Oregon Health Plan

Section 1115 Quarterly Report

10/1/2018 – 12/31/2018
Demonstration Year (DY): 17 (7/1/2018 – 6/30/2019)
Demonstration Quarter (DQ): 2/2019
Federal Fiscal Quarter (FQ): 1/2019

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I. Introduction

A. Letter from Oregon's Deputy State Medicaid Director

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

Lever 1: Improving care coordination

OHA continues to improve care coordination through the Certified Community Behavioral Health Clinic (CCBHC) demonstration program. The CCBHC demonstration program was launched in Oregon on April 1, 2017 and will run through March 31, 2019.

Among the key milestones for this reporting quarter, OHA is pleased to report the validation and submission of clinic-led metrics for Oregon's 21 CCBHC clinics.

Lever 2: Implementing alternative payment methodologies

OHA continues advancing the use of value-based payments (VBP) through several programs including the VBP Roadmap for CCOs. During 2018, the Transformation Center worked with stakeholders and national VBP experts to develop the Roadmap. The Roadmap was approved by the Oregon Health Policy Board (OHPB) in October 2018 and intended to provide valuable tools for communicating and educating CCOs on upcoming VBP requirements. Beginning in 2020, the VBP Roadmap will include annual and five-year value-based payment targets for CCOs and contracted providers.

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

Oregon is maintaining core tenets of the existing Coordinated Care Model through oral integration efforts that include the incorporation of new Hemoglobin A1c (HbA1c) screenings within the scope of dental practices which serve OHP members.

HbA1c monitoring among diabetic patients is considered the standard of care. Increasing HbA1c oral health assessment rates for OHP adults with diabetes provides opportunities to meet quality measures and report metric goals.

Lever 4: Increased efficiency in providing care

While innovator agents continue to connect OHA and CCOs to achieve the goals of Health System Transformation, Oregon has partnered with the Sustainable Relationships for Community Health (SRCH) program to bring together various organizations and sectors within the community. Through these efforts, Oregon will complete a shared system change project sustained beyond the grant period. Invited partners include leadership from prominent decision-making organizations (e.g. local CCOs, clinics, and community-based organizations).

The current SRCH partnership list includes two SRCH Leadership Institute cohorts, 13 local public health organizations and one tribal health partner. OHA's Public Health Division plans to release the Request for

Grant Funding for a 2019-2020 SRCH cohort in Spring 2019, with priority given to consortia who have participated in prior SRCH Leadership Institutes.

Lever 5: Implementation of health-related services

OHA upholds its commitment to promote CCOs' use of health-related services (HRS) by continually working to revise Oregon Administrative Rules, revising CCO contracts, upholding financial reporting standards, and developing additional guidance to assist CCOs as they implement evolving definitions of HRS. As an additional help, OHA published a frequently-asked-questions document about how to use HRS.

Lever 6: Innovations through the Transformation Center

CCOs continue to seek technical assistance through the Transformation Center and are taking action to implement knowledge gained, such as implementing Behavioral Health Collaborations (BHC) recommendations, conducting tobacco cessation activities, and hosting patient-centered counseling training for Medicaid providers around the state.

Lori Coyner, State Medicaid Director

B. Demonstration description

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

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

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

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

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

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

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

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

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 10/1/2018 – 12/31/2018
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III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan eligibility

The Oregon Health Plan (OHP) Processing Center experienced a strong open enrollment period and general backlog within Oregon's fluctuating Marketplace conditions. Despite increased adjustments during the period, enrollment levels have remained steady. There were no policy or system changes affecting eligibility or enrollment.

Monthly automatic case renewal processes continued to save time and effort for both staff and OHP members. Ease of enrollment was a factor in lowering attrition rates, resulting in a positive downstream impact, such as, enhancing seamless enrollment for OHP managed care plans. The positive impact additionally extended to uninsured individuals seeking coverage through the Hospital Presumptive Eligibility process.

2. Coordinated care organization enrollment

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

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

B. Benefits

The Pharmacy &Therapeutic (P&T) Committee developed new or revised prior authorization criteria for the following drugs: severe acne medication; Hepatitis C Direct-acting Antivirals; gonadotropin-releasing hormone (GnRH) receptor antagonists; growth hormones and testosterone. The committee also added the following drugs

to the preferred drug list: multi-sourced oral isotretinoin, topical benzoyl peroxide, topical retinoids, and topical antibiotics.

The Health Evidence Review Commission 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 here.

C. Access to care (annual reporting)

D. Quality of care (annual reporting)

E. Complaints, grievances, and hearings

CCO and FFS complaints

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

Trends

	Jan – Mar, 2018	Apr – Jun, 2018	Jul – Sep, 2018	Oct – Dec, 2018
Total complaints received	5,537	5,882	5,917	5,839
Total average enrollment	1,179,176	1,217,091	1,185,394	1,180,577
Rate per 1,000 members	4.70	4.83	4.99	4.95
* FFS data is included in the totals beginning in October 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports.				

Barriers

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

Interventions

During this quarter, CCOs report they are continuing to provide regular training to internal staff to ensure all complaints are resolved and reported appropriately. One CCO reports they trained internal customer service staff on using tone, empathy, compassion, and general scripting when answering member calls to ensure they provide excellent service to members. CCOs report they are working in various ways to reduce the number of complaints from specific providers, such as NEMT brokerages. Some CCOs are meeting every other week or monthly with NEMT providers and are beginning to see improvements. One CCO uses a peer review committee and is seeing a decrease in the number of complaints. CCOs are also continuing to provide education to members to ensure members provide the correct insurance information at the time of service and members know what to do when they receive a bill.

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

Statewide rolling 12-month totals

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

Complaint category	Jan – Mar, 2018	Apr – Jun, 2018	Jul – Sep, 2018	Oct – Dec, 2018
Access to care	2,213	3,076	3,491	3,422
Client billing issues	457	394	299	373
Consumer rights	230	220	195	207
Interaction with provider or plan	1,682	1,283	1,103	1,082
Quality of care	466	526	476	417
Quality of service	439	345	305	338
Other	50	38	48	0
Grand Total	**5,537**	**5,882**	**5,917**	**5,839**
* FFS data is included in the totals beginning in October 2017, which explains the increase from the previous quarters. FFS data will continue to be included in future reports.				

Related data

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

CCO and FFS appeals and hearings

CCO Notices of Action – Adverse Benefit Determination

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

Notice of Action – Adverse Benefit Determination (NOA-ABD) reason	Total issued
a) Denial or limited authorization of a requested service.	33,284
b) Single PHP service area, denial to obtain services outside the PHP panel	90
c) Termination, suspension, or reduction of previously authorized covered services	135
d) Failure to act within the timeframes provided in § 438.408(b)	48
e) Failure to provide services in a timely manner, as defined by the State	228
f) Denial of payment, at the time of any action affecting the claim.	29,000
Total	**62,785**
Number per 1000 members	72

CCO Appeals

The following table shows the total number of appeals received by CCOs during the quarter. Federal managed care rule changes went into effect for Oregon on January 1, 2018, and Oregon Health Plan (OHP) members are now required to exhaust their appeal rights at the CCO level before a contested case hearing can be requested at the state level. The table below has been revised to reflect only CCO appeal information. CCOs reported that specialty care and outpatient services had a higher number of requests for appeal. CCOs report they provide

education and training to their staff as well as provider staff to increase knowledge about covered benefits. Some CCOs report they have made internal changes to assist providers with access to medical consultations to help reduce the number of denials. CCOs continue to work with members to assist them in finding services they need or finding alternative covered options.

CCO Appeals	Requests
a) Denial or limited authorization of a requested service.	1,203
b) Single PHP service area, denial to obtain services outside the PHP panel	3
c) Termination, suspension, or reduction of previously authorized covered services	1
d) Failure to act within the timeframes provided in § 438.408(b)	2
e) Failure to provide services in a timely manner, as defined by the State	0
f) Denial of payment, at the time of any action affecting the claim.	329
Total	**1,538**
Number per 1000 members	1.76
Number overturned at plan level	481
Appeals decisions pending	11
Overturn rate at plan level	31.27%

CCO and FFS Contested Case Hearings

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

The Oregon Health Authority (OHA) received 492 hearing requests related to the denial of medical, dental, and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 468 were for CCO-enrolled members, and 24 were for FFS members. During this reporting period, 463* cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. There were 32 cases approved prior to hearing where OHA overturned their denial or the CCO overturned their appeal resolution. Members withdrew from 23 cases after an informal conference with an OHA hearing representative. OHA dismissed 347 cases that were determined to be not hearable.

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

Of the 60 cases that went to hearing, the administrative law judge upheld the OHA or CCO decision in 34 cases, reversed or set aside the OHA or CCO decision in five cases, and dismissed 21 cases for the member's failure-to-appear. One case was dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

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

Outcomes of Contested Case Hearings Processed

Outcomes	Count	% of Total
Decision overturned prior to contested case hearing	32	7%
Client withdrew request after pre-hearing conference	23	5%
Dismissed by OHA as not hearable	347	75%
Decision affirmed*	34	7%
Client failed to appear*	21	5%
Dismissed as non-timely	1	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	4	1%
Set Aside	1	0%
Total	**463**	
**Resolution after an administrative hearing*		

Related data

Reports are attached separately as Appendix C – CCO Contested Case Hearings.

F. CCO activities

1. New plans

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

2. Provider networks

Health Share of Oregon (HSO) submitted a request for application (RFA) to select dental plans. As of October 1, 2018, HSO contracts with five dental plans, having closed contracts with four dental plans who were not successful RFA applicants. The RFA and plan change resulted in dental plan changes for 136,000 HSO members. Of those, approximately 78,543 received new ID cards with the new dental plan listed. While most members were able to continue care with current dental providers, HSO reportedly assigned 2,605 members to new dental providers. Throughout this transition, HSO's top priority was to maintain HSO member relationships with established dental providers, whenever possible.

3. Rate certifications

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

OHA submitted final rates to CMS on October 2, 2018 allowing for the required 90-day review window, per CMS rule.

In November 2018, OHA held a public forum to present rate development methodology for the new CCO 2.0 procurement process. All public feedback was submitted in December 2018. Public feedback was reviewed by OHA and used to develop the CCO 2.0 procurement rates (for calendar year 2020). OHA will release a request for application (RFA) and draft procurement rates in January 2019.

4. Enrollment/disenrollment

There are no significant changes in member enrollment or disenrollment.

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

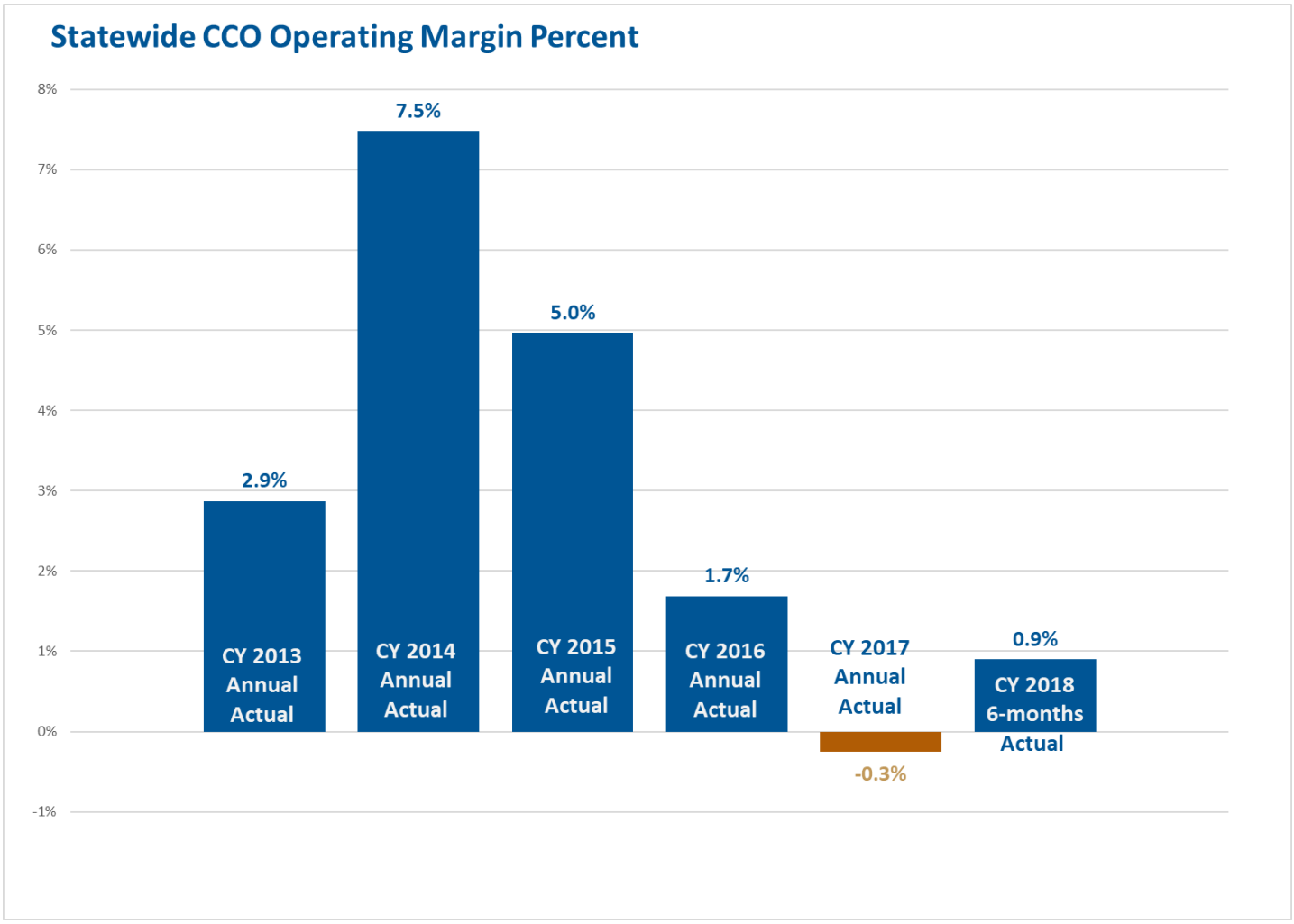
5. Contract compliance

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

6. Relevant financial performance

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

The statewide coordinated care organization (CCO) operating margin was at 1.3% compared to -0.3% for the year ending December 31, 2017. For reference, the capitation rates include a 1% profit margin. CCO operating margins returned to a slightly profitable status after trending downward during the previous three-year period.



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

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

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

7. Corrective action plans

Advanced Health, previously Western Oregon Advanced Health, did not meet the administrative performance (AP) standard for March 2018 and was subsequently placed on a corrective action plan to be monitored and completed by March 2019.

8. One percent (1%) withhold

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

Advanced Health CCO was unable to meet the administrative Performance (AP) standard for March 2018. An appeal was filed and accepted.

9. Other significant activities

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

G. Health Information Technology

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

Medicaid Electronic Health Records Incentive Program

Through the Centers for Medicare and Medicaid Services (CMS) Electronic Health Records (EHR) Incentive Programs (also known as the Promoting Interoperability Programs), eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). Increasing the number of providers adopting, implementing, upgrading, or meaningfully using CEHRT helps promote better health outcomes for Oregonians by increasing access to, and use of, vital health information at the point-of-care. Since 2011, when the Medicaid EHR Incentive Program began, 3,818 Oregon providers and 60 hospitals have received over $197.5 million in federal incentive payments under the program (as of December 31, 2018). Between October and December 2018, 575 Oregon providers and three hospitals received $5.2 million in Medicaid EHR incentive payments. To promote continued participation and success in the program, Medicaid EHR Incentive Program staff hosted an

informational webinar to present updates and requirements to 116 attendees. The Medicaid EHR Incentive Program sunsets in 2021.

Oregon Medicaid Meaningful Use Technical Assistance Program

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

Since the program's launch in 2016, a total of 1,518 providers across 355 clinics have enrolled (as of December 31, 2018). Between October and December 2018, 83 providers across 36 clinics received technical assistance bringing the total number of providers to 1,114. OMMUTAP will sunset in 2019.

Behavioral Health

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

- Of responding agencies, 76% are using electronic health records (EHR);
- Financial cost is a top barrier to EHR use for both agencies with and without an EHR; and
- Though some agencies are exchanging patient information via electronic means, the most commonly used methods of information exchange are fax, secure email, and paper.

At HITOCs request, OHA is convening a Behavioral Health HIT Workgroup that is reviewing and providing feedback on report recommendations and priorities. The workgroup is informing the prioritization of recommended strategies for supporting the behavioral health system's current HIT/HIE needs, which were presented to HITOC in December 2018 and included as an addendum to the report. OHA will release a final report in 2019. HITOC requested OHA continue convening the Workgroup during 2019 to provide input and guidance as OHA pursues strategies in support of behavioral health.

HIT Commons

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

- The **Emergency Department Information Exchange** (EDIE) is a collaboration between the Oregon Health Leadership Council (OHLC), the Oregon Health Authority (OHA) and other partners including hospitals, health plans, CCOs and Emergency Department physicians. Patient visit information is automatically sent to EDIE in real time when patients visit an Emergency Department. Patient care history, known providers, and care coordination information are returned to EDIE users.

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

EDIE and PreManage provide real-time information to reduce emergency department utilization, improve care coordination, care management, and serve as the platform for the Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative. OHA and the OHLC, with the assistance of an interim governance advisory group, completed a business plan and appointed an initial governance board in 2017.

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

Emergency Department Information Exchange and PreManage

The Emergency Department Information Exchange (EDIE) collects emergency department (ED) and inpatient Admit Discharge Transfer (ADT) data from hospitals and pushes notifications back to the ED in real time. EDIE provides notification containing patient ED visit, care team (primary care, behavioral health, etc.), and care guideline information. PreManage is a companion software tool to EDIE. PreManage brings the same real-time hospital event notifications (ED and inpatient ADT data) to those outside of the hospital system, such as health plans, CCOs, providers, and care coordinators. EDIE and PreManage are used statewide, with adoption of PreManage growing rapidly. Between October and December of 2018, the number of primary care clinics (including Federally Qualified Health Centers) using EDIE/PreManage increased to 217, bringing the total number of EDIE/PreManage-enabled entities to 438

Oregon Prescription Drug Monitoring Program Integration Initiative

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

Since the initiative began, PDMP data through integration is now available to more than 3,700 prescribers, 48 health care entities (including hospital EDs), and two retail pharmacies.

Clinical Quality Metrics Registry

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

The CQMR is in its implementation phase, which began with a kick-off in December 2017 with Peraton and Michigan Health Information Network (MiHIN), OHA's prime vendor and subcontractor, respectively. OHA

has continued to engage stakeholders in a subject matter expert workgroup in addition to outreach with other stakeholder groups. Program work in preparation for implementation includes work on communications, legal agreements, and contracting for technical assistance to clinics focused on patient-level eCQM reporting.

The CQMR system testing, security testing, and user acceptance testing have been completed. The CQMR will go live in January 2019 for Medicaid EHR Incentive Program users and in February 2019 for CPC+ and MIPS users. CCO incentive measures for 2018 will be reported using the same method used in previous years and will shift to the CQMR for 2019 reporting.

H. Metrics development

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

Health Plan Quality Metrics Committee

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

The Health Plan Quality Metrics Committee finalized the 2018-2019 workplan, continued work on prioritizing measure domains and gaps, and heard from stakeholders regarding recommendations for the 2020 aligned measure set. The final measure set will come to a vote by the committee in March 2019 and will be published in April 2019. Stakeholders providing recommendations include: the Health Aspects of Kindergarten Readiness Technical Workgroup, the Evidence-Based Obesity Metric Workgroup, and the Integrated Behavioral Health Alliance.

Metrics and Scoring Committee

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

At the October meeting, the committee heard a presentation on the state of public health in Oregon, along with opportunities for incentive measures to aid in improvement. The MSC discussed the overall aims of the incentive measure set and potential areas for exploration over 2019. Discussions were in preparation for the MSC's recommendations to the Health Plan Quality Metrics Committee (HPQMC) regarding the 2020 aligned measures menu, and to aid in its work plan for 2019.

At the November meeting, the MSC heard the measurement strategy recommended by the Health Aspects of Kindergarten Readiness Technical Workgroup (HAKRTW). The proposed strategy includes adding two new measures in 2020: Preventive dental visits and Well-child visits for 3-6 year-olds, developing a CCO-level attestation measure on social-emotional health for use in 2021, and incentivizing the follow-up component to

the existing Developmental screening in the first 36 months of life in subsequent years. The committee also received an update on obesity measure development and discussed the developmental food insecurity measure.

At the December meeting, the committee formally endorsed the full measurement strategy recommended by the HAKRTW. While the committee endorsed the workgroup's recommendations, they will not make final, formal decisions about the entire 2020 incentive measure set until summer 2019. In addition, the committee finalized its recommendation that the HPQMC develop a broad social determinants of health measure.

Health Aspects of Kindergarten Readiness Technical Workgroup

The Health Aspects of Kindergarten Readiness Technical Workgroup (HAKRTW) met twice during this quarter. The workgroup finalized the measurement strategy proposed to the Metrics & Scoring Committee for use in the Coordinated Care Organization (CCO) Quality Incentive Program.

The workgroup ultimately proposed a multi-year measurement strategy that aims to drive health system behavior change and investments that contribute to improved kindergarten readiness and cross-sector collaboration. This approach was taken for numerous reasons, including:

- Kindergarten readiness is complex, and the domains are interrelated. There is no one measure that captures all the health aspects of kindergarten readiness.
- The proposal builds on the existing CCO incentive metrics focused on children prenatal through age five.
- The proposal balances the workgroup's long-term vision with current sense of urgency and includes metrics that are feasible to implement in the next few years and drives toward the development of future metrics necessary for progress toward kindergarten readiness.

The entire proposal is driving toward health system behavior change, investments, and cross-sector efforts that contribute to improved kindergarten readiness. Below are the implementation steps for the next few years recommended by the workgroup:

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

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

I. Budget neutrality

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

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

There are no legislative activities to report for this quarter.

K. Litigation status

Lawsuits and legal actions

Open lawsuits and legal actions related to the Oregon Health Plan, to which the State Medicaid agency (Oregon Health Authority) is a party to, are listed, in aggregate. There are currently 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 not reported in this section are included in this quarterly/annual report under section III. E. and in Appendix C.

L. Public forums

Health Evidence Review Commission

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

November 8, 2018

Testimony for this meeting related to a proposal by HERC's Out-of-Hospital Birth Workgroup Committee. A study was conducted with the purpose of determining whether an update of the 2015 coverage guidance on out of hospital births should be undertaken. Findings would determine if there has been relevant literature published since 2015 and would provide data for alterations to coverage recommendations for comparative effectiveness of planned out of hospital births compared to planned hospital births.

Sharan Fuchs, Out-of-Hospital Birth Workgroup Committee member

Ms. Fuchs delivered her first child outside the hospital in 1979 and filed her first concern with the state about that in 1980. She said there is no other committee doing the work that HERC is doing. She wanted to express appreciation to Dr. Chervenak and for the work of the HERC.

Dr. Duncan Neilson, Legacy Health MD

Dr. Neilson reported that Legacy Health has heard an impassioned plea based on a large study to add another risk factor. He would like to ensure the topic is kept in proper perspective: home births are going to happen. Medical professionals should do the best they can to ensure patient safety. He expressed a desire to be involved in continued discussions.

HERC Value-based Benefits Subcommittee

The HERC's Value-based Benefits Subcommittee (VbBS) reviews all potential changes to the Prioritized List and is comprised of both commission members and other provider and stakeholder representatives. Interim modifications to the Prioritized List of Services are initially forwarded for consideration to the VbBS, which

will often require at least two meetings to first hear the request and then have staff collect the necessary information to decide on an action. The Commission's decisions are always based on what is best for the entire OHP population, and not on one individual case.

October 04, 2018

Testimony for this meeting related to consideration of adding coverage for human donor breast milk for infants born prematurely.

Dr. Nan Dahlquist, Westside Breastfeeding Center Medical Director

Dr. Dahlquist is also a member of the American Academy of Pediatricians and serves as a lactation consultant and member of the advisory board for Northwest Mother's Milk Bank. Dalhquist spoke about complications related to cow's milk-use in micro-preemies. She said the use of pooled human donor milk is, unquestionably, the standard of care in the hospital. The costs of this product should be considered alongside the data about keeping babies in the hospital if they develop necrotizing enterocolitis.

There was an average 18-day reduction in care for medically managed enterocolitis, and a 50-day difference for surgically managed necrotizing enterocolitis. Dalquist works with families after their babies are outside the newborn intensive care unit (NICU). Many of these families are overwhelmed by their time in the unit and are grappling with how sick their babies were. Helping the babies grow and thrive with as little sequalae as possible improves the long-term health of the infant as well as the sustainability of the families. These babies will be raised alongside term peers and face a risk of higher demand for medical services. Dalquist believes human breastmilk deserves the classification of a medication rather than a medical product.

Dr. Ann Loeffler, Randall Children's Hospital, Pediatric Infectious Disease Pediatrician

Dr. Loeflller also serves as an unpaid medical advisor to the Northwest Mother's Milk Bank. Loeffler shared information about the safety of pasteurized milk. There has never been a case of infection in North America through the milk banks. Loeffler said women believe human milk is better and are sharing it and selling it on the internet. Some women lace it with cow's milk or take illicit drugs when selling their milk. Correctly pasteurized milk is of higher quality compared to milk that is informally sold or shared. The subcommittee's recommendation for coverage will legitimize pasteurized donor breast milk. There is data about babies getting pasteurized milk in the NICU and their moms going on to successfully breastfeed those babies. As we look to promote health in a proactive way, what could be better than supporting breastfeeding by promoting donor breast milk? Indications for needing donor breast milk include mothers of premature babies whose body may not produce milk and mothers whose breast milk is not appropriate for their babies due to HIV disease or drug use.

Anna David, NICU Families Northwest member

Ms. David's daughter received donor milk when born at 26 weeks of gestation. David has also donated milk to the milk bank. NICU families are sometimes faced with bills of over a million dollars. In addition, the stress, anxiety and depression resulting from a NICU stay can drastically compromise a mother's ability to produce milk. Human milk is medicine that can prevent deadly disease. Donor milk is the best solution when mother's milk is compromised or unavailable. David has seen devastation for families whose insurance cuts off coverage of donor breast milk. These families can sometimes fight insurance companies for weeks or even months to gain coverage. Adding coverage will ensure that families are given access to lifesaving medicine and food that is safe and nutritionally superior to the alternatives. Donor milk can strengthen the baby's immune system, reduce the length of expensive hospital stays and reduce the need for continued treatment after discharge.

Lesley Mondeaux, Executive Director of Northwest Mother's Milk Bank
Ms. Mondeaux reported that the milk bank charges a processing fee. Medicaid would support the work of the milk bank and improve its reach. Prioritized fragile infants are provided a safe source for human milk. The Milk Bank has distributed over 1 million ounces of pasteurized human milk to hospitalized and outpatient infants. In 2017, 900 families received prescribed human milk. The Milk Bank receives incredible support from mothers donating their milk. Mondeaux's organization is accredited by the Human Milk Bank Association of North America. It follows strict guidelines to ensure safety and quality and appropriate prioritization.

Mondeaux testified that her organization serves all level 3 NICUs in Oregon and serves 68 hospitals throughout the Pacific Northwest (Oregon, Washington, Alaska, a little bit of Idaho and backup service for Montana). Each hospital has its own criteria and guidelines, and these vary widely.

Mondeaux stated that the Milk Bank has had the breastmilk needed to meet hospital orders, which are the number one priority. About 20 percent of the milk reaches outpatient families. They prioritize the milk very carefully. Many families requesting milk for nonmedical reasons do not receive it. A charitable program exists to eliminate processing fees, if needed. The prioritization involves reviewing chart notes and often communication with the provider. The organization also looks at the lactation support provided to the mother. Younger babies and those with low birth weight will have higher priority. Four OHP babies [in an outpatient setting] have been served. All but 1 were CCOs and were older babies that were not tolerating formula or failing to thrive.

While it was pointed out that donor breast milk gets included in the hospital fee, hospitals may cap payment for donor milk when babies reach a certain weight, even while the child is still admitted. Those parents aren't allowed to bring milk into the hospital, even if they purchase it themselves. Mondeaux mentioned that the organization receives calls from families in this situation.

November 08, 2018

Testimony for this meeting is related to multiple topics on genetics testing. The first of these topics involved expanding coverage for carrier screening through panel testing.

Devki Saraiya, Myriad Genetics employee
Ms. Saraiya testified that current OHP coverage for carrier screening is ethnicity-based. Ethnicity-based screenings find only 53% of patients at risk for having a child with a condition, vs. expanded carrier screening approaches. ACOG has guidelines on when tests are included, and labs offering this type of test are following ACOG guidelines. Ethnicity screening is difficult to determine when appropriate for a patient. Labs offer genetic counseling to help to determine when a partner needs to be tested. Variants of uncertain significance are not reported by Myriad in the carrier screening testing. CPT is specific for carrier screening, so if a mother is not affected, but is a carrier, then the partner should be tested. If the partner is a carrier, then the pregnancy has a 25% chance of being affected. This is about pregnancy/preconception decision making. This type of testing might lead to the need for prenatal diagnostic testing. Myriad tries to make genetic counseling available to patients and/or providers to help with interpretation.

Saraiya noted that OHP is already doing cystic fibrosis and spinal muscular atrophy testing for everyone. This expended carrier testing adds more autosomal recessive genes that typically don't have a family history. Saraiya reported that there is a study on clinical utility showing that 37% of couples who tested positive for both being

carriers went on to have prenatal diagnostic testing such as amniocentesis. Therefore, this information is being used for pregnancy decisions.

The second genetic testing topic receiving testimony focused on a request to remove restrictions on who can provide genetic counseling in cases of elective testing in asymptomatic patients for hereditary cancers.

Karen Haller, Myriad genetics unit employee
Miss Haller indicated the issue of access to genetic counseling is real and is discussed every year. There is a lack of providers in Oregon and in the US in general. NCCN delineates criteria for testing in these hereditary cases. NCCN and USPSTF do not state that genetic counselors need to see every patient, and list other types of providers equipped to give this type of counseling. This information is being used more and more frequently in care—screening changes, treatment changes, etc. Providers cannot adequately manage patients without this information. Multiple specialty societies have stated that this type of counseling is within the scope of their specialty.

The third and final genetic testing topic receiving testimony involved a request to expand non-invasive prenatal screening (NIPS) to all women, not just those with a high risk of chromosomal anomalies.

Devki Saraiya, Myriad laboratory employee
Ms. Saraiya testified that all guidelines confirm that using non-invasive prenatal screening (NIPS) in the general population is appropriate, including ACOG. The BCBS TEC report was redone in 2018 and found sufficient evidence that NIPS used in a general-risk population improved health outcomes. Saraiya noted that any screening test performs less well in low-risk populations because prevalence of the conditions being screened for are lower in this population. NIPS provide a hundred-fold lower false positive rate, reduces rates of amniocentesis or CVS and avoids the cost and complications of these procedures. Evidence supports that it is a superior test to serum tests.

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

November 01, 2018
Testimony for this meeting related to the consideration of updating the coverage guidance on planned out-of-hospital births based on a rescan of new evidence that has become available since its completion in 2015.

Silke Akerson, Director of the Oregon Midwifery Council
Ms. Akerson noted that, while she agreed with the overall assessment, there isn't a huge amount of new evidence about the high-risk exclusion criteria. There are several consultation requirements in the coverage guidance that are not evidence-based. These criteria are functioning more as a practice guideline rather than evidence-based coverage guidance. The level of detail in the consultation requirements is taking the place of shared decision-making.

Akerson said that, because the cost of a birth is something that is paid in total, the criteria completely removes access to the option of out-of-hospital birth when the guideline criteria aren't met for most people on the Oregon Health Plan (OHP). She would like to see the consultation criteria based on strong evidence. For

example, OHP currently requires consultation with a provider with hospital privileges. In some cases, this adds significant cost and stress for the patient. Some could be addressed by a primary care provider. In other cases, a provider is consulting with a provider with hospital privileges such as maternal fetal medicine, but OHA rules that it is not an appropriate consultation, and to consult with a hematologist/oncologist instead. Akerson claims the way the guidance is implemented is resulting in increased costs and complications in some specific instances (though not in the majority of the consultation requirements).

Akerson also clarified that the vital records report was reviewed during the original coverage guidance development before the Snowden study came out. At the time her group was concerned as the report looked at about 4000 births total (there are about 2000 out-of-hospital births per year in Oregon). Because negative outcomes are rare, looking at only a few years' data can distort the picture. There has been a rigorous quality improvement program since the study period of 2012-2013. In 2012, the perinatal mortality rate was 3.9 per thousand for planned out-of-hospital births. In 2015 it was 0.98 per thousand; in 2016 it was 1.03 per thousand. Akerson advised caution in looking at the Snowden study, or at small ranges of time for vital records. She said Oregon's data from birth certificates are more reliable in terms of correctly allocating outcomes by intended place of birth than birth certificates from other states. She also said that certified professional midwives are now regulated in 38 states.

Kelsey Fisher, Board of Direct Entry Midwifery
Ms. Fisher is also a Direct Entry Midwife in Oregon. Fisher said her board's rules are open right now. While she recognized that her board's rules are separate from this coverage guidance, there was evidence from the Midwives Alliance of North America (MANA) showing that vaginal birth after cesarean can be safe for women who've previously had a successful vaginal birth. This data shows that the risk for these women is much lower than for women without a prior vaginal birth. In fact, the outcomes are better than for primiparas women.

Dr. Duncan Neilson, Legacy Health Systems, Chief of Women's Health Services
Dr. Neilson has been appointed as the resident expert for HERC coverage guidance. His impression is that the literature since the last HERC review hasn't added anything substantive. In another forum he has heard the concerns Akerson raised and they are real. But addressing these isn't the job of the HERC. Neilson said that the remaining work in this area for Oregon is threefold: addressing implementation issues with the current prior authorization process; disseminating the evidence as it has been compiled by HERC; and addressing perceptions among providers statewide and among payers about out-of-hospital births. Neilson claimed some payers don't understand the actual risks and are reticent to get involved or to be constructive. His primary issue is patient safety, and if things aren't implemented well and if the delivery community doesn't understand what is and isn't safe, then patient safety is compromised. Specifically, he said developing relationships for transfer of care for patients who do risk out of out-of-hospital births is important as relationships are crucial to successful transfers.

HERC staff responded and said that there is a group working to address the implementation of issues discussed, and these would not be in HERC's purview, except for the suggestion to drop some consultation criteria. If the other workgroup requests changes in the HERC guideline note on planned out-of-hospital birth associated with the Prioritized List, HERC could consider that request.

Dr. Amin Medjamia, Abiomed, MD
Dr. Medjamia offered public testimony. He participated in the PROTECT II trial though he did not design it. He noted that, while the study was cancelled based on preliminary data from a smaller subset of patients, the results reviewed today include results from a larger group of patients, some of whom were randomized while the

preliminary data was being analyzed. The larger data is more positive than the preliminary data. He also noted that Impella is different from other alternatives in that it reduces the ischemic threshold of the heart. It is difficult to conduct a clinical trial in an emergent setting. Out of 10 trials attempted, only 2 have completed, and these are only powered to show improved hemodynamic support. Others have stopped for low enrollment.

Medjamia focused on the high-risk percutaneous coronary interventions (PCI) population. It is a small population. It's the surgical turn-downs (those not eligible for surgery). In PROTECT II they asked the physicians to call for a surgical consult to see whether they were eligible for CABG. Sixty-seven percent were not eligible, but the remaining patients were so compromised that the physicians didn't bother to call for a surgical consultation; it was obvious. At the time the study was designed, the assumption was that the complication rate was low in these patients. This was the reason for the composite outcome including 10 adverse events. Medjamia described several issues with the PROTECT II study which may have skewed the results towards ineffectiveness and harms. He claimed that a lack of coverage in Oregon would create tiered coverage, with the sickest, most vulnerable patients lacking coverage for this device. He also mentioned several professional societies which reference the device in guidelines.

Subcommittee response
Kansagara said that the subcommittee feels the responsibility to provide the best coverage. The approval of coverage for some things takes away from other things. Livingston asked Obley to address Medjamia's comments. Obley said that giving the most generous interpretation of the subsidiary analyses of the PROTECT II study, if you were to re-do PROTECT II and add an operator experience requirement, accept the newer definition of MI and include only the newer models of Impella, it might well be a very different trial, though he would not say whether it would be better or worse. However, post hoc analyses introduce bias. Redefining MI post hoc is problematic as one could have chosen any enzyme cutoff which produced the most positive outcome.

HERC Health Technology Assessment Subcommittee

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

November 15, 2018

Testimony for this meeting related to recently passed legislation that directed HERC to develop evidence-based guidelines on patient characteristics and appropriate procedure in the use of newly authorized extended stay centers (ESCs) to be associated with ambulatory surgical centers (ASCs). These ESCs will allow patients to receive care in an ASC/ESC up to a combined 48 hours, compared to the 24-hour maximum currently allowed in ASCs.

Doug Riggs, Oregon Ambulatory Surgery Center Lobbyist
Riggs helped draft the bill and worked to get the bill adopted. Riggs testified that, by the end, the allies included Oregon Medical Association, Oregon Association of Hospitals and Health Systems as well as patient advocate groups and unions. The bill would allow people to extend their recovery period after surgery, and that this was a key to address the deluge of joint surgeries that are needed with the aging of an active population. These surgeries are expected to double in the next 10 years.

Riggs said there are two rulemaking processes ongoing within the Oregon Health Authority. One, with the Public Health Division is complete, related to licensing rules. Those should be effective in January. Another, related to facility guidelines (or an FGI process) to align building standards at the federal level, is nearing completion as well. A third provision in the statute is related to the HERC, which was adopted last. It's important to understand that one of the hospitals in Southern Oregon wanted this provision adopted. He and other proponents of the bill saw the provision shortly before a vote and didn't have a chance to change it. He said it wasn't quite what his group was hoping for. There are only a handful of states that have recovery facilities. What was intended was to begin to collect data on the outcomes from patients who use extended stay centers and develop evidence around outcomes for these patients. However, that's not quite what the bill says. Riggs believes there will be a legislative effort to modify the bill, which he would share within a couple of weeks. He said profitability of ASCs is poor; the number of ambulatory surgery centers is contracting in Oregon because of low reimbursement. He offered to be a resource in the guideline development and continues to work with the hospital association and Oregon Medical Association.

Riggs said the existing bill appears to request the HERC to determine which procedures would be appropriate in an ASC that has an ESC. He said it shouldn't be the procedure that determines this but rather the patient and their needs. For example, an elderly patient may need a little extra time for managing pain or bodily functions. Another patient might not have a caretaker at home but need one after 23 hours and 59 minutes. Or if the caretaker can't arrive because it is 6 a.m. and snowing, an ESC would be available so that the patient could be stabilized and wouldn't need to be transferred to the hospital emergency room at higher cost.

Riggs also clarified that an extended stay center is not for a patient whose condition is deteriorating, but a patient that is recovering. He said data from Colorado support that patients who encounter complications either have this happen in the surgery center or are transferred to the hospital.

Riggs testified that there are approximately 12 of these types of facilities in Colorado and most tend to be midsized (10-15 beds). Some patients may know that an extra 6 or 12 hours of recovery could be of benefit because of the time of year or lack of a caregiver at home. In other cases, a patient might have a little additional trouble managing pain or bodily functions after surgery. The ESCs aren't a profit center because most plans don't pay for this service, though they are working to get reimbursement. The bill directs the Oregon Health Authority to apply for a waiver to allow Medicaid reimbursement. He said ESCs need to be on the same site as an ASC, though they would be licensed separately.

Chris Skagen, OASCA Executive Director

Mr. Skagen said the goal of the ESC is to enhance the patient experience and that the admission criteria for an ASC does not change based on the recovery center.

Skagen offered to share the names of some experts who might be able to assist and put HTAS in touch with physicians as well as CEOs in Colorado who could share their expertise. They may be able to report internal data, though it would not be peer-reviewed. He said that having all ESCs report data is appropriate but having all ASCs report discharge data would be going too far. Skagen said that with respect to the ASA (American Society of Anesthesiologists) classifications, the ASC facility medical board would approve procedures that would matriculate into a recovery center. The types of procedures include joint replacements (hip, shoulder, knee, ankle). Arthroscopies and sports medicine, spinal fusion and hand and upper extremity surgeries are also

common. He said there is a lot of data out there, but there will be a specific list for each facility, followed by a retroactive review of complications for each procedure.

Chronic Pain Task Force

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

December 05, 2018

Testimony for this meeting related to the proposal originally presented at HERC's Value-based Benefits Subcommittee August meeting but re-referred to the task force after a large amount of public testimony was received. The proposal would involve the creation of a new line in the funded region of the Prioritized List that would provide the coverage of treatments for five currently nonfunded conditions involving complex pain syndromes including fibromyalgia. The new line would have to be created as part of the biennial review process so would not go into effect until January 1, 2020 if approved by HERC. New covered treatments under the proposal would include cognitive behavioral therapy, acupuncture, health and behavior assessment, physical/occupational therapy, pain education, yoga, mindfulness-based stress reduction, massage, supervised exercise, and intensive interdisciplinary rehab (if available). Additionally, patients would receive all FDA-approved non-opioid medications such as Tylenol, NSAIDS, duloxetine, pregabalin, antidepressants, etc. Most of the public testimony focused on the tapering of individuals receiving long-term opioid therapy.

Wendy Sinclair

Sinclair read a letter from medical experts from Stanford University that had been sent to Gov. Brown that questioned the evidence basis for the tapering guidelines included in the Task Force proposal.

Eve Blackburn, Chronic pain patient and advocate

Ms. Blackburn read a letter from the American Medical Association (AMA), including its Resolution 235 which opposes the Federal Drug Administration (ADA) prescription to over the counter drug, Paradigm. This letter expressed concerns with forced tapers. She also expressed concern with the inclusion of centralized pain syndrome—how does restrictions on opioids work when a patient has both centralized pain syndrome and another diagnosis that qualifies for opioid therapy? She also requested information on the number of patients whose opioid prescriptions would be affected by the proposed new guideline.

Amara (no last name provided)

Amara reviewed a study on opioids and depression and expressed concerns with the conclusions drawn by the Center for Evidence-based Policy (CEbP) regarding their evidence review on opioid tapering. She noted that no studies in the CEbP report were of high methodologic quality. She felt that the Task Force has been hearing misinformation of outcomes of tapering to below 120 MED, or to zero.

Jaqueline Conne

Ms. Conne testified that she felt tapering should be individualized. She was concerned that only certain diagnoses were stated as appropriate for opioids, which is not individualized. She expressed concern that reducing to <50 MED would be individualized between patient and provider. Most patients on opioids long term are on >50 MED, and lower doses are just not enough. She also expressed concern for false positive UDS results. Substance use disorder allows use of methadone, which is an opioid, which is confusing to her.

Caylee Crusta

Miss Crusta testified that she benefits from high-dose opioids. The guidelines do not consider very rare conditions. She was also concerned that centralized pain conditions are a subjective term and could be applied to almost any painful condition. Taking away opioids from any person with centralized pain condition is dangerous. She reviewed the Washington Medical Condition Guidelines for opioids. 90 MED is not effective for many patients. She requested data on the number of patients whose opioid prescriptions would be affected by the proposed changes. Patients won't know if they are going to be affected because you don't define centralized pain conditions. She felt that these policies will lead to loss of life.

Sue Griffin, chronic pain patient

Miss Griffin testified that she has been taken opioids on and off for 27 years. She feels constant threat that she will have a forced taper based on a guideline. Guidelines don't work in real life as discretionary; doctors are following them due to concern for repercussion.

Shanie Mason, Oregon Medical Association

Mrs. Mason read a letter from the OMA/AMA regarding concerns with the Task Force recommendations that focused on four areas:

1) Maintaining the integrity of the provider-patient relationship

2) Utilizing evidence-based practices in the development of tapering recommendations

3) Ensuring language supports any specified goals as a target to work towards, not a hard and fast metric

4) Ensuring that quantitative goals are measurable and not used by payers to increase the administrative burden on patients and providers.

Cherry Anabison, caregiver for family members with severe pain issues

Miss Anabison testified about her concerns that differences will be created between OHP coverage and private or Medicare coverage of chronic pain based on the proposed guideline. Oregon will be the only state in the country with such a punitive approach to opioids. Her brother had a forced taper in the VA, which she felt led to his suicide. She feels the Task Force is underestimating benefits of opioids. What happens when alternate therapies don't work?

Dr. Allan Chino, Psychologist and previous Oregon Pain Management Commission member

Dr. Chino testified regarding his work with chronic pain patients. In his experience, there is no problems with addiction to opioids for chronic pain. However, guidelines such as the Task Force's creates fear among patients and clinicians, which makes outcomes worse. There is a sociocultural movement going on causing fear in patients who are remembering when their pain was not adequately treated.

Genetics Advisory Panel

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

October 10, 2018

Ashley Allen, Regional Manager, Roche Diagnostics

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

Audience member

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

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

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

Medicaid Advisory Committee

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

October 24, 2018

Testimony for this meeting related to the Public Charge Proposed Rule, released by the Department of Homeland Security on September 22, 2018. The rule proposes to change how the Department of Human Services determines whether immigrants - when seeking admission to the United States, an extension of their stay, or adjustment of status to become a lawful permanent resident - are *"likely at any time to become a public charge"* (i.e., dependent on the government for financial support)

Greg Miller, Pacific Source CCO

Miller commented that there is already a chilling effect happening among immigrants. Patients are declining coming to appointments. There is a group tracking this process, if anyone is interested. It is Protecting Immigrant Families. OHA is also doing data analysis and is a good resource.

Metrics and Scoring Committee

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

October 19, 2018

The committee received written public testimony related to the specifications for the screening, brief intervention, and referral to treatment measure (SBIRT drug and alcohol screening) from a primary care provider.

November 16, 2018

The committee heard oral public testimony from several CCOs noting concerns about changes to the Depression screening and follow-up measure specifications made by the measure steward.

December 14, 2018

The committee received public testimony as below:

- Pacific Source Community Solutions CCO gave testimony about concerns with the changes to the depression screening and follow-up measure specification changes from the measure steward; this was also raised by a provider.
- Eastern Oregon CCO provided testimony related to concerns about the effective contraceptive use measure.
- Georgetown University Center for Children and Families (Georgetown CCF) and the Marion and Polk County Early Learning Hub each wrote in support of the Health Aspects of Kindergarten Readiness Technical Workgroup proposal.

Health Aspects of Kindergarten Readiness Technical Workgroup

The Children's Institute, in collaboration with the Oregon Health Authority and with technical expertise from the Oregon Pediatric Improvement Partnership, convened the Health Aspects of Kindergarten Readiness Technical Workgroup in 2018. The purpose of this technical workgroup is to explore measures of the health sector's role in kindergarten readiness for potential use in the CCO Metric Quality Incentive Program.

December 14, 2018

The workgroup received written testimony from a provider regarding development of a measure on social emotional health.

Health Plan Quality Metrics Committee

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

care organizations (CCO). The HPQMC finalized the 2019 measures and it includes 51 measures and 20 developmental measures.

At the October, November, and December Health Plan Quality Metrics Committee meetings, the committee finalized its 2018-2019 workplan, continued work on prioritizing measure domains and gaps, and heard from stakeholders regarding recommendations for the 2020 aligned measure set. The final measure set will be voted on by committee in March 2019 and published in April 2019. Stakeholders providing recommendations include the: Health Aspects of Kindergarten Readiness Technical Workgroup, Evidence-Based Obesity Metric Workgroup, and Integrated Behavioral Health Alliance. The Metrics and Scoring Committee provided its recommendations in January 2019.

IV. Progress toward demonstration goals

A. Improvement strategies

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

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

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

Certified Community Behavioral Health Clinics

The Oregon Health Authority (OHA) is currently participating in a two-year Certified Community Behavioral Health Clinic (CCBHC) demonstration program. Following a one-year planning grant (2015- 2016), the

CCBHC demonstration program was launched in Oregon on April 1, 2017 and will run through March 31, 2019. Oregon is one of eight states participating in the program, which emphasizes access to quality outpatient behavioral health services by meeting criteria grouped into six program areas:

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

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

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

For this demonstration period, Oregon continued to pay a daily rate to participating clinics, using the selected the Prospective Payment System (PPS) model. The rate for each CCBHC is unique to each organization and was developed based on analysis of cost reports submitted to OHA during the planning grant. Among the key milestones for this quarter:

Clinic-led metrics for Demo year 1 (April 2017- March 2018) validated & submitted to SAMHSA

Patient-Centered Primary Care Homes

Patient-Centered Primary Care Homes (PCPCH) program staff conducted 13 site visits to primary care clinics. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address identified barriers.

Seven additional clinics became PCPCHs this quarter, for a total of 654 PCPCH clinics in the state. This is approximately three-quarters of all primary care practices in Oregon. Fifty-four of those clinics have been designated as 5-STAR, the highest tier in the PCPCH model.

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

support to already recognized PCPCHs to increase their tier level. Thirteen clinics have signed up to participate in the learning collaborative series.

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

Tribal Care Coordination

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

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

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

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

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

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

Comprehensive Primary Care Plus

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

Oregon was selected as a CPC+ region and began implementation January 1, 2017. The Transformation Center manages the Medicaid fee-for-service implementation. Per-member, per-month care management fees are a key component of the CPC+ payment model. In 2018 OHA launched the second key component, a performance-based incentive payment that is paid based on practice performance on quality and utilization metrics. In 2018 each practice that submitted data received an average of $12,500.

The Oregon CPC+ payers continue to have monthly facilitated meetings to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers are moving forward with data aggregation through the existing HealthInsight Oregon Reporting Portal. CPC+ specific measures are being added to the portal and will be available to practices in early 2019.

Value-Based Payment Innovations and Technical Assistance

Over the past year, the Transformation Center worked with stakeholders and national value-based payment (VBP) experts to develop a VBP Roadmap for CCOs. The CCO VBP Roadmap is a required deliverable of Oregon's 1115 waiver and, beginning 2020, will include annual and five-year statewide VBP targets for CCOs and their contracted providers.

The CCO VBP Roadmap was approved by the Oregon Health Policy Board (OHPB) in October 2018, and it is the foundation for the CCO 2.0 VBP policies. The final CCO VBP Roadmap will be released in early 2019, along with the VBP categorization guidance. These will be valuable tools for communicating and educating CCOs on upcoming VBP requirements.

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

Behavioral Health Collaborative Implementation

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

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

The workgroups for the above areas of focus convened between October and December of 2018. They recommended system changes that OHA can implement to attain the BHC's overarching goal: creating a coordinated, seamless health care system that treats each individual as a whole person and not a collection of problems and diagnoses.

Roadmap to Oral Health

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

- Conducting needs assessment calls with Oregon's CCOs to determine what kind of technical assistance they require to support the work of increasing rates of adults with diabetes who receive an oral health evaluation to meet incentive metric goals.
- Disseminating a dental health awareness toolkit to Oregon's CCOs and others to emphasize the role oral health plays in overall health. The toolkit includes a brochure and poster in several languages, as well as key messages, sample tweets, and social media images to share.
- The Oregon Board of Dentistry placed HbA1c screening within the scope of dental practice. OHA will begin the process to incorporate this new practice into services that OHP members receive, starting by opening Medicaid billing.

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

Innovator Agents

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

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

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

CCOs are starting to develop their second Transformation Quality Strategy plans which replace the former CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables. Innovator agents

have assisted by participating in work groups, connecting CCOs with appropriate technical assistance and providing CCOs with feedback on their plans

Public Health Modernization

There are no public health modernization updates for Oct-Dec 2018.

Sustainable Relationships for Community Health program

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

Activities

To build leadership and staff capacity prior to receiving the SRCH grant funding, OHA developed and recruited participants from seven local public health organizations and one tribal health organization for the SRCH Leadership Institute, a 2-day convening for local public health, tribal health and behavioral health to build relationships, identify project and policy opportunities, and build core capacities for health systems transformation. SRCH Leadership Institute 1.1 convened in October 2018 where participants learned techniques and tools to drive large-scale systems change and enhance and sustain community health partnerships. Participants identified stakeholders to support systems change, learned strategies for strengthening and sustaining relationships, developed value propositions and a 90-day action plan including the identification of a strategic health system partners to invite to the second convening (e.g. Coordinated Care Organizations).

Progress and findings

All cohort 1 participants have identified a strategic health system partner that will be joining them in Convening 1.2 that will occur in February 2019. Invited partners are all leadership from decision-making organizations (e.g., local coordinated care organizations, clinics, and community-based organizations). During Convening 1.2, the teams will co-design sustainable systems changes that improve health outcomes, promote equity and contain costs. This work includes co-developing a shared goal, measurable outcomes and specific actions with partners. OHA-PHD staff have recruited participants from six local public health organizations for the second SRCH Leadership Institute cohort with the first convening in January 2019, and the second convening in March 2019.

Trends, Successes or Issues

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

Within the two SRCH Leadership Institute cohorts, 13 local public health organizations and 1 tribal health partner will have participated. The OHA Public Health Division plans to release the 2019-2020 Request for Grant Funding, for another cohort, in Spring 2019; with priority given to consortia who have participated in the SRCH Leadership Institutes.

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

Health-related services

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

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

Transformation Center activities

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

Oral health integration

One CCO completed an oral health integration project with a consultant through the Transformation Center and continues to contract independently with the consultant to deepen its oral health integration work. The center is working with the CCO to develop a webinar to help spread lessons learned to other CCOs.

The center continued to support oral health integration by developing and releasing an additional FAQ and a social network campaign to educate members, providers and community organizations about OHP oral health benefits.

Population Health

Community Advisory Councils

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

- A CAC event will be held in spring 2019.
- Monthly calls with CAC leaders focused on CAC member recruitment and engagement, health equity, and CAC organizational development.

Community Health Assessment and Community Health Improvement Plans

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

CCO incentive metrics technical assistance

Childhood immunization rates

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

Controlling high blood pressure

The Transformation Center contracted with a local Million Hearts® champion to develop a webinar on CCO- and system-level support for implementing best practices for increasing rates of controlled blood pressure. Thirty-two people participated from 14 CCO regions, with all evaluation respondents indicating they planned to implement best practices because of the webinar. The center provided follow-up TA calls to participating CCOs.

The center also contracted with Oregon Health and Science University to build quality improvement (QI) capacity among small- and medium-sized clinics using high blood pressure metric as a focus area. The work in 2018 focused on recruiting clinics and developing the curriculum. The 30 participating clinics will meet regionally for a full-day training in QI techniques and best practices for high blood pressure control, and they will receive five hours of follow-up TA from practice facilitators to work on their improvement projects.

Developmental screening and follow-up

A contractor developed and facilitated four webinars with accompanying tip sheets, guides and supplementary materials. Two webinars for CCOs focused on improving the referral and follow-up process for children with potential delays. Two webinars for primary care practices focused on follow-up to developmental screening and referring to and coordinating with Early Intervention.

Effective contraceptive use

The Latino Network completed TA on increasing effective contraceptive use for one CCO. The consultant trained community members and providers on culturally responsive strategies for engaging the Latino community in sexual and reproductive health. The Latino Network then held one webinar open to all CCOs to discuss learnings from the project. Thirteen people attended.

Emergency department use among members with mental illness

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

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

Tobacco Cessation

Tobacco cessation technical assistance activities this quarter included the following.

- A half-day CCO learning collaborative focused on best practices for reducing tobacco prevalence. Thirty-one CCO staff and partners attended, representing 12 CCOs. Content included data and partnership opportunities presented by OHA Health Promotion and Chronic Disease Prevention (HPCDP) staff, evidence-based clinical and community-based interventions, and CCO case studies.

- Areas CCOs plan to work on include clinical intervention training, improving the referral process to cessation counselors, leveraging OHA's media campaigns, communications to increase benefit awareness, and advocating for taxing initiatives.
- The center collaborated with OHA HPCDP staff to offer two in-person trainings that drew 71 participants (45 in Portland; 26 in Pendleton). The trainings supported implementation of Oregon's Freedom from Tobacco policy that requires residential mental health and addictions providers licensed by OHA to maintain residential properties that are free from tobacco use.
- The Center began offering a virtual community of practice for treating tobacco dependence in behavioral health settings, in January 2019.

Cross-cutting supports

CCOs Advancing Health Equity Workshop

The Transformation Center hosted a one-day peer-to-peer learning event to support CCOs' health equity work. Nearly 80 attendees — representing all 15 CCOs — joined the event. Over 90% of evaluation respondents said the opportunity was valuable or very valuable in supporting their work. Sessions included health equity strategic planning, using a national framework to engage CCO staff and board members on health equity, using data to advance health equity, language access for CCO members, utilizing community health workers, and cultural competency training for CCO staff.

Council of Clinical Innovators

The Transformation Center convened the Council of Clinical Innovators for a day-long learning event focused on addressing social determinants of health in health care settings. Participants included 30 alumni and their guests, and 100% of evaluation respondents rated the event as valuable or very valuable for supporting their work. The council includes alumni and faculty of the Clinical Innovation Fellows program.

Innovation Café: Strategies for Improving Children's Health

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

Transformation and Quality Strategy technical assistance

The Transformation Center managed the review and feedback process for CCOs' first Transformation and Quality Strategy (TQS) progress reports.

Qualitative database

The Transformation Center continued improvements to its innovations database, and in 2018 produced from the database a dozen reports — spanning maternal health to end-of-life care — to inform OHA policy.

Early childhood health coordination

Transformation Center staff shared key information with early learning stakeholders and hub leaders on CCO 2.0 recommendations. Staff helped finalize the Early Learning System strategic plan by providing updates, data points and clarification. Center staff also began coordinating partners around an Oregon oversample for the 2020 National Survey of Children's Health.

Patient-centered counseling training

The Transformation Center opened registration for 11 patient-centered counseling trainings for Medicaid providers around the state in spring 2019. Examples will draw from CCO metric-related topics. Evidence-based health communication models will include motivational interviewing, the FRAMES model and Five A's for tobacco cessation counseling. Continuing medical education credits will be available at no cost to participants.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

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

2. State reported enrollment table

Enrollment	October 2018	November 2018	December 2018
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	936,650	937,510	936,988
Title XXI funded State Plan	87,292	86,813	86,803
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, 2018	November 3, 2018	December 31, 2018

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	Percent change from previous quarter	Percent change from same quarter of previous year
Expansion	**Title 19**	PLM Children FPL > 170%	0	0	0.00%	0.00%
		Pregnant Women FPL > 170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL > 170	60,254	155,756	-22.70%	-48.63%
Optional	**Title 19**	PLM Women FPL 133-170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL < 170%	86,076	225,427	14.00%	41.78%
Mandatory	**Title 19**	Other OHP Plus	156,899	449,837	-0.30%	0.44%
		MAGI Adults/Children	734,528	2,053,137	1.02%	-1.03%
		MAGI Pregnant Women	11,729	27,556	-4.27%	-16.82%
		QUARTER TOTALS	**1,049,486**			

OHP eligible and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
October	969,970	851,327	890	44,260	3,663	510	32,732
November	972,026	848,186	650	44,242	3,661	505	32,825
December	971,635	843,109	631	44,168	3,641	507	32,828
Quarter average	971,210	847,541	724	44,223	3,655	507	32,795
		87.27%	0.07%	4.55%	0.38%	0.05%	3.38%

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

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

Reports are attached separately as Appendix D – Neutrality Reports.