Oregon Health Plan

Section 1115 Quarterly Report

10/1/2017 – 12/31/2017
Demonstration Year (DY): 16 (7/1/2017 – 6/30/2018)
Demonstration Quarter (DQ): 2/2018
Federal Fiscal Quarter (FQ): 1/2018

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I. Introduction

A. Letter from the State Medicaid Director

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

Lever 1: Improving care coordination
OHA continues to improve care coordination through the Patient-Centered Primary Care Home (PCPCH) program and the federal Certified Community Behavioral Health Clinic (CCBHC) project, and we are collaborating with Oregon's federally-recognized tribes in Oregon to improve tribal care coordination.

OHA is tracking all tribal care coordination events and locating the claims billed by non-IHS/tribal providers to switch the funding source to 100% federal funds. We are also in the process of establishing agreements with tribes to reinvest state savings back to the tribes. Collaboration with the tribes has shown that we can establish systematic incentive loops that drive better access and health outcomes for tribal members and much needed investment in tribal health programs.

Lever 2: Implementing alternative payment methodologies (APMs)
OHA continues working toward value-based payments (VBPs) through several programs including the Comprehensive Primary Care Plus (CPC+) programs.

CPC+ launched January 1, 2017, and system modifications are underway to calculate performance-based incentive payment amounts to all participating clinics. Nearly all of Oregon's CPC+ practices have contracts with OHA for Medicaid fee-for-service members, and as of December 31, 2017, 75 have received per-member, per-month care management fees for a total of over $400,000 in 2017.

Also, OHA has established a CCO VBP Roadmap workgroup to advise OHA on definitions, targets, and measurement methods. In 2018, the CCO workgroup will meet several times, and OHA will obtain input from the CCOs' network providers. Stakeholders will also be given the opportunity to provide feedback.

Lever 3: Integrating physical, behavioral and oral health care
Behavioral, physical and oral health integration is also moving forward, and OHA's Statewide Performance Improvement Project (PIP) on Opioid Safety is proving successful.

The Behavioral Health Collaborative (BHC) recommended improvements to Oregon's behavioral health system, and OHA continues to work with stakeholders to operationalize recommendations. Specifically, OHA and stakeholders are working on strategies for increasing the behavioral health workforce, implementing standardized assessments, maximizing health information technology (HIT) usage, and identifying metrics based on Oregon's behavioral health priorities and national quality metrics. OHA also developed, and began distributing, a suite of member and provider education materials highlighting the importance of oral health care as a part of overall health care and dental benefits available to Oregon Health Plan (OHP) members.

While 2017 calendar year (CY) data is not yet finalized, analyses of OHA's Statewide PIP on Opioid Safety show the number of OHA enrollees age 12 years and older who filled a prescription for an opioid pain reliever decreased over 20% from baseline to the current re-measurement period. This decrease in CCO-level study metrics over baseline and many community level outcomes contributed to the success of the PIP.

Lever 4: Increased efficiency in providing care

While innovator agents focus on providing support to CCOs in developing Transformation Quality Strategies (TQS), OHA's Public Health and Health Systems divisions continue to partner to advance the Sustainable Relationships for Community Health (SRCH) grant program.

In an effort to provide CCOs with an opportunity to internally coordinate and align all of their transformation and quality work, their transformation plans and quality assessment and performance improvement deliverables are merging into TQSs. Innovator agents and the Transformation Center are supporting CCOs as they prepare to develop their new TQSs and conclude their transformation plans.

New SRCH teams, comprised of coordinated care organizations (CCOs), local public health authorities and community-based organizations, are beginning projects focused on implementing closed-loop referrals to community-based diabetes prevention and chronic disease self-management programs, as well as colorectal cancer screening.

Lever 5: Implementation of health-related flexible services

OHA continues working to develop additional guidance to assist CCOs as they implement the revised definition of health-related services.

CCOs have expressed the need for greater communication and clarity around tracking and reporting on the use of health-related services and outcomes associated with flexible services. OHA is working to provide greater communication and clarity around tracking and reporting on the use of HRS and outcomes associated with flexible services and exploring mechanisms in rate development to account for quality and efficiency outcomes resulting from investments in HRS.

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. The Transformation Center developed training on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) processes. One CCO has participated in training, and seven more have requested the training. Training for CCO staff to support the transition to the TQS is also available, and so far several CCOs have attended.

The Transformation Center also continues to provide technical assistance to CCOs around incentive metrics, including a new 2018 metric: emergency department use among members with mental illness. Technical assistance on this new metric focused on metric specifications, identifying primary drivers of emergency department use, examples of multi-system care coordination, and innovations for managing patient pain.

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

David Simnitt, State Medicaid Director

B. Demonstration description

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

In January 2017, CMS approved an extension to Oregon's 1115 Medicaid Demonstration waiver 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 coordinated care organizations (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 (CFR);
- Allowing passive enrollment of Medicare and Medicaid dually-eligible individuals into CCOs with the option for each individual to opt-out at any time;
- Specifying the demonstration will not impact American Indian and Alaska Natives (AI/AN) rights to exemption from managed care, or the requirements to comply with the Medicaid Managed Care Regulations;
- Providing for incentive payments for Patient-Centered Primary Care Homes (PCPCHs) and Comprehensive Primary Care Plus (CPC+) providers that reflect provider performance in these programs for Medicaid beneficiaries who are served through the fee-for-service delivery system; and
- Establishing minimum requirements for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

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Demonstration and Quarterly and Annual Reports

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report

Reporting period: 10/1/2017 – 12/31/2017
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III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan eligibility

Oregon Health Plan (OHP) members can now apply, renew, and manage their coverage online with the Oregon Eligibility (ONE) system. During 2017, there was a focused effort to finish processing OHP renewals for individuals who were not processed during the transition to the ONE system. These renewals were completed in August and were reflected in September's enrollment data. With all renewals current, data from this quarter forward should reflect more stable and predictable enrollment and disenrollment activity.

Due to the Federally Facilitated Marketplace's (FFM) open enrollment period, there were expected increases in account transfer referrals during this quarter, and we had slight increases in Title XIX and Title XXI enrollments. Additionally, Title XXI enrollment continued to climb as children moved from Medicaid into the Children's Health Insurance Program (CHIP). The FFM's open enrollment window was shorter this year: 45 days as opposed to last year's 90-day open enrollment period. Despite receiving higher numbers of daily account transfer referrals, OHP Member Services was able to prioritize this body of work and avoid any undue delays in processing.

2. Coordinated care organization enrollment

OHA successfully transitioned to the ONE system and made significant advances in reducing the fee-for-service population. OHA continues to ensure eligible OHP members are appropriately enrolled in coordinated care organizations (CCO). While new member enrollment is an automatic process in the Medicaid Management Information System (MMIS), OHA's quality control measures verify member demographics to make sure members who can be enrolled in a CCO, are enrolled. As a part of this verification process, queries run each month to identify members who are not enrolled. Once these members are identified, OHA staff determine the barriers to CCO enrollment and, when appropriate, enroll the member manually.

B. Benefits

The Pharmacy and Therapeutics Committee developed new or revised prior authorization criteria for the following drugs: GLP-1 Receptor Agonists, Hepatitis C direct acting antivirals, and Insulins. There were no Preferred Drug List changes for this quarter.

The Health Evidence Review Commission (HERC) has made interim modifications to address changes in evidence, medical technology and practice guidelines. Detailed changes are described in the Interim Modifications letter sent to our legislative leadership which can be found at http://www.oregon.gov/oha/HPA/CSI-HERC/PrioritizedList/Interim%20Modifications%20to%20Prioritized%20List%2010-1-17.pdf.

C. Access to care (annual reporting)

D. Quality of care (annual reporting)

E. Complaints, grievances, and hearings

Narrative of significant trends and interventions to address complaints and grievances.

CCO and FFS complaints and grievances

The information provided is a compilation of data from 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. This is the first quarter in which OHA is reporting FFS data, and this addition reflects an increase in the number of overall complaints from last quarter.

Trends

	Jan – Mar, 2017	Apr – Jun, 2017	Jul – Sep, 2017	Oct – Dec, 2017
Total complaints received	3,930	4,225	4,157	4,995*
Total average CCO enrollment	865,701	882,453	855,569	1,106,876*
Rate per 1,000 members	4.54	4.78	4.71	4.51*
* FFS data is included in the totals for October – December 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports.				

Barriers

The access-to-care category continues to receive more complaints than other categories. One CCO reported a specific issue with non-emergent medical transportation (NEMT), and this issue caused an increase in the number of complaints. The remaining CCOs are reporting specific steps they are taking to improve members' experiences with NEMT. Steps include: structured agreements with providers; increased staffing and dedicated phone lines at the provider level; and changes in contracted NEMT providers.

Interventions

CCOs report the implementation of new data collection software is improving their reporting capabilities. One CCO is working to improve behavioral health services in its community by meeting with local providers on a regular basis. Another CCO reports actively tracking the number of billing issues and holding internal meetings in an effort to better understand the high number of complaints in the billing category.

For FFS data, the OHP Member Services has begun recording complaints in the Medicaid Management Information System (MMIS). FFS data for this quarter shows alignment of FFS complaint data with data collected by the CCOs. During this quarter, Member Services recorded an additional 550 records identified as complaints received from members enrolled in CCOs. OHA is working on how to determine that these additional complaints are not duplicative. OHA continues to work on improving the reporting process with a focus on improving how data is collected and reported to OHA.

Statewide rolling 12-month totals

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

Complaint category	Jan – Mar, 2017	Apr – Jun, 2017	Jul – Sep, 2017	Oct – Dec, 2017
Access to care	1,737	1,759	1,719	2,343
Client billing issues	311	310	334	393
Consumer rights	193	239	215	205
Interaction with provider or plan	1,240	1,329	1,293	1,374
Quality of care	283	416	422	313
Quality of service	110	124	131	293
Other	56	48	43	74
Grand Total	3,930	4,225	4,157	4,995
* FFS data is included in the totals for October – December 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

During this quarter, OHA received 650 hearing requests related to the denial of medical services. The number of hearings requested for CCO-enrolled and fee-for-service members were 626 and 24, respectively.

Of all hearing requests received, 195 were approved after a second review (original decisions overturned). There were 188 hearings where the member withdrew their hearing request after an informal conference with an OHA hearings representative. Eighty-three cases were dismissed as not hearable. There were 162 cases that went to hearing, and the administrative law judge upheld the OHA or CCO decision in 86 cases, reversed the OHA or CCO decision in two cases, and dismissed for members' failure to appear in 74. Thirty-five hearing requests were dismissed due to a member requesting the hearing after the allowable 45 days without good cause for the late request.

Notices of Action

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

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
a) Denial or limited authorization of a requested service.	31,262	1257	16 - 190
b) Single PHP service area, denial to obtain services outside the PHP panel	255	6	0 - 6
c) Termination, suspension, or reduction of previously authorized covered services	120	2	0 - 2
d) Failure to act within the timeframes provided in § 438.408(b)	9	0	0
e) Failure to provide services in a timely manner, as defined by the State	0	0	0
f) Denial of payment, at the time of any action affecting the claim.	19,346	320	0 - 131
Total	**50,992**	**1,585**	**16 - 329**
Number per 1000 members	**46**	**1.4**	**1.12 – 3.08**
Number overturned at plan level		**522**	**8 - 119**

Notice of Action (NOA) reason	Total NOAs issued	Total appeal requests	Range of appeal requests
Appeal decisions pending		**8**	**0 - 3**
Number of contested case hearings requested at plan level		**650**	**3 - 125**
Overturned at plan level prior to hearing		**189**	
Overturn rate at plan level		**29.21%**	
Hearing requests per 1000 members at plan level		**1.08%**	

Outcomes of Contested Case Hearings

Outcomes	Count	% of Total
Decision overturned after second review	195	29%
Client withdrew request after pre-hearing conference	188	28%
Dismissed by OHA as not hearable	83	13%
Decision affirmed*	86	13%
Client failed to appear*	74	11%
Dismissed as non-timely	35	5%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	2	0%
Set Aside	0	0%
Total	663	

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 (CCO) or other physical, behavioral, or dental plans serving the Medicaid population.

2. Provider networks

After a competitive request-for-proposal process to select a dental network provider, Yamhill Community Care Organization (Yamhill CCO) announced that they selected Capitol Dental. Yamhill CCO sent letters notifying members of this dental network change, and the CCO began transitioning members in December 2017 with a January 1, 2018 effective date. According to Yamhill CCO, Capitol Dental demonstrated sufficient capacity for all 25,000 Yamhill CCO members. Yamhill CCO reports that their executed contract with Capitol Dental includes additional requirements related to timeliness of data submission, which will allow for improved data tracking and quality-of-care monitoring by the CCO.

3. Rate certifications

OHA contracts with CCOs 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-only (DCO) contracts and a mental-health-only (MHO) contract where capitation rates are developed separately.

During the 2018 CCO rate development process, OHA addressed stakeholder concerns, and an independent review of the process was performed. OHA contracted with Lewis & Ellis, Inc. (L&E Actuaries & Consultants) to perform an actuarial review and Manatt, Phelps, & Phillips, LLP (Manatt) to review to ensure that OHA processes and policies are consistent with federal law, state law and Oregon's 1115 Medicaid Demonstration Waiver. Both independent reviews looked at the OHA rate development process to ensure it was unbiased across all CCOs. The reviews concluded that OHA's methodology was compliant and actuarially sound. OHA submitted the original calendar year (CY) 2018 rates for CCOs' review and approval in November 2017.

4. Enrollment/disenrollment

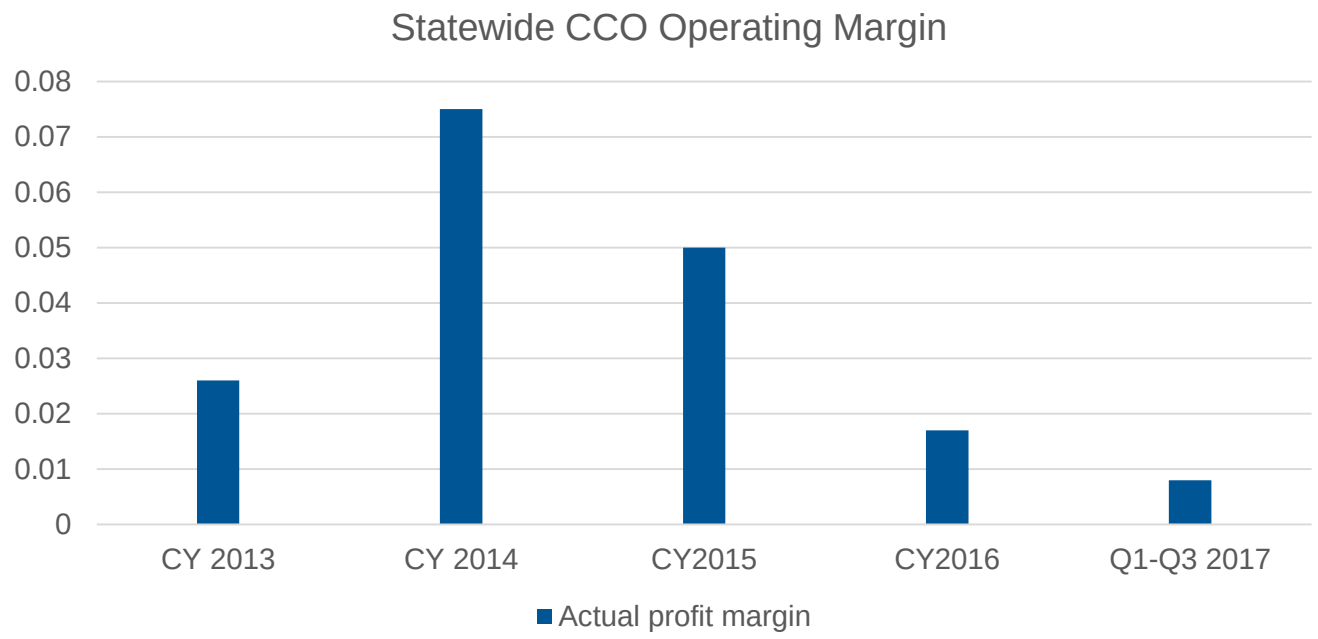
There are no significant changes in CCO-enrollment. Enrollment data is listed in the actual and unduplicated enrollment table in Appendix A.

5. Contract compliance

There are no issues with CCO contract compliance.

6. Relevant financial performance

Data for January through September 2017 show that the CCO's statewide operating margin was at 0.8% compared to 1.7% for 2016. For reference, the capitation rates include a 1% profit margin and a 0.5% risk contingency. CCO statewide operating margins have been trending downward from 5.0% and 7.5% for calendar years 2015 and 2014, respectively.



The CCO member services ratio (MSR) is a key financial metric that calculates the costs of services a CCO provides to its number of members enrolled (this includes both medical and flexible services) as a percentage of total revenue. For January through September 2017, member services accounted for 92.5% of expenses and administrative services accounted for 6.7% of expenses. In 2016, all CCOs met or exceeded the 80% MSR target, a key indicator for medical loss ratio (MLR), and half had MSRs above 90%. For 2017, the target MSR increased to 85%, and as of September 30, 2017, all CCOs are on track to meet that target.

Also as of September 30, 2017, all CCOs meet the net worth requirement, ranging in net assets from $314 to $1,090 PMPM, averaging $604 PMPM for the state.

7. Corrective action plans

There are no open corrective action plans for CCOs.

8. One percent (1%) withhold

OHA's Health Systems Division analyzed encounter data received for completeness and accuracy for the subject months of March through May of 2017. All CCOs met the administrative performance standard for all subject months and no 1% withholds occurred.

9. Other significant activities

Oregon's second largest Medicaid provider, FamilyCare, Inc., told the OHA that it would no longer serve OHP members effective December 31, 2017. OHA, the Oregon Department of Justice, and FamilyCare worked collaboratively to find a solution that allowed the company to reach an agreement to help OHA with an orderly transition of its 113,000 members to other coordinated care organizations (CCOs) by January 31, 2018. OHA's number one priority in the transition was protecting OHP members' access to and continuity of care. The agency's partnerships with CCOs in FamilyCare's service area—HealthShare of Oregon, Willamette Valley Community Health and Yamhill Community Care—will help successfully transition members by January 31, 2018. FamilyCare serves members in Washington, Multnomah, Clackamas, and Marion counties.

CCOs are preparing to develop their transformation quality strategies (TQS). Each CCO's TQS will replace its transformation plan and quality assessment and performance improvement deliverables. The TQS is designed to give CCOs the opportunity to move health system transformation through internal coordination and alignment of all of their transformation and quality work. CCOs are also preparing Community Health Assessments (CHA) and Community Advisory Councils (CAC) in preparation to develop new Community Health Improvement Plans (CHP).

G. Health Information Technology

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

Health Information Technology Oversight Council

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

HITOC continues implementation of Oregon's HIT strategic plan, which incorporates the needs of a broad range of stakeholders including CCOs, providers, health systems, and payers. HITOC met twice during this quarter, in October and December. Meetings focused on HIT needed to support alternative payment models and a review of a recently completed report on the use and adoption of HIT/ Health Information Exchange (HIE) by Oregon behavioral health providers. Work is also underway to complete planning activities and launch the new public-private governance effort, the HIT Commons, by January 2018.

Emergency Department Information Exchange/PreManage

The Emergency Department Information Exchange (EDIE) collects emergency department and inpatient admit discharge transfer (ADT) data from hospitals and provides notifications back to emergency departments (ED) in real-time. EDIE alerts inform ED providers when a patient who is seeking care has: been seen in an ED more than six times in the last 12 months; been seen in an ED at least three times in 60 days; or has a new care guideline provided by a PreManage user. The alert contains brief information about the prior ED visits and, if available, information about the patient's primary care provider and care guideline. EDIE helps ED physicians coordinate with primary care providers, provide the most appropriate care for the patient, and avoid unnecessary ED costs for all patients and payers, including Medicaid.

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

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

- Fifteen of 16 CCOs receiving hospital event notifications: 14 are receiving notifications through PreManage and one is accessing notifications through their HIE. Thirteen of the CCOs that are live with PreManage have opted to expand their license to their key clinical practices.
- Thirteen Assertive Community Treatment (ACT) teams.
- Oregon's fee-for-service contractors (KEPRO and CareOregon).
- All of Oregon's Dental Care Organizations (six are live on PreManage and three are in process).
- All Department of Human Services' (DHS) Area Agency on Aging (AAA) and Aging & People with Disabilities (APD) districts implementing the use of PreManage, which will bring PreManage to more than 30 long-term services and supports (LTSS) offices. The rollout will be complete in February 2018.
- OHA's Pharmacy/Drug Use Research and Management team onboarding to support discharge medication and prescription fill planning using PreManage.
- Three tribal clinics.

Clinical Quality Metrics Registry

The Clinical Quality Metrics Registry (CQMR) will collect, aggregate, and provide clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. Initially, the CQMR will support the Medicaid Electronic Health Records (EHR) Incentive Program and the CCO incentive measures that are EHR-based. CQMR implementation kicked off in December 2017, and the CQMR is expected to go live in 2018. OHA is engaged with stakeholders in exploring options to use the CQMR to support the Comprehensive Primary Care Plus (CPC+) program. OHA envisions that, over time, additional quality reporting programs could also use the CQMR.

Health Information Exchange Onboarding Program

The Health Information Exchange (HIE) Onboarding Program will help connect key Medicaid providers to community-based HIEs that provide meaningful HIE opportunities and play a vital role for Medicaid in their communities. Reliance eHealth Collaborative was selected to receive a contract to provide onboarding services under the Program. Reliance will onboard priority physical, oral, and behavioral health Medicaid providers according to a work plan developed in consultation with Medicaid partners. OHA anticipates launching the onboarding program in spring 2018.

Behavioral Health Information Technology Scan

OHA has completed the initial analysis of the data gathered in a behavioral health HIT scan, which included interviews and an online survey. The scan collected information from behavioral health entities across the state regarding HIT and HIE use, needs, challenges, and priorities. The online survey was sent to all 275 Oregon agencies operating at least one state-licensed behavioral health program, reaching a total of 874 programs. Almost half the agencies responded, representing 60% of state-licensed behavioral health programs. The respondents showed strong engagement with the survey, and 75% agreed to be contacted for follow-up. OHA completed 11 in-depth interviews with respondents that provided rich, detailed information. A draft report, which will be a resource for statewide efforts around HIT/HIE and behavioral health providers, was released to HITOC and other stakeholders in December 2017. OHA is currently reviewing stakeholder feedback and developing next steps. A final report is anticipated in early 2018.

H. Metrics development

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

Activities related to CCO metrics measurement

According to Oregon's Senate Bill 440 (SB440), the publicly funded health plans such as Medicaid, Public Employees Benefit Board and others should align their quality metrics by selecting from a common menu set of quality measures. SB440, created the HPQMC and specified that the current CCO MSC would become a subcommittee that informs the larger committee and does developmental work for the HPQMC measure set. However, the MSC continues to select the specific incentive measures and benchmarks for CCOs. Because of this new relationship, many of the activities were brought jointly before both the MSC and the HPQMC to form a common knowledge of activities related to CCO quality measurement.

Chairs of the MSC presented their 2019 metric recommendations at HPQMC's November meeting. The HPQMC tentatively accepted 12 of the 17 measures previously selected for the 2018 CCO incentive measure set into the 2019 HPQMC metrics list (the remaining 5 measures were tabled for discussion at a later date). The committee specifically focused upon four critical decisions:

- Inclusion of adolescents (15-17) in the effective contraceptive use measure as it was previously only incentivized for adults (though adolescents have always been tracked and reported);
- Disparity measures: emergency department (ED) utilization for members experiencing mental illness, a new metric targeting integration of physical health needs for people with mental illness;

- Weight assessment and nutrition counseling for children and adolescents, a new metric meant to create a glide path for evidence-based treatment after screening; and
- The cigarette smoking prevalence measure as currently defined for CCOs and National Quality Forum (NQF) 0028: Tobacco use screening and cessation intervention meant to align with electronic health record measurement standards in future years.

The MSC discovered that many tribal clinics do not have Patient-Centered Primary Care Home (PCPCH) designations, which created a perverse scoring problem at the clinic level. Due to this discovery, the MSC decided, as a temporary procedure, to partition tribal clinics and their associated members out of the denominators for the 2018 measurement year. The partitioning of tribal members (typically less than 1% in any single clinic) will allow time for the program to certify more tribal clinics into the PCPCH program, removing the disincentives for CCO threshold scores. This temporary partition will be dropped in 2019.

Activities related to metrics development

During this quarter, there were three main activities pertaining to the development of new measures: one near-term metric project for operational purposes (drug and alcohol screening – Screening, Brief Intervention, and Referral to Treatment); and two projects for long-term design having to do with child readiness for school and obesity in children and adolescents.

The first was a pilot project to study the ease or difficulty of collecting a two-part metric for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure from clinical electronic health records (EHR). The two parts are: 1) annual screening for all patients 12 years and older; and 2) the rate of brief intervention and/or referral to treatment for all patients that had a positive screen. The work plan for this pilot study launched with five clinics that use several different EHR versions of software, EHR vendors and CCOs. Outcomes of the operational study are set to be ready to share in spring 2018. Challenges identified thus far are centered on differences in EHR software to collect intervention and referral data, but clinics uniformly support this measure and are committed to the success of the pilot and using the measure as an incentive metric in 2019.

The second project, Health Aspects of Kindergarten Readiness Technical Workgroup, presented to both committees this quarter to inform them of a work plan. During this quarter, OHA partnered with Children's Institute, a private organization that is known locally for their work with preschool-age children. This project will focus on the health aspects/ health system's role in kindergarten readiness and the importance of framing this work as a significant step toward a cross-sector metric. Children's Institute has the expertise and authority to move forward on the foundational work done by other workgroups on this topic. While the ultimate goal is a cross-sector measure of shared accountability, this work group plans to start small, with a clear focus on the unique role the health system can play in preparing children for school.

Related to this work, OHA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor created a questionnaire with five targeted items (chosen by medical and education experts) so parents can self-report behavior of their three-to-five year-old(s). The five items chosen for inclusion in 2018 are:

- How often does this child play well with others?
- When he or she is paying attention, how often can this child follow instructions to complete a simple task?

- In the past two months, were you ever asked to keep your child home from any child care or preschool because of their behavior?
- How often does this child lose control of his or her temper when things do not go his or her way?
- Compared to other children his or her age, how much difficulty does this child have making or keeping friends?

Findings from the CAHPS survey of parental opinions on this topic will likely be available this summer to inform the work group on the school readiness metric from the parents' perspectives.

In a third metrics development project, OHA's metrics team worked with physicians from the Public Health Department and the Health Evidence Review Commission to summarize the latest evidence and public health risk for obesity in Oregon's children and adolescents. In a presentation to the MSC, findings showed a great need for interventions where evidence supports the most beneficial outcomes. The MSC's stated plan is to convene a work group that will identify how to transition from the current screening metric (weight assessment and counseling for nutrition and physical education for children and adolescents, NQF 0024) toward a measure that will include evidence-based, effective treatments.

Hospital Transformation Performance Program

During this quarter, OHA calculated and shared official Year 4 improvement targets with each hospital involved in the HTPP, OHA's hospital incentive measure program. OHA also completed conversations with stakeholders regarding the final year of reporting for HTPP and worked with the Hospital Performance Metrics Advisory Committee and the Hospital Technical Advisory Workgroup on the potential for measure recommendation and selection that might be used by CCOs in the future to represent hospital services in a full continuum-of-care spectrum.

In order to introduce alignment in quality metrics across health plans, the Health Plan Quality Metrics Committee (HPQMC) is in the process of creating a menu list of metrics that may be used by health plans for quality improvement for publicly funded health plans, including Oregon Health Plan (OHP). Though the HTPP presented to HPQMC with a large group of recommended hospital metrics, HPQMC determined that the health plans would limit hospital-focused measures to those already incentivized by CCOs at this time. Ultimately HPQMC selected three metrics for hospital-focused health plan measures: follow-up after hospitalization for mental illness; SBIRT screening in the Emergency Department; and plan all-cause readmissions.

Also, during this quarter, a specification was developed for hospitals unable to calculate a standardized infection ratio (SIR) value based on the Centers for Disease Control and Prevention's (CDC) methodology for Catheter Acquired Urinary Tract Infection (CAUTI) and Central Line Acquired Blood Infection (CLABSI). OHA's decision: If the SIR cannot be calculated *and* the facility has <1 observed infection, the benchmark will be achieved.

As the measurement program came to an end during this quarter, many hospitals expressed support for future hospital incentive metric programs and shared examples of how the incentive program supported local measurement and workflows that would not otherwise have happened without the state hospital incentive program.

Evaluation Activities (2012-2017 Demonstration Waiver Evaluation)

OHA continued contract activities for the Summative Evaluation with Oregon Health and Science University's (OHSU) Center for Health System Effectiveness (CHSE). The summative evaluation analysis plan was presented in draft form and OHA staff provided feedback on the representation of quantitative findings in visual formats. The Summative Evaluation was finalized during this quarter for submission by the external contractor. As a result of data reporting lags and time for analysis, the final report will not include all five years of data from the waiver under evaluation for years 2012 through 2017.

I. Budget neutrality

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

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

There is no new legislative activity to report for this quarter. Highlights from last quarter's legislative activities are below.

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

Other 2017 legislation impacting Oregon's Medicaid program included:

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

K. Litigation status

Lawsuits and legal actions

Oregon Health Authority

Open lawsuits and legal actions related to the Oregon Health Plan (OHP), 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. D. 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.

November 9, 2017

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

F. Douglas Carr, Umpqua Health Alliance Medical Director

Mr. Carr disclosed his financial conflict of interest as an Oregon taxpayer. He said the drug is on the market, but the Food and Drug Administration (FDA) said clinical benefit has not been established. He said the FDA can no longer be trusted to make scientific decisions. He cautioned we should expect more of these types of decisions from the FDA. He called out corporate greed as the cause. He said Oregon makes coverage decisions based on whether the treatment is worthy of funding.

Bennet Garner, Family Care Medical Director

Mr. Garner said the true issue is the FDA's complete lack of consideration of safety and efficacy. He mentioned the perils of another drug, Vioxx, which killed 60,000 people (as many people as died in the Vietnam war) and the drug Avastan, that when added to a chemotherapy drug, killed 50% more people than chemotherapy alone. Both drugs were FDA approved. He said he applauded the Commission for taking up this topic.

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

Ms. McNary read aloud a letter she received from Janet Woodcock of the FDA to address the meaning of the accelerated approval process. She said all commercial plans and other Medicaid programs cover the medication. Why is Oregon different?

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

Ms. Saukko shared a picture of her son, who has the condition, and asked that if other states cover it and mothers say it works, why isn't it covered? She said once the muscle is gone, it is gone. Let the small number of kids get what they need.

Ashley Vanzeldt, attorney representing McNary and Saukko

Ms. Vanzeldt said the drug is being treated as experimental when it is not. She said the Department of Health and Human Services (HHS) said there was a concern that the FDA's accelerated process medications will not

be reimbursed. HHS said they should be reimbursed; they don't want patients to lose ambulation and the patients cannot wait any longer.

Meganne Leach, NP, Oregon Health and Science University (OHSU)
Ms. Leach is a co-investigator on the 202 study and also an Oregon taxpayer. She said this is a rare, progressive condition affecting three-five boys in Oregon. She said she sees patients on the drug walking into their teens and living into their 20s, which was unheard of in the past. It seems cruel to take away the medication.

Lisa Boyle, WVP Health Authority
Ms. Boyle testified that it is her job to care for all lives with their limited resources. Patients should be able to expect proper medication dosing to care for their children but they don't have that option with eteplirsen since there were indications that the dose would need to be higher, yet that level may very well be toxic. She said that one year of this medication costs the same as total health care for 300-400 patients. She urged the Commissioners to examine the evidence closely.

Carl Stevens, CareOregon Medical Director
Mr. Stevens said he is deeply conflicted and would love to cover the medication if there were proven efficacy. How can we remove coverage for other conditions to cover a medication that is not shown to work? His desire is to help, but the evidence is not there.

Mark Helm, MD, a pediatrician from Salem
Dr. Helm said he was a medical director for the Arkansas evidence-based medication review program. He also worked for the pharmaceutical industry. He said there are no effective treatments for DMD; anecdote and emotion are not evidence. There needs to be good science to determine good therapy. He reviewed concerns raised by DMD experts to the FDA about the research on this medication. He said boys with CD40 (cluster of differentiation 40) variations have more rapid declines, and the picture is more complicated than just dystrophin content.

Lisa Borland, Sarepta Pharmaceuticals
Ms. Borland testified to correct a statement in the meeting materials that the mediation is approved and it is not conditionally approved or experimental. She also stated that the FDA-reported adverse events do not mean the drug caused the event. She said patients treated with eteplirsen achieved 150 additional meters in the 6-minute walk test and called that significant. She requested the committee members vote against the recommendation to place the drug on line 660. Prioritizing the drug that low would remove the only FDA-approved medication for the treatment of DMD.

Mike Donabedian, Sarepta Pharmaceuticals
Mr. Donabedian said that waiting for the NICE study blatantly ignores the FDA process. In the two-thirds of all states where Medicaid collaborated with DMD clinical experts, this drug became covered, both with and without restrictions. He said Washington State took this approach. Should HERC move to place the medication on line 660 and eliminate the potential to get the drug, it violates legal obligations under federal Medicaid rebate statute. He said at the last meeting Dr. Saha commented that "approving a drug we don't think works well is irresponsible. If it does work, we should cover it." He said this is a type-one vs. type-two error. A type-two error is to fail to approve a drug only to find out later on that it does work. Failure to cover this medication is harming patients through willful neglect. Please do not place the medication below the funding line on the Prioritized List. He also submitted Anthem's latest coverage policy.

Som Saha, MD, MPH, Health Technology Assessment Subcommittee member
In response to Mr. Donabedian: Regarding statements made about type-two errors, Dr. Saha asked what happens if we decide to cover it and it turns out we got it wrong? Some would say "no harm no foul," but there is harm; money is taken away from services that could be provided to other people. It is not without harm to invest in a treatment that ends up not working. It diverts care from hundreds of other patients.

Alison Little, Pacific Source Health Plans Medical Director
Ms. Little said she was a commissioner for six years, then staff for three, followed by work as a consultant. She is currently a member of the Evidence-based Guidelines Subcommittee and is testifying today as an Oregon citizen to support the work of the Commission and their dedication for using clinical and cost-effectiveness in prioritization decisions. The Commission's work should be from a society prospective rather than the individual; what is essential for the overall well-being for society may not meet the needs and desires of a specific individual. In addition, HERC is statutorily required to consider clinical-effectiveness and cost-effectiveness. As stewards of limited resources, you have to say "no" sometimes, and the only way to do that is based on evidence.

Ericka Finanger, a pediatric neurologist, who cares for patients with DMD in Oregon
Ms. Finanger testified that the medication has FDA approval by the accelerated process that is uses for rare diseases. A rare disease doesn't have the ability to have two 600-person randomized control trials. The accelerated process is specifically for rare diseases such as this. She called 150 meters gained in the 6-minute walk test significant.

Coleen Connolly, MD, Chief Medical Director, Trillium Community Health Plan
Dr. Connolly said there are other drugs approved by the FDA that aren't covered by Oregon Health Plan (OHP). She urged waiting until the NICE review is complete.

HERC Value-based Benefits Subcommittee

November 9, 2017

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

Jamie Saukko, a Duchenne advocate and mother of a 2-year old with DMD
Ms. Saukko brought up concerns that her son was denied treatment with eteplirsen and asked for clarification as to why. Darren Coffman, Clinical Services Improvements manager at OHA, said denials are not from the HERC, but rather a function of OHA's Health Systems Division and her concerns should be directed there.

Mark Helm, MD, a pediatrician from Salem
Dr. Helm said he had been a medical director for the Arkansas evidence-based medication review program. He also previously worked for the pharmaceutical industry. He noted no effective treatments for DMD exist. However, there needs to be good science to determine good therapy. He reviewed concerns raised by DMD experts to the FDA about the research on this medication. Dr. Eric Hoffman, who discovered the DMD genetic defects, testified to the FDA in 2015 that a dystrophin level of about a 20% of normal might result in a clinical benefit for these kids and this drug does not get to that level. He added that boys with CD40 variations have more rapid declines, and the picture is more complicated than just dystrophin content.

Meganne Leach, NP, OHSU
Ms. Leach is a pediatric neuromuscular nurse practitioner and previously worked with Dr. Hoffman. She stated she is a co-investigator on the 202 study on eteplirsen. She said patients in the 202 study have done remarkably well. The patients were doing functionally much better than expected. The FDA did approve this medication for the potential benefits for patients for pulmonary, cardiac and other complications of DMD. Not seeing a decline is a benefit in a progressive disease.

Lisa Borland, Sarepta Pharmaceuticals
Ms. Borland addressed questions about why difference in decline was not shown in the treated boys compared to the natural history cohort. She said it was—the treated boys had a significantly increased walk distance. When asked why the FDA concluded that there was no clinical benefit, Borland said this was due to the nature of the accelerated approval process which was based on surrogate endpoints.

Sarah Servid, Pharmacist, Oregon StateUniversity College of Pharmacy, and staff to the Pharmacy and Therapeutics Committee
Ms. Servid agreed there is a disconnect between the FDA insert and the published study. Because of the inherent nature in the use of historical controls, there are lots of biases introduced that reduce confidence in that study. It is unclear if the standard treatment was the same between groups (e.g. the study group had sooner steroid treatment than the historical controls).

HERC Evidence-based Guidelines Subcommittee

November 2, 2017

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

David Sibell, MD, professor at the OHSU Comprehensive Pain Center
Dr. Sibell noted that the Chou article that the subcommittee was discussing made strong recommendations based on low to moderate evidence. He served on the 2013 panel related to cervical spine pain. He advised as an allopathic doctor who treats spine pain there really isn't much that he can currently provide to OHP patients. In general, he is not allowed to see patients more than once. No follow-ups or visits of any kind are generally allowed. Some coordinated care organizations (CCO) do allow follow-up visits, but no treatments. He said he does believe strongly in comprehensive pain treatment and that his clinic does support cognitive behavioral therapy and employs a massage therapist, an acupuncturist as well as Rolfers. None of these treatments require allopathic pain medicine. He finds it wasteful to cover the pain medicine physician consultations. OHP should come down and say that they see no value in allopathic pain medicine. Otherwise there are a lot of low-value visits. He had a patient sent from Ontario, Oregon, nine hours away, for a consultation with the hope that Sibell would take over Vicodin prescribing because the primary care provider wouldn't do that in Ontario. He gets many consultations like this. He also performs some very valuable consultations, but he can't provide treatment. He also expressed appreciation for the work the subcommittee does.

Responses and discussion to Dr. Sibell's testimony:

Evidence-based Guidelines Subcommittee members: George Waldmann, MD; Eric Stecker, MD, MPH; and Lynnea Lindsey, PhD; David Sibell, MD, professor at the OHSU Comprehensive Pain Center; and Janna Friedly, MD, appointed expert

- Dr. Waldmann said that when he requested consultations as a rural family physician, he wanted help understanding what was happening and to receive training about what he could do to treat the patients in the community. The second reason is to provide treatment.
- Sibell said he understands that consultations can be valuable, but under current coverage policy he can't provide any treatment, and coverage of other treatments for back pain is well-known by providers throughout the state.
- Waldmann said that having a pain specialist consultation could still be valuable in certain cases to help understand the cause of the patient's pain; it could be metastatic disease, radiculopathy or something else.
- Sibell suggested that in cases like that the consultation form needs to make a specific request. Often the requests are in the form of "here are some notes, you figure out what I want."
- Waldmann agreed that these kinds of requests are not valuable.
- Dr. Stecker agreed that this is a problem. Some of it depends on whether the specialist is a procedural specialist, nonprocedural specialist, or a mix and whether the procedures are covered and whether the consultation is set up correctly. All these affect the value of the pain specialty consultation.
- Sibell said that part of the problem is that some pain clinics recommend procedures for a high proportion of patients. In his clinic, only between a quarter and a third of patients get procedural care. The majority don't. He chooses to work at OHSU because he is able to collaborate with other professionals such as psychologists and physical therapists.
- Dr. Lindsey said that there is ongoing research into providing combinations of physical care with psychological care.
- Sibell said it is difficult to study three mixed interventions. He said when studies don't match clinical experience, to him it's a problem with the studies. Ideally he would love to study a combination of physical therapy and radiofrequency ablation for patients with axial back pain identified by medial branch blocks. He and Dr. Friedly have sought funding for such research but it has not been approved. As long as that is the situation, there won't be better studies.
- Dr. Friedly added that psychological interventions can be as important as--or more important than--the physical therapy or procedures.
- Sibell agreed and stated his clinic has hired several psychologists, as behavioral therapy is important.
- Lindsey agreed, saying that it is important to address the catastrophizing patterns common in chronic pain patients. There is research coming from Stanford that will help with this. The studies are multidisciplinary. But unfortunately we don't have a lot of research into whole person care, which is what we are trying to get to.

Kim Mauer, director of the OHSU Comprehensive Pain Center

Dr. Mauer also provided testimony. She thanked the subcommittee for hearing testimony from staff and patients from the clinic, and acknowledged that the patients had been a little rough on the subcommittee in testimony. They feel passionate about these issues. She recognizes the state of the evidence. Part of the reason the subcommittee has taken so much time on this issue is that it can be hard to face a patient who is suffering and not have a lot to offer them. Medicaid covers 50% of rural Oregonians and 25% of Oregonians overall. She

works with these patients every day. She said she has spoken with Dr. Chou about this and he would agree with her that while reviews are black and white, people are grey. It is heartbreaking not to be able to help these patients. They need procedures, acupuncture and psychology. She is not arguing for a medial branch block or radiofrequency denervation for every patient, but only for those who meet appropriate criteria.

Responses and discussion to Dr. Mauer's testimony:

Evidence-based Guidelines Subcommittee members: George Waldmann, MD; Devan Kansagara, MD; Eric Stecker, MD, MPH; Leslie Sutton, Policy Director, Oregon Council on Developmental Disabilities, and Alison Little, MD, MPH; Kim Mauer, director of the OHSU Comprehensive Pain Center; and Cat Livingston, MD, MPH

- Dr. Waldmann agreed it is a difficult situation, but that it doesn't just affect her patients. Patients with anal fissures, cholilethiasis, and hernias that aren't complicated should also be taken care of, but the taxpayers through their government leaders have decided there is not enough money to do all that.
- Mauer acknowledged that money is a limiting factor, but she would like there to be a way to cover some services in each specialty.
- Dr. Kansagara said this discussion presents an opportunity. Can there be opportunities for bundled payment or other approaches which allow more flexibility? How can we make this whole person approach viable in our state? What does a meaningful consultation mean? He doesn't know what the forum is for that discussion.
- Dr. Stecker said that it would be the same conundrum, since someone would want an evidence review to determine how to use the bundled payment. It would, however, lower the stakes so that if providers thought providing a patient with a non-covered service was critical it would not require medical director review and prior authorization. He asked what the status of pain treatment is in CCOs.
- Dr. Little said that at PacificSource, chronic pain is very prevalent, but there is a lack of multidisciplinary pain clinics in central Oregon, and the primary care provider performs a lot of these services. Other covered treatment modalities are available.
- Stecker explained that procedures can cross-subsidize multidisciplinary care in a pain clinic. If multidisciplinary treatment is available in other places, then that's fine. But if you're going to take away access to a pain clinic or make the pain clinics less viable financially when multidisciplinary treatments are not available elsewhere, it's a problem.
- Waldmann said he doesn't believe it's the job of the committee to try to get all these treatments available in smaller communities. He practiced in Madras for many years and people who live in small communities understand there will be less access. That said, chiropractic and osteopathic manipulation, acupuncture and physical therapy are available in most communities of a few thousand people.
- Dr. Lindsey said people in Prineville doing advanced primary care or primary care homes had added behavioral health and other staff to provide evidence-based pain programs. Often, however, the team is worn down and needs a consultation to get additional eyes on the problem. Other providers don't want to address chronic pain because they don't have the training or it's not in their scope. She said if you can't interrupt a pain signal for a patient for long enough for them to access behavioral care they can become severely disabled, and a responsibility of the state as a disabled person. Access to cognitive behavioral therapy for chronic pain is improving across the state, but providers' ability is variable.

- Ms. Sutton said that there are issues with access to cognitive behavioral therapy for people with intellectual or developmental disabilities. Some providers don't have skills and experience working with people who use other than verbal means of communication. This is true statewide, not just in rural areas.
- Dr. Livingston said staff would raise these concerns at the Chronic Pain Task Force as well as at the Quality Health and Outcomes Committee, which includes CCO medical directors. She said that she hears that there are a lot of pain clinics who provide large numbers of sometimes inappropriate procedures, so CCOs are reluctant to work with those pain clinics.

HERC Health Technology Assessment Subcommittee

November 30, 2017

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

Robert Skinner, MD, president of the Oregon Urologic Society

Dr. Skinner offered testimony. He cited a study from the British Journal of Cancer from 2015 that shows that some of this testing is better at predicting cancer progression. He said there are many areas of grey with the current scale and we need something that is reproducible that you can take from patient to patient. He said that societies are starting to update their guidelines. Many of his colleagues try to obtain the test for patients who have prostate cancer in the grey risk area, or when they're looking for an extra piece of information in deciding not to operate. He said the decision is difficult because you have to weigh the balance of significant expense and complications from surgery with the risk of not catching the cancer in time. He said it may be helpful, for example, in a patient with a Prostate-Specific Antigen (PSA) of 9 and a Gleason score of 6. He said he agrees that the best evidence would be a randomized study but the slow growth of the cancer makes collecting the needed data difficult. He said that Medicare has been helpful in funding some of this outside of industry support. Liability for the state of Oregon is fairly low since there are narrow recommendations for this kind of testing and the only patients eligible will have had to undergo a prostate biopsy. As it is, it is a two-tier system for patients eligible for state assistance versus those on Medicare.

Responses and discussion to Dr. Skinner's testimony:

Som Saha, MD, MPH, Health Technology Assessment Subcommittee member; and
Adam Obley, MD, Health Evidence Review Commission contractor

- Dr. Saha said that the Commission does consider equity issues, but the Commission requires evidence that a service would benefit the patient; the belief by a provider doesn't qualify a service for coverage.
- Dr. Obley said he agrees about the importance of giving deference to the experience of practicing urologists. He also said he hopes for better data in the future. At this point these tests are at the very beginning of the validation pathway for genomic testing. These tests may show some prognostic promise, but there is still uncertainty how that information translates into decision-making, and making sure that decisions made on these tests don't result in adverse outcomes for patients.

Karen Heller of Myriad Genetics

Ms. Heller said that validation studies of Prolaris on conservatively-managed patients have been published twice: in 2012 and 2015. In both studies the genomic test did show greater prognostic ability than the nomograms and clinical pathologic variables. In terms of impacting changes in management, Shore and colleagues published a study showing changes in management; management changed 48 percent of the time.

She's not sure what additional information the subcommittee would want. She also quoted an additional sentence from the NCCN guideline which said that prospective trials are unlikely to be done and that men with localized cancer may consider using these tests. She said her company asked a statistician to model out the number of patients required for 80 percent power to detect a statistically-significant change in prostate-cancer-specific death with low and intermediate risk patients. To detect a 25-percent difference in death at 5 years, you would need between 33,000 and 43,000 patients. At ten years you could get by with fewer patients. Such a trial is very unlikely to occur.

Responses and discussion to Ms. Heller's testimony:

Health Technology Assessment Subcommittee members Vinay Prasad, MD and Som Saha, MD, MPH

- Dr. Prasad said that a prospective trial would not be the only way to validate such a test; breast cancer tests were evaluated retrospectively using tissue banked from previous trials.
- Dr. Saha agreed that it is important to recognize when you have the best evidence you are going to get. At this point better evidence may still arise. He gave the analogy of a tarot card—just because you convince someone to change decisions based on a tarot card does not mean it's a valid predictor. We need more than that. If you could show that people were convinced to choose active surveillance based on a benign-looking profile and show that it reduced patient anxiety and that they stayed in active surveillance over and above what we have now, this would demonstrate some clinical utility.

Metrics and Scoring Committee

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

October 20, 2017

The committee received public testimony and reviewed and discussed numerous letters from Federally Qualified Health Centers and the Oregon Primary Care Association (OPCA) supporting the inclusion of the food insecurity measure for what the committee proposes to the Health Plan Quality Metrics Committee (HPQMC). [NOTE: OPCA clarified that there was some confusion about which year the committee was discussing in its recommendations for the HPQMC. Though letters in support of their food insecurity measure state 2018, the committee's recommendations are for the menu list from which it will choose 2019 measures. This point was clarified with the OPCA, but there was not time to amend their letters of support and they were allowed to continue their testimony.] Committee discussion included this clarification. They also discussed the fact that there is not a validated measure yet for the social determinants of health. The food insecurity measure developed by OHA and the Food Bank of Oregon seems feasible. The group mentioned there are a lot of resources to address food insecurity that are underutilized, and that such a measure could be helpful on this topic.

Sara Love, ND, Policy Director, CCO Oregon

Ms. Love expressed support of two measures: dental care for adults with diabetes; and preventive dental services utilization for adults. For the preventative services measure, she noted that the measure being considered by the committee does not include oral and periodontal evaluations. CCO Oregon is not opposed to the current metric, but would like the opportunity to work with the CCO metrics technical advisory group and OHA staff on it.

Letters reviewed which requested inclusion of a food insecurity metric to the set of CCO incentive metrics to be presented for recommendation to the HPQMC were sent by the following:

- Carly Hood-Ronick, MPA, MPH, Social Determinants of Health Manager, OPCA;
- Robert M. Trachtenberg, MS, Executive Director, Oregon Health and Sciences University Family Medicine of Richmond;
- Charla DeHate, Chief Executive Officer, LaPine Community Health Center;
- Nic Powers, Chief Executive Officer, Winding Waters Medical Clinic;
- David Edwards, Chief Executive Officer, One Community Health;
- Megan Haase, FNP, Chief Executive Officer, Mosaic Medical; and
- Denise Weiss, RN, Quality Director, Rinehart Clinic.

November 17, 2017

The committee debriefed from the HPQMC and discussed input on health aspects of kindergarten readiness measure development. The committee did not receive public comment at this meeting.

Medicaid Advisory Committee

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

October 25, 2017

The committee discussed the Social Determinants of Health workgroup purpose, reviewed the revised timeline for MAC social determinants of health work and critical milestones, discussed the stakeholder survey plan, and reviewed a draft definition of the social determinants of health. The committee did not receive public comment at this meeting.

November 3, 2017

The committee reviewed and discussed the draft definition of Social Determinants of Health for Oregon's CCOs, received brief Medicaid updates from OHA and the Department of Human Services (DHS), and discussed how CCOs can and do address social determinants of health. See below for public comment.

Lynn Knox, Oregon Food Bank

Ms. Knox provided the following written testimony:

- The common significant casual element of all chronic disease is poor diet.
- Most recent data shows that 71% of Medicaid recipients are food insecure.
- Many medical conditions are caused by food insecurity such as depression, ADHD, children's behavioral and development problems, poor diabetes management, intestinal problems and more.
- We need to find ways to partner with CCOs to show more interest in nutrition and health food access.

December 6, 2017

The committee reviewed the process for the Oregon Health Policy Board's CCO 2.0 initiative, discussed and developed recommendations on the role of CCOs in addressing social determinants of health, and heard

highlights from CCOs and a community partner about their work in social determinants of health. The committee did not receive public comment at this meeting.

Oregon Health Policy Board

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

October 3, 2017

The board discussed the OHA leadership changes, OHPB committee, collaborative, and workgroup updates, OHPB committee planning, Health Information Technology Oversight Council updates, and CCO 2.0 planning.

Kevin Fitts, Oregon Mental Health Consumer Association

Kevin relayed a quote from Governor Brown and noted incoming OHA Director Allen's charge to build trust with stakeholders and members. He noted the need to ensure the voice of those receiving public mental health services be heard during important discussions. He stated concerns with pharmaceutical treatment choice by members and encouraged peer supports and long term goals to build communities around those who need intensive and long term treatment.

November 7, 2017

The board meeting included updates from OHA leadership regarding organizational changes and Children's Health Insurance Program (CHIP) funding, OHPB committee updates, CCO 2.0 planning, Healthcare Leaders panel and discussion, and Local Community Innovations panel and discussion. During this meeting, the board voted to establish a committee to tackle issues related to high-cost drugs and to introduce legislation to move all state agencies into the Oregon Prescription Drug Program (OPDP) unless they can demonstrate savings by remaining outside OPDP. The board did not receive public comment at this meeting.

December 5, 2017

The board meeting included an organization update from OHA leadership, OHPB committee updates, Healthcare Workforce Committee updates, Public Health Advisory board and Public Health Modernization updates, OHPB high-cost drugs update and committee development, and CCO 2.0 planning.

Robin Traver, Director of Clinical Pharmacy Services, Umpqua Health Alliance

Traver talked about the direction of clinical pharmaceutical services for CCO issues and concerns with a single or aligned preferred drug list (PDL). She stated that OHPB consider the highest 2% of high cost drug spend be targeted instead.

Amy Burns, PharmD, BCPS, Health Director of Population Health, AllCare Health

Dr. Burns talked about managed care pharmacy for CCO and issues with concepts of a single or aligned PDL.

Caryn Mickelson, PharmD, Director of Pharmacy Services, Western Oregon Advanced Health

Dr. Mickelson expressed concerns with a single or aligned PDL and advocated for a Pharmacy and Therapeutics Committee and Health Evidence Review Commission representative be added to OHPB's High-Cost Drug
Committee charter.

Mark Bradshaw, MD, Chief Medical Officer, AllCare Health

Dr. Bradshaw talked about advocating against a single or aligned PDL because of misalignment with the CCO global budget concept and local flexibility to make formulary changes.

Kevin Fitts, Oregon Mental Health Consumer Association

Mr. Fitts talked about issue with director of office of consumer activities in OHA position and a stakeholder review panel consisting of at least one member who is a recipient of or has received public care services.

Robert Judge, Director of Pharmacy Services, Moda Health

Judge talked about Moda Health's role as Oregon Prescription Drug Program (OPDP) administrator for several government entities and spreading the model. OPDP can be available to CCO and fee-for-service (FFS) formularies. One CCO is in OPDP and others are currently reviewing; other government entities could also benefit from OPDP purchasing.

Art S., FamilyCare Health

Art addressed the CCO rate review process. He shared concerns that the review process was not comprehensive or unbiased and reported FamilyCare will probably not continue as a CCO in 2018 if the rates are not changed. He requested that Director Allen reach out to FamilyCare CEO Jeff Heatherington.

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

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes (PCPCH).
- Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes.
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care.
- Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources.
- Lever 5: Implementation of health-related services aimed at improving care delivery, enrollee health, and lowering costs.

- Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Oregon Health Authority's (OHA) Transformation Center

2012-2017 Demonstration Waiver Evaluation

OHA continued contract activities for the Summative Evaluation with Oregon Health Sciences University's (OHSU) Center for Health System Effectiveness (CHSE). The summative evaluation analysis plan was presented in draft form and OHA staff provided feedback on the representation of quantitative findings in visual formats. The Summative Evaluation was finalized during this quarter for submission by the external contractor. As a result of data reporting lags and time for analysis, the final report will not include all five years of data from the waiver under evaluation for years 2012 through 2017.

2017-2022 Demonstration Waiver

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

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

Patient-Centered Primary Care Homes

Patient-Centered Primary Care Homes (PCPCH) program staff conducted 21 site visits to primary care clinics to provide customized technical assistance on PCPCH model implementation. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address identified barriers. Program staff provide each clinic a written report summarizing the site visit.

Between October and December 2017, two "Transformation in Practice" webinars were held. Program staff provided in-depth technical assistance on featured PCPCH measures: complex care coordination and care plans and referrals, access, and continuity. During each webinar, staff from a recognized PCPCH described how they have implemented the measure to transform their practice. More webinars are planned for 2018.

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

As of December 31, 2017, 629 clinics are recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Thirty-nine PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model. These clinics are located in both rural and urban areas.

Certified Community Behavioral Health Clinics

Twelve organizations continue to participate in the Certified Community Behavioral Health Clinic (CCBHC) demonstration. Representatives from CCBHCs have participated in monthly meetings, monthly technical assistance calls, and one technical assistance session held in October 2017. A draft report was created based on test data submitted from CCBHCs covering the first quarter of the demonstration program (April 1, 2017 – June 30, 2017). The first test data pull showed the majority of CCBHCs were able to report on caseload characteristics and the nine clinic-led metrics. However, electronic health records (EHR) functionality remains a challenge in CCBHC data collection. CCBHCs continue to collaborate with vendors and the OHA CCBHC project team to ensure EHR functionality and quality reporting will be ready for the first required formal data period.

Tribal Care Coordination

In February 2016, CMS issued State Health Official (SHO) letter #16-002 which provided guidance extending cases where the state Medicaid agency could claim 100% federal funding for services provided to tribal members. Prior to the guidance, the Oregon Health Authority (OHA) was able to claim 100% Federal Medical Assistance Percentages (FMAP) for services provided to tribal members by Indian Health Service (IHS) and tribal health providers. Under the new guidance, state Medicaid agencies may also claim 100% FMAP for services received through an IHS/tribal facility. This means that for non-IHS/tribal facilities providing services for tribal members that were requested and coordinated by the IHS/tribal facility, OHA may claim 100% federal funding when the claim is billed by the non-IHS/tribal provider. Oregon is one of the only states in the nation that is taking the next step to reinvest the savings generated by tribal care coordination back to the IHS/tribal facility.

In collaboration with the nine federally-recognized tribes in Oregon, OHA has established systematic capabilities and operating procedures to track all care coordination events and locate the claims billed by non-IHS/tribal providers to switch the funding source to 100% federal funds. We are in the process of establishing savings reinvestment agreements with tribes to begin issuing quarterly payments in 2018. Our collaboration with the tribes has shown that we can establish systematic incentive loops that drive better access and health outcomes for tribal members and much needed investment in tribal health programs. We intend to optimize the Medicaid Management Information System (MMIS) to further automate the program.

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

Quality pool – CCO incentives (semi-annual reporting)

Disbursement of the CCO quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures. Funds from the quality pool will be distributed on an annual basis, with the calendar year payment made by June 30 of the following year.

The quality pool for measurement year 2017 will be the same as measurement year 2016 at 4.25% of all claims paid. In previous rules, this percentage may not exceed 5% in any measurement year. There are currently no requirements for expenditure of the incentive pool dollars except that the money must be reinvested into health system transformation. OHA may choose to collect data on how incentive dollars are used once they have been distributed to provide more robust data on this subject as needed. Current anecdotal feedback suggests that CCOs have a wide variation on how they use their incentive pool dollars for health care transformation.

Federally Qualified Health Center Alternative Payment Methodology Program

Fourteen Federally Qualified Health Centers (FQHC) and one Rural Health Center (RHC) are currently participating in the Advanced Payment and Care Model (APM). Two more FQHCs and one RHC are currently engaging in onboarding activities for a potential July 2018 transition to the APM.

Oregon Health Authority (OHA), participating health centers, and the Oregon Primary Care Association established that health centers must report quarterly on eight quality measures. Failure to reach the predefined target on at least four of the measures within the reporting period will result in the development of a performance improvement plan. Additionally, health centers report Care STEPs, which were formerly known as Touches (non-billable enabling type services that address social determinants of health), on a quarterly basis. Oregon Health Plan (OHP) members who were not engaged through a billable office visit or Care STEP over the prior 24 months will be dis-enrolled from the health center and no longer generate per-member per-month payments for the health center later in 2018. Systems are currently being designed to capture Care STEP data.

Comprehensive Primary Care Plus

OHA continued implementing Comprehensive Primary Care Plus (CPC+), which launched January 1, 2017. Modifications to MMIS are underway to calculate performance-based incentive payment amounts to all participating clinics. Of the 154 Oregon CPC+ practices, 145 have contracts with OHA for Medicaid fee-for-service members. As of December 31, 2017, 75 practices have received per-member, per-month care management fees for a total of over $400,000 in 2017.

The Oregon CPC+ payers meet monthly with a facilitator to discuss opportunities for coordination and alignment to support the Oregon CPC+ practices. This quarter the group discussed technical assistance, payment alignment and options for data aggregation.

Value-Based Payment Innovations and Technical Assistance

The Transformation Center is working with national value-based payment (VBP) experts at Bailit Health to develop a VBP Roadmap, which will set VBP targets for CCOs. The VBP Roadmap is a required deliverable in Oregon's 1115 waiver. CCOs are an integral partner in the development of the roadmap, and OHA has established a CCO VBP Roadmap workgroup to advise OHA on definitions, targets, and measurement methods. The CCO workgroup will meet three times in 2018. OHA will also obtain input from the CCOs' network providers. A draft of the roadmap will be shared with stakeholders for input in May 2018 and finalized in October 2018.

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

Statewide Performance Improvement Project

Oregon Health Authority's (OHA) Statewide Performance Improvement Project (PIP) on Opioid Safety was adopted in July 2014 for calendar-year performance monitoring for all 16 coordinated care organizations (CCOs) to adopt. Overall, PIP project management is conducted through OHA's External Quality Review Organization (EQRO), HealthInsight Assure, in accordance with the 2012 Centers for Medicare and Medicaid Services (CMS) PIP Protocol. The EQRO met with CCOs during September and October 2017 to discuss the progress of their Statewide PIPs and to provide feedback on report documentation. In addition to a general overview of their project, CCOs were asked to discuss their efforts in meeting the Oregon Health Plan (OHP)

January 1, 2018, opioid coverage deadline (no chronic opioids for members with back and spine pain diagnoses).

Project metric

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

Outcomes

Due to a lag in claims data collection, complete aggregated statewide second re-measurement results were not available for this report, and comparisons were made with the current re-measurement period data (November 1, 2016 – October 31, 2017). Analyses show that the percentage of OHA enrollees age 12 and older who filled opioid prescriptions for both ≥ 120 and ≥ 90 MED for at least one day fell significantly ($p<.001$) between baseline (calendar year 2014) and current re-measurement. The study denominator (the number of OHA enrollees age 12 years and older who filled a prescription for an opioid pain reliever in the measurement period) decreased over 20% from baseline to the current re-measurement period.

In general, decreases in the CCO-level study metrics over baseline contributed to the success of the statewide PIP, but there are also many community level outcomes that signify success, including:

- A cultural shift in the attitude of providers and members about opioids and pain management;
- Engagement and establishment of strong relationships with other CCOs, public health departments, community organization, law enforcement and the community;
- Increased number of buprenorphine and naloxone prescribers;
- Increased utilization of alternative, non-opioid therapies and services; and
- Development of better data collection processes and tools.

Interventions

One community benefit included multiple CCOs in the Southern Oregon region collaborating and working together as one community to improve the health and safety of their citizens. The Southwest (SW) Oregon Opioid PIP Collaborative:

- Developed standardized member and provider notification letters and taper forms;
- Facilitated coordination of opioid prescribing guidelines and benefits among CCO partners;
- Planned, developed, funded, and launched a regional media campaign to promote opioid safety, safe storage of opioids, naloxone awareness, and how to talk with your doctor;
- Launched the Stay-Safe-Oregon website; and
- Sponsored an Acceptance and Commitment Therapy workshop for mental health providers in the region.

Additional interventions across the state included, but are not limited to:

1. **Communication**: Educating members and providers about naloxone; one-on-one meetings with high prescribers; member communication about alternative medications to opioids; and recruitment of a customer service department to educate members about opioid policies, opioid adverse effects, and alternative treatments.

2. **Improved medication-assisted treatment (MAT) access and availability**: developing and implementing a buprenorphine program model; and increasing the number of medication-assisted trained providers from one in 2016 to thirty by the end of 2017 (individual CCO).
3. **Pharmacy coordination**: Implementing point-of-sale pharmacy limits; and working with the pharmacy benefit manager to develop better monitoring and more robust reporting.
4. **Provider education**: Technical assistance to clinics on developing policies, workflows and data management; developing a community health worker training that includes modules on chronic pain; developing an online pain school to accommodate rural membership; provider training on implementing taper plans, medication-assisted therapy and alternative pain treatment; and coaching to primary care teams on chronic pain and opioid management provided by a Behavioral Integration Specialist.
5. **Use of Data**: Increased Prescription Drug Monitoring Program (PDMP) enrollment.

Behavioral Health Collaborative Implementation

The Behavioral Health Collaborative (BHC) recommended improvements to Oregon's behavioral health system. Using the coordinated care model that integrates behavioral health with physical and oral health, the BHC envisions a system that:

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

OHA continues to work with stakeholders to operationalize the recommendations of the BHC. OHA will pilot Regional Behavioral Health Collaboratives (RBHC), which will require CCOs, community mental health programs (CMHP), local public health authorities, tribes, and other key system partners including: hospitals; schools; and corrections, to collaborate and focus on behavioral health priorities within the local communities. This is intended to build on existing innovations and collaborations. The Transformation Center will be providing technical assistance and facilitation for these pilots.

Workforce is a critical issue for behavioral health. Not only does Oregon have a shortage of qualified behavioral health providers, but there is high turnover. OHA is in the process of completing a needs based behavioral health workforce assessment. Once the assessment is complete, OHA will develop a recruitment and retention strategy.

With integration a priority, Oregon needs to prepare the workforce to work in integrated settings. As a first step, OHA is consulting with the University of Colorado's Farley Center to develop core competencies for an integrated workforce.

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

In order for behavioral health to integrate, technology must be available to support integration and coordination. OHA has completed a survey of behavioral health providers electronic health records (EHR) and health

information technology (HIT) needs, with preliminary recommendations. A small group of behavioral health providers is being convened to further investigate the findings and the preliminary recommendations. A report will be published and a plan based on the recommendations will be implemented.

As behavioral health is integrated with physical and oral health, metrics must be developed. OHA has convened a Data Workgroup, which is identifying metrics based on Oregon's behavioral health priorities and national quality metrics.

Roadmap to Oral Health

Oregon continues to improve integrated oral health care for Medicaid members, building on ongoing efforts. In 2016, OHA's Medicaid Advisory Committee convened a workgroup on oral health access that developed a definition and framework for improving oral health access in Medicaid. The workgroup identified lack of member awareness and understanding of benefits as one barrier to oral health access. In response, OHA developed a suite of member and provider education materials. During this quarter, OHA finalized and began to distribute a brochure and poster highlighting the importance of oral health care as a part of overall health care and dental benefits available to Oregon Health Plan members. CCOs can customize the documents for their members.

OHA's dental director and Medicaid fee-for-service dental program manager participated in the Center for Health Care Strategies' 2017 State Oral Health Leadership Institute and completed their state-specific project addressing dental opioid prescribing in Oregon. The project's goals are to: promote responsible, consistent, and compassionate dental prescribing guidelines for opioids and increase registration and usage of the Prescription Drug Monitoring Program by Oregon dentists. While the formal program work has been completed, they will continue to use the tools developed and lessons learned to move these goals forward.

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

Sustainable Relationships for Community Health program

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

Activities

Two new SRCH teams were selected in December 2017 to begin new projects focused on implementing closed-loop referrals to community-based diabetes prevention and chronic disease self-management programs, as well as colorectal cancer screening. In addition, OHA continued to support three CCOs who are receiving continued funding for implementing Diabetes Prevention Programs (DPP) through June 2018 as part of the National Association of Chronic Disease Directors' *Promoting Medicaid Delivery Models for the National Diabetes Prevention Program through Managed Care Organizations and/or Accountable Care Organizations* grant.

OHA staff from the Public Health Division and Health Systems Division take part in monthly check-ins with the National Association of Chronic Disease Directors (NACDD) to provide updates and identify areas of technical assistance for SRCH grantees (CCOs, local public health authorities and DPP provider organizations). SRCH grantees funded to work on the NACDD grant are building partnerships with seven DPP provider organizations to contract with and enroll 435 CCO members into DPP by January 31, 2018. These SRCH grantees implemented strategies for patient and provider engagement for NDPP. SRCH grantees have met with many clinic providers in Multnomah, Washington, and Clackamas counties to review the National Diabetes Prevention Program (NDPP) and promote referrals to the NDPP programs. Outreach materials for NDPP were created and distributed to patients and providers, including CCO member-facing materials translated into other languages (Spanish, Chinese, and Vietnamese).

Progress and findings

NACDD DPP grantee teams reported considerable progress on their initiatives through increasing patient referrals to and enrollment in DPPs, implementing closed-loop referrals, developing and refining patient recruitment and retention strategies, and exploring sustainable funding strategies.

Trends, Successes or Issues

The third cohort of SRCH grantees was selected through a competitive proposal process, and will be completing projects between January and August 2018.

Innovator Agents

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

During this quarter, innovator agents focused on providing support to CCOs as they prepare to develop their new Transformation Quality Strategies (TQS) and conclude their transformation plans. The TQS will replace transformation plans and quality assessment and performance improvement deliverables. The merging of these documents is an endeavor to provide CCOs the opportunity to move health system transformation through internal coordination and alignment of all of their transformation and quality work. The innovator agents have participated in TQS training and have worked closely with the Transformation Center in assuring CCOs have access to training and technical assistance. Innovator agents have reviewed early iterations of the TQS, provided feedback, and connected the CCOs with other assistance through the Transformation Center, as needed.

Innovator agents continue to assist CCOs in preparing their Community Health Assessments (CHA) and Community Advisory Councils (CAC) in preparation to develop new Community Health Improvement Plans (CHP). As CACs incorporate social determinants of health, trauma-informed care, and health equity into their new CHPs, innovator agents provide information, feedback, and connections to technical assistance. Agents have coordinated community and CAC members to participate in the “Planning a Collaborative CHA and CHP for Your Unique Community” one-day training. The training provides an opportunity for CCOs to collaborate with local public health and tribal health departments, hospitals, and local mental health authorities to collaboratively develop CHAs and CHPs.

Public Health Modernization

Since 2013, state and local public health authorities have been working to modernize how public health services are provided to people and communities across Oregon. This work has been directed by Oregon's legislature in the last three legislative sessions. Most notably, the legislature passed 2015's House Bill 3100, which established a new model for public health in Oregon based on the provision of foundational programs intended to improve health outcomes.

For the 2017 – 2019 biennium, the Oregon legislature made an initial investment of $5 million to modernize Oregon's public health system. In November, Oregon Health Authority awarded $3.9 million to eight regional partnerships of local public health authorities and other organizations for the period of December 1, 2017 – June 30, 2019.

Regional partnerships will use funding to:

- Develop regional systems for communicable disease (CD) control;
- Emphasize the elimination of communicable disease-related health disparities; and
- Build sustainable regional infrastructure for new models of public health service delivery.

OHA and the public health system use a set of public health accountability metrics to track progress toward achieving population health goals. The initial set of public health accountability metrics was established by the Public Health Advisory Board in 2017, with a baseline metrics report to be released in 2018. This set of metrics includes communicable disease metrics for two-year-old immunization rates and gonorrhea rates. While Oregon is unlikely to see significant changes in two-year-old immunization rates or gonorrhea rates during the 18-month funding period, regional partnerships may see changes in rates as a result of new systems put in place and engagement of community members most likely to experience communicable disease-related health disparities.

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

Health-related services

OHA revised Oregon Administrative Rules, is working to revise CCO contracts and financial reporting standards, and is developing additional guidance to assist CCOs as they implement the revised definition of health-related services (HRS). Guidance includes an HRS brief released this quarter that provides background information, defines HRS and exclusions, and provides more detailed information for CCOs about current and future use of HRS and incorporating HRS into CCO payments.

OHA continues work to provide greater communication and clarity around tracking and reporting on the use of HRS and outcomes associated with flexible services. We are in the process of revising financial reports, and OHA will provide technical assistance to CCOs.

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

Community advisory council

The Transformation Center held a webinar for CAC members focused on peer-delivered services. Staff continue to convene CAC leaders for monthly calls focused on member recruitment and engagement, and registration opened for the annual CAC leader event in April.

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 CCOs and clinics technical assistance in key strategic areas.

Behavioral health integration

The Center offered each CCO up to ten hours of technical assistance to work on a behavioral health integration project of their choosing. Hours can be used at the CCO or clinic level and must be used by the end of April 2018.

Community Health Assessment and Community Health Improvement Plan development

The Transformation Center hosted a webinar for new CCO CAC members to provide an overview of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) process and held a one-day CHA/CHP development training with one CCO. Planning is underway for seven more CCOs that requested training, which will be held in 2018. The training is intended for CCOs, local public health authorities and hospitals, with potential to also include local mental health authorities. The curriculum is grounded in the Mobilizing for Action through Partnership and Planning framework, with the focus on collaboration to meet collective CHA/CHP requirements.

CCO incentive metrics technical assistance

Adolescent well-care visits

The Transformation Center began exploring ways to provide technical assistance to increase adolescent well-care visits for young adults 18–21 years old, as this group has the lowest use of these key preventive health visits. Two needs assessment calls were held with CCO staff.

Controlling high blood pressure

The Transformation Center began exploring ways to provide technical assistance to support the controlling high blood pressure metric. Two needs assessment calls were held with CCO staff.

Effective contraceptive use

Thirteen CCOs participated in individual consultation calls focused on increasing effective contraceptive use. These CCOs can access up to 10 hours of follow-up technical assistance toward an effective contraceptive use project of their choosing.

Emergency department use among members with mental illness

The Transformation Center partnered with Multnomah County Health Department to deliver a webinar focused on tobacco cessation programs for African Americans and hosted four webinars to support a new 2018 CCO incentive metric focused on emergency department use among members with mental illness. Emergency

department use webinar topics included: metric specifications; identifying primary drivers of emergency department use; examples of multi-system care coordination; and innovations for managing patient pain.

Colorectal cancer screening
Building upon colorectal cancer (CRC) screening technical assistance successes of last year, the Transformation Center and Public Health Division are partnering with consultants to deliver targeted technical assistance focusing on reducing CRC screening disparities. Consultants will host an interactive, web-based learning collaborative for up to six CCOs on evidence-based approaches to increase CRC screening. See how one CCO increased CRC screening by 9.2 percent with the help of technical assistance: http://www.oregonhealthstories.com/people-screened-colon-cancer-thanks-easy-home-program/.

Cross-cutting supports

Transformation and Quality Strategy technical assistance
Starting in 2018, the Transformation and Quality Strategy (TQS) will replace the CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables. This streamlined approach aims to move health system transformation by providing CCOs an opportunity to internally coordinate and align all of their transformation and quality work. In 2017, the Transformation Center hosted five webinars for CCO staff to support this transition. An average of 13 CCOs attended each webinar.

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee
The Transformation Center facilitated one statewide CCO learning collaborative session this quarter, which focused on the role of data in advancing health equity.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports
Reports are attached separately as Appendix A – Enrollment Reports. (Oct-Dec 2017, as posted at this link, is a preliminary report.)

2. State reported enrollment table

Enrollment	October 2017	November 2017	December 2017
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	950,802	950,755	951,330
Title XXI funded State Plan	79,294	80,091	80,994
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	October 31, 2017	November 30, 2017	December 31, 2017

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	Percent change from previous quarter	Percent change from same quarter of previous year
Expansion	**Title 19**	PLM Children FPL > 170%	0	0	0.00%	0.00%
		Pregnant Women FPL > 170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL > 170	89,556	240,953	3.30%	30.32%
Optional	**Title 19**	PLM Women FPL 133-170%	3	5	-1600.00%	-10066.67%
	Title 21	SCHIP FPL < 170%	50,113	131,536	-6.47%	-12.49%
Mandatory	**Title 19**	Other OHP Plus	156,208	447,905	-0.99%	-3.69%
		MAGI Adults/Children	742,065	2,047,130	-3.14%	-7.71%
		MAGI Pregnant Women	13,702	31,911	-10.08%	-23.76%
		QUARTER TOTALS	1,051,647			

OHP eligible and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
October	961,717	831,306	742	674	33,277	43,380	3,652
November	962,452	841,382	756	656	33,443	43,721	3,664
December	963,997	835,116	740	658	33,256	43,577	3,654
Quarter average	962,722	835,935	746	663	33,325	43,559	3,657
		86.83%	0.08%	0.07%	3.46%	4.52%	0.38%

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

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

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

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.

Reports are attached separately as Appendix D – Neutrality Reports.