will serve to undermine and stifle progress in this area of personalized medicine. The subcommittee should either postpone its decision until it can perform a comprehensive review of the literature or reverse the recommendation.

Dann Wonster and Jacqueline Fusari (Fusari was not present)

Mr. Wonster read Ms. Fusari's letter, which said she had been living with Stage IV Non-Small Cell Lung Cancer for six years, since 2012. At the time she was running, hiking, and doing yoga but somehow this cancer had spread through her lungs at the age of 26 though she had never smoked. The prognosis was not good, and she didn't have options. After receiving NGS tests it was discovered that she had the Alkaline Phosphatase (ALP) gene mutation, giving her the opportunity to use a targeted medication for the ALP mutation. The drug worked miraculously. Without this she knows she wouldn't be here today. These tests are necessary parts of treatment for all patients. She is currently in her second year of graduate school studying Chinese medicine and cycling while she receives another targeted therapy.

Mr. Wonster then told his own story. His lung cancer was discovered after a broken rib. He is a nonsmoking vegetarian who works out at the gym every day and had no risk factors. After chemotherapy and surgery, he had additional chemotherapy. His life expectancy was measured in months. He continued working out, eating healthy, and getting lots of sleep. He said lung cancer can happen to anyone. The chemotherapy he took had a low success rate but worked for him for a time. Five years later he was re-diagnosed with Stage IV lung cancer. The chemotherapy did not work; the chemotherapy maintenance drug caused kidney damage but stopped the cancer for 18 months. After NGS, he found he could be treated with a targeted therapy. After 16 months he qualified for another trial of a new targeted therapy, which was only available to those who have NGS. The new drug has been working for 47 months without progression. There are 11 targeted therapies available and none can be given without NGS. He asked the subcommittee not to send Oregonians to an early grave by restricting them to the same crude options available decades ago.

The HTAS Chair acknowledged the poignant testimony and clarified that the Oregon Health Plan does cover targeted testing for genetic mutations associated with the FDA-approved targeted therapies for Non-Small Cell Lung Cancer.

Karen Heller, MS, CGC, Myriad Genetics

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

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

Chronic Pain Task Force

The Health Evidence Review Commission's (HERC) Chronic Pain Task Force (CPTF) is an ad hoc group representing pain care providers and the patients they treat. It was created to help HERC staff form a proposal on potential changes to the Prioritized List related to the treatment of nonpalliative, noncancer chronic pain other than back pain. This proposal is expected to focus on the use of nonpharmacologic treatments not currently covered under the Oregon Health Plan (OHP) for certain conditions involving chronic pain and potential limits of pharmacological treatments, such as opioids, that have evidence of harm. This proposal will be taken to the Value-based Benefits Subcommittee and then HERC for consideration in early 2019 as part of the biennial review of the Prioritized List.

September 20, 2018

Testimony for this meeting related to a proposal by HERC's CPTF. The proposal would involve the creation of a new line in the funded region of the Prioritized List that would provide the coverage of treatments for five currently non-funded conditions involving complex pain syndromes, including fibromyalgia; the proposal is detailed under the HERC August 9, 2018 meeting notes above. This meeting was held after the presentation to the Value-based Benefits Subcommittee to allow for further consideration given the large amount of public testimony.

Diane F. Weaver, MS, Senior Manager, Health Economics and Health Policy, Avanos Medical, Inc.

Ms. Weaver testified on behalf of Avanos Medical, Inc. which manufactures a non-opioid medical device that applies cooled thermal radiofrequency to an area in the operating room and ablates a nerve, interrupting the pain signal from the nerve to the brain. She provided a packet of materials supporting the efficacy of this procedure. Its effects last up to 24 months.

Kate Nicholson, Civil Rights Attorney

Ms. Nicholson had her testimony read by another attendee. She expressed concerns with the removal of choices of treatment, mainly opioids, from chronic pain patients, which goes against all professional guidelines. She personally has chronic pain and has had various treatments including opioids. She noted that chronic pain can put patients on disability.

Richard A. Lawhern, PhD, Alliance for Treatment of Intractable Pain

Dr. Lawhern had his testimony read by another attendee. He stated that groups prescribed opioids do not have higher mortality than groups not prescribed opioids. He noted that only a very small minority of patients on opioids go on to abuse these medications. Addiction is not a predictable result of opioid prescribing.

Stefan Streck

Mr. Streck noted that Amsterdam has a solution to the opioid issue. Heroin addicts can be given heroin by the government. He felt that the solution is to legalize heroin and leave legitimate pain patients' prescriptions alone. He noted that the task force proposal increased cost to the public by substituting suboxone for cheaper opioids. He said the current task force proposal is also cruel.

Amara (no last name given)

Amara asked the Task Force members if they agreed with taking away her opioids.

Kera McGee, chronic pain patient

Ms. McGee testified that she has a connective tissue disorder and is a chronic pain patient. Opioid pain medications are the only thing that works for her pain. She is also a recovering addict. After overdosing on her opioid pain medications, her opioids were taken away by her provider. Her function is much worse without the opioid therapy. She is upset because doctors treat her as a criminal and at one point she felt suicidal after being taking off her medications.

Kelly Howard, chronic pain patient

Ms. Howard testified that she is a chronic pain patient, as well as a medical research specialist. She can work due to responsible use of pain medications. She stated that the Scottish Intercollegiate Guidelines Network (SIGN), National Institute for Health and Care Excellence (NICE), etc. say opioids are safe and effective. She noted that alternative therapies provide some benefit for her. She noted that in the Strategies for Prescribing Analgesics Comparative Effectiveness (SPACE) trial, there was no misuse or overuse among opioid medication users.

Trisha E. Wong, MD, MS, Assistant Professor of Pediatrics, Oregon Health & Science University

Dr. Wong testified that she is a pediatric hematologist at Oregon Health & Science University (OHSU) who cares for sickle-cell patients. She requested other inherited chronic pain conditions be considered for removal from this proposal. Dr. Ariel Smits clarified that sickle-cell and similar conditions are currently covered and not part of the current CPTF proposal.

BJ Cavnor, Executive Director, One in Four Chronic Health

Mr. Cavnor objected to Oregon Health Authority (OHA) Director Pat Allen's op-ed title in the Wall Street Journal. He stated that there is a difference between people misusing medications and responsible chronic pain patients. Stigma, shaming, and shunning continue to affect chronic pain patients.

Tim Harless, chronic pain patient and advocate

Mr. Harless testified that he is a chronic pain patient and an advocate for the American Chronic Pain Association. This is a peer-led support group. He is concerned about the suicide rate among chronic pain patients. The Veterans' Administration cut him off his opioids, without any support. He ties chronic pain to increased suicide risk.

Vern Saboe, Jr., DC, DACAN, FICC, DABFP, FACO

Dr. Saboe testified on behalf of the Oregon Chiropractic Association. He noted that the final CPTF proposal did not include chiropractic care. He wanted to clarify that chiropractors do more than spinal manipulation. Chiropractors can do physical therapy and provide other services to chronic pain patients. He also requested that the Task Force clarify which physical therapy modalities should be included for chronic pain patients.

Patrick Starnes, Independent candidate for Oregon Governor

Mr. Starnes testified that he is an advocate for legacy chronic pain patients. He requested two additional members be added to the Task Force: a chronic pain patient and a pain provider. He was insulted that a pain patient was not added to the Task Force. The Task Force is missing something by not bringing all the stakeholders to the table. [Note: the CPTF already includes a pain patient that these advocates don't acknowledge because she has made money in the past from coaching other pain patients and the entire remainder of the task force is made up of pain providers.]

Patty Brennan, chronic pain patient

Ms. Brennan testified that she is a chronic pain patient with fibromyalgia. She is very stressed over the thought of an opioid taper. She has done alternate therapy for years, as well as taking opioids. She has been on the same opioid regimen for a decade. She can function because of the opioids and does not misuse her opioids.

Evelyn Blackburn, chronic pain patient

Ms. Blackburn testified that she is a chronic pain patient. She stated that she has gone down 62% in her dosage in past months. She has done lots of alternative treatments. Opioids are an important part of her protocol. She uses other medications and alternative treatments, including an anti-inflammatory diet. She requested that an evidence review of opioid tapering be done before decisions are made.

General question from the audience –

There was a general question from the audience about the referral process for alternative treatments. There is a prior authorization process which is a barrier and the 30-visit limit on PT modalities is also a barrier. Another barrier is that cognitive behavioral therapy may be limited to one session in some CCOs.

Genetics Advisory Panel

The Genetics Advisory Panel (GAP) assists in developing recommendations on the potential coverage and prioritization of specific genetic testing, including potential coverage of gene panel testing, exome and genomic testing, and mitochondrial genome testing.

October 10, 2018

Ashley Allen, Regional Manager, Roche Diagnostics

Ms. Allen noted that non-invasive prenatal screening (NIPS) is a more sensitive and specific test than traditional screening and will reduce the number of women requiring invasive procedures such as amniocentesis, which lowers cost and has adverse outcomes. She states that most private payers in Oregon (Premara, Regence, Anthem) cover all risk women for NIPS. Not covering for Oregon Health Plan (OHP) causes disparities.

Audience member

It was noted by an audience member that the American College of Obstetricians and Gynecologists (ACOG) guideline says that any type of screening is appropriate, but it does not say that NIPS should be restricted to high-risk women. Therefore, the current ACOG opinion could be interpreted to indicate that ACOG feels that NIPS is appropriate for all-risk women. The GAP decision was to make no change in the current restriction of NIPS to high-risk women. HERC staff will monitor for the new ACOG statement expected to come out in favor of universal NIPS screening. If ACOG publishes such an opinion, GAP would be in favor of changing the prenatal genetic testing guideline to allow use for low and high-risk women.

James L. Gajewski, MD, MACP, President, Oregon Society of Medical Oncology

Dr. Gajewski testified that GAP should consider recommending coverage of whole exome sequencing. This test is appropriate for a child with clinical descriptive genetic abnormality and no specific diagnosis. Children and families need a specific diagnosis in many cases to receive services from schools, appropriate medical supportive services, etc. The GAP members felt that this was worth consideration, but that there were no materials to review for this meeting. Whole exome sequencing will be placed on the agenda for the 2019 GAP meeting.

Medicaid Advisory Committee

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

July 25, 2018

The MAC heard a presentation from an OHP member, who shared her family story and her experience getting diapers for her medically complex child with a disability. Her child carries an OHP Open Card, meaning services are provided on a fee-for-service basis, so that she can have continuity of care. She needs special absorbent diapers, and to find ones covered by OHP she had to call several vendors and advocate on behalf of her daughter. She shared some suggestions to make things easier for OHP families:

1. Is a new prescription necessary every time the brands and/or combination of products change, even though the total amount can never go over 200?
2. Can "exceptions" be made transferrable to different vendors?
3. Can OHP provide a vendor list for families?
4. The OHP member hopes that OHP will continue asking families for suggestions on how to improve the system.

September 24, 2018

Shayla Duke, previous relative care provider

Ms. Duke sent an email on September 20th, 2018 to be shared with the committee. She suggested that more effort be made to allow members to participate remotely, and the agency could perhaps consider sending public notices for meetings by mail. She expressed concern about CCOs managing services for dual eligible members, and noted that some members, including tribal members, cannot be required to join a CCO.

Metrics and Scoring Committee

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

July 20, 2018

The committee received public testimony from two of Oregon's coordinated care organizations (CCO).

- HealthShare of Oregon commented that CCOs should be held accountable for the quality incentive metrics during significant periods of change.

- PacificSource Community Solutions commented about dental quality incentive measures for 2019 and 2020.

August 17, 2018

The committee received written public testimony from the Oregon Academy of Family Physicians in support of the decision to keep the Patient-Centered Primary Care Home (PCPCH) enrollment measure in the 2019 coordinated care organization (CCO) Incentive Measure Set and in support of keeping it as a must-pass or gateway metric for achieving 100% of the quality pool.

September 21, 2018

The committee received testimony from a CCO staff member about setting benchmarks. The coordinated care organization (CCO) staff member encouraged the use of statistical tools. The committee also received public testimony about incentive measures and the pediatric population.

IV. Progress toward demonstration goals

A. Improvement strategies

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

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes.
- Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes.
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care.
- Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources.
- Lever 5: Implementation of health-related services aimed at improving care delivery, enrollee health, and lowering costs.
- Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Oregon Health Authority's Transformation Center

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes

Certified Community Behavioral Health Clinics

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

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

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

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

Patient-Centered Primary Care Homes

Patient-Centered Primary Care Homes (PCPCH) program staff conducted 20 site visits to primary care clinics. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address identified barriers.

Five additional clinics became PCPCHs this quarter, for a total of 655 PCPCH clinics in the state. This is approximately three-quarters of all primary care practices in Oregon. Fifty-two of those clinics have been designated as 5 STAR, the highest tier in the PCPCH model.

Oregon Health Authority

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

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

Tribal Care Coordination

State Health Official letter SHO#16—002, issued on February 26, 2016, reinterpreted Section 1905(b) of the Social Security Act so that health services coordinated by Indian Health Service and Tribal 628 facilities would be considered services "received through" such facilities, and thus eligible for 100% federal matching funds. Governor Kate Brown followed up on this federal policy change with a letter to the tribes on September 7, 2016, directing the Oregon Health Authority (OHA) to develop a method to direct these state savings back to the tribes for reinvestment into tribal health programs and services.

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

OHA continues to work with the tribes to process claims submissions and issue payments in alignment with the requirements of SHO#16—002. Four payments to the tribes have been processed thus far. OHA has concluded contracts with six tribes to participate in this program, and negotiations are ongoing with a seventh tribe to begin receiving payments. OHA is currently working with the nine federally-recognized Oregon tribes to develop a methodology for issuing savings reinvestment payments for tribal coordinated care organization (CCO) members. Currently, payments are only issued for fee-for-service members.

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

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

Comprehensive Primary Care Plus

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

Care management fee payments for participating practices are continuing. OHA began issuing prospective performance-based incentive payments (PBIP) in June at 50% of practice eligibility. Retrospective payments of 50% practice eligibility were also issued. OHA calculated practice scores for the two OHA utilization metrics: Ambulatory Care: Emergency Department Utilization; and Plan All-Cause Readmission. These scores will be

combined with the quality scores from the Centers for Medicare and Medicaid Services (CMS) to calculate final PBIP for each practice and will be reconciled at the end of the year.

OHA is developing a clinical quality metrics registry for the Medicaid program. CPC+ practices can use the registry to submit quality data to Oregon CPC+ payers and CMS. The registry will be used to calculate eligibility for paying quality incentives to CCOs and Medicaid electronic health record (EHR) incentives to providers. The state will use the registry data to help produce information on utilization, cost, and performance.

Advanced Payment and Care Model

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

1. Oregon Health Plan members attributed to a participating FQHC/RHCs who have not been engaged through an encounter or a Care STEP in the past 8 quarters will be dis-enrolled from the health center, and the health center will stop receiving PMPM payments; and
2. Health centers will be placed on a performance improvement plan (PIP) for failing to reach the average coordinated care organization (CCO) performance on three or more incentive measures over four consecutive quarters. Failure to achieve the improvement targets set within the PIP will result in a 2-to-3.5% PMPM rate reduction depending on the number of targets missed (There are five total incentive measures.).

Health centers will begin submitting their Quality Metric Reports under the new accountability plan. This quarter's reports are due October 31, 2018. For the Care STEPs accountability measure, OHA is in the process of building the Care STEPs database to query for patient engagement.

On July 1, 2018, two RHCs and two FQHCs joined the APCM. Roughly half of all Oregon FQHCs are now on the alternative payment methodology.

OHA is currently in the process of establishing an APCM Total Cost of Care dashboard and has produced the initial prototype. The dashboard is intended to display cost trends for APCM attributed populations throughout the entire Medicaid delivery system. In the future, this may be used to compare APCM cost trends to overall Medicaid cost trends as reported for the 1115 Medicaid Demonstration Waiver's Health Systems Transformation spending growth trend.

Primary Care Payment Reform Collaborative

The Oregon Health Authority (OHA) convenes the Primary Care Payment Reform Collaborative, a multi-stakeholder advisory group working toward developing a sustainable payment model for primary care. This model emphasizes paying for quality of care rather than quantity, as well as integrating behavioral health and addressing social determinants of health. The collaborative is developing recommendations to be presented to the Oregon Legislature and the Oregon Health Policy Board (OHPB) in December 2018.

Value-Based Payment Innovations and Technical Assistance

Following the value-based payment (VBP) Roadmap development period, the Transformation Center completed an extensive period of public engagement, including statewide public meetings in English and Spanish, to collect feedback on proposed VBP policies. The VBP definitions, policies, targets, reporting and measurement strategies were also reviewed by the Oregon Health Policy Board's (OHPB) Health Equity Committee and will be presented to OHPB for approval in October 2018. The final coordinated care organization (CCO) VBP Roadmap is on schedule to be released in January 2019, and it will be a valuable tool to communicate with and educate CCOs on VBP requirements.

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

Behavioral Health Collaborative Implementation

The Behavioral Health Collaborative (BHC) was a group of 50 stakeholders that met in 2016-2017 and submitted recommendations to the Oregon Health Authority (OHA) on how to improve the behavioral health system. The BHC made high-level recommendations to OHA, and OHA responded by partnering with existing stakeholder groups to establish workgroups focusing on the following areas:

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

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

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

Governance and Finance Workgroup (G&F)

Risk Sharing with Oregon State Hospital: The Governance and Finance (G&F) workgroup has recommended OHA work in collaboration with coordinated care organizations (CCO), community mental health providers (CMHP), and hospitals to identify a risk-sharing model with the state hospital. OHA has convened a Risk Sharing workgroup that includes the listed stakeholders and partners. This work is in progress as the workgroup identifies opportunities, barriers, and impact of implementing this recommendation.

Standards and Competencies

The Standards and Competencies (S&C) workgroup has recommended implementation of a standardized suicide risk assessment in Oregon. This recommendation is in alignment with the Zero Suicide Initiative that Oregon committed to in 2016, when the state established the Oregon Youth Suicide Prevention Five-Year Plan. OHA has convened an internal workgroup to identify options for implementing standardized assessment and reporting by all providers. The options are being vetted through various stakeholder groups such as community

mental health providers (CMHP), substance-use disorder (SUD) providers, Oregon Suicide Prevention Alliance, Certified Community Behavioral Health Clinics (CCBHC), and others.

The S&C workgroup recommended that OHA assess the minimum core competencies of behavioral health providers in Oregon: merits, gaps, and minimum requirements for providers in various settings. OHA staff are consulting with the Eugene S. Farley Jr., Health Policy Center from the University of Colorado to develop core competencies for behavioral health providers working in integrated behavioral health ambulatory settings. OHA has received the draft recommendations and will be sharing with stakeholders and engaging in a consensus process in December 2018.

Workforce

Behavioral Health Care Workforce Assessment: The BHC recommended a thorough assessment of Oregon's behavioral health care workforce: licensed, unlicensed, certified, uncertified, and registered. OHA, through a contract with the Eugene S. Farley Jr., Health Policy Center, is conducting this assessment. It will identify gaps in workforce capacity; a report will be available in February 2019. The Behavioral Health Mapping tool will be updated to reflect the assessment's results.

The workforce assessment will lead to the development of a recruitment and retention plan for the behavioral health workforce. This plan will be completed in spring 2019.

Roadmap to Oral Health

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

- Conducting an annual clinical training for School Dental Sealant Programs on August 17, 2018. This provided dental hygienists with technical assistance around the coordinated care organization (CCO) incentive metrics for 2019 and trauma informed care practices. Programs that were unable to attend the training in person could access an OHA-produced webinar on August 28, 2018 to provide technical assistance around the CCO incentive metrics for 2019.
- Through the Metrics and Scoring Committee, adopting a measure set for 2019 with an incentive metric measuring the rate of oral evaluations for adults with diabetes. One of the goals of including this measure is to encourage CCOs to work across physical and oral health to increase oral health care for the population with this chronic disease.
- Completing presentations to targeted audiences about opioid use and registration with Oregon's Prescription Drug Monitoring Program, with the goal of making oral health providers aware of their role in decreasing opioid abuse.

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

Innovator Agents

During this quarter, the Oregon Health Authority's (OHA) innovator agents collaborated with coordinated care organizations (CCO), community partners, and Community Advisory Councils (CACs) as they develop their new Community Health Assessments and Community Health Improvement Plans. Innovator agents have made connections for technical assistance, participated in planning committees, and clarified Oregon Administrative

Rules. Innovator agents have acted as conduits for information to Community Advisory Councils and CCOs as the Oregon Health Authority (OHA) plans for CCO 2.0. They have been assisting with community forums to gather feedback and provide information, have been available to CCOs to provide clarification as questions arise and have continued to give updates to CACs.

Innovator agents helped the Transformation Center plan a recent health equity conference by gathering information from their respective CCOs about their successes and barriers. This information helped guide the conversation as CCOs shared health equity best practices. Two innovator agents have been working with National Nurse Family Partnership staff, two CCOs and their executive leadership, local Public Health leadership, and Greater Oregon Behavioral Health to explore the creation of a 15-county Nurse Family Partnership project. This evidence-based home-visiting program would bring great benefits to rural Oregon counties.

Public Health Modernization

In September, the Oregon Health Authority (OHA) released the Public Health Modernization Interim Evaluation Report for the 2017-19 biennium. The Oregon Legislature's $5 million public health modernization investment is allowing counties to partner with each other and share staff resources, so they can better prepare for and respond to communicable disease threats. The 2017 investment, $3.9 million of which went toward funding communicable disease control efforts at eight regions of local public health authorities, is improving health equity by identifying and engaging populations disproportionately affected by communicable diseases. Key findings from the report include the following.

- New and expanded inter-governmental partnerships are resulting in increased surge capacity for outbreak investigations and better preparation for public health emergencies.
- Local public health authorities are working with tribes, Regional Health Equity Coalitions, and other partners on regional health equity assessments to ensure that health equity and community engagement principles are embedded in communicable disease prevention strategies.
- Local public health authorities are partnering with coordinated care organizations (CCO) and working with health care providers on new systems to prevent, and respond to, communicable disease threats.

Sustainable Relationships for Community Health program

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

Activities

Two new SRCH Program grantee consortia (Yamhill Coordinated Care Organization and Klamath County Public Health) started their year-long projects in January 2018 and finished their third and final Institute in July 2018. This cohort of SRCH grantees participated in three two-day institutes in February, May, and July. The

teams developed and implemented closed-loop referral systems to colorectal cancer screening, chronic disease self-management, chronic pain self-management, and the National Diabetes Prevention Program (NDPP).

At the site visit and first institute, the teams mapped their local systems, defined the various roles of partners, identified their aims, drivers, and activities, and developed their workplans. In May, teams continued testing and evaluating new strategies, and in July the teams developed sustainability plans and determined opportunities for spreading their identified health improvement strategies across their region.

Progress and findings

The outcomes from the 2017-2018 SRCH grantee cohort showed that all grantee teams reported considerable progress on their initiatives through increasing patient referrals to evidence-based self-management programs, piloting new intervention strategies, developing standardized workflows, implementing closed-loop referrals, developing patient identification, and screening criteria, and creating new educational/communications materials. Both teams leveraged lessons learned from past SRCH grantees specific to reimbursement strategies for diabetes prevention lifestyle change programs in preparation for upcoming Medicaid coverage of NDPP in January 2019. All teams also significantly increased inter- and intra- team collaboration and built new relationships that will continue beyond the grant period.

Trends, Successes or Issues

As described in the last section, the prior SRCH grants were successful in meeting their aims of implementing closed-loop referrals, and building sustainable relationships between CCOs, public health agencies and community partners in two local communities in Oregon.

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

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

Health-related services

Coordinated care organizations (CCO) receive a global payment for each member, which provides CCOs the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. Under Oregon's 1115 Medicaid Demonstration Waiver for 2017–2022, the Oregon Health Authority (OHA) continues its commitment to promote CCOs' use of HRS to achieve the triple aim of better health, better care, and lower costs for all Oregonians. OHA published a frequently-asked-questions document about how to use HRS.

Oregon administrative rules require CCOs to have HRS policies that include how members, communities, and primary care teams are engaged in the use of HRS. OHA developed a process and form for annual review of these policies. CCOs also submit quarterly HRS expenditure reports and an annual comprehensive report. OHA developed processes for providing feedback to individual CCOs about their spending that does not meet the federal definition of HRS, and for publishing a deidentified summary report for all CCOs to learn from.

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

Transformation Center activities

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

Behavioral health integration

The Transformation Center is continuing with eight technical assistance projects requested by CCOs on the integration of behavioral health. New topics include integrating behavioral health into pediatrics and implementing a plan for an embedded behaviorist model.

The Transformation Center is supporting a Portland tri-county Regional Behavioral Health Collaborative (RBHC) to improve behavioral health outcomes through collaboration and collective action across organizations responsible for behavioral health. The Oregon Health Authority (OHA) will convene a broad set of stakeholders to initiate the RBHC. Participants will develop strategies and an action plan with an initial focus on peer-delivered services and substance-use disorders. A regional, multi-stakeholder planning group that met over the summer informed this initial focus.

Population Health

Community Advisory Councils

The Transformation Center continues to provide targeted supports to CCO community advisory councils (CACs) for CAC member recruitment and engagement.

- A CAC event will be held in spring 2019.
- Monthly calls with CAC leaders focused on CAC member recruitment and engagement, health equity, and CAC organizational development.
- An online seminar on mindfulness was held for CAC members; 21 people attended.

Community Health Assessment and Community Health Improvement Plans

Consultants updated the curriculum for the Community Health Assessment and Community Health Improvement Plans (CHA/CHP) development training. It's now available in a two half-day format, and it includes tools for implementing House Bill 2675, which requires CHPs to include a strategy for integrating physical, behavioral, and oral health care services. The training is available to CCOs upon request.

CCO incentive metrics technical assistance

Childhood immunization rates

All CCOs met the benchmark or improvement target for childhood immunization in 2017. Technical assistance for this metric is on hold and efforts will be redirected to other metrics.

Controlling high blood pressure

The Transformation Center held a Continuing Medical Education- (CME) accredited webinar for clinicians on controlling high blood pressure. Twenty people participated, and all evaluation respondents said the webinar was valuable or very valuable. The recording will be available for CMEs through September 2019.

The Oregon Rural Practice-based Research Network will provide TA on quality improvement to up to 30 clinics using high blood pressure control as the learning tool.

Developmental screening and follow-up

A contractor is developing three webinars, with accompanying tip sheets and guides, for CCOs focused on identifying children not getting developmental screenings and improving the referral and follow-up process for children with potential delays. Thirteen people (representing five CCOs) attended the first webinar. The contractor will also be developing and facilitating two webinars for primary care practices on follow-up to developmental screening and referring to and coordinating with Early Intervention.

Effective contraceptive use

Follow-up technical assistance on increasing effective contraceptive use continued for one CCO. The Latino Network is developing training for community members and providers on culturally responsive strategies for engaging the Latino community in sexual and reproductive health.

The Transformation Center is working with a consultant to develop a metrics brief to support clinic staff in understanding and documenting the effective contraceptive use measure.

Emergency department use among members with mental illness

Four CCOs requested the 20 hours of follow-up technical assistance offered for this metric. Projects include a community convening to inform a collaborative approach to addressing care and health needs of members with severe and persistent mental illness; building staff capacity to improve systems of care and data-informed decision-making; and standardizing use of care plans across the community using PreManage.

Transformation Center staff have also been planning a winter learning collaborative series on reducing emergency department visits among members with mental illness.

Tobacco Cessation

Tobacco cessation technical assistance activities this quarter included the following.

- A contractor worked with seven CCOs to develop tailored tobacco cessation benefits communications for members.
- A contractor developed a provider-focused e-module to provide training in the Five A's and brief intervention, as well as cessation counseling during pregnancy. The training will include no-cost CMEs.
- The Transformation Center is planning a half-day learning collaborative for CCOs focused on best practices for reducing tobacco prevalence. The event will include evidence-based clinical and community-based strategies.

Cross-cutting supports

CCOs Advancing Health Equity Workshop

The Transformation Center is planning a one-day event in October that will focus on peer-to-peer sharing of recent highlights and "best practices" by CCOs in advancing health equity.

Council of Clinical Innovators

The Transformation Center is planning an October convening of the Council of Clinical Innovators for a day-long learning event focused on addressing social determinants of health in the health care setting. The council includes alumni and faculty of the Clinical Innovation Fellows program.

Innovation Café: Strategies for Improving Children's Health

The 2019 Innovation Café will focus on sharing innovation and best practices to address social determinants of health. The planning committee will begin meeting in November.

Transformation and Quality Strategy technical assistance

CCOs submitted their first Transformation and Quality Strategy (TQS) progress report. Technical assistance included webinars to walk through the progress report template and share global feedback from the first annual TQS submissions. A CCO workgroup made recommendations on the 2019 deliverables and assessment methods.

Qualitative database

The Transformation Center updated the qualitative database with CCO Transformation Plan reports and new data on innovations throughout the CCO system. Staff responded to requests about innovations in diabetes care, housing as a social determinant of health, and oral health access and care.

Early childhood health coordination

Transformation Center staff presented to early learning hubs and regional cross-sector early childhood initiatives about current early childhood work within health system transformation and emerging practices in health and early learning collaboration. Staff also engaged Oregon's early learning hubs to provide information and receive input on the CCO 2.0 policy options.

Transformation Center staff also collaborated with the Office of Health Analytics to produce a CCO metrics update for the early learning hubs and provide updates and outreach to the early learning hubs regarding the work of the Health Aspects of Kindergarten Readiness Technical Workgroup.

Patient-centered counseling training

The Transformation Center is planning 11 patient-centered counseling training sessions for Medicaid providers around the state in spring 2019. Examples will draw from CCO metric-related topics. Evidence-based health communication models will include motivational interviewing, the FRAMES Model: Feedback, Responsibility, Advice, Menu Options, Empathy, and Self-Efficacy and Five A's: Ask, Advise, Assess, Assist, and Arrange for tobacco cessation counseling. Continuing medical education credits will be available at no cost to participants.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

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

2. State reported enrollment table

Enrollment	July 2018	August 2018	September 2018
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	936,333	938,031	935,564
Title XXI funded State Plan	86,785	86,508	86,065
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A
	N/A	N/A	N/A
Enrollment current as of	July 31, 2018	August 31, 2018	September 30, 2018

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	Percent change from previous quarter	Percent change from same quarter of previous year
Expansion	**Title 19**	PLM Children FPL > 170%	0	0	0.00%	0.00%
		Pregnant Women FPL > 170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL > 170	73,934	192,547	-17.26%	-17.14%
Optional	**Title 19**	PLM Women FPL 133-170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL < 170%	74,025	186,828	20.35%	27.92%
Mandatory	**Title 19**	Other OHP Plus	157,377	450,558	0.16%	-0.24%
		MAGI Adults/Children	727,070	2,040,584	-0.20%	-5.26%
		MAGI Pregnant Women	12,230	28,667	-0.66%	-23.33%
		QUARTER TOTALS	**1,044,636**			

OHP eligible and managed care enrollment

OHP Eligibles*	Coordinated Care	Dental Care	Mental Health

		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
July	967,606	844,092	654	43,685	3,569	502	31,956
August	969,666	847,614	624	43,692	3,601	496	32,268
September	968,648	844,341	608	43,995	3,600	500	32,334
Quarter average	968,640	845,978	616	43,844	3,590	498	32,301
		87.34%	0.06%	4.53%	0.37%	0.05%	3.33%

**Total OHP Eligibles include: GA, ACA expansion, CX Families, OAA, ABAD, CHIP, FC and SAC.*
Due to retroactive eligibility changes, the numbers should be considered preliminary.
***CCOA: Physical, Dental and Mental Health; CCOB: Physical and Mental Health; CCOE: Mental Health only; CCOG: Mental and Dental*

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

Reports are attached separately as Appendix D – Neutrality Reports.

E. CCO Incentive Measures, 2019

Reports are attached separately as Appendix E – CCO Incentive Measures, 2019.