KATE BROWN
Governor

July 20, 2016

The Honorable Sylvia Mathews Burwell
Secretary, U.S. Department of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington D.C. 20201

Dear Secretary Burwell,

The Centers for Medicare & Medicaid Services (CMS) granted Oregon its initial section 1115 demonstration waiver to implement the innovative Oregon Health Plan (OHP) more than two decades ago, phasing in coverage under the initial demonstration beginning in 1994. Since its establishment in 1994, the Oregon Health Plan has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth and saving the federal and state governments more than $29.7 billion over the life of the waiver.

In 2012, CMS approved Oregon's current section 1115 demonstration that began groundbreaking health system transformation through the coordinated care model. The combination of the new waiver and Oregon's expansion of Medicaid eligibility under the Affordable Care Act has led to remarkable results:

1. Oregon's transformation efforts allowed the state to stand up a new model of care before the Affordable Care Act expansion. Since then, the state has enrolled 436,000 (a 71 percent increase) newly eligible Medicaid enrollees into a new model of care. This model of care – the coordinated care model – is more financially sustainable and has already accrued significant savings to the federal government as it pays the greater portion of costs for the expansion;

2. Oregon's delivery system reform reaches over 1.1 million Oregonians, approximately 25 percent of Oregon's population;

3. With nearly 95 percent of Oregonians now enrolled in health care coverage, Oregon has one of the lowest uninsured rates in the nation; and

4. By 2017, the current demonstration will have saved the federal and state government over $1.7 billion ($1.4 billion to the federal government). The goal of the demonstration was to provide better care and improve health, while also lowering the rate of growth of per capita cost.

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WWW.GOVERNOR.OREGON.GOV

While Oregon has had many successes in transforming the health system, the current foundation requires continued improvement and sustained efforts to further improvements in population health, social determinants of health, and health care quality. In the waiver renewal, Oregon proposes targeted modifications to its current waiver to ensure integration of health care services, including physical, behavioral and oral health; continue to improve health outcomes by deepening the focus on improving social determinants of health and health equity, including for American Indians and Alaskan Natives; continuing to maintain a sustainable rate of growth of health care costs; and expanding the coordinated care model to provide high-quality, cost-effective, patient-centered health care.

The Oregon Health Authority and the Governor's Office have engaged leaders and stakeholders across the state, including Oregon's Tribal and urban Indian populations, consumers, health systems, providers, and other state agency partners, in the development of the renewal request. Tribal government and stakeholder engagement will continue to be a priority as the state moves forward with implementation of the various requests highlighted in the proposed 1115 demonstration renewal.

It is my pleasure to support the state's application for a section 1115 demonstration renewal. Oregon is committed to building on the health care policy advancements made in partnership with this Administration, and hopes to continue building upon health system transformation within the state. I hope that you will continue your support for Oregon's health system transformation and help the state meet its overall goals to improve patient experience, improve health and reduce costs. Please feel free to reach out to Jeremy Vandehey in my office with any questions.

Sincerely,

[redacted]

Governor Kate Brown

KB:jv

cc: Andy Slavitt, Acting Administrator, CMS
Vikki Wachino, Director of Medicaid and CHIP Services, CMS
Eliot Fishman, Director, State Demonstrations, CMS
Susan Johnson, Director, HHS Region X
Lynne Saxton, Director, Oregon Health Authority
Lori Coyner, Medicaid Director, Oregon Health Authority
Jeremy Vandehey, Health Care Policy Adviser, Office of the Governor

Health Policy and Analytics Division
Medicaid Policy

Kate Brown, Governor

Oregon Health Authority

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July 27, 2016

Ms. Victoria Wachino
Centers for Medicare and Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Wachino,

The Oregon Health Authority is pleased to request a renewal of the Oregon Health Plan (OHP) 1115 Demonstration under Section 1115(a) of the Social Security Act for a five-year period from July 1, 2017 through June 30, 2022. The state has conducted this highly successful demonstration since February 1994. For 22 years, the OHP has been a major asset to the state in its efforts to address the health care needs of vulnerable Oregonians and to advance an effective framework to provide high quality and accessible health care coverage. Oregon's current demonstration waiver, approved in 2012, has helped transform the delivery system to one of coordinated care, with 16 coordinated care organizations (CCOs) now delivering the vast majority of physical, oral and behavioral health services to OHP members. Today, approximately 90 percent of OHP members are enrolled in a CCO.

Oregon was among the first wave of states to expand Medicaid eligibility under the Affordable Care Act. Since the 2014 expansion, the impact of the state's delivery system reform now reaches over 1.1 million Oregonians, or approximately 25 percent of Oregon's population. Additionally, Oregon has one of the lowest percentages of uninsured residents, with nearly 95 percent of Oregonians having health care coverage.

The state believes that the current 1115 demonstration and the collaborative effort to reshape the health delivery system has led to important gains and laid the groundwork for the next level of reform. Oregon has met its commitment to reduce the rate of growth in per member per month (PMPM) spending and calendar year 2015 data from Oregon's robust quality measurement program show significant quality improvements. Highlights include:

1. **Decreased emergency department visits.** Emergency department visits by CCO enrollees have decreased by 39 percent since 2011.

2. **Decreased hospital readmissions**: The percent of adults who had a hospital stay and were readmitted for any reason within 30 days has improved by 33 percent since 2011.

Fifteen of 16 CCOs have met or exceeded the benchmark. This measure is also shared with the Hospital Transformation Performance Program.

3. **Decreased hospital admissions for short-term complications from diabetes:** Hospital admissions for short-term complications from diabetes decreased 29 percent since 2011. Admissions for COPD, congestive heart failure, and asthma have all also decreased from 2011 baseline.

4. **Increased access to primary care for children and adolescents**: The percent of children and adolescents who had a visit with their primary care provider in the past year has increased from 2014. This may be due to the increased focus on improving childhood immunizations and developmental screenings. Adolescent well-care visits have also increased 38 percent since 2011.

5. **Patient-centered primary care home enrollment continues to increase:** Coordinated care organizations continue to increase the proportion of members enrolled in patient-centered primary care homes. PCPCH enrollment has increased 69 percent since 2012.

6. **Increased member satisfaction:** The percent of CCO members who report they received needed information or help and thought they were treated with courtesy and respect by customer service staff has increased almost 10 percent since 2011 baseline.

These improvements translate directly to better health for Medicaid enrollees and savings for Oregon and the federal government. As more people are covered through plans adopting the coordinated care model, the benefits spread across the state and create critical momentum for Oregon and CMS to achieve mutual reform goals. More and more Oregonians – beyond the Oregon Health Plan – are receiving care through this transformed system.

Oregon is committed to building on the gains it has made in partnership with this Administration, and to renewing this demonstration so Oregon can take health system transformation to the next level through targeted modifications to the current waiver. Oregon will continue its coordinated care model and using CCOs, which were developed during the current demonstration period. We have learned a great deal post-implementation and have identified several areas, through our current evaluation and CCO and stakeholder engagement, which necessitate additional focus and concentrated efforts over the next several years to continue to move health system transformation forward. While the major components of Oregon's health system transformation will remain in place, Oregon will expand and refine in key areas, such as the integration of behavioral health, and deepen its focus on improving social determinants of health – all while continuing to maintain a sustainable rate of growth of health care costs. With this waiver renewal, Oregon seeks to build on our success with the coordinated care model to meet the following key goals during the next five years:

1. Build on Oregon's Medicaid delivery system transformation with a stronger, expanded 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. Deepen the state's focus on addressing the social determinants of health and improving health equity across all low-income, vulnerable Oregonians to improve population health outcomes;

3. Commit to ongoing sustainable rate of growth that includes the 2 percent test, putting the federal investment at risk for not meeting targets and adopting a payment methodology and contracting protocol for CCOs that promotes increased investments on 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.

With this renewal, Oregon will request that most of the state's existing 1115 demonstration authorities remain in place. These authorities have allowed the state the flexibility to improve Oregon's delivery system under the current waiver renewal. An extension of existing authorities will allow the state to continue to deliver a significant portion of the coordinated care system services that emphasize prevention and patient-centered care.

The State of Oregon looks forward to your support and to working with you to renew the demonstration that will further the goals of health system transformation and Oregon's goal for better health, better care, and lower costs for Oregonians. Thank you for your consideration of proposed 1115 demonstration renewal and amendment request. If you have any questions or would like further information, please do not hesitate to contact me.

Sincerely,

[redacted]

Lori Coyner, MA
Medicaid Director

cc: Andy Slavitt, Acting Administrator, CMS
Vikki Wachino, Director of Medicaid and CHIP Services, CMS
Eliot Fishman, Director, State Demonstrations, CMS
Susan Johnson, Director, HHS Region X
Lynne Saxton, Director, Oregon Health Authority
Jeremy Vandehey, Health Care Policy Adviser, Office of the Governor

Application for Renewal and Amendment

Oregon Health Plan
1115 Demonstration Project

Medicaid and Children's Health Insurance Program

Submitted: August 12, 2016

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I. Program Description

The Centers for Medicare & Medicaid Services (CMS) granted Oregon its initial section 1115 demonstration waiver to implement the innovative Oregon Health Plan (OHP) more than two decades ago, phasing in coverage under the initial demonstration beginning in 1994. CMS approved Oregon's current section 1115 demonstration in 2012 that began groundbreaking health system transformation in Oregon through the coordinated care model.

This application outlines proposed modifications to Oregon's existing demonstration under Section 1115(a) of the Social Security Act. As currently implemented, the demonstration renewal will continue to operate statewide and will cover the 1.1 million Oregonians currently receiving benefits through the OHP. The state seeks to renew this demonstration for the period from July 1, 2017 through June 30, 2022 so Oregon can take health system transformation to the next level through targeted modifications to Medicaid and CHIP programs under the current waiver. These modifications will allow the state to meet its overall goals that are aligned with the triple aim to improve patient experience, improve health, and reduce costs.

Since its establishment in 1994, the OHP demonstration waiver has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth and saving the federal and state governments more than $29.7 billion over the life of the waiver. Oregon's current demonstration waiver, approved in 2012, has helped transform the delivery system to one of coordinated care, with 16 coordinated care organizations (CCOs) now delivering the vast majority of physical, oral and behavioral health services to OHP members. Today, approximately 90 percent of OHP members are enrolled in a CCO. The combination of the new waiver and Oregon's expansion of Medicaid eligibility under the Affordable Care Act has led to remarkable results:

1. Oregon's transformation efforts allowed the state to stand up a new model of care before the Affordable Care Act expansion. Since then, the state has enrolled 436,000 (a 71 percent increase) newly eligible Medicaid enrollees into a new model of care. This model of care – the coordinated care model – is more financially sustainable and has already accrued significant savings to the federal government as it pays the greater portion of costs for the expansion

2. Oregon's delivery system reform reaches over 1.1 million Oregonians, approximately 25 percent of Oregon's population;

3. With nearly 95 percent of Oregonians now enrolled in health care coverage, Oregon has one of the lowest uninsured rates in the nation; and

4. By 2017, the current demonstration will have saved the federal and state government over $1.7 billion ($1.4 billion to the federal government). The goal of the demonstration

was to provide better care and improve health, while also lowering the rate of growth of per capita cost.

Oregon is committed to building on the gains it has made in partnership with this Administration, and to renewing this demonstration so Oregon can take health system reform to the next level through targeted modifications to the current waiver. Oregon will continue its coordinated care model and using CCOs, which were developed during the current demonstration period. While the major components of Oregon's health system transformation will remain in place, Oregon will expand and refine in key areas, such as the integration of behavioral health, and deepen its focus on improving social determinants of health – all while continuing to maintain a sustainable rate of growth of health care costs. Oregon will build on the lessons learned and take transformation to the next level.

The Next Level of Reform

The intense, collaborative effort to reshape the health delivery system in Oregon over the last five years has led to important gains and laid the groundwork for the next level of reform. We have learned a great deal post-implementation and have identified several areas, through our current evaluation and CCO engagement, which necessitate additional focus and concentrated efforts over the next several years to continue to move health system transformation forward. With this waiver renewal and amendment, Oregon seeks to build on our success with the coordinated care model to meet the following key goals during the next five years (2017-2022):

1. Build on Oregon's Medicaid delivery system transformation with a stronger, expanded 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. Deepen the state's focus on addressing the social determinants of health and improving health equity across all low-income, vulnerable Oregonians to improve population health outcomes;

3. Commit to ongoing sustainable rate of growth that includes the 2 percent test, putting the federal investment at risk for not meeting that target and adopting a payment methodology and contracting protocol for CCOs that promotes increased investments on health-related services and advances the use of value-based payments;

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.

We anticipate employing the following strategies to achieve these key goals; not all require a waiver amendment.

Build on transformation, including integration

1. Expand the behavioral health services integration through partnerships with counties, Tribes, corrections, primary care providers and other community-based programs.

2. Continue to reward CCOs for providing high quality care and access to services through the quality pool, but move towards more outcome-based performance metrics.

3. Continue investing in the Hospital Transformation Performance Program, which furthers transformation goals, ensures sustainable funding, and aligns care coordination across the delivery system.

4. Refine and advance the coordinated care model through a robust measurement program, expanded Patient-Centered Primary Care Home program and an expanded Health Information Technology infrastructure and Transformation Center.

Address social determinants of health and health equity

1. Through an enhanced rate setting methodology and new contracting strategies, promote CCO and provider use of health-related services, including flexible services and community benefit initiatives aimed at addressing the social determinants of health.[1]

2. In partnership with CCOs and regional entities, fund homelessness prevention, care coordination, and supportive housing for targeted populations.

3. Ensure access to health care services, and improve health outcomes for American Indians and Alaska Natives.

4. Expand the use of traditional health care workers within the delivery system.

Commit to sustainable rate of growth

1. In addition to enhancing the CCO rate-setting methodology, in order to promote greater use of health-related services and investments in social determinants of health, promote greater adoption of value-based payment arrangements between CCOs and their network providers and encourage reinvestment into community health. Oregon seeks approval of the proposals discussed in the health-related services concept paper (see Appendix D) by December 2016.

[1] Flexible services, specifically authorized through the waiver, are cost-effective services offered instead of or as an adjunct to covered benefits (e.g., home modifications and healthy cooking classes). Community benefit initiatives are community-level—as opposed to member-specific—interventions, such as investments in provider capacity and care management capabilities. Both flexible services and community benefit initiatives (collectively referred to as "health-related services") aim to address the social determinants of health.

Expand the coordinated care model

1. Increase the health care workforce in underserved areas and in behavioral health settings using evidenced-based, best practices for recruiting and retaining workforce.

2. Promote better coordination and improve health outcomes for Medicare and Medicaid dual-eligible members.

The Oregon Health Authority will test the following research hypotheses through the section 1115 demonstration:

- Further integration of physical, behavioral, and oral health care will result in reduced growth of encounter-based spending and improved quality of care, access to care, and health outcomes for OHP members.
- Increased focus on social determinants of health will result in improved population health outcomes as evidenced by a variety of health indicators.
- Automatic enrollment (opt-out model) into CCOs for members with Medicaid and Medicare eligibility (dual-eligibles) will result in improved quality and experience of care, access to care, health outcomes, and decreased spending when compared to the fee-for-service delivery system.
- A focus on health equity improvements for specific populations that have experienced disproportionately poor health outcomes will result in improved health outcomes, increased access to care, and a reduction in the gap between outcomes for populations of focus and those that have historically experienced favorable health outcomes.
- Expansion and increased use of health-related services will result in improved care delivery and member health and community-level health care quality improvements.
- Adoption and use of value-based payment arrangements will align CCOs and their providers with health system transformation objectives and lead to improvements in quality, outcomes, and lowered expenditures.
- A move towards more outcomes-based measures that are tied to incentive programs will improve quality of care, advance state and CCO priorities (e.g., behavioral health and oral health integration, health equity), increase regional collaboration, and improve coordination with other systems (e.g., hospitals, early learning hubs).
- Continued engagement of hospitals through the Hospital Transformation Performance Program will result in improved outcomes, quality of care, and increased care coordination with CCOs by Oregon's DRG hospitals.
- Emphasis on homelessness prevention, care coordination and supportive housing services for vulnerable and at-risk adults and families will result in reduction in avoidable hospitalizations and unnecessary medical utilization (e.g., lower emergency

department), transitions to more appropriate community-based settings, increased access to social services, reduction in overall Medicaid costs, and improved regional infrastructure and multi-sector collaboration.

These hypotheses collectively are focused on improving the triple aim of better health, better care and lower costs – the primary focus of the current demonstration. While we have made gains in the current demonstration, we plan to further the improvements in the triple aim over the next five years. To better assess the proposed demonstration period from 2017-2022, Oregon proposes to shift its evaluation effort from assessing transformation activities as a whole to assessing activities in specific focus areas of the waiver as outlined in the evaluation section of this document (see page 83).

Financing Support and Initiatives

Oregon will request targeted federal financial participation for a select number of key state programs to support continuation and refinement of the coordinated care model and allow the state to take health system transformation to the next level, and to provide a financial incentive for meeting the 2 percent test annually. The targeted programs identified for investment are vital to advancing health system transformation and improving social determinants of health, such as investing in a more robust behavioral health system for Oregon's most vulnerable residents. Currently, state funds support these services and programs to meet health-related needs that Medicaid, as it is currently structured, does not.

Historical Narrative and Key Accomplishments

Under the Section 1115 OHP demonstration, Oregon promotes the objectives of Titles XIX and XXI of the Social Security Act. The 1994 approval allowed the state to manage benefits and utilization using Oregon's unique Prioritized List of Health Services, which remains in use and has been an effective and efficient foundation of the Oregon Health Plan, as well as marking the beginning of using managed care plans to serve the major portion of OHP beneficiaries. After extensions in 1998 and 2002, the 2007 demonstration renewal allowed the state to broaden the population of children and adults served under OHP, and built the state's premium assistance program, the Family Health Insurance Assistance Program (FHIAP). In 2009, the renewal of the demonstration brought an important expansion in health care coverage for children in Oregon with the Healthy Kids programs; and in 2012, the transformation demonstration elevated the state's ability to integrate multiple aspects of care for beneficiaries and brought new approaches to value-based coverage for Oregon's delivery system.

During the current approval period of July 5, 2012 through June 30, 2017 the demonstration has been invaluable in helping build a firm foundation of quality and value-based care by transforming Oregon's health care delivery system to one of coordinated care, with 16 Coordinated Care Organizations (CCOs) – which geographically cover the entire state – now delivering the majority of physical, oral and behavioral health services to OHP members.

Oregon was among the first wave of states that expanded Medicaid eligibility under the Affordable Care Act. Since the 2014 expansion, the impact of the state's delivery system reform now reaches over 1.1 million Oregonians, or approximately 25 percent of Oregon's population. Additionally, Oregon has one of the lowest percentages of uninsured residents, with nearly 95 percent of Oregonians having health care coverage.

In the last five years, Oregon transformed its Medicaid system. A high level summary of key accomplishments:

1. Oregon passed bipartisan legislation in 2011 and 2012 to establish a new integrated and coordinated approach to deliver Medicaid health care services throughout Oregon.

2. Stood up 16 coordinated care organizations (CCOs), covering the entire state geographically.

3. Enrolled approximately 90 percent of all Medicaid enrollees into CCOs and this new model of care, including the vast majority of the 436,000 newly eligible Medicaid enrollees under the Affordable Care Act;

4. Integrated new services and budgets into the CCO model, including behavioral health, oral health, non-emergency medical transportation, addiction services, and children's wraparound services. These services were not part of the prior managed care model.

5. Bent the cost curve by staying within the 3.4 percent sustainable rate of growth which is 2 percent less than the President's 2012 budget projection of 5.4 percent.

6. Developed a successful, robust measurement and public reporting process to align incentive metrics; 5 percent of CCO budgets are now paid based on meeting incentive targets.

7. Established a vigorous evaluation of the demonstration and an ongoing learning environment among CCOs.

8. CCOs have developed governance structures that include major components of the health system and community partners. Community partnerships have been integral to addressing health improvement goals in individual communities.

Because of the success of the current demonstration in transforming the health system, Oregon is in a position to take health system transformation to the next level.

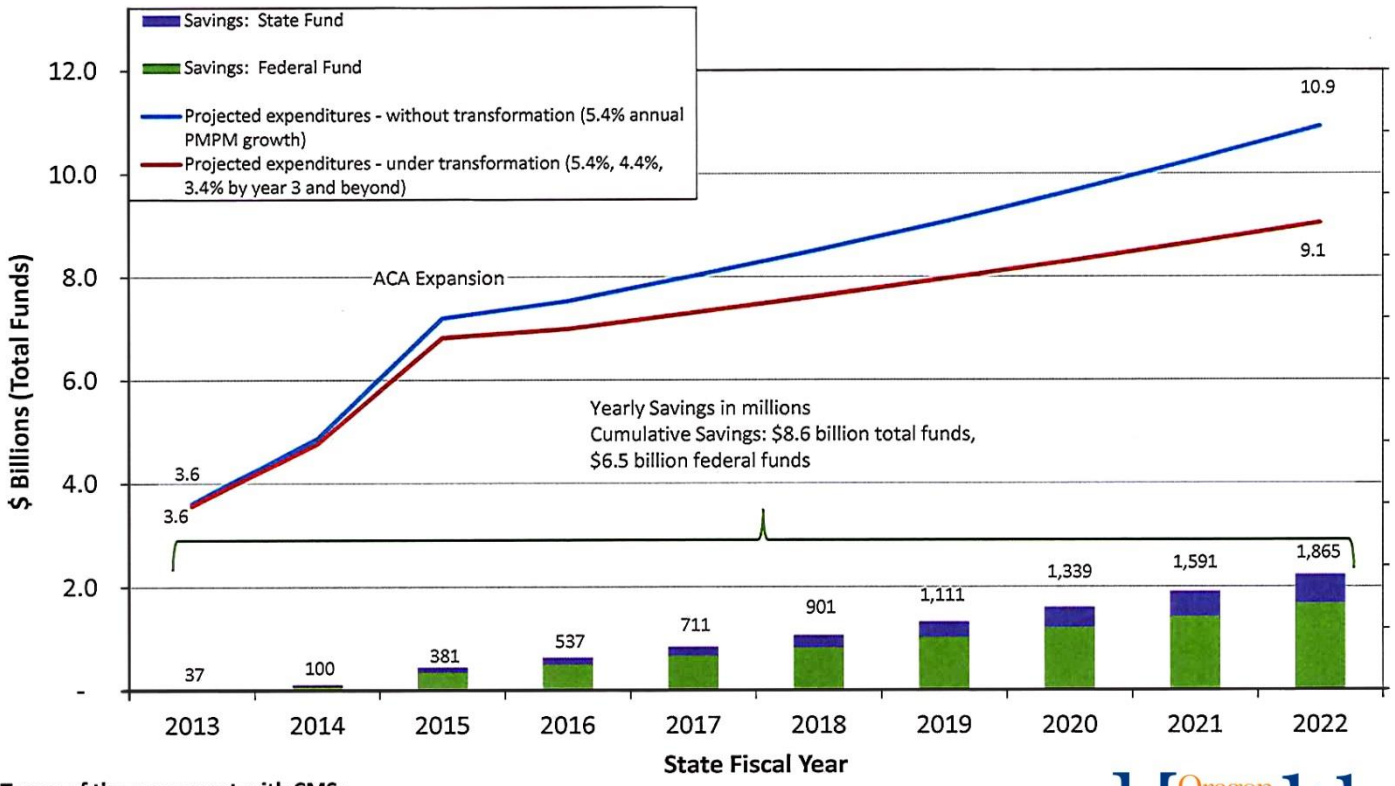
Significant Progress

This new health delivery model has led to better health, better care and lower per capita costs, saving the federal and state government over $1.7 billion ($1.4 billion to the federal government) by the end of the current waiver in 2017. By continuing the demonstration for another five years and staying within a 3.4 percent growth rate, as opposed to 5.4 percent without transformation,

the demonstration is projected to save the federal government $6.5 billion over the period from 2012-2022 (excluding high-cost prescription drugs). Health system transformation has kept costs below the national rate of growth for health care expenditures (see graph below).

Continuing Oregon's Demonstration Would Save the Federal Government $6.5 billion

In the 2012-2017 waiver agreement, the state committed to reduce the Oregon Health Plan's per capita medical expenditure trend by 2 percentage points over the final three years of the demonstration, while maintaining standards of access and quality. To date, the federal government has saved more than $500 million and is expected to save $1.4 billion by the end of the current waiver.



Terms of the agreement with CMS:
Without transformation baseline trend = 5.4% PMPM growth annually (President's Budget trend, OMB).
With transformation savings targets = PMPM expenditures increases cannot exceed 4.4% in the year 2 of the demonstration (July 2013 – June 2014) and 3.4 percent in year 3 (July 2014 – July 2015) and beyond.

Oregon Health Authority

Data as of 10/2015

Even while bending the cost curve, there have been significant improvements in quality, access and health outcomes according to data from Oregon's robust quality measurement program (for a full report of health system transformation in calendar year 2015, see www.oregon.gov/oha/Metrics/Pages/index.aspx). Highlights include:

1. **Decreased emergency department visits.** Emergency department visits by CCO enrollees have decreased by 39 percent since 2011.

2. **Decreased hospital readmissions**: The percent of adults who had a hospital stay and were readmitted for any reason within 30 days has improved by 33 percent since 2011.

Fifteen of 16 CCOs have met or exceeded the benchmark. This measure is also shared with the Hospital Transformation Performance Program.

3. **Decreased hospital admissions for short-term complications from diabetes:** decreased 29 percent since 2011. Admissions for COPD, congestive heart failure, and asthma have all also decreased from 2011 baseline.

4. **Increased access to primary care for children and adolescents**: The percent of children and adolescents who had a visit with their primary care provider in the past year has increased from 2014. This may be due to the increased focus on improving childhood immunizations and developmental screenings. Adolescent well-care visits have also increased 38 percent since 2011.

5. **Increased use of dental sealants:** The percent of children ages 6-14 who received a dental sealant on a permanent molar in the past year increased 65 percent since 2014.

6. **Increased use of effective contraceptives**: The percent of women ages 15-50 who are using an effective contraceptive increased almost 9 percent since 2014, even with the addition of thousands of new OHP members in 2014.

7. **Increased enrollment in patient-centered primary care homes:** Coordinated care organizations continue to increase the proportion of members enrolled in patient-centered primary care homes. PCPCH enrollment has increased 69 percent since 2012.

8. **Increased member satisfaction:** The percent of CCO members who report they received needed information or help and thought they were treated with courtesy and respect by customer service staff has increased almost 10 percent since 2011 baseline.

These improvements translate directly into better health for Medicaid enrollees and savings for Oregon and the federal government. With the approval of Oregon's Health System Transformation demonstration amendment, CMS required the state to reduce the Oregon Health Plan per capita expenditure growth rate by:

1. One-percentage point below the 5.4 percent (without HST) growth rate for DY 12 (7/1/2013-6/30/2014), and

2. Two-percentage points below the 5.4 percent (without HST) growth rate for DY 13, 14 and 15 (7/1/15-6/30/17).

Oregon reports quarterly to CMS on its progress in meeting the growth rate reduction requirement, using a growth reduction test template. The Oregon Health Plan quarterly reports demonstrate that the state has and continues to meet the requirement to reduce the per capita growth under the parameters of the test. Oregon projects it will meet the test requirements through the end of the current demonstration period, ending June 30, 2017.

In the current waiver period, OHA has engaged external evaluators to assess OHAs' and CCOs' activities aimed at transforming Oregon's Medicaid delivery system.

Mathematica evaluation: An evaluation conducted by Mathematica Policy Research in early 2015 assessed the extent to which OHA and CCOs supported and implemented activities to transform Medicaid, and provided insight into transformation areas where CCOs focused their efforts. The evaluation showed that OHA and CCOs made significant progress implementing transformation activities. CCOs were most transformed in the areas of physical health, mental health, and addiction services integration and care coordination, and less transformed in the areas of alternative payment methods (APMs), health information technology (HIT), and workforce transformation.

This report also evaluated access to care and quality of care in the 21 months following CCO implementation and whether that could be attributed to CCOs. The evaluator found few statistically significant changes associated with the introduction of CCOs, with significant changes concentrated in the area of improving primary care. The analysis included a limited timeframe and omitted the use of a comparison group. The report can be found here: www.oregon.gov/oha/OHPB/Documents/Final%20Report%20for%20the%20Midpoint%20Evaluation%20%204-30-2015.pdf

OHSU evaluation: An evaluation conducted by OHSU Center for Health Systems Effectiveness, began in spring 2016. It will assess trends in spending, quality, access, member experience, and health status to determine the impact of the Medicaid waiver. The evaluation will describe transformation activities on which OHA and CCOs focused and did not focus, synthesizing information from existing evaluations, and provide specific and actionable recommendations for continuing health system transformation. The evaluation will be completed in early 2018.

State Innovation Model (SIM) Grant evaluation: An evaluation to assess the spread of the coordinated care model among health care payers and providers is being conducted by OHSU Center for Health Systems Effectiveness. Final results will be available at the end of September 2016.

Consistent with findings from the midpoint evaluation, surveys conducted by Providence Center for Outcomes Research and Education (CORE) as part of the SIM evaluation showed that CCOs and other payers initially focused intensively on integration and care coordination. They were less focused on areas of alternate payment methodology, health information technology, and the health care workforce. Providers initially focused on prevention and social determinants of health, as well as informed care, workforce transformation, and integration and care coordination. Providers were less focused on data for population health management.

CORE also conducted a document review of CCO transformation plans and other narrative descriptions of activities to better understand where transformation efforts are focused. Findings include that transformation efforts are numerous, with CCOs reporting more than 2,600 distinct

transformation activities, and that most CCOs are meeting milestones (incremental short-term steps), although CCOs struggle the most in the areas of meeting members' culturally diverse needs and eliminating health disparities.

State Health Access Reform Evaluation (SHARE): This national evaluation project supported by the Robert Wood Johnson Foundation looked at the impact of CCOs on health care access and quality, as well as patient engagement, health behaviors, and health outcomes over time. It also looked at utilization patterns and costs over time, and documented mechanisms of transformation, assessing CCOs' defining characteristics, similarities, and differences. The evaluation found that CCO members had better access to care over time, relative both to those who were in Medicaid and not in a CCO, and those who were uninsured. It also found that CCOs were associated with more frequent primary care use, better connections to personal care providers, and better improvements in self-reported health. Results were published in fall 2015.

Patient-Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency: This evaluation, conducted by Portland State University, assessed implementation of the PCPCH model and analyzed the effect of PCPCH recognition on health care utilization and spending. Evaluators found that PCPCH recognition increased preventive care procedures and decreased specialty care visits, pharmacy claims, and spending on primary care and specialty office visits. The report was published in August 2014 and can be found here: www.oregon.gov/oha/pcpch/Documents/2014%20PCPCH%20Cost%20and%20Efficiency%20Evaluation.pdf

In addition to the evaluations noted above, John McConnell PhD, Director of OHSU Center for Health Systems Effectiveness has published a number of journal articles on CCOs and transformation, including:

- Oregon's Medicaid Transformation: Observations on Organizational Structure and Strategy. The article can be found at www.researchgate.net/publication/269223984_Oregon%27s.
- Oregon's Medicaid Transformation: An Innovative Approach to Holding a Health System Accountable for Spending Growth. The article can be found at www.researchgate.net/publication/262880822_Oregon%27s.
- Oregon's Medicaid Coordinated Care Organizations. The article can be found at http://jama.jamanetwork.com/article.aspx?articleID=2490523.

These evaluations have shown early results that point to the effectiveness of Oregon's health system transformation and point to the need to continue the model to demonstrate more substantial results.

As more people are covered through plans adopting the coordinated care model, the benefits spread across the state and create critical momentum for Oregon and CMS to achieve mutual reform goals. More and more Oregonians – beyond the Oregon Health Plan — are receiving

care through this transformed system. Today, about 94 percent of Oregon's providers serve OHP members at their primary practice site. When these providers transform their model of care, the changes reach not only OHP members, but also patients across a provider's practice. Along with increased provider and community accountability, payment reform including alternative payment methodologies that promote quality, improvements to the state's health care workforce and the use of flexible services and Traditional Health Workers (THW), these enhancements translate directly into better health for Medicaid enrollees and savings for CMS.

Oregon's demonstration is unique in its longstanding use of a prioritized list of health care conditions and treatments that enables the state to focus resources on prevention and use of the prioritized list as a method to control health care costs and assure accountability. It is envisioned that under this waiver modification, the prioritized list would continue to be used.

Under this demonstration renewal, Oregon intends to further spread the coordinated care model, the basis of health system transformation, to additional Medicare and Medicaid dual-eligible beneficiaries. Key components of the coordinated care model have been included in the contracts for the Public Employees Benefit Board (PEBB) (which provides coverage for state employees and universities) and will be expanded further in 2016-2017 contracts for the Oregon Educators Benefit Board (OEBB) (which provides coverage for K-12 school and community college employees), touching an additional 267,000 total lives. As the delivery of care is increasingly based on the tenets of the coordinated care model, the benefits of health system transformation spread across the state and create critical momentum for Oregon and CMS to achieve mutual reform goals.

The impact of Oregon's efforts to transform Medicaid is also driving transformation efforts in other markets and has become a core component of the Oregon health care story. Last year, the Oregon Legislature passed bipartisan legislation for a public process to develop and align metrics across all state programs. Supported by the Comprehensive Primary Care Initiative, multi-payer collaboratives have developed to support Patient Centered Primary Care Homes. A legislatively created work group and process will determine how to better integrate Emergency Medical System providers into transformation efforts and support their work to reduce emergency room visits.

Oregon has achieved these improvements without reducing eligibility or benefits. Instead, the state has employed a number of care coordination, payment and quality strategies that have proved highly successful in driving savings and quality improvement.

Health System Transformation 2.0

While Oregon has had many successes in transforming the health system, the work is not done. There have been lessons learned that indicate where the state needs to concentrate its efforts for the next several years. Though there is evidence of improvements in quality and health outcomes, measured improvements in population health, social determinants of health, and health care quality can take several years and require sustained effort.[2,3] CCOs have started to integrate behavioral, physical and oral health, but it will take additional time, effort, and coordination among various entities (e.g., providers, corrections, counties, other agencies) to fully integrate health services. Addressing social determinants of health requires the deployment of various strategies, including the use of health-related services, payment enhancements (i.e., enhanced rate setting methodology) and contracting strategies. Oregon will continue to spread its coordinated care model that was developed during the current demonstration period, and will further integrate physical, behavioral, and oral health services and improve social determinants of health, while continuing to maintain a sustainable rate of growth of health care costs.

Through this renewal and amendment, Oregon, with a shared commitment from the federal government, seeks to build on our success for another five years with the coordinated care model to meet the following key goals:

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

2. Improve the social determinants of health and health equity across all low-income, vulnerable Oregonians with the goal of improving population health outcomes;

3. Commit to ongoing sustainable rate of growth that includes the 2 percent test with penalties and an integrated global budget that promotes increased spending on health related services and advances the use of value-based payments; and

4. Establish supportive partnerships with CMS to 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.

[2] McConnell K. Oregon's Medicaid Coordinated Care Organizations. JAMA. 2016;315(9):869-870. doi:10.1001/jama.2016.0206.
[3] Oregon Health Authority. Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update. OHA: January 2016. Accessed at: www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf

1. Build on transformation of Oregon's Medicaid delivery system

Expand behavioral health services integration through partnerships

Advancing behavioral health integration through existing initiatives, projects, and committees

A key component of the CCO model is the integration of behavioral, physical and oral health. Oregon has several initiatives, projects, and committees focused on advancing behavioral and physical health care services and supports.

The Oregon Health Policy Board's Healthcare Workforce Committee has a subcommittee focused on behavioral health integration. The group has identified three deliverables to be completed by early 2017 to further integration efforts:

1. Identification of activities and processes necessary to achieve a foundational level of behavioral health integration emphasizing best practices that are scalable;
2. Address gaps in education and curriculum needed to train physical health and behavioral health providers to work in a team-based system; and
3. Develop policy changes to overcome barriers to behavioral and physical health integration faced by providers.

In 2015, the Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee reconvened and revised the PCPCH standards with a particular focus on physical and behavioral health integration. An additional task for that group was to recommend standards for Behavioral Health Homes (BHH). These are sites focused on the provision of behavioral health services; primary care is integrated into those sites.

A learning collaborative for these sites was established in May 2014. The ten clinics in this learning collaborative are working to integrate primary care into behavioral health focused clinics. The lessons learned from this group helped inform the standards development.

In 2015, Oregon was awarded a Certified Community Behavioral Health Clinics (CCBHC) Planning Grant and will use this opportunity to advance the development of these sites. Oregon has chosen to add nine behavioral health home standards to the federal standards for CCBHCs. To be certified as a CCBHC a clinic will also need to meet the behavioral health home standards.

The Transformation Center has been a valuable resource to advance behavioral health integration. Targeted technical assistance on behavioral and physical health integration is available to CCOs. Thirty hours of technical assistance are available to each CCO to achieve the integration standards established by the Patient-Centered Primary Care Standards Advisory Committee. The Transformation Center has also supported Oregon's Project ECHO initiative.

Project ECHO is a tele-mentoring program to connect specialty providers with rural and frontier areas that have limited access. The Transformation Center plans to support an organization to establish a statewide Project ECHO infrastructure with initial focus on adult and pediatric psychiatric medication management. In an effort to address payment models that support behavioral and physical health integration, the center recently released a Request for Proposals for carriers to plan and implement value-based payment arrangements that support behavioral and physical health integration.

Expanding access to psychiatric clinicians through telephonic consultation

One particular area of concern for behavioral health integration is limited access to prescribing psychiatric clinicians, especially child psychiatrists, in some parts of the state. Oregon funds a psychiatric telephonic consultation service for children and adolescents known as the Oregon Psychiatric Access Line for Kids (OPAL-K). The state provides $1.5 million in state general funds for this program. This program enables same day telephonic consultation between a pediatric clinician or primary care physician and a board certified child psychiatrist. The is a collaboration between OHSU's Division of Child and Adolescent Psychiatry, the Oregon Pediatric Society (OPS) and the Oregon Council of Child and Adolescent Psychiatry (OCCAP). There are over 900 providers registered for the program and OPAL-K is averaging eight calls a day. The program expands the availability of high-quality mental health treatment to Oregon youth via timely psychiatric consultation, medical practitioner education, and connections with mental health professionals throughout the state.

Oregon would like to expand the OPAL-K concept for adults. Oregon would use the existing partnership with OHSU to expand the population focus of the OPAL-K program to include adults. There is also a shortage of psychiatrists treating adults, especially psychiatrists with geriatric expertise. Oregon is interested in piloting a psychiatric telephonic consultation line for adults and older adults.

Further investments in telehealth and mobile health

The following proposal has been incorporated into the waiver renewal as a result of public comment. As Oregon expands its use of innovative health care service delivery and care coordination models, telehealth and mobile health applications are emerging as key components of a robust health care delivery system. Telehealth has successfully lowered barriers to accessing health services for rural and other underserved populations and can support increased capacity for behavioral health. Mobile health (e.g., smart phone applications) has been shown to encourage increased consumer engagement in personal health and wellness, and new technology standards (FHIR) are emerging to ensure electronic health information can be accessed by mobile health applications. In order to capitalize on the rapidly changing technology environment and prepare for advances and changes in the way consumers utilize technology to improve and maintain their health, Oregon will develop and implement pilots that explore innovations and expansion in telehealth and mobile health services. Pilots will focus on nimble

tools and applications to support providers and consumers. Results from the pilots would be shared and successful efforts may provide enough evidence to warrant sustainable funding from CCOs and other entities.

Promote a recovery-based model of care and strengthen substance use diversion services through a Substance Use Disorders amendment in 2017

In order to continue to build a recovery-oriented service system and seamless transitions in treatment and recovery, the state intends, in the future, to request CMS approval of a substance use disorder (SUD) amendment to the state's 1115 demonstration. Outcomes of this improved system will include expanded access; a focus on diversion and preventative services; diminished use of hospital Emergency Departments; and reduced recidivism in outpatient and residential treatment. The state has formed an SUD Advisory Council that will provide recommendations to increase housing, peer support and employment opportunities for people in recovery. The council will also provide guidance on how the State might best invest available resources to ensure accountability. This is intended to serve as the foundation of a comprehensive system that is bolstered by evidence-based benefit design and standards of care that comply with all state and federal requirements for provider performance, payments and quality.

Integration of adult mental health residential services into CCOs

The Oregon Health Authority has been working for several years towards full integration of adult mental health residential services into CCOs. Integration of these services is complex because of the diversity of the provider network delivering these services, complicated reimbursement structures with a combination of Medicaid funding and 100 percent state general fund payments, new federal Medicaid home and community based setting requirements, and a vulnerable population that relies on stable and consistent residential services. We have continued to make progress towards integration with the help of internal and external workgroups that have developed and modified strategies, but that progress has been slow. Most recently, we started an "early adopter" program that includes three CCOs that have partnered with OHA to perform prior authorizations and plan of care review approvals for the fee-for-service program. We have learned a lot about what is working on our integration strategy and where we still have work to do. We are currently making contract changes with our independent assessment provider and more closely connecting that assessment work with plan of care development and conflict free person-centered planning. Next we will be focusing on simplifying the reimbursement structure so that transition of services to CCOs can be as seamless as possible. We plan to continue this integration work throughout the current waiver period, and are proposing to continue this work during the next waiver period.

Refine and advance the coordinated care model through an expanded Patient-Centered Primary Care Home Program, Health Information Technology infrastructure, and the Transformation Center

Expanding the Patient-Centered Primary Care Home Program

As one of the original seven focus areas for transformation, Oregon's Patient-Centered Primary Care Home (PCPCH) program is integral to health system transformation.[4] Oregon intends to build on the success of the PCPCH program and continue using the model and its standards to improve primary care for the OHP population (Appendix A: Supports for Health System Transformation). More than 600 clinics have been recognized for their commitment to patient-centered care to-date, and approximately 90 percent of CCO members are enrolled in a PCPCH. Recognition through the Oregon PCPCH program shall meet the requirements of a Patient-Centered Medical Home (PCMH) recognition for federal programs and applications. Proof of the recognition decision may be obtained from the Oregon PCPCH program. Ongoing evaluations of the PCPCH model indicate it is improving patient access to and experience of care, as well as health outcomes. For evaluation reports, visit www.oregon.gov/oha/pcpch/Pages/reports-and-evaluations.aspx.

In 2015, the PCPCH Standards Advisory Committee reconvened to revise these standards and refine the current tier structure and measurement system. The proposed changes are designed to incrementally adapt the model to the changing health care needs of the state, align the model with evidence-based research and practices, and improve the effectiveness of the standards and measures. The Committee also developed recommendations for integration of primary physical health care into clinic settings predominantly offering behavioral health care services. These revised standards and recommendations will guide the future implementation of Oregon's PCPCH program. Additional details about the PCPCH program are provided in Appendix A: Supports for Health System Transformation.

Leveraging health information technology for health system transformation

The vision for Oregon is a transformed health system where health IT and health information exchange efforts ensure that the care all Oregonians receive is optimized by health IT. In a health IT-optimized health care system:

1. Providers have access to meaningful, timely, relevant, and actionable patient information at the point of care including information about the whole person, and information pertaining to relevant physical, behavioral, social and other needs.

[4] K. John McConnell. March 2016. Oregon's Medicaid Coordinated Care Organization. Portland: Center for Health System Effectiveness and Department of Emergency Medicine, Oregon Health and Sciences University.

2. Systems (health plans, CCOs, health systems, and providers) have the ability to effectively and efficiently use aggregated clinical data for quality improvement, population management and incentivizing value and outcomes. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.

3. Individuals, and their families, can access and engage with their clinical information and are able to use it as a tool to improve their health and engage with their providers.

Also in 2013, the Oregon Legislature approved $30 million in Health System Transformation Funds. The OHA Transformation Center awarded $27 million in Transformation Fund Grant Awards to help CCOs launch innovative projects aimed at improving integration and coordination of care for Medicaid patients. Specifically, the Legislature directed the funds to be used for projects that would create services targeting specific populations or disease conditions, enhance the CCO's primary care home capacity, and invest in information technology and electronic medical records. Almost all of the CCOs invested a portion of their grant funds in health IT initiatives, including electronic health records (EHRs), health information sharing and exchange, data aggregation tools for population health, metrics collection, and telemedicine.

All 16 CCOs agreed to support OHA's plan to use the remaining $3 million of state Transformation Funds to leverage and secure significant federal matching funds for investing in statewide health IT infrastructure. These funds are being used to support OHA's vision of a statewide approach for achieving health IT-optimized health care. OHA-supported health IT infrastructure will connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

In general, all 16 CCOs have made an investment in health IT (either through state Transformation Funds or otherwise) in order to facilitate healthcare transformation in their community. Nearly all CCOs are pursuing and/or implementing both health information exchange/care coordination tools as well as population management/data analytics tools. See Appendix A for more information about CCO and OHA investments in health IT.

Oregon hospitals and providers have leveraged significant federal funding to support their investments in technology as well. Through the CMS EHR Incentive Programs, eligible Oregon providers and hospitals can receive federal incentive payments to adopt, implement or upgrade and meaningfully use certified EHR technology. Since the inception of the programs in 2011, 6,846 Oregon providers and 61 hospitals have received a total of $394.2 million in federal incentive payments. ($265.6 million under the Medicare EHR Incentive Program and $128.6 million under the Medicaid EHR Incentive Program, as of October 31, 2015).

Beyond EHRs and CCO investments, Oregon has a multi-faceted HIT infrastructure, which includes:

- Statewide hospital event notifications, connecting data from all Oregon hospitals and Washington emergency departments – through the Emergency Department Information Exchange (EDIE) and an associated tool, PreManage, which provides real-time notifications to CCOs, health plans, primary care and other care teams.
- Statewide Direct secure messaging, which supports simple sharing of care plans and other protected information through a HIPAA-compliant, electronic, encrypted method commonly used by hospitals and associated with EHRs. OHA offers Direct secure messaging for those that face barriers to exchange through the CareAccord program.
- Regional and organizational health information exchange efforts – several regions and organizations in Oregon have invested in data sharing infrastructure (many of which support Direct secure messaging as one component).
- Statewide provider directory (coming in 2017) will provide a "white pages" of Oregon providers and any other entity participating in health information exchange such as a social service provider, leveraging the upcoming Oregon Common Credentialing Program data and other sources.
- Other efforts: telehealth, population management, quality metrics and care coordination tools, etc. Providers, hospitals, health plans, CCOs, and others have invested in a wide variety of tools to support care coordination, information sharing, and population management.

Oregon intends to leverage new federal funding to support Oregon's Medicaid providers, including behavioral health, long-term care, and other social services, to connect to health information exchange (HIE) entities, such as those listed above. In early 2016, CMS issued guidance about the availability of federal funding at the 90 percent matching rate for activities to promote HIE and encourage the adoption of EHR technology by Medicaid providers to enable eligible professionals to meet meaningful use requirements. Oregon intends to explore using these funds to increase Medicaid providers' capability to exchange health information by supporting the costs of an HIE entity (e.g., regional HIEs) to onboard providers, with or without an EHR. Oregon is considering requiring HIE entities to meet minimum criteria to be eligible for support. Criteria have not yet been determined but may include that the HIE entity uses standards-based or certified health IT; is interoperable and participates in statewide HIE connectivity (e.g., through Direct secure messaging); participates in Oregon's state-level provider directory (once it is available); reports to OHA's clinical quality metrics registry and public health registries as appropriate; and does not engage in practices that would result in health information blocking.

Continuing to spread the coordinated care model through the Transformation Center

Launched in 2013, the Oregon Health Authority Transformation Center serves as the state's hub for innovation, improvement and learning to support the triple aim across Oregon's health system. The Transformation Center helps good ideas travel faster through learning collaboratives, targeted technical assistance, and other methods for sharing best practices and innovations. The Transformation Center responds to challenges faced by CCOs, PEBB and OEBB as determined by performance metrics and evaluation outcomes, and advances the integration of population and behavioral health within the health system to improve health outcomes.

OHA intends for the Transformation Center to continue this role, providing more focused and targeted support to meet CCOs' evolving needs.

Learning Collaboratives

The Transformation Center has convened more than 80 sessions across six learning collaboratives to-date, which have proven successful with regard to both attendance and evaluations. More than 90 percent of participants in 2015 reported they found sessions valuable or very valuable. Oregon intends to continue convening learning collaboratives, honing in on CCOs' specific, technical needs as opposed to providing a broad platform for learning about a range of topics.

Learning collaboratives that will likely be continued will focus on specific CCO incentive metrics, effectiveness of Community Advisory Councils (CACs), and promoting health equity through enhanced language access or culturally competent workforce. Emerging topics may also result in future learning collaboratives, including behavioral health integration; value-based payments for specific populations and/or settings; oral health integration; child and family well-being initiatives, including nurse home visiting programs; and promotion of population health by expanding the use of health-related services (i.e., flexible services and community-benefit initiatives).

Clinical Innovation Fellows

The Transformation Center has facilitated two cohorts through the Clinical Innovation Fellows Program, which strives to build the capacity of health system transformation leadership within Oregon. All 28 participants reported that the program has been valuable to their growth as a leader, and identified mentoring, networking, and project management skill development as the most helpful aspects of the program. Project successes include fostering primary and behavioral health care integration, coordinating access to tele-dermatology through primary care providers, and improving care transitions. Future goals of this program will include involving clinical leaders who are increasingly diverse with respect to demographics, professional discipline, and affiliation with other payers beyond Medicaid, including Medicare and commercial payers.

Convening Stakeholders

The Transformation Center has convened multiple statewide events, including Coordinated Care Model Summits, Community Advisory Council Summits, Complex Care Collaborative meetings, an Innovation Café, and an Improvement Science in Action training. These events have been effective in spreading innovative ideas and practices. For example, the vast majority of survey respondents for the 2014 Coordinated Care Model Summit planned to implement at least one innovative practice they learned at the summit (88 percent) and follow up with colleagues and organizations they connected with at the summit (91 percent). Over the coming years, the Transformation Center plans to focus on convening smaller, more targeted events, such as continuing to support CCO Innovation Cafes, as the "world café" model – which has been well-received – promotes in-depth sharing and learning between CCOs on specific topics.

Technical Assistance

The Transformation Center offers CCOs and their Community Advisory Councils (CACs) the opportunity to receive technical assistance from external consultants through a Technical Assistance Bank. Requests have focused on community advisory council development, health equity, quality improvement and alternative payment methods. Evaluation results show that all CCOs rated the assistance as very valuable or valuable. In the future, this technical assistance will evolve from being solely driven by CCO requests to the development of specific technical assistance initiatives that are offered to the CCOs to help them achieve success in areas critical to health system transformation.

The Transformation Center works in collaboration with OHA's Innovator Agents to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities. Innovator Agents are assigned to CCOs to serve as an effective and immediate line of communication with OHA and help champion and share innovative ideas in support of transformation. Innovator Agents are critical in linking the needs of OHA, the community, and the CCO. They work closely with the community and the CCO to understand the health needs of the region and the strengths and needs of the CCO's health resources. Innovator Agents work closely with the CCOs and their individual communities to enhance CCO accountability for achieving the triple aim.

Innovator Agents' core functions and responsibilities include:

1. Serving as a point of contact between the CCOs and OHA, providing an effective and immediate line of communication and allowing streamlined reporting, reducing the duplication of requests and information, and identifying and facilitating resolution on CCO questions and issues with OHA.

2. Working with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. Attend Community Advisory Council meetings. Provide assistance for the development of the CCO's

Community Health Assessment. Provide resources, consultation and support in addressing local health disparities.

3. Working in collaboration with the Transformation Center to identify key technical assistance needs and develop strategies to effectively spread the rate of transformation throughout the state and to ensure that learning and improvement strategies are identified and implemented.

4. Informing and working in partnership with OHA leadership and staff regarding opportunities and obstacles related to system and process improvements and propose solutions, and track opportunities, recommendations, and results.

5. Assisting and supporting CCOs in developing and implementing their transformation plans.

6. Assisting CCOs in the implementation of innovative projects and pilots.

7. Supporting CCOs in developing strategies to support quality improvement and the adoption of innovations in care through facilitating collaboration and knowledge sharing across the state.

8. Participating in community meetings or other gatherings as required by, or are beneficial to, OHA and the CCO.

9. Assisting the CCO in managing and using information to accelerate innovation, quality and health system improvement.

10. Attaining and maintain knowledge about health system innovation in consultation with state and national leaders and models.

11. Actively participating in collaboration and projects related to population or member health that intersects with other agencies such as public health, seniors and people with disabilities, child welfare, community safety, housing, etc.

Move to more outcome-based metrics for measuring performance and quality incentives

Oregon's quality and measurement programs have been key levers in advancing the coordinated care model and supporting the triple aim. Since 2011, coordinated care organizations have made significant improvements across quality, access, and health measures. Additionally, initial statewide performance improvement projects (PIPs) have been successful in allowing CCOs to focus on integrating behavioral and physical health by developing foundational systems and tools that can be used for other quality improvement efforts. To foster innovation and improvement, PIPs are developed at the local and regional level for implementation. Best practices and lessons

learned across quality improvement efforts by CCOs are shared at the Quality and Health Outcomes Committee (QHOC) for the purpose of adoption, and/or peer learning.

Oregon intends to continue its journey toward a new integrated model of care by supporting and encouraging continuous learning and transformation, and setting clear expectations and incentives for improvement. Oregon will also carry on its commitment to robust measurement and evaluation, quality improvement efforts, and public transparency.

OHA will continue measuring quality of care and access to care for individuals enrolled in CCOs, and for the population as a whole. Oregon will maintain a modified quality and access test to ensure that OHP members are not being harmed as a result of Oregon's health system transformation and continued bending of the cost curve. To date, even with the increase in Medicaid members under the Affordable Care Act expansion, CCOs have demonstrated improvements in quality and access measures (for report of Health System Transformation, see: www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf). Updated parameters for the quality and access test are detailed in Appendix C: Measurement Strategy.

OHA will continue utilizing multiple measure sets for monitoring and accountability across domains of interest, which will likely also include an increased emphasis on measures of health outcomes, population health, and social determinants of health. The measurement strategy will evolve to further advance priorities such as behavioral health and oral health integration, CCO collaboration, and coordination with other systems such as early learning hubs and hospitals, health equity, and specific populations of interest, such as members with severe and persistent mental illness. Future measure sets are also expected to reflect increased state and national focus on measure alignment across programs and payers. Measure sets, potential measures, and plans for public reporting are detailed in Appendix C: Measurement Strategy.

Oregon will continue its incentive programs for both CCOs and hospitals, utilizing the pay for performance programs as levers to drive focus on quality improvement efforts across the health system. Both CCO and hospital incentive programs will continue for the length of the waiver, which will be guided by the legislatively appointed public committees to review program performance, select measures and set benchmarks on an annual basis. Additional details about the CCO and hospital incentive programs are provided in Appendix C: Measurement Strategy.

Oregon's measurement strategy will better support CCO quality efforts with the goal of improving OHP members' health and reducing administrative burden on the CCOs through aligned metrics, performance improvement projects, and other transformation activities. Additional measurement strategy details are provided in Appendix B: Quality Strategy.

The OHA intends to expand its quality strategy to continue to ensure that Oregon's Medicaid managed care system meets all federal requirements. The quality strategy will incorporate critical activities for health system transformation to move from innovation to application by:

- Ensuring members' voices are represented in quality processes and evaluations;
- Providing coaching to CCOs developing their individual quality programs for assessment, improvement, monitoring, and evaluation to safeguard members' rights, access, and quality; and
- Enhancing quality assurance monitoring through contracts, external quality review activities, and trainings.

Oregon also intends to improve coordination and alignment of quality activities across the state with other programs and state agencies, community partners, and external quality organizations. Increased coordination and alignment will support the triple aim while ensuring health system transformation resources are efficiently and adequately utilized and supported. Additional details are provided in Appendix B: Quality Strategy.

Invest to continue success and support for Hospital Transformation Performance Program that furthers goals of transformation, ensures sustainable funding, and aligns care coordination across the delivery system

Oregon's vision for achieving transformation and the triple aim means that all components of the delivery system must coordinate their efforts, including diagnostic-related group (DRG) hospitals. Oregon does not have public safety net hospitals, but rather all hospitals in the state serve Medicaid members. Therefore, the Hospital Transformation Performance Program (HTPP) provides a mechanism to engage hospitals in health system transformation where Medicaid members account for, on average roughly 25 percent of inpatient stays. Oregon envisions the program being fully integrated within the 1115 demonstration, to advance collaboration between hospitals and CCOs and help Oregon achieve the triple aim. Therefore, the OHA proposes continuing the program for additional years beyond Year 3 (2016).

Consistent with Oregon's focus on improving quality and outcomes across the delivery system, OHA uses the existing Hospital Assessment Program, which has been authorized in Oregon since 2004. Half of one percent of the Hospital Assessment Program (capped by CMS at $150 million per year) is used to fund the HTPP, which will continue to provide an important mechanism for OHA to hold DRG hospitals accountable for transforming and improving quality and coordinating care with CCOs in order to qualify for a portion of these dollars.

To date, the HTPP has led to increased engagement by hospitals and hospital systems in health system transformation.[5] While there have been some growing pains in the initial years of the

[5] See HTPP report for year 1: www.oregon.gov/oha/Metrics/Pages/Hospital-Reports.aspx.

program as measures were defined and new data systems and workflows were established, hospitals are investing resources and working to make improvements. Data from the program's second year indicate hospitals are on track to improve quality and patient-safety (for report see: www.oregon.gov/oha/Metrics/Documents/HTPP_Year_2_Report.pdf).

An initial evaluation of the HTPP demonstrates participating hospitals' performance over time in comparison to hospitals not in the program and highlights the successes, barriers, changes in practice, quality improvements and investments hospitals are making. Key informant interviews conducted early in the evaluation process have highlighted some of the significant changes and investments that hospitals are making under this program. A complete report of the findings will be made available at the end of August. A presentation reviewing key findings is available at http://www.oregon.gov/oha/analytics/HospitalMetricsDocs1/July%2012,%202016%20Presentation.pdf (starting on page 33).

For future years of the program (beginning Year 4, 2017), OHA is proposing shifting from measures being either hospital or hospital-CCO collaboration focused to measures which integrate collaboration between hospitals and CCOs throughout their communities. This shift would be facilitated by moving to a core and menu measure set approach, as well as modifying the payment methodology to include a challenge pool. These proposed changes are described in detail in Appendix C: Measurement Strategy.

2. Improve social determinants of health and health equity

Increase access to housing and housing supportive services

Care Coordination, Housing and Medicaid Integration: Oregon Context

Homelessness remains a complex public health challenge in Oregon. Oregon faces an unprecedented housing crisis – in 2015, Oregon's homeless population increased by 9 percent (from 2014), and on a single night there were 13,176 homeless individuals of which 3,991 were chronically homeless.[6] In Oregon's most populous region, Multnomah County, more than half of those counted as homeless in 2013 suffered from one or more serious physical, mental or substance use-related conditions. Limited services exist to address homelessness, and often available care coordination and supportive housing services contain gaps, lack coordination and education to ensure services are available and used.

Homeless individuals and families are at greater risk of poor health outcomes, including complications of chronic illness, substance use disorders, and behavioral health issues such as

[6] The U.S Department of Housing and Urban Development (2015). The 2015 Annual Homeless Assessment Report to Congress. Available from: https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf

post-traumatic-stress disorder.[7] Compared with other states, Oregon experienced the third highest percentage increase in the number of homeless individuals from 2014-2015, has the highest rate of unsheltered homeless people, and was the only state in which more than half of the homeless people in families with children were unsheltered (53 percent).[8] In addition to the unprecedented housing crisis in both rural and urban communities, Oregon's current health care system faces several challenges in caring for those at-risk of homelessness or experiencing homelessness. This is largely due to the fact that federal, state, and local programs that target homeless individuals and families, or those at risk of becoming homeless are often siloed. The diverse number of programs often have a targeted client base, and lack the critical care coordination infrastructure required to integrate availability of services across federal, state and local programs serving similar populations. For example, in Oregon, there is no vehicle through which Medicaid can pay for transitional services or supportive housing services for people who do not qualify under the state's Section 1915 waivers and state plan for eligibility and covered services.

Coinciding with Oregon's housing crisis was Oregon's Medicaid expansion. In the first two years (2014-15), 436,000 low-income adults became newly enrolled in the Oregon Health Plan (OHP) through the Affordable Care Act (ACA). Expansion dramatically altered the age and gender distribution of Medicaid members – adults now outnumber children on OHP and there are significantly more adult male members. With expansion, a significant number of Oregon's chronically homeless and individuals at-risk of homelessness are now eligible and enrolled in Medicaid. The opportunities in Oregon with respect to addressing the social determinants related to health and housing are:

- Oregon's successful health system transformation and 16 CCOs can be leveraged;
- Oregon's Legislature and local municipalities have invested millions in expanding affordable housing (2015 and 2016).
- An existing US Department of Justice agreement with Oregon and the Oregon State Hospital to improve community behavioral health treatment and programs is in place.

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status. To avoid unnecessary utilization of health care services and increases in total Medicaid costs, Oregon seeks to address social service needs of high-risk, high-need individuals by ensuring development of infrastructure, partnerships and resources to deliver care in appropriate

[7] Brickner, P., Scharer, L., Conanan, B., Savarese, M., Scanlan, B. (Eds). (1990). Under the Safety Net: The Health and Social Welfare of the Homeless in the United States.

[8] U.S. Department of Housing and Urban Development (November 2015). 2015 Annual Homeless Assessment Report (AHAR) to Congress. www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf

settings and provide supportive housing services.[9] To avoid unnecessary utilization of health care services and increases in total Medicaid costs, Oregon proposes creating Coordinated Health Partnerships (CHPs) to pilot the improvement of housing services and health service needs of homeless individuals or individuals at risk of homelessness.

1115 Waiver Demonstration: Oregon's Strategy

To promote population health and further address social determinants of health, Oregon proposes to create a five-year pilot program, referred to as the Coordinated Health Partnerships (CHP), for adults at risk of homelessness, including adults eligible for both Medicare and Medicaid programs (often referred to as dual eligibles), and families. Through the CHPs, at-risk populations would be offered a combination of housing, health care integration, care transitions and supportive services to improve health outcomes and reduce Medicaid costs. The CHPs interventions are designed to help communities across Oregon adopt a multi-faceted and multi-sectoral approach to simultaneously address issues around access to health and health care and those of the physical environment such as housing that affect behavioral and physical health outcomes among those served by Medicaid. The CHPs serve as an unprecedented opportunity to address policy, system, organizational and individual level changes through the development of new community-based partnerships that focus on transitions of care and stable, affordable housing. [10] The CHPs will also offer an effective set of strategies for improving health and health care for underserved individuals, communities and populations across Oregon. Because the CHPs have been designed as a pilot program, Oregon recognizes that the CHPs will be limited in their ability to address the broad array of social determinants that contribute to health inequities. Nonetheless, the program will provide Oregon an opportunity to develop, implement, and evaluate new and innovative interventions that will begin to address housing issues and care transitions from institutional settings to the community.

Oregon is proposing a multi-faceted, incremental approach to the state's integration of health care and supportive housing for the 2017-2022, 1115 demonstration renewal:

- Year 1: Convening and planning initiatives, regionally and statewide. Select proposals and create CHPs.
- Years 1-5: Statewide investment in infrastructure development and creation of CHPs
- Years 2-5: Pilot and test new models of housing supportive programs among CHPs
- Years 2-5: Transition from paying for process to paying for outcomes based on evidence-based practices

[9] Hwang, S., Tolomiczenko, G., Kouyoumdjian, F., Garner, R. (2005). Interventions to improve the health of the homeless. American Journal of Preventive Medicine. 29(4) 311-19.

[10] Brennan Ramirez LK, Baker EA, Metzler M. (2008). Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

- Years 3-5: Dissemination and spread of best practices

Coordinated Health Partnerships

Overview

Coordinated Health Partnerships (CHPs) pilot program will be a voluntary program funded throughout the five-year waiver renewal. The CHPs will test new models to increase collaboration and coordination among CCOs, local hospitals, community-based organizations, housing authorities, county government and public health agencies, affordable housing providers, corrections and behavioral health and substance use disorder (SUD) providers. The program will provide funding to local CHPs to increase integration of services and build infrastructure among the participating entities. CCOs will serve as lead entities for the CHPs. OHA is currently working with tribal governments to develop a CHP(s) for tribal members.

The CHP pilot program will develop and advance locally designed solutions through a menu of strategies implemented by the lead entities and partnering organizations (see pages 39-40). The CHP pilot program will achieve the following:

- Support care coordination among non-medical settings and promote transitions from institutional settings to less costly community-based care settings;
- Reduce inappropriate emergency, inpatient and residential treatment facility utilization;
- Increase access to and use of primary, behavioral and substance use disorder services;
- Increase coordination of housing supportive services for targeted at-risk populations; and
- Invest in health IT infrastructure among non-traditional providers to improve data collection and sharing among local entities to support ongoing case management, monitoring, and sustainability for CHP pilots.

CHP Target Population

Target populations will include but are not limited to high-risk, high needs individuals:

- With repeated incidents of avoidable emergency use or hospital admissions;
- With two or more chronic conditions;
- With mental health and/or substance use disorders;
- Who are eligible for Medicare and Medicaid;
- Who are currently experiencing homelessness; and/or
- Individuals who are at risk of homelessness, including those eligible for Medicare and Medicaid, and Indian Health Services (IHS), Tribal, and Urban Indian program constituents; and,

- Individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, Institutions of Mental Diseases (IMD), county jail).

CHPs will have the ability to define the populations they would like to target based on regional needs and the broad criteria for the population included in the proposal. CHPs may choose to limit the population served within their pilot application and OHA will work with CHPs to determine the number and focus of the target population. OHA anticipates that individuals who are not currently enrolled in CCOs but are served through fee-for-service will be eligible for the CHP pilot program. Oregon will ensure that services are not duplicated with other services currently offered through existing waiver and state plan authority.

Program Design and Key Components

The CHP program consists of three foundational elements, referred to as domains. Taken as a whole, the domains create a continuum of services available within a community to the defined target population. Each CHP pilot will be expected to provide services in all three domains (see CHP framework on pages 39-40).

- *Homelessness Prevention/Transitions of Care*: support to ensure care coordination among non-medical settings; fund services to support an individual's ability to move from institutional settings to less costly community-based care settings.
- *Housing Transition Services*: invest in pre-tenancy services to decrease health care costs and reduce use of high-cost health care services.
- *Tenancy Sustaining Services*: invest in services that support the individual in being a successful tenant in his/her housing arrangement.

In an effort to address the social determinations of health, the CHPs will have the flexibility to address interpersonal violence and trauma informed care under the homelessness prevention/ transitions of care domain. This is in recognition that there is a likelihood of trauma among individuals experiencing homelessness, as well as a causal relationship between domestic violence and rates of homelessness for women and families.[11]

[11] United States Interagency Council on Homeless (2015). See: www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf

To date, Oregon is proposing several other requirements that will apply to the entire program.

- Individuals eligible for Medicaid coverage in Oregon can opt out of services at any time; individuals will be provided with information about their enrollment options to make an informed choice.
- Each CHP will be required to develop its own payment methodology and strategies for financing of services and distribution of funds among its partners, within broad parameters that are consistent with the state's federal approvals for payment.
- Payments to CHPs will be based on meeting process measure targets in the first 3 years; by the fifth year, payments will be made based on outcomes of members.

Through the CHP pilot program and the proposed domains, Oregon's goal is to improve care transitions and coordination with a focus on ensuring effective care transitions from institutional to community-based settings, particularly among county correctional facilities, the Oregon State Hospital and acute care facilities. The lead entities of the CHPs will target pre-adjudicated incarcerated individuals in county correctional facilities and individuals in an institution for mental diseases since these populations often experience disruptions in care when entering institutions and often experience poor health and housing outcomes when exiting these settings. Pre-adjudicated individuals comprise 61 percent of the county jail population; two-thirds have mental illness and/or substance use disorders, with an average length of two-week stay for pretrial (<12 days).[12] In 2014, there were 179,332 bookings across Oregon's county jails.

For the justice-involved population, failure to ensure access to health care services upon release has a major impact on recidivism rates and the rising health care costs that Oregon's health system transformation aims to reduce. Based on feedback received during the public comment period, Oregon will also explore whether the pilot target population should include pre-adjudicated juveniles.

In Oregon, a person's hospitalization at the state hospital (IMD) continues to be an overall disruption to an individual's health care – individuals are dis-enrolled from Medicaid/CCO upon entry and the CCO is not involved in the individual's care from entry to discharge from the Oregon State Hospital (OSH). Oregon proposes to engage CCOs in the discharge planning process during the last 30 days of an individual's time at the Oregon State Hospital. Oregon would like to increase the ability of Oregon State Hospital members to successfully re-enter and remain in the community, which can be achieved by increasing care coordination services during the last 30 days prior to discharge. Timely and effective discharges and transitions into the community will increase available beds in the Oregon State Hospital and will minimize the burden on other parts of the adult mental health system – a recent problem is psychiatric boarding in emergency departments while individuals wait for an acute care bed. Oregon wants

[12] Association of Oregon Community Health Programs (2013). 2013 County Jail Survey (unpublished).

to avoid solutions to psychiatric boarding that require an increase in acute care beds and instead focus our efforts on providing effective transitions to community-based services.

The CHP networks will also require participation by local hospitals. Each CHP will be required to work with local hospitals to identify high-risk patients (i.e. homeless admitted for in-patient services) for needed medical, behavioral, and social services available through the CHPs. The goal is to incentivize the use of community-based care options and use of transitional housing to reduce avoidable hospital use and over-utilization of expensive, inpatient care in hospital settings. Short-term transitional housing of up to 60 days to receive health services coupled with care management services is intended to support longer-term rehabilitation, stabilization, and self-management for the program's target population.

Implementation Considerations

Oregon will develop and implement a robust accountability framework for the CHP pilots, including financial accountability, safeguards and performance metrics to demonstrate the impact of the pilot program in terms of health outcomes and overall cost-savings.

Leveraging the success of OHA's Transformation Center, the Transformation Center will convene the new partnerships to share learnings with each other. The Transformation Center will facilitate Learning Collaboratives to spread best practices across Oregon and promote use of flexible services to fund medically appropriate housing supportive services and services not funded through the CHP program.

The final design and implementation details will be based on extensive public input and involve robust collaboration among Indian Tribal leaders, CCOs, housing authorities, affordable housing providers, health care providers (including behavioral and substance use disorder providers), counties and local public health agencies, corrections and organizations serving Oregon's homeless population. OHA anticipates convening a CHP Advisory Committee. The committee will consist of a broad range of stakeholders and initially will be tasked with informing the final design of the program and the implementation work plan.

The committee will be convened in the summer of 2016, while OHA requests federal approval for the program, and will provide an opportunity for extensive public input prior to the launch of the program. The committee will continue to meet throughout the duration of the demonstration. The committee will advise OHA on a range of potential issues that may include:

- Refining the definition of the target population.
- Advising on the structure of CHPs when there are multiple CCOs in a single region.
- Advising on the specific requirements for creation of CHPs and make recommendations on the criteria for Request for Proposals.

- Addressing differences between rural and urban CHPs, including availability of affordable housing units and local area housing supportive service providers (i.e. workforce).
- Recommending process and outcome requirements for payment to CHPs.

HIT infrastructure needed to support CHPs:

As a result of the public input process, OHA will support the health information technology (HIT) component of CHPs by building upon the current physical health-centric health information sharing infrastructure to support data exchange between the partners involved, including between corrections, social services, CCOs and health care providers. Current infrastructure supports Direct secure messaging (through state-operated CareAccord, regional HIE efforts, and organizational electronic health records), as well as more robust exchange affiliated with certain communities or organizations. OHA intends to partner with the CHPs to further understand remaining gaps in HIT and necessary actions for strengthening the infrastructure. In addition, OHA will leverage new federal HITECH Health Information Exchange (HIE) onboarding funds to connect behavioral health, long term care, corrections, and other social services providers where appropriate to regional and statewide health information exchange services. Finally, OHA will support the development of notification to CCOs and their partners of transitions in and out of the corrections system, the State Hospital, and other settings as appropriate; and supplementing Oregon's current statewide hospital event notifications infrastructure (Emergency Department Information Exchange/PreManage).

Coverage of Homelessness Prevention/Transitions of Care Services, Housing Transition Services, and Tenancy Sustaining Services in CHP Pilot

Oregon is proposing to fund a range of care coordination and supportive housing services based on the types of services described in the June 26, 2015 CMCS Information Bulletin.[13] Additional services may include outreach to individuals experiencing homelessness and care management services for care coordination, see page 38. Oregon is not requesting federal authority to use Medicaid funds to cover the cost of room and board or pay rental assistance, except for those transitioning from acute care facilities to transitional and affordable housing units to receive needed health services (up to 60 days coverage).

Oregon is proposing that care coordination services offered by the CHPs be covered by Medicaid during the final 30 days prior to discharge for individual's undergoing treatment at the Oregon State Hospital. Care coordination would focus on providing relevant community treatment information to the state hospital for treatment and discharge planning (e.g., community services and discharge planning). As directed by the Supreme Court's Olmstead decision, individuals can be swiftly returned to an integrated setting in the community. Oregon also believes that well-

[13] CMCS Informational Bulletin. June 26, 2015. www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

coordinated short lengths of stay could support the decreased use of higher levels of care upon discharge. For example, of the (approximately) 45 patients currently on the ready-to-discharge list, about 90 percent have been referred to secure residential treatment.

Several research studies indicate that individuals involved with the criminal justice system are considered high utilizers of acute care services. Individuals with mental illness are 14 times more likely to be incarcerated than hospitalized.[14] A recent Miami-Dade County study of individuals with serious mental illness found that individuals with several incarcerations were high utilizers of hospital services – over a five year period, 97 individuals with serious mental illness were arrested 2,200 times and utilized 13,000 days at an emergency department or psychiatric facility. Oregon is proposing that CHPs be able to provide care coordination services to pre-adjudicated individuals while they are in jail. CHPs would have the opportunity to put resources in place to provide care coordination services for the first 30 days of an individual's incarceration in jail, which would help coordinate treatment and care planning at the beginning of incarceration (e.g., arranging proper medication) and assist in re-entry into the community, given that the average length of a county jail stay is approximately 12-15 days.[15]

To authorize federal financial participation to provide care coordination services to individuals in Institutions of Mental Diseases (IMD) and for pre-adjudicated incarcerated individuals in county correctional facilities, Oregon seeks to waive federal authorities in 42 CFR §438.3, 42 CFR § 435.1009 and 42 CFR § 435.1010. Recent guidance from the Centers for Medicare and Medicaid Services (SHO# 16-007) indicates that individuals who are on parole, probation, or have been released to the community pending trial are not considered inmates, and thus are not subject to the prohibition on federal financial participation (FFP) for providing Medicaid-covered services to inmates. If the individual is otherwise eligible for Medicaid, FFP is available for covered services provided to such individuals.

Partnership Requirements and Integrated Networks for CHP Pilots

Key community partnerships led by CCOs or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/Us) can build the capacity of high-need, at-risk individuals for self-support through strategies that identify homelessness and assist individuals in accessing appropriate housing that includes health-related supportive services. CHP lead entities will be responsible for coordination with all partner entities participating in the CHP. CHPs will be comprised of the following entities:

- CCOs (lead)
- Tribes (may be lead)
- County and/or city government

[14] Steven Leifman. March 24, 2015. Ending the Criminalization of Mental Illness. Speech: Miami, Florida.
[15] A 2013 Jail Survey conducted by the Association of Oregon County Mental Health providers found that 61.5% of individuals in jail were pre-adjudicated and two-thirds of those had a mental illness or substance use disorder.

- Local housing agencies
- County jails and/or State Hospital
- Local public health departments
- Hospitals
- Affordable housing providers
- Supportive housing service providers
- Community-based organizations (CBOs) focused on health equity

OHA will work with the CHP advisory committee and tribal governments to develop the minimum criteria for entities that must be included in CHP applications. Lead entities for the CHP will be expected to partner with local housing entities to help build an understanding of the housing situation in the region. CHPs may select to involve other entities and organizations that serve the targeted populations selected by individual regions. Other entities could include those focused on diversity, disabilities, aging, youth, etc.

CCOs will be provided with the flexibility to develop their individual integrated networks based on existing delivery systems, affordable housing providers, and additional regional partners that will be involved in the CHP pilot. To help ensure successful CHP pilots, Oregon plans to require CHPs to deploy case managers or care coordinators from varying professions, including but not limited to social workers, counselors, behavioral specialists, nurses, resident advocates, community health workers, and peer support specialists.

To achieve the overall goal of the CHP Pilot Program, the individual pilots require flexibility in types of workforce needed to support the different projects that reflect community resources, availability of the local workforce, and redeployment of existing professions and staff in terms of health care providers and housing supportive specialists. The CHPs will likely consist of multidisciplinary teams made up of physical, behavioral, and substance use treatment providers, social workers, traditional health workers, and other care providers. Oregon will ensure there is a set of minimum standards for CHP pilots to protect the health and welfare of the individuals served by the pilots. If applicable, Oregon seeks to waive federal authority in 42 CFR §441.700 pertaining to federal requirements regarding provider qualifications for Home and Community-based Supports (HCBS) program.

Initial Financing and Return on Investment

Oregon is requesting federal support for five-year pilots to CCOs to support capacity-building, developing community-based partnerships and infrastructure investment, as well as care management funding to target essential non-medical services. OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. With the CHP advisory committee, counties and tribal governments, OHA will explore the possibility of

including intergovernmental transfers (IGTs) as part of the CHP infrastructure to provide additional investment in the CHP programs.

During the demonstration, Oregon will assess whether homelessness prevention, care coordination and supportive housing services through the CHPs result in significant reductions in total Medicaid costs among the target population, including which services may contribute to lower monthly costs on a per member per month basis (PMPM). The goal is to demonstrate that upfront investments through the CHP pilot projects will achieve cost-savings for federal and state Medicaid, producing a positive return on investment.

Based on several Oregon-based studies, we anticipate that the CHP pilots will result in up to 10 to15 percent total reduction in Medicaid costs among the population served during the waiver period, with the largest gains in savings likely transpiring in years 3-5 of the program.[16,17] This is based on the assumption that more efficient management of health needs in appropriate settings and addressing social needs, including stable housing, will reduce the incidence of acute health crises, decrease the use of more expensive types of utilization, and improve health outcomes, ultimately producing reductions in overall Medicaid costs.

Oregon Health Authority's Office of Health Analytics conducted a series of analyses using Medicaid claims, encounter, and enrollment data to estimate the potential number of individuals currently in OHP who could be eligible for the CHP pilot program including estimating the potential number of high-risk populations using the criteria for the target population within a two-year period from October 2013 through September 2015.

Based on OHA's preliminary analysis, we anticipate that between 10 to 20 percent of OHP clients (219,112 individuals out of 1.1 million individuals enrolled in OHP) could benefit from targeted interventions through the CHP pilot program. Many of those included in the analysis are at higher-risk of homelessness due to increased complexities in health and often have other challenges that contribute to poor health status, are often disconnected from community services, and have unmet, complex needs that span the social service continuum.

The total expenditures for the individuals included in the analysis is roughly $3.5 billion over the two year period (2013-2015). If the CHPs are successful during the five-year renewal period in achieving a decrease of 10 to 15 percent in Medicaid costs for the target population, Oregon could potentially realize as much as $350 -$525 million of savings during a two-year biennium during the waiver renewal period.[18] OHA will work with CMS to further refine the potential savings to federal and state Medicaid costs during the five year renewal period.

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[16] Wright, B., Vartanian, K., Royal, N., Li H., & Matson, J. (2016). Formerly homeless people had lower overall health expenditures after moving into supportive housing. *Health Affairs, 35(1),* 20-27.

[17] Wright, B., Vartanian, K., Li, G., & Weller, M. (2016, February). Health and Housing: Exploring the intersection between housing and health care. *Providence Center for Outcomes Research and Education.* Portland, OR.

[18] The cost savings estimate included in this proposal is based on the 10-15 percent savings found in the Providence CORE research. Savings may be less than the noted amount and OHA will work with CMS to refine the cost savings.

Table 1. OHP Members Identified as High-Risk, High-need – Oct. 2013 through September 2015

Population definition	Number of Medicaid beneficiaries	Total actual costs (2-year period)
Non-duals that met the following definitions: • Repeat emergency department use/hospital use and two or more chronic conditions • Repeat ED use/hospital use and mental health or substance use disorder • Repeat emergency department use/hospital use • Chronic conditions (two or more) • Mental health or substance use disorder	142,855	$2,488,951,687
Individuals dually eligible for Medicare and Medicaid	76,257	$1,028,014,524
Total	**219,112**	**$3,516,966,211**

Source: OHA Office of Health Analytics, May 2016

Oregon also analyzed data available from the Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) funded by the Center for Medicare and Medicaid Innovation (CMMI) and fielded in 2014. The survey gathers information from adult Medicaid members about:

- Behaviors that put health at risk
- Behaviors that are protective of health
- Receipt of clinical preventive services
- Health care access and use
- Social and environmental determinants of health

The survey asked enrolled, adult Medicaid members about needing or receiving housing services over the past 12 months. Statewide, 15.9 percent of adult Medicaid individuals responded with having needed or received housing services. Based on the survey results, 48,906 Medicaid enrollees indicated having at least one chronic condition and experiencing housing instability during the past 12 months. The survey also collected information to assess situations in which an individual is: (1) homeless or residing in a shelter, or (2) at-risk of being homeless. The homelessness indicator is based on whether an individual indicated *currently* as "homeless" or residing in a "shelter" and had at least one chronic condition. The at-risk indicator is based on whether an individual responded that they "needed shelter" or "housing services" in the past 12 months and had at least one chronic condition.

Table 2. Housing Instability among Oregon Adult Medicaid Enrollees with Chronic Conditions, 2014

Coverage 2014	Homelessness/shelter	At-risk for homelessness
ACA Expansion	2,386	26,278
Traditional Medicaid	1,268	22,628
Total	**3,654**	**48,906**

Evaluation of CHP Pilot Activities

Oregon will assess whether transitions of care and supportive housing services for the target populations result in improved outcomes. Potential measures that will be assessed for including in the CHP pilots will include:

- Reductions in ED use and psychiatric acute care hospitalizations or boarding
- Decreases in inpatient admissions and hospital days
- Rate of emergency department visits
- Increases in primary care and behavioral health care use, including medication adherence
- Decreased discharges to secure residential treatment facilities
- Increase in transitions from recovery to permanent housing settings
- Increase in access to care and quality of care after moving into housing
- Retention in housing unit for 12 months or longer
- Increase in percentage of adults accessing employment and benefits services
- Increase in the percentage of individuals that transition to affordable housing (market rate housing/community housing placement)
- Increase in self-sufficiency among those served

CMS Innovation Accelerator Program (IAP): Alignment with CHP Proposal

Oregon was selected to participate in two Medicaid Innovation Accelerator Programs (IAPs), sponsored by the Centers for Medicare and Medicaid Services (CMS). These programs consist of a series of webinars, tools, and technical assistance designed to assist participating states in leveraging Medicaid dollars to pay for housing supports, and to better align efforts between state and local service and housing agencies. The initiatives through the IAP program serve to complement Oregon's CHP planning efforts.

Through the IAP, Oregon will develop a "State Action Plan" and framework to help forge a closer partnership between Oregon's housing and Medicaid agencies that will prepare the state to launch the CHP Pilot Program in July 2017.

Pilot domain[19]	Program	Partners	Program goals and potential measures	Target populations	List of services

Homelessness Prevention/ Transitions of Care
 	
Support to ensure care coordination among non-medical settings; fund services to support an individual's ability to move from institutional settings to less costly community-based care settings
	Select one program (at minimum):
	
	• Care coordination services for pre-adjudicated criminally justice involved (initial 30 days after entry)
	• Care coordination services for Oregon State Hospital (OSH) patients (admission to discharge)
	• Acute care transitions to less costly community-based settings
		• Lead entity:
		  ○ CCOs
		  ○ Tribes or I/T/Us
		• Additional partners:
		  ○ Local hospital(s)
		  ○ County health departments
		  ○ State Hospital
		  ○ County Jails and Oregon Department of Corrections
		  ○ Care management entities
		  ○ Affordable housing providers
		  ○ Community-based organizations (CBOs) focused on health equity
			• Reductions in ED use and psychiatric acute care hospitalizations
			• Decreases in inpatient admissions and total hospital days
			• Increases in primary care and behavioral care use including medications
				Individuals with:
				• Repeated incidents of avoidable emergency use or hospital admissions, or nursing facility placement; or
				• Two or more chronic conditions; or
				• Mental health and/or substance use disorders; or
				• History of or current homelessness and/or at risk of being homeless, including:
				  ○ Pre-adjudicated criminally justice involved
				  ○ Oregon State Hospital (OSH) patients
				  ○ Dual eligibles
				  ○ Tribal members
					• Ensuring that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health
					• Ongoing assessment of medical, mental health, substance use disorder or dental needs
					• Case management and coordinating the access to and provision of services from multiple agencies
					• Establishing service linkages with community providers, such as transportation for CHP enrollees in rural communities.

Housing Transition Services
 	
Invest in pre-tenancy services to decrease health care costs and reduce use of high-cost health care services
	Pre-tenancy support services that aid an individual's ability to prepare for and transition to housing
	
	CHPs must identify and implement one program
		• Lead entity:
		  ○ CCOs
		  ○ Tribes or I/T/Us
		• Additional partners:
		  ○ Primary, behavioral and SUD providers
		  ○ Local hospital(s)
		  ○ Local housing agencies
		  ○ City and county agencies
		  ○ Affordable housing providers
		  ○ CBOs focused on health equity
			• Reductions in ED use and psychiatric boarding
			• Decreases in inpatient admissions and total hospital days
			• Decreased discharges to secure residential treatment facilities
			• Increase in transitions from recovery to permanent housing settings
			• Increase in access to care and quality of care after moving into housing
					• Tenant screening and assessment
					• Assistance with housing searches and applications, move-in assistance, short-term expenses such as security deposits, other landlord-required rental or lease costs
					• Moving costs, basic furnishings, food and grocery supports
					• Adaptive aids and environmental modifications
					• Housing support crisis plan and intervention services
					• Care coordination services with medical homes, behavioral health and SUD providers, including transportation to medical appointments for CHP enrollees in rural communities.

Tenancy Sustaining Services
 	
Invest in services that support the individual in being a successful tenant in his/her housing arrangement
	Services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy including permanent	• Lead entity:
		  ○ CCOs
		  ○ Tribes or I/T/Us
		• Additional partners:
		  ○ Primary, behavioral and SUD providers
		  ○ Local hospital(s)
		  ○ Local housing agencies
			• Reductions in ED use
			• Decreases in inpatient admissions and total hospital days
			• Increases in primary care and behavioral health
			• Retention in housing unit for 12 months or longer
					• Tenancy rights/responsibilities education; coaching in maintaining relationships with landlords
					• Eviction prevention (paying rent on time, conflict resolution, lease behavior requirements)
					• Utilities management (e.g. help with paying monthly bills)

[19] CHP pilots must provide services across all three domains.

Pilot domain[19]	Program	Partners	Program goals and potential measures	Target populations	List of services
	supportive housing and family housing CHPs must identify and implement one program	○ City and county agencies ○ Affordable housing providers ○ Other community based entities ○ CBOs focused on health equity	• Reductions in eviction rates. • Increase in percentage of individuals that access employment and benefits services • Increase in the percentage of individuals who transition to affordable housing (market rate housing/community housing placement) • Increase in self-sufficiency among those served		• Crisis interventions and linkages with community resources to prevent eviction when housing is jeopardized • Utility assistance (e.g. financial assistance to pay utility bills) • Linkages to education/job training, employment • Care coordination services with medical homes, behavioral health and SUD providers

Improving prenatal and early childhood outcomes

Expansion of nurse home visiting services

To improve access to early intervention services that can improve health outcomes and social-emotional well-being for at-risk families and children, ranging from prenatal support to age five, Oregon intends to expand access to nurse home visiting programs to fill the gaps of care for at-risk families and children, in partnership with Public Health, and the counties. A focus on early intervention supports the upstream approach to address social determinants of health in Oregon and can help prevent costly and avoidable negative outcomes in the future.

Using a State Plan Amendment, Oregon will expand the use of Targeted Case Management codes that allow for nurse home-visiting programs (including those focused on social services, care coordination, and wraparound services) to directly bill Medicaid for a defined set of services. Billable services could include in-home case management, transportation, parenting education, infant/child growth and development screenings, goal-planning, school readiness, family support, self-sufficiency, and building the child-family relationship. This change would allow CCOs to help categorize family supportive services as "health-related" services and be eligible for reimbursement. Billable codes would also allow for gathering of sufficient data and metrics that can be used to track process measures related to nurse home-visiting services across CCOs.

Targeted Case Management (TCM)

Through this waiver renewal, Oregon requests that TCM continue to be carved out of the CCO integrated global budgets through the next waiver period. During much of the last year, we sought guidance and feedback from CMS on our proposed financial model for using local government funds to leverage Medicaid match for case management of targeted populations. That model sought to preserve many aspects of the Fee-For-Service (FFS) program, as well as introduce additional flexibility we believed would be available in the managed care setting. CMS and Oregon have been unable to determine a way to put the local and leveraged funds into the capitated rate that allows CCOs the flexibility they need in these relationships, protects the counties, and receives approval from the Financial Management Group (FMG) at CMS. Previous guidance indicated that we would need to require CCOs to pay the cost-based, per visit rate for nurse case management home visits. Though we are requesting that TCM continue to be carved out of the CCO integrated global budget, Oregon plans to continue to convene the existing workgroup to develop strategies to coordinate TCM services with other CCO provided services. To further address other social determinants of health (e.g., food insecurity), the state is interested in adding other critical partners to the workgroup, including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Ensure access to health care services for American Indians/Alaska Natives

Oregon is home to nine federally recognized Tribes and an estimated 126,944 Indians (U.S. Census Bureau, 2014). "Indian" or American Indian/Alaska Native (AI/AN) means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian tribe, resides in an urban center and meets one or more of the four criteria:

- Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Medicaid is a critically important program for Indians, serving as both an insurance program covering physician, hospital, and other basic health care for eligible individuals, and a source of revenue for an Indian Health Care Provider (IHCP). An "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Over 50 percent (n =18,682) of Oregon's eligible Indians are enrolled in Coordinated Care Organizations (CCOs) (OHA data, 2016).

Goals for July 2017 - June 2022:

- Ensure enhanced and improved effective consultation and collaboration between the state and IHCPs;
- In year 1, identify best practices for developing and funding care coordination at IHCPs;
- Facilitate care coordination agreements for IHCPs between CCOs and other specialty care providers;
- In partnership with tribes, evaluate the 100% FMAP opportunities and potential barriers and develop a strategy for moving forward;

- Include IHCPs as a potential lead entity(s) in the Coordinated Health Partnership pilot program;
- Continue and expand the use of the Tribal Uncompensated Care Program (UCCP);
- Evaluate the effectiveness of the UCCP; and
- Require CCOs to contract with willing IHCP providers.

Tribal Uncompensated Care Program (UCCP)

In October of 2013, during the most recent renewal period, the demonstration was amended to implement the Tribal Uncompensated Care Program (UCCP) to extend payments to Tribal providers for certain services previously not funded under OHP. The Uncompensated Care Program was established to broaden the numbers of services that can be reimbursed by Medicaid funds, thereby allowing other health care funding streams to be used toward the goal of eliminating health disparities in this population.

While Oregon's UCCP moves towards being fully operational statewide, there are four clinics that are utilizing the program and others that have indicated they plan to do so. During the upcoming demonstration period, OHA will be better able to evaluate participating facilities' staff level changes, service level changes or changes in percentages of budget represented by Medicaid payments to assess the success of initial implementation. Barriers to reimbursement through UCCP will be evaluated and addressed in collaboration between OHA and the tribes.

The broadened federal interpretation of the 100 percent FMAP for services received through IHS/Tribal facilities to include referred services may be helpful in developing and implementing care coordination agreements with non-IHS/Tribal providers. This added flexibility may improve Indians' access to care and further enhance the scope of the uncompensated care program. OHA will work with the tribes to evaluate the benefits and barriers to leveraging 100 percent FMAP.

Health System Transformation

Throughout the demonstration, the state will ensure effective consultation and collaboration with the tribes through a mutual process resulting in agreed-upon policies that clearly define expectations and responsibilities. As a result of consultation, the state will explore the possibilities for creating an IHCP led Collaborative Health Partnership pilot to improve transitions of care and housing supports and services for at-risk adult tribal members.

Formal linkages between the tribes and CCO networks will continue to be developed, and the Indian population will take an active role in advising the state around improvements to ensure effective collaboration between tribes, health care providers, and CCOs. This collaborative effort between the various tribal and health care delivery system partners will positively affect access to health care services and provider reimbursements. OHA believes that the system-wide changes brought by health system transformation present an unprecedented opportunity to

explore new ways to collaborate with health providers serving Indians and improve health care and health status.

The state will use the "Model QHP Addendum for Indian Health Care Providers" published by CMS on April 4, 2013 (Model IHCP Addendum). The state will require that the Model IHCP Addendum be used by all CCOs to assure that CCOs comply with key federal laws that apply when contracting with IHCP providers, minimize potential disputes, and lower the perceived barriers to contracting with IHCP. CCOs will offer contracts to all IHCPs which will include the Model IHCP Addendum. CCOs will negotiate and finalize contracts with IHCPs interested in entering into a contract with a CCO within six months of the CCO's offer. However, IHCPs will not be required to contract with the CCOs or plans. IHCPs, contracted or not with a CCO, will be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers at a rate negotiated between the CCO and the IHCP; or in the absence of a negotiated rate, at the IHS encounter rate, FQHC PPS encounter rate (if eligible), or a rate not less than the level and amount of payment that the CCO would make for the services to a non-IHCP participating provider, whichever is higher.

CCOs will continue to provide access to specialty and primary care within their networks to IHS beneficiaries seen and referred by IHCPs, regardless of the entity's status as contracted provider within the CCO network. All Indian cost-sharing protections in statute, regulation, and policy apply to the Indian population under this demonstration.

The state will also encourage CCOs to partner with IHCPs, in addition to local public health and mental health organizations and hospital systems, to ensure that the Community Health Needs Assessment includes a focus on health disparities in the community and on addressing social determinants of health.

Several tribes are developing or implementing strategies to support enhanced care coordination given Oregon's health system transformation, CCO development, and recent CMS guidance on federal funding for referred services. In partnership with tribes, the state is exploring expanded opportunities for effective care coordination for Indians. The state will continue to collaborate with the IHCP on delivery of care coordination services to Indians in Oregon.

Other provisions of this demonstration specific to tribes, Indians and IHCPs are set forth in the Standard Terms and Conditions (STCs).

Develop Deeper Cultural Competence for Language Interpreters and Expand Use of Traditional Health Care Workers

The ACA and Oregon House Bill 3650 (2011) set the stage to advance several health equity strategies through Oregon's health system transformation. The legislation and resulting CCO contracts require that Oregon Health Plan (OHP) members receive assistance from a "health equity workforce" that increases access to culturally and linguistically appropriate care.

Health Care Interpreters

Oregon is among the states with the highest language diversity.[20] More than 40 percent of OHP members have a non-English language on record. After English, the top six known spoken languages are: Spanish, Russian, Vietnamese, Chinese languages, Somali, and Arabic. OHP members speak 68 other languages (Oregon's Health System Transformation: Annual Update, January 2016).

In 2001, Oregon passed legislation creating a qualification and certification process for health care interpreters. However, due to the voluntary nature of the statute and the high cost of training and testing, very few health care interpreters, who are able to practice in Oregon without certification, voluntarily chose to engage in the process. By including a contractual requirement for CCOs to use qualified or certified Health Care Interpreters (HCIs) whenever possible, the state has seen a significant increase in HCIs seeking qualification or certification. Recognizing the barrier of training and testing costs, OHA's Office of Equity and Inclusion (OEI) sought and received CMMI State Innovation Model funds to provide training free of charge to HCIs. As a result, Oregon has seen a 231 percent increase in qualified or certified HCIs since 2014. Currently, there are 265 qualified or certified HCIs providing interpreter services in 26 languages in Oregon.

During the waiver renewal period, OHA's Office of Equity and Inclusion will continue to:

1. Help HCIs in Oregon fulfill training and certification to meet current CCO requirements;
2. Diversify the health care workforce in Oregon;
3. Provide high-quality health care interpretation to Oregon's growing diverse populations; and
4. Promote health equity.

Doulas

Doulas are intended to serve as an adjunct to the conventional doctor, clinic, hospital delivery system, and to provide culturally appropriate care in the right setting and at the right time to achieve the best and most cost effective outcome. In Oregon, doulas, who are certified professionals, provide personal, non-medical support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. Doulas are a part of Oregon's overall strategy to improve birth outcomes funded by Medicaid by addressing health inequities in Oregon's birth outcomes. In 2013, the rate of preterm birth in Oregon was highest for black infants (12.3%), followed by Native Americans (12.2%), Hispanics (10.2%), Asians (10.0%) and whites (8.6%). In the same year, black infants (9.4%) were about two times as likely as white

[20] U.S. English Foundation (2016). Many Languages, One America: Most Linguistically Diverse States. Accessed at: www.usefoundation.org/userdata/file/Research/Regions/oregon.pdf.

infants (5.9%) to be born low birth weight during 2011-2013 (average). During 2011-2013 (average), the infant mortality rate (per 1,000 live births) in Oregon was highest for Native American infants (11.5), followed by blacks (8.3), Hispanics (4.7), whites (4.7) and Asians (4.1).[21]

In Oregon, doulas can work with Medicaid-enrolled practitioners to serve OHP members on a fee-for-service basis. Doulas are required to have an agreement with the practitioner, which allows for reimbursement of doula services as a practice expense. For labor and delivery, the practitioner must be a physician or advance practice nurse (e.g. certified nurse midwife) enrolled with Medicaid. For maternity case management support, the practitioner must be a licensed Medicaid-enrolled physician, physician assistant, nurse practitioner, certified nurse midwife, direct entry midwife, social worker or registered nurse. Additionally, doulas must be certified and registered as Traditional Health Workers (THW) through OHA and certified to work in Medicaid.

Under federal regulations and statute, doulas are considered to be non-traditional health workers that are not licensed providers.[22] OHA is requesting to waive the federal authority requiring doulas to be supervised by an existing licensed medical provider to provide services within a licensed practitioner's scope of practice. Oregon will ensure that our rules and regulations require doulas and THWs to coordinate and share information with recognized PCPCHs and CCOs, which are foundational partners in health system transformation.

Traditional Health Workers

With respect to community health workers, personal health navigators, peer wellness specialists, and other health workers not regulated or certified by the state, Oregon's House Bill 3650 (2011) set requirements for Oregon to develop and establish a) criteria and descriptions of traditional health workers (THWs) to be utilized by coordinated care organizations, and b) education and training requirements for THWs. The Oregon Legislature also passed HB 3311 requiring OHA to explore options for providing or utilizing doulas in the state medical assistance program to improve birth outcomes for women facing a greater risk of poor birth outcomes. As a result, OHA's Office of Equity and Inclusion convened a workgroup to identify the roles, core competencies, scope of practice, training and certification requirements, and reimbursement models for traditional health workers. The workgroup defined the scope of work for THWs under the following four roles: outreach and mobilization of patients; community and cultural liaising; case management, care coordination, and system navigation; and health promotion and coaching.

The state certification process requires successful completion of approved training, completion of a background check and continuing education to maintain certification. As of December

[21] Sources: www.marchofdimes.organd http://kff.org/other/state-indicator/infant-mortality-rate-by-race-ethnicity/#table
[22] Federal authorities: 1905(a)(6) & 42 CFR 440.60

2015, 878 THWs were certified – dramatically exceeding the 300 required in our current demonstration.

OHA's Office of Equity and Inclusion will continue to support the training and use of traditional health workers including supporting the THW Commission. The Commission promotes the traditional health workforce in Oregon's health care delivery system to achieve the triple aim goals of better health, better care, and lower costs. The Commission advises and makes recommendations to OHA to ensure the program is responsive to consumer and community health needs, while delivering high-quality and culturally competent care. Key focal areas include increasing employment and effective supervision of THWs through targeted activities such as new and enhanced internships and other incentive programs; pursuing strategies to integrate THWs into the CCOs; advancing community engagement opportunities; and developing and implementing ongoing revisions to the THW scope in the context of health system transformation. The targeted focus requires CCO engagement to define the role and use of THWs in community settings and to increase the percentage of CCOs and their providers that employ them, to the extent needed within a community.

Race, ethnicity, language and disability (REAL+D) data

In 2013, Oregon passed legislation that required OHA and the Department of Human Services (DHS) to collect standardized race, ethnicity, language and disability status data at a disaggregated level to unmask inequities in health outcomes between and within populations/groups. The REAL+D data legislation was implemented in 2015 by incorporating the defined standards for REAL data into the Medicaid eligibility process (certain disability data cannot be used in eligibility determination, per federal requirements). Data collected through eligibility determination is fed into an integrated services database (ICS), which allows unique identifier matching with clients receiving other services. While the ICS is being designed to capture disability status, the revised ONE application does not yet include disability status. Therefore, the Office of Equity & Inclusion is currently checking into what it would take to include disability status on the ONE application. Ultimately, through this process we anticipate collecting disaggregated race, ethnicity, language and disability data for 80 percent of individuals receiving services from OHA and DHS.

CCO Transformation Plan: Health Equity Elements

CCOs are required and will continue to submit and update Transformation Plans annually that describe elements related to health system transformation. Three elements of their transformation plans focus on health equity strategies that are tied to the Office of Minority Health Culturally and Linguistically Appropriate Service standards:

1. Element 6: addressing members' cultural, health literacy and linguistic needs;
2. Element 7: provider network and staff ability to meet culturally diverse community needs; and

3. Element 8: quality improvement plan for eliminating racial, ethnic and language based disparities.

The Office of Equity and Inclusion provides staff and contracted technical assistance without charge to CCOs and their provider panels. CCO staff may also participate in the Developing Equity Leadership through Training and Action (DELTA) Program, a 9-month training program focused on identifying and advancing health equity strategies within organizations and service delivery. In September 2016, OEI will have completed three cohorts that include 43 CCO or CCO contractors as program participants. This work will continue through the renewal demonstration.

3. Commit to the sustainable rate of growth

Advance the integrated global budget and rate development strategies to promote health related services; investments in social determinant of health projects; and value-based payments

In 2012, under an amendment to its 1115 demonstration, Oregon implemented the use of the capitated or integrated global payment for CCO members. The integrated global budget, as described by Oregon statute (ORS 414.025), is a total amount established prospectively by the Oregon Health Authority to be paid to a CCO for the delivery of, management of, access to and quality of the health care delivered to members of the CCO. Through the integrated global budget, CCOs have the freedom to offer flexible services, in addition to covered health services, to improve care delivery and member health. Flexible services are patient-centered, cost-effective services offered voluntarily to individuals instead of or as an adjunct to covered benefits, to promote the efficient use of resources and, in many cases, target social determinants of health. OHA has since determined that a broader category of services, called "health-related services," is more appropriate; these services include flexible services *and* community benefit initiatives (community-level interventions focused on improving population health and health care quality).

Under the same amendment in 2012, Oregon established an annual sustainable rate of growth target of 3.4 percent for aggregate health care costs. To date, Oregon has succeeded in achieving this growth target as evidenced by the decline in the medical expenditure trend. Going forward, Oregon is committed to continuing efforts to bend the cost curve in the immediate and long-term with a continued, sustainable rate of growth of expenditures of 3.4 percent.

To continue progress with the integrated global budget, Oregon has determined that there are additional actions that are necessary to ensure CCOs and the providers and community organizations with which they partner are positioned to drive the delivery of cost-effective, quality care and advance population health. To achieve the triple aim of better health, better care and lower costs – the core of the State's transformation objectives – OHA seeks to increase the

use of cost-effective health-related services among CCOs and their network providers. In support of this goal, Oregon's demonstration renewal, CCO contracts and rate setting methodology will address the following barriers to increase the use of health-related services:

1. Costs associated with health-related services are currently counted as administrative (not "medical") expenses in the CCO capitation rate.

2. As investment in cost-effective health-related services reduces utilization of state plan services (on which the capitated rate is based), CCO rates may decline over time. As this decline (referred to as "premium slide") occurs, there is neither funding nor incentive for CCOs to continue investing in these services.

3. When CCOs reimburse network providers on a fee-for-service basis, there is little incentive and few resources for providers to invest in health-related services.

To increase the use of cost-effective health-related services, OHA will take the following steps – all of which will be reflected in the demonstration renewal, but only one of which requires a change to the current demonstration STCs. Oregon seeks approval of the proposals discussed below by December 2016.

1. Include the costs of health-related services that qualify as "activities that improve health care quality," pursuant to 45 C.F.R. § 158.150, in the medical portion of the CCO capitation rate (i.e., treat them as benefit expenses for rate setting purposes). In order to take this step, OHA will need to remove the current demonstration's STC 34(c).

2. Amend the CCO contracts to implement a reinvestment requirement that could involve a medical loss ratio (MLR) standard of 88 percent – the MLR currently used for rate setting purposes – with a tiered corridor of 3 percent, where:

    a. CCOs that have an MLR *below* the 3 percent corridor (i.e., below 85 percent) must remit to the State the difference between their MLR and 85 percent; and

    b. CCOs that have an MLR *within* the 3 percent corridor (i.e., between 85 percent and 88 percent) may be eligible, depending on their performance on quality and cost measures, to retain some or all of the difference between their MLR and 88 percent, so long as the amount of the difference is reinvested in health-related services. Any portion of the difference that is not reinvested must be returned to the State. Such a reinvestment requirement enables some or all of the CCO's savings achieved to remain in the rates going forward (instead of being returned to the State) and be reinvested in members' care. The corridor could be tiered in a way that results in higher performing CCOs being allowed to retain a higher percentage of the difference than lower performing CCOs.

    For the purposes of calculating CCOs' MLRs to determine compliance with the State's MLR standard of 88 percent, spending on *all* health-related services would be included

in the numerator (consistent with 42 C.F.R. § 438.8). Furthermore, given that spending on health-related services qualifying as "activities that improve health care quality" can be included in the base of the capitation rate, any reinvestment in those services would also be included in the base and therefore remain in the system. CCOs with an MLR at 88 percent or above will not be subject to any remittance or reinvestment requirement. OHA will work with CMS and CCOs to further develop this reinvestment requirement.

3. Require CCOs to enter into value-based payment (VBP) arrangements with network providers. Oregon's current demonstration calls for CCOs to adopt alternative payment arrangements to align CCOs and their providers with the State's transformation objectives. In this demonstration renewal, the State seeks to ensure that such arrangements are being adopted by requiring a specific percentage of CCO payments to network providers to be made through VBP arrangements. Accordingly, the demonstration renewal will require the State to submit to CMS a VBP plan that describes how the State and CCOs will achieve a specific percentage of VBP payments by the end of the demonstration period, including amendments to CCO contracts. The VBP plan will also include a timeline that ensures *phased-in* implementation over the duration of the waiver, as well as a clear definition of "value-based payments" that involves both the sharing of risk, shared savings arrangements and the meeting of quality measures.

4. Implement a CCO performance incentive program. To further incentivize CCOs to utilize health-related services, Oregon will enhance the rate setting methodology to prevent premium slide and compensate CCOs identified as high performing (e.g., CCOs showing quality improvement and cost reduction). Two approaches to such an incentive program are described below. These approaches would require the State to develop a mechanism for measuring CCO performance. None of the approaches would replace the existing risk factor adjustments. Oregon will leverage, to the maximum extent possible, the existing cost and quality metrics included in the waiver.

    a. Margin augmentation: The State could develop rates with a profit margin range, such as 1 percent to 3 percent, as opposed to a fixed percentage of premium, which is used today. The margin percentage built into the rate would vary based on CCO-specific scoring within each rating region, where higher performing CCOs would receive higher percentages than lower performing CCOs for the following 12-month period.

    b. Base a portion of CCOs' capitated rate on quality and cost measures: The State could develop a prospective adjustment to each CCO's rate based on the CCO's past performance on key quality and cost measures. To do this in a budget neutral manner, OHA could set aside a portion of the capitated rate and allocate it to CCOs based on performance. For example, the State could assign scores to CCOs based on their performance in cost reduction and quality improvement;

CCOs with high scores in both areas of measurement would be allocated more dollars than CCOs with lower scores.

While the details of measuring CCO performance still need to be developed, the overall goal is to incorporate an approach, like the three described above, in the State's rate setting methodology in a manner consistent with all Actuarial Standards of Practice and CMS and OACT guidance. Appendix D includes a concept paper with additional detail.

Sustainable rate of growth and 2 percent test

Under Oregon's current demonstration waiver, the state agreed to reduce the Oregon Health Plan's per capita medical expenditure trend (i.e., the increase in capitation) by 2 percentage points over the final three years of the demonstration (July 2014 through June 2017). If the state did not meet the 2 percentage point reduction, the state would receive less funding for Designated State Health Programs. The 2 percentage point reduction has been evaluated based on expenditures for:

1. All services provided through CCOs over the course of the demonstration;
2. Wrap-around payments to health centers for services provided through CCOs; and
3. Incentives and shared savings payments to CCOs.

The 2 percentage point reduction in per capita spending growth has been measured from a 5.4 percent annual projected trend over the course of the waiver, as calculated by the Office of Management and Budget (OMB). Calendar year 2011 served as the base year. Oregon has been successful throughout the current demonstration in bending the cost curve and maintaining a sustainable rate of growth of 3.4 percent since the third year of the demonstration (July 2014 – June 2015).

Prior to Oregon's 2012 Demonstration, health care costs were increasing unsustainably. A key goal of health system transformation has been to reduce the growth in statewide Medicaid spending, per member, per month (PMPM). Oregon has successfully bent the cost curve and plans to continue the goal into the next waiver period. Oregon will continue to commit to maintain a sustainable rate of growth under the two percent (2%) per-member-per-month (PMPM) calculation while putting federal financial participation dollars at risk for not meeting the test consistent with the current demonstration. In reviewing national trends (Uninsured, January 2015), (Office of the Actuary, Centers for Medicare and Medicaid Services, 2014) (Office of the Actuary, Centers for Medicare and Medicaid Services) Oregon has determined that the Medicaid trend ranges from 4.5 to 5.5 percent growth. Therefore, Oregon proposes to continue to bend the cost curve at a 3.4 percent rate of growth. In addition, Oregon proposes to continue using the current base year of 2011 for rate development and will not rebase for the new waiver period. Oregon requests that the state work with CMS to update the return on investment calculation included in the current template to ensure that it reflects the appropriate information.

OHA proposes that the calculation be updated and targeted to capture specific cost and savings outcomes. To simplify reporting, Oregon will only report on services and expenditures included in the test (e.g., Medicaid expenses for CCO enrollees). Oregon will work with CMS to identify expenditures that will be excluded from the test, including:

1. Fee-for-service mental health drugs
2. Fee-for-service personal service workers (PC 20)
3. FQHC/RHC new and change in scope after July 1, 2011
4. Primary care rate increase/rate bump (ended 12/31/14)23
5. Mental health habilitative
6. Hospital presumptive eligibility
7. Health insurer fee
8. Future federally mandate changes affecting caseloads or costs
9. High cost, emerging drug therapies

Given the unpredictability of emerging high-cost drug therapies and their rapidly rising share of health care spending, OHA recommends that high cost, emerging therapies such as drugs for Hepatitis C and Cystic Fibrosis and biologics are excluded from the sustainable rate of growth calculations.

4. Expand the Coordinated Care Model

Promote better coordination and improve health outcomes for those dually eligible for Medicare and Medicaid

The Oregon legislature originally intended that those eligible for both Medicare and Medicaid, or dual eligible members, be included in new Coordinated Care Organizations as outlined in HB 3650. However, during the current demonstration, dually eligible individuals must opt in to CCOs. Over the past several years, approximately 56.8 percent of dual eligible beneficiaries have voluntarily enrolled in Coordinated Care Organizations. The state is currently conducting an evaluation to compare outcomes for dual eligible members in coordinated care to fee-for-service outcomes for the same population. Preliminary looks at Medicaid data confirm the state's belief that costs and care outcomes are better for dual eligible beneficiaries enrolled in managed care. Oregon has also had low turnover of dual eligible individuals who have been in

[23] Although the primary care rate bump ended in December 2014, Oregon is currently considering reintroducing primary care value-based payments under the Comprehensive Primary Care Plus program, which will require the removal of the primary care rate bump from the list of exclusions for the two percent test.

CCOs, Currently, 99 percent of full dual eligibles in fee-for-service in the aging and disabled populations are eligible to enroll in CCOs, which include all Medicaid services in an integrated and coordinated managed care plan. For some, however, there has been a lack of clarity about their local opportunities and choices. For example, where partial enrollments for dental and/or behavioral health have taken place, beneficiaries may have received more than one proof of eligibility, at times leading to confusion about their physical health plan membership.

The state believes this can be addressed by moving to an opt-out auto-enrollment process. In this scenario, the state would automatically enroll all eligible individuals into a CCO unless the individual actively chooses not to enroll and notifies the state of this choice. CMS guidelines will be followed to ensure individuals are able to exercise their right if they choose not to be enrolled in managed care. Dual eligibles who live in an area with two CCOs will be enrolled using the same process as other OHP members, which is based on previous enrollment, enrollment of other family members , and CCO area capacity limit. Dual eligibles who are enrolled in a dual eligible special needs plan (D-SNP) will be assigned to the affiliated CCO. Additionally, dual eligibles who are enrolled in a Medicare Advantage plan will be assigned to the affiliated CCO.

Oregon's opt-out process will ensure that CMS-approved communication tools are used to ensure due process and that opt-out notification meets the CMS standards that were previously adopted. In Oregon, the welcome letter communication would be sent 90 days in advance of auto-enrollment, assuring more than the minimum 60 day notice for members to opt-out, giving them the chance to determine if their current providers are part of the CCO network and to make an informed decision. The state will provide a clear opt-out process by mail or by phone, and ensure that CCOs provide a minimum 120 day care continuity transition timeline.

Oregon would also submit a state plan amendment to STC 24.a.iv, to indicate that dually eligible individuals are not required to make an affirmative voluntary choice for CCO enrollment. The intent of the state plan amendment to STC 24.a.iv is not to change benefits or other rights for dual eligibles. Oregon would also need to initiate a CCO enrollment administrative rule change and employ a complete communications strategy and plan for internal and external communications for the opt-out process. With CMS approvals, the timeline for implementation could take a minimum of 12 months to 18 months, including gathering CCO, DHS and advocate input into proposed processes. OHA will coordinate with agencies focused on aging and disabilities to make the proposed change around dual eligibles' opt out. The agency will develop talking points and messages for our Aging and People with Disabilities staff that work with members who are Medicare eligible, and for our OHA phone call centers. We would work with dual eligible members already in CCOs to develop video segments that explain the benefits of coordinated care organizations for coordination of care, ease of one-stop customer service, etc. Additional background information can be found in Appendix E.

Increase the health care workforce in underserved areas and in behavioral health settings using evidenced-based, best practices for recruiting and retaining workforce

The Health Care Workforce Committee was established by the Oregon Legislature to coordinate efforts to recruit and educate health care professionals and retain a quality workforce. This work is necessary if Oregon is to meet the demand created by the expansion in health care coverage, health system transformation, and an increasingly diverse population. In 2013, the Health Care Workforce Committee developed a strategic plan for recruiting primary care providers to Oregon.[24] The plan included three overarching goals for primary care provider recruitment, along with strategies to achieve these goals: grow our own; acquire from elsewhere (other states beyond Oregon); and empower communities to enhance their capacity around recruitment and retention. What follows is a brief description of each goal and high-level action being taken, which will continue in the years ahead during the demonstration renewal period.

Grow Our Own

This goal is focused on a longer-term strategy that speaks to the "pipeline" for training Oregonians to become health care providers. This goal is intended to produce more primary care professionals in Oregon in order to increase the size of the recruitment pool accessible to most clinics. First, it should be noted that Oregon has only two medical schools, so most doctors complete their formal medical training outside of Oregon. The number of residency slots is also quite limited, although the newly formed Graduate Medical Education Consortium is working to expand this number so that more physicians can complete their training in Oregon. Part of the focus around physicians is to enhance the likelihood that those attending medical school outside of Oregon come back to practice after completing their medical training. For other disciplines, beyond primary care, the focus is more on ensuring adequately sized training programs within the state. Other strategies to expand the pipeline include:

1. Identifying additional funding for Regional Area Health Education Centers to deliver additional targeted programs to high-school age youth to encourage careers in the health care profession;

2. Continued support of the Graduate Medical Education Consortium to expand the number of residency slots available to Oregonians to finish their training in the state; and

3. Hold dialogue with the 12+ graduate programs for training licensed behavioral health specialists and explore ways to increase the sizes of the programs.

[24] *www.oregon.gov/oha/OHPR/HCW/Documents/5-Year%20Strategic%20Plan%20for%20Pimary%20Care%20Provider%20Recruitment%20-%20HB%202366.pdf*

Acquire from Elsewhere

Under this goal, Oregon intends to deploy a combination of targeted incentives and marketing efforts to attract providers to the state. Recently, the Oregon University System sponsored the "Promise of Oregon" marketing campaign, which was designed to attract promising students to come to Oregon for post-secondary education and contribute to our state. Additional strategies that the state will employ to attract providers from other states include:

1. National marketing of Oregon's current provider incentive programs: these incentive programs include a suite of differing programs that can be overlaid on one another to incentivize providers to locate in rural and underserved areas. In addition to our aggressive use of the federal Nurse Corps and National Health Services Corps, Oregon has created a tax credit for providers in rural areas, loan repayment for those who serve a high Medicaid patient population, and Behavioral Health Loan Repayment to support behavioral health providers working toward licensure adding their skills to an overall capacity for mental/behavioral health.

2. Restructuring and potentially expanding the availability of loan repayment, loan forgiveness and other provider incentives to fulfill Oregon's policy objectives to ensure an adequate supply and distribution of providers in the areas and disciplines where they are needed; and

3. Developing a full-scale marketing campaign (e.g., "Oregon: The State of Health") to be released through social media and training program platforms around the nation.

Empower Communities to Enhance their Capacity around Recruitment and Retention

This goal is intended to empower rural and underserved communities in their own efforts to recruit and retain primary care providers. This goal can be advanced through coordination of effort by statewide organizations involved in recruitment and retention (e.g., Primary Care Office, Office of Rural Health, Area Health Education Centers, etc.) and promoting promising practices. One such practice is known as "the Rimrock Model" – in which significant, upfront work is done by a group of community partners as part of the recruitment process, and providers are checked in on over time to gauge satisfaction with the clinical practice environment and quality of life in the community. This model was developed in Oregon and has been shown to be an effective support for a community in terms of short- and medium-term provider retention. Additionally, OHA's Primary Care Office and State Office of Rural Health continue to provide education and assistance to communities to rural and underserved communities to ensure they take advantage of existing provider incentive programs. Additional strategies to address this goal include:

1. Funding deployment of the Rimrock Model for a targeted number of communities that are struggling with health care retention and recruitment within the community; and

2. Ensuring coordination among OHA and the Office of Rural Health in working with CCOs and practices to take advantage of the suite of incentive programs available for workforce recruitment in Oregon.

The Oregon Health Authority has been leading the way in supporting clinicians to come and practice in rural and underserved areas of the state and for underserved populations. The Primary Care Office, as the state liaison for the National Health Service Corps (NHSC) and other HRSA-funded incentive programs, has expanded marketing and outreach around the federal provider incentive programs. As a result, Oregon had the fourth highest number of new NHSC provider awards in 2015 among all states, and the number of sites participating in the NHSC rose by over 6 percent during the 2015 year. OHA has partnered with the state Primary Care Association and Office of Rural Health Association to ensure that practices in these areas are aware of these resources to help them in their recruitment efforts.

So far, in the 2015–17 biennium, over 560 awards for loan repayment and loan forgiveness have been made to providers in underserved areas through state and federal resources. In addition to the 42 providers who received awards under the Medicaid Primary Care Loan Repayment Program (directed by the previous waiver agreement), Oregon will be making an additional 20-30 awards during the rest of this biennium as a result of additional funding made available by the Legislature – beyond what was required in the original waiver agreement.

II. Demonstration Eligibility

Populations Affected by or Eligible under the Demonstration from July 2017–June 2022

The table below illustrates the populations affected by or eligible under the demonstration and the eligibility and benefit criteria applied to each. There are no anticipated changes for the 2017–2022 renewal period from the 2014-2017 post-ACA period. All groups are eligible under various Title XIX authorities and subject to the terms and conditions of the 1115 demonstration. All population groups receive the full OHP Plus benefit package, with enhanced and/or protected benefits for children and pregnant women, and with no benchmark-equivalent coverage currently authorized. There are no enrollment limits on any population and no anticipated changes in eligibility processes or procedures outside of continued implementation of the state's automated eligibility systems. All Affordable Care Act and Modified Adjustment Gross Income (MAGI) transitions have been accomplished as planned.

Long-term services and supports are not furnished under the demonstration, although individuals eligible for both Medicaid and Medicare are an integral part of the Oregon Health Plan and will be included in CCO auto-enrollment with the approval of this renewal. Benefits provided under the demonstration are the same as those under the Medicaid and CHIP State Plans and apply generally to all populations (see below).

The state intends to continue with the current delivery system, largely based on coordinated care organizations (CCOs), utilizing patient-centered primary care home models to a great extent; and the state has a fee-for-service population as well. The system continues to drive toward integration and coordination of accessible and quality-based health care for the OHP population and to emphasize care coordination at all levels, including primary care case management.

I. Medicaid Populations-1115 Demonstration

Population	Description	Funding	Authority	Income limits	Resource limits	Benefit package	EG group	Delivery system
1	Pregnant Women	Title XIX	Title XIX state plan and section 1115	0% up to 185% FPL	None	OHP Plus with enhanced pregnancy benefits	Base 1	Managed Care or Fee-for- Service
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL** Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus with enhanced pregnancy benefits	Base 1	Managed Care (CCO) or Fee-for-Service
4	Children 0 through 18	Title XXI	Title XXI state plan and section 1115	134% up to 300% FPL	None	OHP Plus	Base 1	Managed Care (CCO) or Fee-for-Service
5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	$2,000	OHP Plus	Base 2	Managed Care (CCO) or Fee-for-Service

Population	Description	Funding	Authority	Income limits	Resource limits	Benefit package	EG group	Delivery system
6	Medicaid mandatory section 1931 low income families. (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1	Managed Care (CCO) or Fee-for-Service
7	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus	Base 2	Managed Care (CCO) or Fee-for-Service
8	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	$2,000 single individual, $3,000 for a couple	OHP Plus	Base 2	Managed Care (CCO) or Fee-for-Service

Population	Description	Funding	Authority	Income limits	Resource limits	Benefit package	EG group	Delivery system
9	Former Foster Care Youth to age 26	Title XIX	Title XIX state plan and Section 1115	No FPL limit if in Oregon Foster Care at age 18	None	OHP Plus	Base 1	Managed Care (CCO) or Fee-for-Service
21	Uninsured or underinsured women under the age of 65 receiving treatment services under the Breast and Cervical Cancer Treatment Program (BCCTP)	Title XIX	Title XIX state plan and Section 1115	0% up to 250% FPL	None	Case-by-case basis	Base 1	Managed Care (CCO) or Fee-for-Service
23	Low-Income Expansion Adults (MAGI)	Title XIX	Title XIX state plan and Section 1115	0% up to 133% FPL	None	ABP (OHP Plus)	Base 2	Managed Care (CCO) or Fee-for-Service

III. Demonstration Benefits and Cost Sharing Requirements

Under this renewal request, Oregon intends to maintain all existing benefits and cost sharing requirements outlined in the current 1115 demonstration. Benefits and cost sharing requirements under the renewal demonstration period will not differ from those under the Medicaid and/or CHIP state plan.

1) Indicate whether the benefits provided under the demonstration differ from those provided under the Medicaid and/or CHIP State plan:
   - ☐ Yes
   - ✓ No
2) Indicate whether the cost sharing requirements under the demonstration differ from those provided under the Medicaid and/or CHIP State plan:
   - ☐ Yes
   - ✓ No

The following chart details the current benefits and cost sharing requirements that Oregon will maintain under the renewal request submitted to CMS.

Cost-sharing in Oregon[25]

The Oregon Health Plan has no premiums or other cost-sharing, but eligible individuals may be required to pay small co-payments for outpatient services and some prescription drugs.

[25] Co-payments for specified services constitute the only cost-sharing in Oregon for Medicaid beneficiaries.

Populations subject to co-pays	Exempt populations	Services subject to co-pays	Exempt services	Range of co-pays	Other
• Adults (age 19 and over) who receive OHP • Clients with both Medicare and Medicaid coverage[26]	• Youth in foster care through age 20 • Pregnant women • Individuals who receive services under a home and community-based waiver (HCBS) • Inpatients in a hospital or nursing facility • Certain American Indians/Alaska Natives[27]	• Some prescription drugs[28] • Office visits • Home visits • Hospital emergency room services when there is not an emergency • Outpatient hospital services • Outpatient surgery • Outpatient chemical dependency treatment • Outpatient mental health treatment • Outpatient therapies • Vision exams • Restorative dental services	• Emergency services • X-ray and lab services • Durable medical equipment and supplies • Routine immunizations • Drugs ordered through the home delivery pharmacy program • Family planning services and supplies • Diagnostic and preventive dental services • Certain services for clients with third-party liability (TPL)[29]	$1-$3	The health care provider or pharmacy collects the co-pay at the time of service or during the regular billing cycle.

[26] Clients with both Medicare and Medicaid coverage have co-pays for the applicable Medicaid services.

[27] Those who are members of a federally recognized Indian tribe or receive services through a tribal clinic.

[28] $2 for generic drugs and $3 for brand-name drugs.

[29] Services paid by the TPL where the TPL's payment is as much or more than what DMAP would normally pay for the service/drug.

Oregon Co-Payments, by service type

Service or benefit	Co-payment
Acupuncture services	$3
Ambulance services (emergency)	$0
Ambulatory Surgical Center	$3
Audiology services	$3
• Hearing Aids	$0
Chemical dependency services	
• Outpatient services	$3
• Medication dosing/dispensing, case management	$0
• Inpatient hospital detoxification	$0
Chiropractic services	$3
Dental services	
• Diagnostic oral examinations used to determine changes in the patient's health or dental status, including x-rays, laboratory services and tests associated with making a diagnosis and/or treatment.	$0
• Preventive services-routine cleanings fluoride, sealants	$0
• Restorative treatment or other dental services	$0
DME and supplies	$3
Home visits for	
• Home health	$3
• Private duty nursing	$3
• Enteral/Parenteral	$3
Hospital	
• Inpatient care	$0
• Outpatient surgery	$3
• Emergency room services	$0
• Outpatient, other	$3
• Non-emergent visit performed in the ER	$3
Mental health services	
• Inpatient hospitalization- includes ancillary, facility and professional fees	$3
• Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners	$3
• Outpatient hospital- Electroconvulsive (ECT) treatment including facility, professional fees and anesthesiology fees	$3
• Medication Management by psychiatrist or psychiatric mental health nurse practitioner	$0
• Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician	$0
Naturopathic services	$3
Podiatry services	$3
Prescription drugs	
• Non-preferred PDL or generics in non-PDL classes costing >$10	$1
• Preferred PDL generic or generics in non-PDL classes costing <$10	$0
• Preferred PDL brand	$0
• All other brands	$3
Professional visits for	
• Primary care, including urgent care by a Physician, Physician Assistant, Certified Nurse Practitioner	$3
• Specialty care	$3
• Office medical procedures	$0
• Surgical procedures	$0
• PT/OT/Speech	$3
Radiology	

• Diagnostic procedures • Treatments	$0 $0
Vision services • Exams- for medical purposes or solely for glasses • Frames, contracts, corrective devices	 $3 $0

IV. Delivery System and Payment Rates for Services

Though significant changes are not being made to the existing CCO delivery system under this demonstration renewal, the proposed Coordinated Health Partnerships (CHP) pilot program will include a few minor changes to the delivery system. As previously noted (reference pages 25-40), CCOs or Tribes and I/T/Us will be encouraged to develop regional partnerships with county and city government, local health departments and housing agencies, hospitals, affordable housing providers, and supportive housing service providers. Currently, OHP members are not generally served by integrated networks that include the various providers and entities identified as critical partners for the CHP pilot program. Additionally, Oregon seeks to provide CHPs with the option of providing care coordination services to pre-adjudicated incarcerated individuals in county correctional facilities and individuals in an institution for mental diseases (IMD). For a specified period of time, these populations would be eligible to receive care coordination services from the CCOs and CHP partners to assist in their transition into the community. Oregon expects that the CHP pilot program will result in improvements to quality, access, cost of care, and health outcomes for high-risk and high-need populations. For additional discussion about the CHP and the impacts on quality and outcomes, please reference pages 25-40 of this document.

Oregon will use the following delivery system in the demonstration renewal:

- Coordinated Care Organization (Managed Care Organization)
- Fee-for-service
- Patient-Centered Primary Care Homes

The demonstration renewal will not alter the current delivery system used for each eligibility group. The chart on pages 58-60 outlines the current eligibility groups and corresponding delivery systems that will be used in the demonstration renewal period from 2017-2022. OHA will work with Tribal partners to determine if Primary Care Case Management can be implemented to improve care coordination for tribal members. Therefore, the use of Primary Care Case Management may be an additional delivery system employed by OHA.

As previously mentioned, Oregon stood up 16 CCOs during the current demonstration period that deliver the majority of physical, oral and behavioral health services to OHP members. Long term services and supports are not provided by the CCOs and are not included in the existing and renewal demonstration. Oregon will continue to use the CCOs to provide health care services including physical, behavioral, and oral health services to OHP members under the demonstration renewal. All OHP members will continue to be required to enroll into a CCO unless they qualify for an exemption – granted if the individual is an American Indian or Alaska

Native, dual eligible beneficiary, or on a case-by-case basis. Under this demonstration renewal, Oregon proposes to automatically enroll dual eligibles into CCOs unless the individual actively chooses not to enroll and notifies the state of this choice. CMS guidelines will be followed to ensure individuals are able to exercise their right if they choose not to be enrolled in managed care. Beyond the dual eligible proposed change, all other exemptions will remain the same as in the current demonstration.

As required by CFR 438.202(d), Oregon assesses how well the Coordinated Care Organizations (CCO) and Managed Care Organizations are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees, and consumer satisfaction data. Additional details on the quality strategy can be found in Appendix B. Oregon's evaluation plans will also inform the quality and appropriateness of care provided to Medicaid beneficiaries.

CCOs and their provider networks are currently under contract with the state of Oregon to provide health care services. In compliance with state statute and contracting requirements, CCOs will continue as the state's delivery system to procure health care services.

Under this waiver renewal, Oregon will continue to use its Prioritized List of Health Services to manage benefits under the Oregon Health Plan. The state will continue to use its waiver authority to provide services that appear above the funding line established by the Oregon Legislature, including ancillary services for these conditions. The state will also provide medically appropriate diagnostic services required to establish a diagnosis or guide treatment decisions. The funding line can only be moved to a higher position (resulting in fewer services provided) at the request of the Oregon legislature and as approved by CMS. The state will continue to provide treatment for conditions that do not appear above the funded line when associated with a co-morbid condition which appears in the funded region of the list. All state plan benefits will be provided by CCOs with the exception of the following:

- Long term services and supports;
- Adult mental health residential;
- Hospice services provided in a skilled nursing facility; and
- Targeted Case Management.

Fee-for-service payments will be made by the agency for services provided to individuals not enrolled in a CCO or in situations where services are carved out, and those payments are all made according to state fee schedules and state plan methodologies.

The Oregon Health Authority contracted with Optumas to revise the rate methodology for the 2015 capitation rates, and the same methodology was used to develop the 2016 rates for all 16 CCOs. The rate methodology is based on grouping 16 CCOs into four rating regions and developing a regional benchmark for each rating cohort. This regional approach is supplemented with CCO-specific risk factors that reflect the unique risk of each CCO. These risk factors are

applied to the regional benchmark resulting in CCO payment rates that are commensurate with the CCOs' unique risk. More information on the rate methodology can be found at the following link: www.oregon.gov/oha/analytics/Pages/OHPrates.aspx.

As mentioned above (see pages 48-51), Oregon is proposing to categorize health-related services as "activities that improve health care quality" and include the costs of these services in the benefit component of the CCO capitation rate (i.e., treat them like medical expenses for rate setting purposes). OHA will continue to break this component out in the rate certification for CMS' review.

Oregon will continue its incentive programs for both coordinated care organizations and hospitals, utilizing the pay for performance programs as levers to drive focus on quality improvement efforts across the health system. Both CCO and hospital programs will continue for the length of the waiver, which will be guided by the legislatively appointed public committees to review program performance, select measures and set benchmarks on an annual basis. Additional details about the CCO and hospital incentive programs are provided in Appendix C: Measurement Strategy. Under the demonstration renewal, CCOs will be required to enter into value-based payment arrangements with network providers.[30] Oregon's current demonstration calls for CCOs to adopt alternative payment arrangements to align CCOs and their providers with the State's transformation objectives. In this demonstration renewal, the State seeks to ensure that such arrangements are being adopted by requiring a percentage of CCO payments to network providers to be made through value-based payment (VBP) arrangements.

[30] Efforts under the CPC+ initiative will be recognized as movement towards value-based payment arrangements.

V. Implementation of Demonstration

Implementation Schedule: All of the changes proposed in the demonstration renewal application will be implemented in year 1 (July 1, 2017), with the exception of the Coordinated Health Partnerships, and will continue through the five-year demonstration period. For the Coordinated Health Partnerships, Oregon is proposing a multi-faceted, incremental approach to the state's integration of health care and supportive housing for the 1115 demonstration renewal:

- Year 1: Convening and planning initiatives, regionally and statewide. Select proposals and create CHPs.
- Years 1-5: Statewide investment in infrastructure development and creation of CHPs.
- Years 2-5: Pilot and test new models of housing supportive programs among CHPs.
- Years 2-5: Transition from paying for process to paying for outcomes based on evidence-based practices.
- Years 3-5: Dissemination and spread of best practices.

Notification and Enrollment of demonstration participants: Oregon will continue to use its current notification process under the demonstration renewal. For this demonstration renewal, Oregon is requesting approval to automatically enroll duals into CCOs and provide notice to duals on opt out procedures. Oregon's opt-out process will ensure that CMS-approved communication tools are used to ensure due process and that opt-out notification meets the CMS standards that were previously adopted. In Oregon, the welcome letter communication would be sent 90 days in advance of auto-enrollment, assuring more than the minimum 60-day notice for members to opt-out, giving them the chance to determine if their current providers are part of the CCO network and to make an informed decision. The state will provide a clear opt-out process by mail or phone, and ensure that CCOs provide a minimum 120 day care continuity transition timeline. Under the Coordinated Health Partnerships, OHP members will have the ability to voluntarily join the regional pilot program.

Contracting with managed care organizations: The state is currently contracted with the 16 CCOs that cover members throughout Oregon through December 31, 2018. CCOs will continue as the state's delivery system for managed care.

VI. Public Notice and Comment Process

In an effort to build on the state's health system transformation success and to continue to promote excellence in health care access, quality, and health outcomes across the state, Oregon has been engaging key leaders and stakeholders and asking for public input on the waiver renewal. The public process has allowed Oregon Tribal and urban Indian populations, consumers, health systems, CCOs, providers, and other key stakeholders and the public the opportunity to comment on the proposed renewal of the 1115 demonstration; this process has been public and accessible. Printed copies or alternate formats of the application or any information were made available by request: Janna Starr by email at Janna.Starr@state.or.us, by USPS mail at Oregon Health Authority, The Human Services Building, 500 Summer Street NE, Salem, OR, 97301, or by phone at 503-947-1193.

Printed copies were made available at:

- The Human Services Building, 500 Summer Street NE, Salem, OR
- The Portland State Office Building, 800 NE Oregon Street, Portland, OR

Additional details were available online at: http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx.

In addition to receiving input in writing and through public meetings and consultations, OHA posted a survey to its Waiver Renewal website. The survey was distributed through an agency stakeholder list and was open during the same timeframe as the public comment period. Sixty-seven respondents completed the survey. Please see Appendices J and K for complete documentation of the state's public notice and comment process.

The Oregon Health Authority and Governor's Office staff have engaged leaders and stakeholders across the state. The renewal was developed in consultation and collaboration with the Governor's office, other state agencies partners, such as the Housing and Community Services Division and Legislative committee partners, and Tribal Health Leaders.

OHA has met with and received feedback from organizations, groups and individuals, including:

- **Consumer and member advocacy groups**, including the Human Services Coalition of Oregon; Oregon Food Bank; the Health Equity Alliance; Asian Pacific American Network of Oregon; a number of interpersonal-violence-focused organizations; organizations advocating for individuals with specific conditions or circumstances such as Hepatitis C, HIV/AIDS, homelessness or risk of homelessness; the Oregon Law Center; children's advocates and foster youth advocates; senior advocates and advocates for individuals with disabilities.
- **Policy leaders**, including state legislators.

- **Hospitals and Health Systems leaders**, including the Oregon Association of Hospitals and Health Systems; the Oregon Health Leadership Council; OHSU Family Medicine; the Oregon Primary Care Association; Indian Health Care Programs (IHCPs).
- **Coordinated care organization leaders**, including CCO Chief Executive Officers; CCO Medical Directors; CCO Behavioral Health Directors and other representatives of CCOs and the Coalition for a Healthy Oregon (COHO).
- **Governments and local government organization**, including Oregon's nine federally recognized Tribes; the Oregon Association of Community Mental Health Programs; the Oregon Association of Counties Housing Committee and the Coalition of Local Health Officials (CLHO).
- **Health and health care committees**, **advisory groups and work groups, and boards**, including the Oregon Health Policy Board (public meetings); Medicaid Advisory Committee (public meetings); the OHA Consumer Advisory Council and the OHA Ombuds Advisory Council.
- **Other community leaders and Medicaid consumer-involved agencies and organizations**, such as Pacific Northwest Enterprise Partners; Innovative Housing, Inc. and the Housing Alliance.
- **Health care contractors and special interest groups**, such as PhRMA and KEPRO.

OHA staff logged 87 meetings and opportunities for comment through June 1, 2016. Prior to the beginning of the public comment period, Oregon engaged stakeholders through meetings to develop the draft waiver posted online on May 2. All meetings have been included as a reference in Appendix K. Comments and feedback received during the public comment period (May 2-June 1) were logged and responses are included in the logs included in Appendix K.

Table 1 Total meetings, comments from meetings and written comments

Comments/questions by group or source	Meetings/consultations and written communications	Comments responded to in log (see Appendix K)
Tribal meetings/consultations	10	33
Public meetings – • Oregon Health Policy Board (OHPB) • Medicaid Advisory Committee (MAC)	2 2	27 27
Legislative Committee meetings	4	12
Other meetings (various)	69	59
Written comments (letters)	77	77
Letters of support	24	24
Online survey	67	67
TOTAL	**87 – Meetings** **101 – Written** **67 - Survey**	**326**

Summary of Comments

In general, the vast preponderance of comments on the renewal request have been positive and helpful. Many commenters expressed support for continuing health system transformation and moving forward the innovative solutions it presents, such as flexible health-related services and global budgets.

Constituents and partners presented a number of creative ideas that OHA incorporated throughout the waiver application. Extensive comments were submitted in support of the Coordinated Health Partnerships (CHP) pilot proposal, and several recommendations were incorporated as a result of public comment. The CHP proposal includes the following items as a result of public comment:

- OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments.
- CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain.
- OHA has added a reference to encourage CCOs to support trauma informed care and services.
- OHA will convene a CHP advisory group to provide recommendations for program implementation

- Addition of health equity focused Community Based Organizations to partner list for CHPs.
- OHA will explore the inclusion of juveniles in detention centers as a target population under the Transitions of Care domain.
- Incorporation of language to build health information exchange infrastructure to support the CHPs.
- Further investments in telehealth and mobile health to support the health care delivery system.
- Opportunity for fee-for-service beneficiaries, such as dual-eligibles, to participate in local CHPs.
- Allowing tribes to function as a lead entity for a CHP.

With respect to Tribal comments, OHA made changes to the waiver to address requests around care coordination, contractual arrangements with CCOs and the need for increased access to fee-for-service specialty providers. In the revised waiver application, OHA made a commitment to work with tribes to implement a requirement for CCOs to engage in good faith contractual arrangements with tribes and Indian Health Care Programs (IHCPs) and to establish effective care coordination options for American Indians and Alaska Natives and the IHCPs that serve them.

With respect to health related services, stakeholders support the state's efforts in this request to make it more feasible for OHP members to receive health-related services via an improved structure in rate setting. As a result of public comment, OHA made the following changes to the proposals around health-related services, integrated global budgets, the 2 percent test and the sustainable rate of growth:

- Provided clearer definitions of health-related services and community benefit initiatives.
- Proposed an MLR standard of 88% - the MLR currently used for rate setting purposes – with a tiered corridor of 3% (85%).
- Any CCO reinvestment in health-related services would be included in the base of the CCO capitation rate and therefore remain in the system. CCOs with an MLR at 88% or above will not be subject to any remittance or reinvestment requirement.

As a result of public comment, OHA has incorporated information about the continued effort and work to integrate adult mental health residential services into CCOs although this does not require waiver authority.

Additional new language in the waiver renewal includes directing the Traditional Health Worker Commission to focus on increasing employment and effective supervision of THWs through targeted activities such as new and enhanced internships and other incentive programs.

Though there was extensive support for the move towards outcomes-based metrics, payments and incentives, OHA incorporated recommendations to address social determinants of health as an eighth focus area under the Performance Improvement Project (PIP) and encourage CCOs to address health equity through all PIPs and quality improvement efforts. Another addition includes the development of PIPs at the local and regional level to foster innovation and improvement.

Stakeholders were generally supportive of the proposal to have dual-eligibles automatically enrolled into CCOs with an opt-out option, yet some concerns were raised related to the implementation of such a proposal. OHA has addressed those concerns by incorporating the following recommendations:

- Dual eligible that live in an area with two CCOs will be enrolled using the same process as other members, except with preference if a CCO also provides their Medicare Advantage plan or other services such as D-SNP to promote better care coordination.
- OHA will implement the dual eligible enrollment change over time and work closely with CCOs to minimize the impact to members.

Documentation of Oregon's Public Notice and Comment Process is found in Appendix J.

Public Hearings: OHA held two public hearings in April to share the concept and vision broadly. These served as introduction to the visions and concepts in the waiver renewal, prior to the posting of the draft applications. The meetings included:

- **April 5, 2016:** Oregon Health Policy Board; OHSU Center for Health & Healing;
  3303 SW Bond Ave. Floor 3, Room 4
  Portland, OR 97239;
  Call-in information for the public: Conference Call Number: 1-888-808-6929
  Public Participant Code: 915042#
  Web information (live events and recordings can be found here):
  https://echo360ess.ohsu.edu:8443/ess/portal/section/b797fe67-ce31-4277-b211-8612761c05ce
  Input taken in-person and in writing.
- **April 27, 2016:** Medicaid Advisory Committee; Oregon State Library;
  250 Winter Street, NE; Room 102; Salem OR 9730
  Call-in information: 888-398-2342
  Input taken in-person and in writing.

The Oregon Health Authority also held two public hearings after the draft waiver application was posted on May 2, 2016.

- **May 3, 2016:** Oregon Health Policy Board; OHSU Center for Health & Healing;
  3303 SW Bond Ave. Floor 3, Room 4

Portland, OR 97239;
Call-in information for the public: Conference Call Number: 1-888-808-6929
Public Participant Code: 915042#
Web information (live events and recordings can be found here):
https://echo360ess.ohsu.edu:8443/ess/portal/section/b797fe67-ce31-4277-b211-8612761c05ce
Input taken in-person and in writing.

- **May 25, 2016:** Medicaid Advisory Committee; Oregon State Library;
  250 Winter Street, NE; Room 102; Salem OR 9730
  Call-in information: 888-398-2342
  Input taken in-person and in writing.

Video recordings of the Portland Oregon Health Policy Board meetings, including the waiver presentations and public input can be found online at:
https://echo360ess.ohsu.edu:8443/ess/portal/section/b797fe67-ce31-4277-b211-8612761c05ce

Written input: Public input was also taken by email (Janna.Starr@state.or.us) and USPS mail (Janna Starr, Oregon Health Authority, The Human Services Building, 500 Summer Street NE, Salem, OR, 97301).

Survey: For those that preferred a survey format, public input was taken through a survey available at www.surveymonkey.com/r/QP7W23N. Survey results are highlighted in Appendix K.

Tribal consultation

The State had regular consultations and meetings with the nine federally recognized Indian tribes in Oregon, urban Indian populations and Indian health providers and provided the constituents with opportunities to comment on all proposals for renewing the OHP demonstration. OHA met with Tribal Health Leaders ten times from March to June. Tribal consultations took place on May 5, May 27, and June 20 and agenda items are included in Appendix J. All tribal meeting dates are detailed in Appendix J.

The OHA Tribal Affairs Director notified all Tribal Health Leaders of meetings and consultation opportunities. Emails documenting the notification process for tribal consultations are included in Appendix J. In addition, OHA also sent Tribal Health Leaders a memorandum requesting comments on the draft waiver application. This letter was also posted online at https://www.oregon.gov/oha/OHPB/Documents/request-for-comments.pdf.

Tribal Health Leaders were engaged in the development and review of waiver language that ensures access to health care services for American Indians and Alaska Natives.

Post-Award Public Forum

On Dec. 11, 2012, the Oregon Health Policy Board and Oregon Health Authority (OHA) hosted a statewide public forum to gather perceptions, feedback and input on the progress to date of Oregon's Health System Transformation efforts. The feedback obtained through the forum was used by staff to ensure that coordinated care organizations (CCOs) were being implemented with the input and interest of Oregonians across the state. The feedback helped both CCOs and OHA create a health care system that ultimately provides better health at lower costs, with the patient at the center of their care. Input gathered through the forum was also included in OHA's Quarterly Report to the Centers for Medicare and Medicaid Services (CMS) as required by the state's agreement with CMS.

To ensure the widest possible participation from all parts of the state, OHPB and OHA set up numerous ways in which people could both watch the meeting and offer feedback:

All Oregonians were invited to participate. Email blasts and public meeting notices, as well as announcements through OHA's website, social media, and newsletters were disseminated widely. The board meeting was held at the Multnomah County Commissioners' board room. An estimated 200 people attended in-person in Portland. The meeting was also captured on video and broadcast to satellite meeting rooms in five offsite locations around the state: La Grande, Eugene, Tillamook, Bend and Medford. In each of those locations, participants could both watch the video stream and interact with the board by reporting back and offering testimony through video. An estimated 75 people attended the five satellite locations.

The meeting could also be watched live through either an online webinar or a live Web stream. Those who watched the meeting through the webinar were able to give oral testimony at the end of the meeting and answer relevant poll questions during the meeting. An additional 304 people watched online through the webinar or the live Web stream.

The board also accepted written testimony through its email: ohpb.info@state.or.us. Over 180 people submitted emails offering input on health system transformation. During the board meeting, 17 people provided oral feedback. Lastly, feedback forms were provided at all six meeting locations that allowed participants to offer further input.

Input

Comments received orally at meetings and during presentation, and received in writing were varied. Comments ranged from what services should be covered under the Oregon Health Plan and CCOs (such as naturopaths and physical activity coordinators) to how best to integrate dental care into CCOs in 2014 or sooner. One person provided ideas for marketing mantras for health transformation. There were also broad recommendations on how to design CCOs successfully (such as the importance of transparency and Community Advisory Councils) as well as specific recommendations like utilizing local fire departments and tracking specific 911 calls.

Overall, the comments, both written and oral, were optimistic, appreciative, and cautious. Oregonians, stakeholders, and organizations across Oregon expressed an understanding of the imperative of fixing a health care system that is too expensive and does not produce better health. Largely, comments embraced a cultural shift in how we deliver health care to Oregonians on the Oregon Health Plan, but a majority had at least some concern that specific, vital services might be lost within the change. Some highlights of the comments and feedback included: 137 people – over half of all emailed input – wrote OHPB supporting the inclusion of midwives under new CCOs. Prevention was mentioned over fifteen times in comments, from nutrition services to early childhood services to the importance of primary care physicians. Behavioral health, specifically how it can be integrated with physical health also was an important issue, with five different people commenting on the topic in writing.

VII. Federal Authority Requests: Proposed Waiver and Expenditure Authorities

Waiver Authority

As detailed in the attached matrix (see Appendix F) there are several changes that will occur to the OHP based on this amendment, but the state believes that its existing authority already allows for many of the proposed changes. The state anticipates changes to its Special Terms and Conditions to reflect the proposed programmatic changes. Additionally, the state will be requesting state plan amendments to implement some features of the transformation, including the ability to expand the services provided through nurse home visits to high-risk families.

Oregon's current waiver includes authority that the state wishes to maintain. This authority allows the state to:

1. Contract with managed care entities and insurers that operate locally;
2. Offer benefits consistent with a prioritized list of conditions and treatments, subject to certain exceptions for protected benefits;
3. Provide coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one;
4. Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans;
5. Not pay a disproportionate share of hospitals payments for managed care enrollees; and
6. In general, permit coordinated care organizations to limit periods during which enrollees may dis-enroll, with an amendment the state is seeking with this renewal (see below).

Oregon's current Demonstration also includes *expenditure* authorities that the state wishes to maintain. These authorities allow the state to:

1. Provide expenditures to cover providers that do not comply with disenrollment restrictions on enrollees;
2. Provide 6 to 12-months of benefits for eligible individuals, including children, when they cease to be eligible for Medicaid during the 6-12 month period after enrollment;
3. Provide coverage for certain chemical dependency services for targeted beneficiaries;

4. Receive federal financial participation for certain state-funded health care programs;
5. Continue Uncompensated Care payments for Tribal Health Facility Program; and
6. Continue to provide incentive payments to participating hospitals through the Hospital Transformation Performance Program.

In addition to Oregon's existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow for:

Issue	CFR/SSA reference
• Value based payment methodologies to reimburse on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care and comprehensive care coordination, including requiring CCOs to make value-based payments for a minimum percentage of contracted services	42 CFR § 438.6
• The inclusion of flexible, health-related, services as a medical expense in capitation rate setting for CCOsrather than as administrative costs	42 CFR § 434.20-21, SSA § 1902 42 CFR § 438.6
• Reinvestment of CCO savings into health-related services	42 CFR § 434.50 42 CFR § 438.116
• Extension of the state's Hospital Transformation Performance Program (HTPP)	Section 1115 (a)
• Extension of the state's Tribal Uncompensated Care Program (UCCP)	Section 1115 (a)
• Care coordination for individuals 30 days from discharge from an institution for mental diseases (IMD) • Care coordination for pre-adjudicated incarcerated individuals in local correctional facilities for up to 30 days of the initial incarceration period	42 CFR 438.3, 42 CFR § 435.1009 42 CFR § 435.1010 SSA § 1115(a)
• FFP for community-based Coordinated Health Partnerships (CHPs) pilots focusing on supportive housing services to targeted population(s); utilization of local government and other allowable funds to serve as state match; temporary rental assistance for transitional housing for up to 60 days for patients leaving an acute care setting who require health care services	42 CFR § 1905(a)
• Psychiatric telephonic consultation line pilot for adults and older adults to address Oregon's limited access to prescribing psychiatric clinicians	SSA § 1905(a)
• Doulas to provide services within the doula's scope of practice without supervision of an existing licensed medical provider	SSA § 1905(a); 42 CFR § 440.60
• Permitting enrollees dually eligible through Medicare and Medicaid to disenroll from CCOs without cause at any time	42 CFR § 438.50 42 CFR § 438.56
• Receive federal financial participation (FFP) for certain designated state-funded health care programs	SSA § 1115(a)

Issue	CFR/SSA reference
• Care Coordination facilitation for American Indians/Alaska Natives, including PCCM	SSA § 1905(a)
• Expand Nurse Home Visiting and access to Targeted Case Management (State Plan)	SSA § 1905(a)

Oregon will not seek authority to continue the existing waiver of retroactive eligibility (section 1902(a)(34)), which is a waiver to enable the state to not provide three months of retroactive coverage (applies to all Medicaid state populations, except 7 and 8, listed on pages 58-60).

Expenditure Authorities

In addition to the waiver authorities outlined above, Oregon is requesting an amendment to authorize federal financial participation (FFP). These programs would be authorized by Section 1115(a) cost not otherwise matchable authority (CNOM). The target request is approximately $250 million per year over the 5-year demonstration renewal. This expenditure request will continue to support the momentum of health system transformation, as well as the infrastructure building required to create and facilitate Coordinated Health Partnerships. These expenditure authorities will promote the efficiency and quality of care through initiatives to transform delivery to support better care transitions, improved health outcomes, increased access to health care services for Medicaid members and other low-income populations in Oregon.

Programs have been identified that are vital for the success of health system transformation, spanning mental health, housing services, and child health services. Currently, state funds support these services and programs to meet health needs that Medicaid, as it is currently structured, does not. Many Oregonians served by these dollars receive services alongside of people who are Medicaid eligible, and many of them are individuals who churn in and out of Medicaid, creating a confusing and inefficient system for consumers and communities to navigate. We ask for federal investment in these programs in which the state has committed significant general fund dollars in recognition that they are vital to improving the health of Medicaid enrollees and the communities in which they live and to support the investment in the development and demonstration of the Coordinated Health Partnership pilots.

Oregon's request has been developed after similar approved requests in other states, and Oregon hopes to be given the same opportunity. CMS approval of this request will allow Oregon to move forward with our mutual reform goals to advance health system transformation and improve the social determinants of health of our most vulnerable members and build cross community partnerships to coordinate care transitions. These pilots will decrease medical expenditures through lower emergency department use, in patient hospitalizations and residential treatment stays.

Finally, the State would also like to explore with CMS the mechanism for using county and tribal Intergovernmental Transfers.

VIII. Financing and Budget Neutrality

Financing

There are no changes in the Oregon Health Plan Medicaid demonstration extension request application that will directly increase or decrease annual enrollment.

The current demonstration includes the Hospital Transformation Performance Program with an annual limit of $150 million for hospital incentive payments. The extension application requests continuation of this program.

The current demonstration authorizes federal funding for Designated State Health Programs (DSHP), generating up to $1.9 billion in federal investment. The extension application will include the request for continued federal investment under DSHP or other federal authorities, or both, to claim Medicaid matching funds for programs and services not otherwise eligible for Medicaid matching funds. The State is requesting $250 million per year in continued federal investment over the five-year extension period to further advance Health System Transformation. A significant portion of that federal investment will support Oregon's proposed Coordinated Health Partnership Model, described above. The state will work with CMS to explore funding mechanisms that allow for Medicaid matching through waiver benefits as much as practicable.

The attached display provides the historical Oregon Health Plan Medicaid demonstration performance since its inception in 1994 (see appendices G and H). Cumulative savings through the end of the current State Fiscal Year (SFY) 2017 is approaching $30 billion.

The five-year projection for the demonstration extension is approximately $37.2 billion. That projection includes Oregon's request for $150 million per year to continue the Hospital Transformation Performance Program and $250 million per year for continued federal investment to further advance Oregon's Health System Transformation.

Budget Neutrality

Oregon understands that the state must demonstrate budget neutrality for the Oregon Health Plan (OHP) demonstration. Budget neutrality means that Oregon may not receive more federal dollars under the demonstration than it would have received without it. The state is requesting a five-year extension to its Section 1115 Medicaid demonstration in order to maintain and further advance Oregon's health system transformation. This section discusses the budget neutrality test for the extension application.

The budget neutrality test performed for this extension application will build upon the methodology that was adopted for the OHP demonstration approvals that were originally granted in 1993.

The attached spreadsheets are Oregon's budget neutrality calculations for the demonstration extension request. Also attached is a spreadsheet showing Oregon's Title XXI CHIP allotment historical spending and projections for the requested five-year extension period (see appendix I).

Components of the Budget Neutrality Test

Oregon requests that the current Section 1115 demonstration methodology be used for the purpose of evaluating budget neutrality for the five-year extension period. This methodology uses a set of specified annual per capita costs multiplied by the actual or projected enrollment for each year of the five-year extension period. The result of this calculation is an aggregate allowable (i.e., without waiver) expenditure level, or ceiling.

Oregon proposes to use the CMS-approved demonstration Year (DY) 15 (State Fiscal Year 2017) per capita costs for the various eligibility groups under the current demonstration as the basis to determine the expenditure limit (ceiling) for five-year extension.

Trending Factors. The CMS-approved demonstration year 2015 per capita rates are trended by the CMS-approved allowable trend rates for each year through demonstration year 2020 (State Fiscal Year 2022).

Beneficiaries and Services Included. For both the expenditure ceiling (without waiver) and Oregon's projected expenditures (with waiver), no populations or services are removed or added to the budget neutrality calculations.

Requested Investments. Oregon's projected expenditures includes:

1. $150 million in total funds a year for continuation of the Hospital Transformation Performance Program;
2. $250 million in total funds a year for continued federal investment to further advance Oregon's Healthcare System Transformation; and
3. $6.5 billion in expended savings.

Historical Savings. Oregon is a demonstrated leader in delivering high quality care and containing spending growth in its Medicaid program. Oregon is requesting to continue use of the historical demonstration savings (currently estimated at $30 billion Total Funds through demonstration year 2015). This figure reflects the savings estimates identified by Oregon and CMS through the life of the OHP demonstration. Administrative costs will continue to be reimbursed based on the allowed federal matching rates of 50 percent, 75 percent or 90 percent of the administrative expense and are not subject to the budget neutrality test.

Caseload Estimates. All populations are reported as the average number of persons covered for the entire period. The Office of Forecasting, Research and Analysis, Department of Human Services, prepared the caseload estimates through DY 17 (State Fiscal Year 19). The caseloads for the remaining years reflect a 1.2 percent Oregon population growth rate.

Cost Estimates. Budget neutrality spreadsheet provides the projection of expenditures for the Title XIX program and present the budget neutrality for the requested Section 1115 demonstration (see Appendix H). These spreadsheets provide:

1. The budget neutrality summary from the beginning of the OHP demonstration project through this extension request.
2. The calculation of Oregon' budget neutrality expenditure limit (ceiling) based on allowable per capita and projected populations.
3. The state's actual and projected (with waiver) expenditures.
4. At the end of the demonstration extension, the state is projecting a savings of almost $60 billion Total Funds.

IX. Evaluation

2012-2017 Evaluation Overview

In the 2012–2017 demonstration period, Oregon supported evaluations that assessed the State's and CCOs' activities to transform Medicaid using six "levers" of transformation and analyzed the relationship between transformation activities and key outcomes. These evaluations include the Midpoint Evaluation conducted by Mathematica Policy Research and the Summative Evaluation that will be conducted by Oregon Health & Science University's Center for Health Systems Effectiveness (CHSE). The State also carried out targeted evaluations of activities to advance specific levers and used findings to improve its transformation efforts. While evaluation of the 2012 – 2017 demonstration is still in progress, preliminary results of OHA-supported and external evaluations indicate that the demonstration meaningfully affected patterns of care without negatively impacting key outcomes:

1. For the Midpoint Evaluation, Mathematica Policy Research assessed the extent to which OHA and CCOs supported and implemented activities to transform Medicaid, and provided insight into transformation areas where CCOs focused their efforts. This evaluation showed that OHA and CCOs made significant progress implementing transformation activities. CCOs were most transformed in the areas of physical health, mental health, and addiction services integration and care coordination, and less transformed in the areas of alternative payment methods (APMs), health information technology (HIT), and workforce transformation.

   The report also evaluated access to care and quality of care in the 21 months following CCO implementation and whether that could be attributed to CCOs. The evaluator found few statistically significant changes associated with the introduction of CCOs, with significant changes concentrated in the area of improving primary care. The analysis included a limited timeframe and omitted the use of a comparison group. Importantly, it was noted that early results from the extensive transformation of Oregon's Medicaid delivery system "do not suggest widespread negative results as a consequence of introducing the CCO model."[31]

2. An evaluation by researchers at Portland State University (PSU) and the Providence Center for Outcomes Research and Education (CORE) looked at the impact of CCOs on health care access and quality, as well as patient engagement, health behaviors, and health outcomes over time. It also looked at utilization patterns and costs over time, and documented mechanisms of transformation, assessing CCOs' defining characteristics, similarities, and differences. The evaluation found that CCO members had better access to care over time, relative to both those who were in Medicaid and not in a CCO, and

[31] Irvin et al. 2015. Midpoint Evaluation of Oregon's Medicaid Section 1115 Demonstration: Mid-2012 through mid-2014. Mathematica Policy Research.

those who were uninsured, as well as finding that CCOs were associated with more frequent primary care use, better connections to personal care providers, and better improvements in self-reported health. Results were published in Fall 2015.[32]

3. Preliminary results from an evaluation by researchers at OHSU's Center for Health System Effectiveness also suggests that CCOs meaningfully affected patterns of care in their first year. Comparing claims-based outcomes for CCO members and a commercial comparison group, it was found that CCOs were associated with an increased rate of primary care visits and a decreased rate of emergency department visits, as well as increased primary care spending and decreased emergency department spending per member, per month. Final results from this analysis are pending.

The Summative Evaluation of the 2012 – 2017 demonstration, conducted by OHSU Center for Health Systems Effectiveness, began in Spring 2016 and will assess trends in spending, quality, access, member experience, and health status to determine the impact of the Medicaid waiver. The evaluation will describe transformation activities where OHA and CCOs focused and did not focus, synthesizing information from existing evaluations, and provide specific and actionable recommendations for continuing health system transformation. The evaluation will be completed in early 2018.

Additional Evaluations of OHA and CCO Transformation Activities

1. The State Innovation Model Grant evaluation being conducted by OHSU Center for Health Systems Effectiveness will assess the spread of the coordinated care model among health care payers and providers. Consistent with findings from the midpoint evaluation, surveys conducted by Providence Center for Outcomes Research and Education (CORE) as part of the SIM evaluation showed that CCOs and other payers initially focused intensively on integration and care coordination, with less focus on areas of alternate payment methodology, health information technology, and the health care workforce. Providers initially focused on prevention and social determinants of health informed care, workforce transformation, and integration and care coordination. Providers were less focused on data for population health management.

   CORE also conducted a document review of CCO transformation plans and other narrative descriptions of activities to better understand where transformation efforts are focused. Findings include that transformation efforts are numerous, with CCOs reporting more than 2,600 distinct transformation activities, and that most CCOs are meeting milestones (incremental short-term steps), although CCOs struggle the most in the areas of *meeting members culturally diverse needs* and *eliminating health disparities.* Final results will be available at the end of September 2016.

[32] State Health Access Reform Evaluation (SHARE) Program. 2015. *Achieving the Triple Aim in Medicaid: Evaluating the Access, Quality, Health and Cost Impacts of Coordinated Care Organizations in Oregon.*

2. The Patient-Centered Primary Care Home Evaluation, conducted by Portland State University, assessed implementation of the PCPCH model and analyzed the effect of PCPCH recognition on health care utilization and spending. Evaluators found that PCPCH recognition increased preventive care procedures and decreased specialty care visits, pharmacy claims, and spending on primary care and specialty office visits. The report was published August 2014.[33]

3. The Hospital Transformation Performance Program (HTPP) evaluation, conducted by OHSU Center for Health Systems Effectiveness, in collaboration with Providence CORE, is estimating the impact of the hospital transformation performance program on hospital performance and quality improvement activities. The evaluation will also synthesize lessons learned from the program and provide guidance on incentives for hospitals and CCOs. The final report will be available June 30, 2016.

4. The Behavioral Health Home Learning Collaborative evaluation, conducted by OHSU, is evaluating the Behavioral Health Home Learning Collaborative, which assists clinics with integrating primary care into behavioral health settings. Results will be available in Summer 2016.

5. The Dual-Eligible Medicare-Medicaid Evaluation, conducted by OHSU Center for Health Systems Effectiveness, will assess the effect of CCOs on access, utilization, quality of care, and costs for dual eligibles. Results will be available in Fall 2016.

Evaluation design for Demonstration waiver renewal (2017-2022)

Waiver Focus Areas

For the 2017 – 2022 demonstration period, the focus of Oregon's evaluation effort will shift from assessing transformation activities as a whole to assessing activities in specific focus areas of the waiver:

1. Improving population and social determinants of health.

2. Improving quality of care, access to care, experience of care, and health status, and reducing costs for members with Medicaid and Medicare eligibility (i.e., dual eligibility).

3. Integrating physical, behavioral, and oral health care.

4. Enhancing health equity.

5. Implementing health-related services to improve care delivery and member health.

[33] Report can be accessed at: www.oregon.gov/oha/pcpch/Documents/2014%20PCPCH%20Cost%20and%20Efficiency%20Evaluation.pdf

6. Implementing value-based payments that reward quality and efficiency.

7. Improving hospital quality through the Hospital Transformation Performance Program.

8. Improving access to sustainable housing for members needing behavioral health services and other vulnerable populations.

Evaluation of activities in each area may be conducted independently, with distinct research questions and activities for each area. Evaluations may be conducted by the State, by a single contractor, or by multiple contractors, with each contractor conducting the evaluation in one or more areas.

Evaluation Topics: Implementation, Outcomes, and Impacts

The evaluation will assess three aspects of the State's activities in each focus area: implementation, outcomes, and impacts.

1. Implementation: Implementation encompasses whether activities in each focus area are being carried out as planned and how well these activities are being carried out. Assessing implementation will provide evidence about why the State's activities contributed (or did not contribute) to expected outcomes, such as reduced spending or increased quality of care. In addition, implementation assessment will provide rapid-cycle feedback that the State and its partners can use to improve their activities throughout the demonstration period.

2. Outcomes: Outcomes represent changes in measures or indicators of progress in each focus area. For example, increased childhood immunization rates may be an expected outcome of the State's activities in the area of improving population health. The evaluation will track outcomes in each area over the course of the demonstration. Although outcomes alone are insufficient evidence that an activity caused a change in a measure or indicator, they provide a basic check and measure of accountability for the State's activities.

3. Impacts: Impacts represent the extent to which the State's activities caused changes in measures or indicators in each focus area. To estimate whether a specific activity caused an observed change, the evaluation will incorporate an estimate of what would have happened in the absence of the activity, called a counterfactual. In experimental designs for medical and some social science evaluations, the counterfactual is provided by a control group in a randomized controlled trial; however, Oregon does not expect to be able to randomize receipt of activities (such as value based payments or health related services) in order to assess their impact. Where feasible, the evaluation will use a comparison group to provide the counterfactual. Where an appropriate comparison group is unavailable, the evaluation will use a pre/post or interrupted time-series design to estimate the impact of the State's activities.

a. A comparison group is a group of people who are similar to Medicaid members in terms of their observable characteristics, but are not affected by the State's activities under the demonstration. Potential comparison groups for waiver evaluation may be non-Medicaid populations in Oregon, Medicaid populations of other states, or the national population. Evaluators will use appropriate statistical techniques for matching comparison group members with Oregon Medicaid members or weighting comparison group members to ensure they match Oregon Medicaid members.

b. Pre/post and interrupted time-series designs use outcomes for Medicaid members before the demonstration as the counterfactual, and assume that pre-demonstration trends would have continued in the absence of the demonstration. Because these designs do not account for external factors that would affect Medicaid members in the absence of demonstration activities, they are considered less rigorous than randomized controlled trials or comparison group designs.

The evaluation may estimate the impact of the demonstration *overall* on outcomes in each focus area. In this case, evaluators would compare outcomes for Oregon Medicaid members to outcomes for people not enrolled in Oregon's Medicaid program (or in the case of pre/post or interrupted time-series designs, outcomes for Oregon Medicaid members before the demonstration). The evaluation may also estimate the impact of *specific activities* on outcomes in each focus area. In this case, evaluators would compare outcomes for Oregon Medicaid members affected by specific activities with outcomes for Oregon Medicaid members or other populations who were not "exposed" to the activities. For example, evaluators might compare members who received care and services under value-based payment arrangements with people who received care and services under traditional fee-for-service arrangements. Estimating the impact of specific activities would require tracking activities at the individual level (that is, tracking whether individual Medicaid members participated in certain activities or received certain services).

Research Questions and Data Sources

The evaluation will address research questions about implementation, outcomes, and impacts of the State's activities listed in the table below. The State may add research questions as the evaluation progresses.

The tables below include potential data sources that may be used to answer research questions. For some questions, existing data sources may be used. For other questions, Oregon anticipates new data sources will need to be established; these data sources are *italicized* in the table. Data sources listed in the table are tentative; the State may use different data sources or add new data sources as needed to answer the research questions.

1. Improving Population Health

Potential research questions: implementation	**Potential research questions: outcomes/impacts**	**Potential data sources**
1. What kinds of activities did OHA carry out to improve the health of Oregon's population or populations in specific geographies? 2. What kinds of activities did CCOs carry out to improve the health of Medicaid members? Did other CCO activities (e.g., flex services, APMs, integration) affect population health? The evaluation will focus on Oregon's public health priorities, such as priorities in the State Health Improvement Plan. For example, the evaluation may focus on activities in the following areas: • Preventing and reducing tobacco use • Slowing the increase of obesity • Improving oral health • Reducing harms associated with alcohol and substance use • Preventing deaths from suicide • Improving immunization rates • Protecting the population from communicable disease 3. How many community members were reached by, or participated in, OHA's efforts to improve population health (e.g., how many people were reached by advertising campaigns)? 4. How many community members were reached by, or participated in, CCO efforts to improve population health?	Did population health improve across Oregon or in specific geographies? / Did OHA's activities result in improved population health indicators? For example: 1. Did tobacco use decrease? / Did OHA's activities result in decreased tobacco use? 2. Did obesity decrease? / Did OHA's activities result in decreased obesity? 3. Did oral health indicators improve? / Did OHA's activities result in improved oral health? 4. Did injury and death rates from alcohol and substance use decrease? / Did OHA's activities result in decreased injury and death rates? 5. Did suicide rates decrease? / Did OHA's activities result in decreased suicide rates? 6. Did immunization rates improve? / Did OHA's activities result in improved immunization rates? 7. Did infection rates for select communicable diseases decrease? / Did OHA's activities result in the decrease?	1. *Documents describing OHA's population health improvement activities* 2. *Documents describing CCOs' population health improvement activities including Community Health Improvement Plans and Transformation Plans* 3. *Interviews with OHA staff who implemented population health activities* 4. *Interviews with CCO staff and health care providers who implemented population health activities* 5. *Interviews with local public health and community organizations who partnered with CCOs to implement population health activities* 6. *Vital statistics (e.g., death certificates)* 7. *Communicable disease surveillance* 8. *Surveys with population health indicators (e.g., Oregon BRFSS, Oregon Healthy Teens)* 9. *Immunization registry*

2. Improving Quality of Care, Access to Care, Experience of Care, and Health Status, and Reducing Costs for Members with Dual Eligibility

Potential research questions: implementation	**Potential research questions: outcomes/impacts**	**Potential data sources**
1. What kinds of activities did OHA carry out to improve outcomes for members with dual eligibility? 2. What kinds of activities did CCOs carry out that would be expected to improve outcomes for members with dual eligibility (either activities targeting members with dual eligibility or a broader group of CCO members)? 3. To what extent did CCOs coordinate with Medicare Advantage (MA) plans and agencies providing long-term services and supports (LTSS) for members with dual eligibility? 4. How did services targeting members with dual eligibility (e.g., targeted care coordination efforts) differ from services provided to members with dual eligibility who were not enrolled in CCOs? 5. What role did health care providers play in activities targeting members with dual eligibility? 6. How did members with dual eligibility experience care provided by CCOs, and how does their experience compare with that of members with dual eligibility who were not enrolled in CCOs?	1. Did spending decrease for members with dual eligibility? / Did membership in a CCO or specific services targeting members with dual eligibility result in decreased spending? 2. Did quality of care improve for members with dual eligibility? / Did membership in a CCO or specific services targeting members with dual eligibility result in improved quality of care? 3. Did access to care improve for members with dual eligibility? / Did membership in a CCO or specific services targeting members with dual eligibility result in improved access to care? 4. Did experience of care improve for members with dual eligibility? / Did membership in a CCO or specific services targeting members with dual eligibility result in improved experience of care? 5. Did health status improve for members with dual eligibility? / Did membership in a CCO or specific services targeting members with dual eligibility result in improved health status?	*1. Documents describing OHA and CCOs' activities to improve outcomes for members with dual eligibility* *2. Interviews with OHA staff who were involved in activities targeting members with dual eligibility* *3. Interviews with CCO staff and health care providers who were involved in activities targeting members with dual eligibility* *4. Interviews or focus groups with members with dual eligibility* *5. Claims/encounters with paid amounts or re-pricing, including claims from the federal Medicare program* *6. Surveys with access to care and experience of care items that can be matched to members with dual eligibility status* *7. Medical records that can be matched to members with dual eligibility status* *8. Vital statistics (e.g., death certificates) that can be matched to members with dual eligibility status*

3. Integrating Physical, Behavioral, and Oral Health Care

Potential research questions: implementation	**Potential research questions: outcomes/impacts**	**Potential data sources**
1. What kinds of activities did OHA carry out to facilitate integration of physical, behavioral, and oral health care? 2. What kinds of activities did CCOs carry out to facilitate integration of physical, behavioral, and oral health care among health care providers? 3. To what extent did providers in CCOs' networks integrate physical, behavioral, and oral health care? 4. What challenges and successes did providers experience with integrating physical, behavioral, and oral health care? 5. How did members who received integrated care experience the care they received? 6. Were there gaps in receipt of integrated care for any populations of focus (see Table 4 on page 91).	For CCO members overall, and for members who integrated care: 1. Did behavioral or oral health care spending increase? / Did CCO membership or receipt of integrated care result in increased behavioral or oral health care spending? 2. Did indicators of behavioral or oral health care quality improve? / Did CCO membership or receipt of integrated care result in improved behavioral or oral health care? 3. Did access to behavioral or oral health care improve? / Did CCO membership or receipt of integrated care result in improved access to behavioral or oral health care? 4. Did behavioral or oral health improve? / Did CCO membership or receipt of integrated care result in improved behavioral or oral health? 5. Did experience of care improve? / Did receipt of integrated care result in improved experience of health?	*1. Documents describing OHA and CCOs' activities to facilitate integration of physical, behavioral, and oral health care among providers* *2. Administrative records or surveys indicating the extent to which specific providers integrated physical, behavioral, and oral health care that can be matched to member records and other data sources (e.g., claims/encounters and surveys)* *3. Interviews with OHA staff involved in activities to integrate care* *4. Interviews with CCO staff involved in activities to integrate physical, behavioral, and oral health care among providers* *5. Interviews with providers whose practices integrated physical, behavioral, and oral health care* *6. Interviews with members who received care from integrated providers* *7. Claims/encounters with paid amounts or re-pricing* *8. Surveys with access to care, experience of care, and health status items* *9. Medical records* *10. Vital statistics (e.g., death certificates)*

4. Promoting Health Equity

The evaluation will address health equity for specific *populations of focus*. These are groups that have historically experienced disproportionately poor health outcomes, or that have been identified by Oregon's health policy leadership as appropriate populations on which to focus the state's health improvement efforts. For the purpose of addressing research questions, promoting health equity will be defined as:

1. Outcomes for populations of focus improved over the demonstration period; and

2. The gap between outcomes for populations of focus and a reference population decreased. A reference population is a group that has historically experienced favorable health outcomes relative to other groups.

Populations of focus and reference populations for the evaluation will be specified in a final evaluation plan based on input from Oregon's health policy leadership and data availability. Following is a list of populations that *may* be used in the evaluation:

Area	Population of focus	Reference population
Race	Non-white members (by race group)	Racial group with the best outcome on a given indicator
Ethnicity	Hispanic members	Non-Hispanic members
Age	Members age 0 – 17, 35 – 64, and ≥ 65	Members age 18 – 34
Gender	Female members	Male members
Geography	Members residing in rural areas	Members residing in urban areas
Language	Members in non-English-speaking households	Members in English-speaking households
Disability	Members whose eligibility for Medicaid is based on disability (by disability category)	Members whose eligibility for Medicaid is not based on disability
Severe and persistent mental illness (SPMI)	Members diagnosed with SPMI	Members not diagnosed with SPMI
Substance use disorder (SUD)	Members diagnosed with SUD	Members not diagnosed with SUD
Behavioral health conditions (broader category of diagnoses than SPMI above)	Members diagnosed with behavioral health conditions	Members not diagnosed with behavioral health conditions
Tribal members	Members enrolled in a Tribe	Members not enrolled in a Tribe
Dual Eligibles	Members who are dually eligible	Members who are not dually eligible

4. Promoting Health Equity (continued)

Potential research questions: implementation	Potential research questions: outcomes/impacts	Potential data sources
1. What kinds of activities did OHA carry out to promote health equity? 2. What kinds of activities did CCOs carry out to promote health equity among their members? 3. Which populations of focus did CCOs target to promote health equity, and why did they choose these populations? 4. What role did health care providers play in CCOs' activities to promote health equity? 5. What successes and challenges did CCOs experience with their activities to promote health equity?	1. Did specific types of spending (e.g., primary care, behavioral health) increase for populations of focus? Was the gap between spending for populations of focus and the reference population reduced? / Did membership in a CCO or specific activities to promote health equity result in increased spending for populations of focus or reduce the gap? 2. Did quality of care improve for populations of focus? Was the gap between quality of care for populations of focus and the reference population reduced? / Did membership in a CCO or specific activities to promote health equity result in improved quality of care for populations of focus or reduce the gap? 3. Did access to care improve for populations of focus? Was the gap between access to care for populations of focus and the reference population reduced? / Did membership in a CCO or specific activities to promote health equity result in improved access to care for populations of focus or reduce the gap? 4. Did experience of care improve for populations of focus? Was the gap between experience of care for populations of focus and the reference population reduced? / Did membership in a CCO or specific activities to promote health equity result in improved experience of care for populations of focus or reduce the gap? 5. Did quality of care improve for populations of focus? Was the gap between quality of care for populations of focus and the reference population reduced? / Did membership in a CCO or specific activities to promote health equity result in improved quality of care for populations of focus or reduce the gap? 6. Did health status improve for populations of focus? Was the gap between health status for populations of focus and the reference population reduced? / Did membership in a CCO or specific activities to promote health equity result in improved health status for populations of focus reduce the gap?	*1. OHA and CCO documents describing activities to promote health equity* *2. Interviews with OHA staff who carried out activities to promote health equity* *3. Interviews with CCO staff and health care providers who carried out activities to promote health equity* *4. Claims/encounters with paid amounts or re-pricing* *5. Surveys with access to care, experience of care, and health status items* *6. Medical records* *7. Vital statistics (e.g., death certificates)*

5. Implementing Flexible Services

Potential research questions: implementation	**Potential research questions: outcomes/impacts**	**Potential data sources**
1. What kinds of activities did OHA conduct to expand the use of flexible services? 2. What types of flexible services were provided by CCOs, and how many members received each type of service? 3. How did CCOs determine whether to provide flexible services to individual members? 4. What role did health care providers play in providing flexible services? 5. What successes and challenges did CCOs experience providing flexible services? 6. How did CCOs use flexible services to affect other levers of transformation, e.g., population health, integration, health equity?	1. Did overall spending or spending in specific areas (e.g., emergency department, specialist care) decrease for members who received flexible services? / Did flexible services result in decreased spending overall or in specific areas? What types of flexible services resulted in decreased spending? 2. Did health status improve for members who received flexible services? / Did flexible services result in improved health status? What types of flexible services resulted in improved health status? 3. Rigorously estimating the impact of flexible services will depend on identifying a group of individuals who had the same need for flexible services as flexible services recipients, but who did not receive flexible services. Estimating the impact of flexible services using pre/post or interrupted time series may be more feasible.	*1. CCO documents describing how flexible services were provided, including policy and procedures* *2. Interviews with OHA staff involved in flexible services* *3. Interviews with CCO staff and health care providers involved in decisions to provide flexible services* *4. Interviews with members who received flexible services* *5. Records of flexible services received by individual members that can be linked to other data sources (e.g., claims/encounters and surveys)* *6. Claims/encounters with paid amounts or re-pricing* *7. Surveys with health status items* *8. Medical records* 9. *Vital statistics (e.g., death certificates)*

6. Implementing Value-Based Payments (VBPs) that Reward Quality and Efficiency

Potential research questions: implementation	**Potential research questions: outcomes/impacts**	**Potential data sources**
1. What kinds of activities did OHA conduct to support and/or expand VBPs? 2. What types of VBPs were implemented by CCOs? Did VBP implementation evolve over time? 3. To what extent did CCOs work with health care providers to implement VBPs and achieve buy-in? 4. To what extent did CCOs implement VBPs for dual eligibles, or in alignment with Medicare VBPs? 5. What kinds of investments did CCOs and providers make to implement VBPs (e.g., information technology infrastructure, provider outreach and training)? 6. To what extent did providers change delivery practices in response to VBPs (e.g., to earn incentive-based payments)? 7. How many members received services paid for through VBPs, and what kinds of services did they receive? 8. What was the volume and value of services paid for through VBPs?	1. Did spending decrease for members who received services paid for through VBPs? Overall or in specific areas? Did VBPs result in decreased spending? 2. Did quality of care improve for members who received services paid for through VBPs? / Did VBPs result in improved quality of care? 3. Did member experience of care improve for members who received services paid of through VBPs? / Did VBPs result in improved quality of care? 4. Did member health status improve for members who received services paid for through VBPs? / Did VBPs result in improved quality of care? 5. Research questions may be tailored to fit the type of VBPs implemented by CCOs. For example, if CCOs implement VBPs that reward favorable patient experience ratings, the State may focus on tracking whether VBPs resulted in improved experience of care.	*1. OHA and CCO documents pertaining to VBP implementation (e.g., VBP designs, communications with providers)* *2. Claims/encounters with flags to indicate payment through a VBP* *3. Member records with flags to indicate enrollment in capitation or sub-capitation* *4. Provider records with flags to indicate participation in a VBP and amount of incentive-based payments* *5. Interviews with OHA staff involved in VBPs* *6. Interviews with CCO staff who implemented VBPs* *7. Interviews with health care providers who participated in VBPs* *8. Surveys with health status items that can be matched to member records* *9. Medical records that can be matched to member records* 10. *Vital statistics (e.g., death certificates) that can be matched to member records*

7. Improving hospital quality through the Hospital Transformation Performance Program (HTPP)

Potential research questions: implementation	**Potential research questions: outcomes/impacts**	**Potential data sources**
Research questions will be informed by the results of the ongoing evaluation	Research questions will be informed by the results of the ongoing evaluation	1. *Interviews or surveys of hospital staff involved with the HTPP* 2. *Interviews with CCO staff who worked with hospitals on the HTPP* 3. *State records showing number of hospitals that received incentive payments and dollar value of payments* 4. *Claims/encounters with paid amounts or re-pricing* 5. *Surveys with patient experience items* 6. *Medical records*

8. Improving access to care coordination and housing supports through Coordinated Health Partnerships for high risk / high needs members and other populations

Potential research questions: implementation	Potential research questions: outcomes/impacts	Potential data sources
1. What kinds of partnerships and organizations participated in developing community-based models off housing transition and sustaining services? 2. What kinds of activities and services did Coordinated Health Partnership grantees provide to address unmet health and housing needs for high risk / high needs members and other populations (care coordination, pre-tenancy, and tenancy sustaining services)? 3. What successes and challenges did CCOs and CHP partners experience carrying out activities to help high risk / high needs members with care coordination, housing supports and residential stability? 4. How many high risk / high needs members became permanently housed, and how long did they stay housed? What were their demographic characteristics, health status? 5. To what extent were specific activities associated with members becoming housed and staying in housing that met their needs?	1. Did the percentage of high risk/high needs members who participated in the CHP pilots experienced: improvements in stable and affordable housing placements (e.g. retention in housing for >12 months), community integration (e.g. decrease use of higher cost settings and fewer days in institutions), and an increase in self-sufficiency? 2. Did receipt of targeted care coordination services through the CHP pilots result in an increased percentage of members who accessed appropriate health care utilization with a focus on behavioral health and substance abuse disorder services? 3. Was access to care coordination and transition services associated with improved health outcomes for high risk / high needs members? Health outcomes related to housing access and stability may include health care quality (for example, receipt of specific services), access to needed care, and changes in self-reported health status. 4. What elements of the CHP pilots resulted in increases in care coordination across multiple care settings, access to care, and quality of care among participants (e.g. reductions in ED use, decrease in inpatient admissions and total hospital days) 5. What key elements of the CHP model resulted in access to employment, education, and social services/benefits among CHP enrollees? 6. Did CHP pilots result in decrease in expensive cycling through EDs, shelters, local jails, and psychiatric hospitals? 7. Did overall health care utilization and costs change for the target populations (e.g. impatient and ED services)? Overall, what was the percentage of savings achieved in Medicaid through the CHP pilots?	1. *OHA and CCO documents describing activities to help high risk / high needs access care coordination and housing* 2. *Records describing members' risk and needs that can be linked to other data sources (e.g., claims/encounters and surveys)* 3. *Interviews or surveys of CCO staff involved in activities to help members with high risk / high needs access housing* 4. *Interviews or surveys of CHP participants* 5. *Claims/encounters with paid amounts or re-pricing* 6. *Surveys with access to care, experience of care, and health status items* 7. *Enrollee assessments, Medical records*

X. Demonstration Administration

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Appendix A: Support for Health System Transformation

Introduction

To meet the goals of the triple aim, Oregon's coordinated care model and fee-for-service delivery system 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 through the supports described in this document, 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 health conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes (PCPCH).

Lever 2: Implementing alternative payment methodologies 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 flexible 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 Transformation Center.

Supports include the Oregon Health Authority's Transformation Center, Innovator Agents, Patient-Centered Primary Care Home program, and programs and activities across the agency, including the Office of Equity and Inclusion, the Public Health Division, and the Office of Health Information Technology.

Transformation Center

Launched in 2013, the Oregon Health Authority's Transformation Center serves as the state's hub for innovation, improvement and learning for Oregon's health system in support of the triple aim: better health and better care at lower costs for all Oregonians. The Transformation Center (Center) helps good ideas travel faster through learning collaboratives, targeted technical assistance and other methods for sharing best practices and innovations. OHA intends for the Transformation Center to continue this role, with a priority of delivering more focused and targeted support to meet coordinated care organizations' (CCO) evolving needs. The Center will focus on responding to identified and prioritized challenges with CCOs, the Public Employees Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) based on performance metrics and evaluation outcomes, as well as advancing the integration of population and behavioral health within the health system to improve health outcomes.

Activities to be performed by the Transformation Center

Examples of the types of activities that the Transformation Center will implement include:

- Technical assistance strategies to connect CCOs with resources for advancing work on a variety of topics, including behavioral health integration, value-based payment arrangements, health-related services, population health, Community Advisory Council development, health equity, and more.
- Technical assistance to support performance improvement on the CCO incentive measures.
- Technical assistance to support the development and implementation of value-based payments.
- Technical assistance to CCO Community Advisory Councils (CAC) to improve the effectiveness, in areas such as member recruitment, engagement and retention.
- Support for implementation of Community Health Improvement Plan priorities.
- Coordination of the Clinical Innovation Fellows Program to support local clinical leadership development and the spread of innovation across Oregon.
- Convening CCOs and other stakeholders to share and spread best practices to further advance health system transformation.
- Learning collaboratives, as described below.

For more information, see the Driver Diagram in Attachment A below.

Learning Collaboratives

Building on its first few years of work, the Transformation Center intends to continue convening learning collaboratives. In alignment with the evolution of Oregon's health system transformation efforts in general, the focus of these learning collaboratives will become much more focused and targeted to meet CCOs' needs. Specifically, during the early stages of health system transformation, the Transformation Center's learning collaboratives were a vehicle for supporting relationship-building between CCOs and promoting learning about a broad range of topics related to transformation. The future learning collaboratives will hone in on the CCOs' specific, technical needs related to, for example, reaching targets for specific incentive metrics; promoting health equity through enhanced language access or culturally competent workforce; and enhancing the effectiveness of CACs by supporting recruitment and retention of Oregon Health Plan membership. In addition, a number of emerging topics may result in future learning collaboratives, such as behavioral health integration; value-based payments for specific populations and/or settings; oral health integration; nurse home visiting; and moving upstream to promote population health by expanding the use of health-related services (i.e., flexible services and community-benefit initiatives) such as housing.

Of particular note, the Transformation Center will develop a learning collaborative focused on nurse home visiting. The goal of the learning collaborative will be to increase coordination and partnership with other agencies including Early Learning Hubs and CCOs in an effort to foster collaboration on child and family well-being initiatives related to health. Additionally, the learning collaborative will focus on increasing CCOs' understanding of the range of nurse home-visiting programs, the benefits of the programs and how to appropriately partner with home visitors in their regions. The desired outcome would be to create regional home-visiting partnerships (CCOs, Early Learning Hubs, Nurse home-visitors, social workers, and the Department of Human Services).

Finally, the Oregon Clinical Innovation Fellows Program – which strives to build the capacity of health system transformation leadership within Oregon – will continue over the coming years. Future goals of this program will include increased demographic and workforce diversity represented by the fellows.

Convening Stakeholders

The Transformation Center convenes a Statewide CCO learning collaborative as required by STC 25d, the purpose of which is to promote innovations and activities that contributes to the objectives of health system transformation and accountability for achievement of the triple aim. The Statewide CCO learning collaborative enables CCOs to share best and emerging practices on the CCO incentive measures and in areas such as value-based payments; opiates and pain management; leading change; health equity; and quality improvement. The purpose of the collaborative is to facilitate peer-to-peer learning and networking; identify and share information

on evidence-based best practices and emerging best practices; and help advance innovative strategies in all areas of health care transformation.

Sessions take place within the OHA Quality and Health Outcomes Committee, a monthly public meeting. Most attendees participate in person and some attend by phone. Collaboratives convene monthly, and this frequency is established by contract. Also established by contract is a requirement that when a CCO is identified by OHA as underperforming in access, quality or cost against established metrics, the CCO will be required to participate in an intensified innovator/learning collaborative intervention.

Technical Assistance

The Transformation Center will continue to offer CCOs and their CACs the opportunity to receive technical assistance through external consultants. However, the technical assistance provided by the Center will evolve from being solely driven by CCO requests of Technical Assistance Bank consultants to the addition of specific technical assistance initiatives that are offered to the CCOs to help them achieve success in areas critical to health system transformation. For example, the Transformation Center will develop programs for delivering targeted technical assistance around incentive metrics that are particularly problematic for the CCOs, as well as any new metrics that are added over the coming years. In addition, the Center plans to offer technical assistance to the CCOs to help them achieve their Transformation Plan benchmarks. This process will entail individual needs assessment conversations with CCOs, followed by pairing the CCOs with consultants who can effectively support the CCOs' goals in areas related to, for example, behavioral health integration or addressing health disparities.

Grants

Building on the Center's experience with managing the disbursement and oversight of the $27 million Health System Transformation Fund, which the Oregon Legislature awarded to CCOs during the 2013 legislative session to support health system innovation, the Center plans to continue to award strategic grants to seed innovation within CCOs. Potential areas for grant funding include implementation of the CCOs' community health improvement plan (CHIPs) priorities or developing alternative payment methods to promote behavioral health or oral health integration.

Measures of Effectiveness

The Transformation Center's evaluation measures will vary according to the specific technical assistance activities provided. Examples of possible measures include:

- Percent of Transformation Center planning interviews or consultations that result in CCOs receiving technical assistance.

- Percent of CCOs that receive consultant support on a variety of topics, including behavioral health integration, population health integration, and health-related services and that report implementing some/all of what they learned.
- Percent of all technical assistance evaluations identifying the support provided as effective/very effective in meeting the technical assistance project goal(s).
- Number of CCOs that receive metrics-related technical assistance that meet the benchmark or improvement target, or make progress toward achieving those targets.
- Identification of distinguishing factors of CCOs that are able to move the metric and how TC support was involved.
- Number of CCOs receiving value-based payment technical assistance that implement a new value-based payment.
- Number of Clinical Innovation Fellows who rate the program as valuable or very valuable.
- Learning collaborative evaluation surveys to measure what actions participants took as a result of the collaborative.

The Transformation Center works closely with the Innovator Agents to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities.

Innovator Agents

Senate Bill 1580 (2012) required OHA to provide CCOs with Innovator Agents to provide a key point of contact between the CCO and OHA and to help champion and share innovation ideas, within the CCOs and the state agency. During the current waiver period, the Innovator Agents have promoted innovation and implementation of the coordinated care model within the CCOs, providers and community partners by:

- Providing an effective and immediate line of communication that allows streamlined reporting and reduced duplication of requests and information;
- Identifying and facilitating resolution on CCO questions and issues with OHA;
- Actively supporting the Community Advisory Councils; and
- Fostering vital connections with the CCOs and community partners to build partnership and support for innovation.

Innovator Agents, initially part of the Transformation Center, were transitioned to the newly created Division of Health Systems in 2015. The transition helps to ensure that Innovator Agents provide a direct linkage between the CCO and Medicaid program staff and leadership. This linkage provides a direct avenue to identify key technical assistance needs and develop strategies

to effectively increase the rate of transformation throughout the state. The Innovator Agents work closely with the Transformation Center to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities.

Each Innovator Agent is uniquely positioned within their assigned CCOs and communities to have first-hand, on-going observations and participation in CCO health system transformation success and challenges.

Innovator Agents work closely with CCOs to innovate local health systems in numerous areas and are actively involved in areas such as: integration of behavioral health, oral health and physical health services, quality metrics, alternative payment methodologies, health information technology, Community Health Improvement Plans and Transformation Plans, testing ways to impact social determinants and reduce health disparities, integrating Non-Emergent Medical Transportation, increasing the use of Traditional Health Workers, developing CCO transformation initiatives, developing new partnerships and services to achieve greater population wellness, promoting clinical innovation, developing approaches to trauma informed care, and assisting development implementation of changing contract, policy, and benefit structures.

Innovator Agent Role

Under the waiver renewal period (2017-2022), the role of the innovator agents will be to:

1. Serve as a point of contact between OHA & CCOs to provide an effective line of communication and streamlined reporting, reducing the duplication of requests and information, and identifying and facilitating resolution on CCO questions and issues with OHA.

    a. Facilitate problem solving between OHA and CCOs.

    b. Facilitate the flow of information between OHA and CCOs through regular contact with OHA and CCO leadership.

    c. Partner with HSD Account Representatives to ensure positive customer service for CCOs.

2. Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. Attend Community Advisory Council meetings. Provide assistance for the development of the CCO's Community Health Assessment. Provide resources, consultation and support in addressing local health disparities.

    a. Attend all CAC meetings and work with CCO staff and CAC chair on work associated with the CAC.

b. Actively participate in work related to the CHA, CHIP, and Transformation Plan.

3. Innovator Agents will work in collaboration with the Transformation Center to identify key technical assistance needs and develop strategies to effectively spread the rate of transformation throughout the state and to ensure that learning and improvement strategies are identified and implemented.

    a. Engage with Transformation Center and facilitate TA and training needs for CCO.

    b. Provide regular updates on transformation happening both nationally and locally.

    c. Attend in person Innovator Agent meetings monthly and virtually twice weekly with OHA leadership and stakeholders

    d. Collaborate and share best practices with other Innovator Agents, CCOs, community stakeholders and/or OHA.

4. Inform and work in partnership with OHA leadership and staff regarding opportunities and obstacles related to system and process improvements propose solutions, and track opportunities, recommendations, and results.

    a. Partner with OHA Managed Care Delivery System unit to ensure positive customer service for CCO.

5. Assist and support the CCOs in developing and implementing their transformation plans as stipulated in the CCO/OHA contract.

    b. Actively participate in work related to the Transformation Plan, including the CHA and CHIP.

6. Assist CCOs in the implementation of innovative projects and pilots.

    a. Ensure rapid-cycle stakeholder feedback to identify and solve barriers.

    b. Assist with adapting innovations to simplify and/or improve rate of adoption.

    c. Engage and facilitate stakeholder involvement.

7. Support the CCO in developing strategies to support quality improvement and the adoption of innovations in care through facilitating collaboration and knowledge sharing across the state.

8. Participate in community meetings or other gatherings that are required or beneficial to OHA and the CCO.

    c. Build and facilitate partnerships and collaboration between OHA, the CCOs, stakeholders, and other government entities to support effective innovation.

9. Assist the CCO in managing and using information to accelerate innovation, quality and health system improvement.

    a. Actively participate in work related to the CHA, CHIP, and Transformation Plan.

    b. Engage with Office of Equity and Inclusion on health equity related work.

    c. Work directly with Health Analytics in OHA and CCO to assist with problem solving and clarification of OHA incentive metrics.

    d. Actively participate in CCO quality strategies and implementation.

10. Attain and maintain knowledge about health system innovation in consultation with state and national leaders and models.

    a. Provide regular updates on transformation happening both nationally and locally to CCO and OHA.

    b. Disseminate information and models of transformation locally and nationally.

11. Actively participate in collaboration and projects related to population or member health that intersects with other agencies such as public health, seniors and people with disabilities, child welfare, community safety, housing, etc.

    a. Provide best practice information that is occurring in other communities around the state.

    b. Provide updated information from OHA and other agencies.

Methods for Sharing Information

A critical role of the innovator agents will be to share information with OHA, the CCO, other innovator agents and community stakeholders. Information will be shared through the following mechanisms:

- Weekly in-person meetings and/or phone conversations with OHA and other innovator agents.
- Daily contact with the CCO and/or community stakeholders.
- Community meetings and/or forums.
- Not less than once every month, all of the innovator agents must meet in person to discuss the ideas, projects and creative innovations planned or undertaken by their assigned coordinated care organizations for the purposes of sharing information across CCOs and with OHA.

Office of Equity and Inclusion

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain communities. These communities are often less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider. It is critical to address equity in these areas that impact a person's health.

The connections among the CCO, its Community Advisory Council, community health workers, and local community health and community advocacy organizations will further this goal.

Through the Transformation Center, the Office of Equity and Inclusion (OEI) will continue to assist in developing a curriculum for CCOs and Medicaid providers that will include webinars, group training, individual coaching, information sharing, and technical assistance related to health equity. This would include topics such as:

- Language access services such as interpretation, translation, signage, web sites.
- Job descriptions, training, recruitment and retention of community health workers and other non-traditional health workers.
- Diversifying the health care workforce.
- Diversity and inclusion of best practices.
- Diversifying community advisory boards.
- Including equity and diversity in CCO community health assessments and improvement plans.
- Cultural competence continuing education for all staff.
- Race, ethnicity, and language data collection, analysis, and reporting for quality improvement, and
- Community outreach and partnership with trusted culturally competent community and faith based organizations.

Traditional Health Workers

Traditional Health Workers (THW) include community health workers, peer wellness specialists, patient navigators, and doulas and are an integral part of effectively implementing the coordinated care model and reducing health disparities across all delivery systems, including reaching fee-for-service members. THWs take health care beyond the four walls of clinics and

hospitals, out into homes and the community, supporting healthcare transformation in a variety of ways.

By focusing on culturally sensitive and linguistically appropriate approaches, THWs support adherence to treatment and care plans, coordinate care and support system navigation and transitions, promote chronic disease self-management, and foster community-based prevention.

Patient-Centered Primary Care Home (PCPCH) Program

The Patient-Centered Primary Care Home (PCPCH) Program was created by the Oregon Legislature through passage of House Bill 2009 as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon's vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon's version of the "medical home" which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

PCPCHs are an important part of healthcare transformation in Oregon, and are a foundational component of the Coordinated Care Model (CCM) Oregon has adopted as the basis for this transformation.

There are five core functions supported by OHA's PCPCH Program: (1) practice recognition, (2) PCPCH Standards refinement, (3) technical assistance and resource development, (4) communication and provider engagement, and (5) aligning payment with quality.

The PCPCH Program has achieved a number of critical milestones since its inception and during our current 1115 Waiver. Oregon's 16 Coordinated Care Organizations (CCOs) have embraced the program with the vast majority of OHP members enrolled in a provider site that's recognized as a PCPCH in a CCO network. The adoption of Patient-Centered Primary Care Homes has been integral to transforming the health system and is supported by Oregon's statewide PCPCH standards and measures.

Following the legislative directive of HB 3650, as a component of the coordinated care model, coordinated care organizations are required to use PCPCHs for primary care delivery to the greatest extent possible in their networks and must report to OHA the number of members enrolled in a PCPCH. From 2012 – 2017, CCOs were eligible for financial incentives if at least 60 percent of their members were enrolled in a PCPCH. See Appendix C: Measurement Strategy for additional details about monitoring PCPCH enrollment.

Notable Achievements during 1115 Waiver Period

By the end of end of 2015 there were 604 recognized PCPCHs, representing over 50 percent of all eligible clinics in Oregon and serving approximately 2 million Oregonians (over half the state's population). More than 95 percent of clinics recognized as PCPCHs chose to reapply for recognition to maintain their PCPCH status.

The percentage of CCO members receiving health care from a recognized PCPCH has increased from 51.8 percent in 2012 to 80.4 percent in 2014. The increase in enrollment of CCO members in a PCPCH has been especially dramatic in Eastern Oregon where enrollment has increased from just 3.7 percent to 68.6 percent, over the same time period.[34] Through the ACA Section 2703, recognized clinics received an increase per-member per-month payment for OHP members.

Oregon implemented the PCPCH Program as part of the state's strategy to achieve the triple aim of improving the individual experience of care, improving population health management and decreasing the cost of care. A 2013 survey of PCPCH recognized clinics found that:

- 85 percent of practices felt that PCPCH model implementation was helping them improve the individual experience of care, and
- 82 percent reported progress towards improving population health management.[35]

A recent study examined the change in health care service utilization and costs over time in PCPCHs compared to non-PCPCH clinics. The study found a significant increase in preventive procedures and a significant reduction in specialty office visit use and cost in the PCPCH group.[36] Furthermore, PCPCH clinics demonstrated significantly higher mean scores than non-PCPCH clinics for diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years.[37]

Through our partnership with Oregon Health Care Quality Corporation, the Patient-Centered Primary Care Institute (PCPCI) is advancing practice transformation state-wide through technical assistance opportunities and resources. In 2014 PCPCI hosted 15 webinars for over 600 participants, and worked with 24 clinics in a series of Learning Collaboratives focused on primary care home model implementation.

In 2012 PCPCH Program staff began conducting on-site visits to verify the clinic practice and patient experience in the practice accurately reflects the measures a clinic attested to on their PCPCH application. By the end of 2015 over 100 site visits had been completed in Oregon.

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[34] Oregon Health Authority. (2015). Oregon's Health System Transformation: 2014 Mid-Year Report. Retrieved from www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

[35] Gelmon, S. B. & Trotta, R. (2013). Patient-Centered Primary Care Home (PCPCH): Report on the Results of the 2012–2013 Supplemental Surveys, August 2013. Portland State University. Submitted to the Oregon Health Authority.

[36] Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency. Portland State University. Submitted to the Oregon Health Authority.

[37] Oregon Health Care Quality Corporation. 2013. Information for a Healthy Oregon: Statewide Report on Health Care Quality. Retrieved from http://qcorp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20August%202013%20for%20web_1.pdf

Accelerating the Spread of PCPCH

OHA is working with public and private payers across Oregon to pursue innovative payment methods that move us toward a health care system that rewards quality, patient-centered care. For example, OHA's Public Employee's Benefit Board (PEBB) provides an age-adjusted, per-member-per-month incentive payment to Tier 2 or Tier 3 recognized primary care homes in the PEBB Statewide plan, administered by Providence Health & Services. A number of CCOs offer incentive payments for recognized primary care homes and have incorporated alternative payment methodologies (APMs). Oregon is one of seven states selected to participate in the federal Comprehensive Primary Care Initiative (CPCI). Nearly 70 Oregon primary care practices were selected to participate and each is required to be recognized as a PCPCH.

Looking Ahead to 2017 and Beyond

In 2015, the PCPCH Standards and Advisory Committee was convened to assist the OHA with revising model. Proposed changes to be implemented in 2017 and confirmed through administrative rulemaking in 2016 include clarifying and strengthening existing standards and measures, the addition of one new "must pass" measure, and a redistribution of total available points across five tiers. The proposed changes are designed to incrementally adapt the model to the changing health care needs of the state, align the model with the best evidence where it is available, and also to improve the effectiveness of the standards and measures overall, with a focus on fostering integration of physical and behavioral health care services.

Detailed information about the PCPCH Program is available at: www.oregon.gov/oha/pcpch/

Other Support

Community Advisory Councils

Community Advisory Councils (CACs) are statutorily and contractually required of each CCO to ensure that the health care needs of the consumers and the community are being addressed. At least one member of the CAC sits on the governing board of the CCO, and the CCO's assigned Innovator Agent is required to attend CAC meetings. The council must:

- Include representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership;
- Meet no less frequently than once every three months; and
- Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the CCO and members of the governing body of the CCO.

The duties of the council include, but are not limited to:

- Identifying and advocating for preventive care practices to be utilized by the CCO;
- Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization; and
- Annually publishing a report on the progress of the community health improvement plan.

Community Advisory Council members will be surveyed annually to assess their satisfaction with the level and quality of their engagement with the functions of the CCO board.

Community Health Assessments and Community Health Improvement Plans

Community health assessments and the resulting community health improvement plan are required of each CCO. The CCOs are required to submit an annual community health improvement plan progress report. The community health assessment and community health improvement plan serve as a strategic population health and health care system service plan for the community served by the CCO.

The community health improvement plan adopted by the CAC should describe the scope of the activities, services and responsibilities that the CCO will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- Health policy;
- System design;
- Outcome and quality improvement;
- Integration of service delivery;
- Reduction of health disparities; and
- Workforce development.

Internal Coordination and Coordination with Other State Agencies

OHA Public Health Division

Many of the factors that lead to poor health outcomes are caused by social conditions beyond the immediate control of a single individual or coordinated care organization—such as persistent mental illness, addiction, homelessness, unemployment, lack of transportation and lack of quality education. Community interventions are needed to address the root causes of poor health outcomes as well as corresponding risk factors such as tobacco use, poor nutrition and physical inactivity. Oregon's health system transformation initiative supports CCOs in addressing the root causes of poor health outcomes through the community health assessment and community health improvement plan process, which is overseen by the CCO Community Advisory Council and developed in collaboration with state and local public health agencies and community partners.

In collaboration with the OHA Transformation Center, the OHA Public Health Division will provide opportunities for CCOs, Community Advisory Councils, local public health authorities and their partners to develop the skills necessary to complete robust community health assessments and community health improvement plans that utilize evidence-based practices to ensure maximum population health impact. The division will provide access to county and CCO-level community health improvement plan goals. The division provides annual updates to its State Health Profile indicators and manages the Oregon Public Health Assessment Tool, an online database that allows CCOs and local public health authorities access to a variety of population data sets and lets users create and save their own customizable queries.

The OHA Public Health Division will also provide CCOs, Community Advisory Councils, local public health authorities and their partners with information about evidence-based population health interventions that can be included in community health improvement plans. Using Oregon's State Health Improvement Plan as a guide, the division will provide leadership for statewide interventions that aim to reduce the prevalence of the leading causes of death and disability in Oregon. Together with the OHA Transformation Center, the OHA Public Health Division will provide opportunities for local partners to convene and share strategies for improving population health by collaborating across health systems and public health.

Finally, the OHA Public Health Division will provide resources and expertise to CCOs in pursuit of improvement on their incentive measures, specifically those that focus on a population health issue or leverage the public health system for best performance. Technical assistance will be provided individually, at regular meetings of CCO medical directors and quality improvement specialists, and through written guidance documents. The division will equip local public health authorities to provide this type of support to their CCOs at the local level as well.

Oversight for Oregon's governmental public health system is provided by the Public Health Advisory Board, which is a subcommittee of the Oregon Health Policy Board. This relationship ensures that health system transformation and public health are consistently working towards the same goals and leveraging every opportunity to improve population health in Oregon.

Early Learning Council and Oregon Department of Education

Early investments in human capital that improve skill and health formation are critical to ensure long-term health outcomes and cost-savings for Oregon. Concurrent with its health reform efforts, Oregon is undergoing education system reform from preschool through higher education. Specific attention has been given to the reorganization of Oregon's early learning services for children ages 0-6.

Oregon's Early Learning Council (ELC) is legislatively charged with developing and overseeing a unified system of early childhood services centered on improving child outcomes. In order to redesign and integrate existing services into a high functioning early learning system, adaptive change across multiple sectors is required. OHA is coordinating with the ELC to ensure that a broad view of early learning is adopted, one that encompasses more than traditional pre-school environments, but rather includes all settings where children are served from childcare to health and human services. Working together, the ELC and OHA are seeking shared opportunities for coordination of services, workforce training, data sharing, quality measurement, and accountability for child outcomes.

Oregon Health Information Technology

The Three Goals of Health IT-Optimized Health Care

The vision for Oregon is a transformed health system where health information technology (IT) and health information exchange (HIE) efforts ensure that the care all Oregonians receive is optimized by health IT. In a health IT-optimized health care system:

1. Providers have access to meaningful, timely, relevant, and actionable patient information at the point of care including information about the whole person, and pertaining to relevant physical, behavioral, social and other needs.

2. Systems (health plans, CCOs, health systems, and providers) have the ability to effectively and efficiently use aggregated clinical data for quality improvement, population management and incentivizing value and outcomes. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.

3. Individuals, and their families, can access and engage with their clinical information and are able to use it as a tool to improve their health and engage with their providers.

Overview of CCO Health IT Efforts

In 2013, the Oregon Legislature approved $30 million in Health System Transformation Funds. The OHA Transformation Center awarded $27 million in Transformation Fund Grant Awards to help CCOs launch innovative projects aimed at improving integration and coordination of care for Medicaid patients. Specifically, the Legislature directed the funds to be used for projects that would create services targeting specific populations or disease conditions, enhance the CCO's primary care home capacity, and invest in information technology and electronic medical records. Almost all of the CCOs invested a portion of their grant funds in health IT initiatives, including electronic health records (EHRs), health information sharing and exchange, data aggregation tools for population health, metrics collection, and telemedicine.

In general, all 16 CCOs have made an investment in health IT (either through Transformation Funds or otherwise) in order to facilitate healthcare transformation in their community. Nearly all CCOs are pursuing and/or implementing both health information exchange/care coordination tools and population management/data analytics tools.

Even with those similarities, each of the 16 CCOs chose to invest in a different set of health IT tools. Through their implementation and use of health IT, CCOs reported early successes in achieving goals such as:

- Increased information exchange across providers to support care coordination
- Making new data available to assist providers with identifying patients most in need of support/services and to help providers target their care effectively

- Improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data.

In general, CCOs sought to understand which health IT and EHR resources were in place in their community and provider environments, identify which health IT capabilities were needed to support the CCO's efforts, and identify strategies to meet those needs including leveraging existing resources or bringing in new health IT tools to fill priority needs. Ultimately, the combination of different CCO community, organizational, geographic and provider contexts as well as the variation in EHR and existing health IT resources led to a number of differing approaches to health IT.

Changing Approaches and Next Phases for CCO's HIT Efforts

Many CCOs are in the process of building upon their progress to date and are pursuing additional and/or improved health IT tools to add to (or replace) what they initially implemented:

- Connecting providers to health IT through integration with their EHR workflows
- Moving from administrative/claims-based case management and analytics to incorporating and extracting clinical data from provider's EHRs
- Incorporating behavioral health information, long-term care and social services in order to increase care coordination across different provider types
- Working with providers and providing technical assistance to establish clinical data reporting
- Supporting providers in new ways by providing data and performance metrics/dashboards back to them
- Investing in new tools for patient engagement and telehealth

CCO accountability for health information technology (STC 23c (1))

Each CCO is contractually obligated to meet standards in foundational areas of health IT. This includes facilitation of providers' adoption and meaningful use of EHRs and ensuring that every provider either is registered with a statewide or local Direct-enabled health information service provider (HISP), or is a member of a health information organization (HIO) that enables electronic sharing of information with other providers in the CCO's network. Also, each CCO must develop a transformation plan that demonstrates, among other elements, how it will develop EHRs, HIE and meaningful use. The Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) are also investigating the inclusion of measures for HIE in future contracts.

Adoption of Electronic Health Record Technology and Meaningful Use (STC 23c (2))

Through the Centers for Medicare & Medicaid Services EHR Incentive Programs, eligible Oregon providers and hospitals can receive federal incentive payments to adopt, implement or upgrade and meaningfully use certified EHR technology. Since the inception of the programs in 2011, 6,846 Oregon providers and 61 hospitals have received a total of $394.2 million in federal incentive payments. ($265.6 million under the Medicare EHR Incentive Program and $128.6 million under the Medicaid EHR Incentive Program, as of October 31, 2015).

Minimum benchmarks based on federal targets for EHR adoption have been successfully surpassed by all CCOs. The incentives for EHR adoption has transformed beyond paying for adoption; CCOs must demonstrate the advanced use of EHRs by reporting and meeting thresholds for clinical quality metrics and other EHR-based measures. OHA in conjunction with the Metrics and Scoring committee will continue to monitor the CCOs use of EHRs. If CCOs fall below the minimum threshold or standards, a plan will be implemented to move the CCO(s) to achieve at least the minimum threshold. This could be in the form of a corrective action plan, reinstating the EHR adoption metric and/or technical assistance. See Appendix C: Measurement Strategy for details on measures and benchmarks.

State Health IT Role and Activities (STC 23c (3))

In 2013, all 16 CCOs agreed to support OHA's plan to use the remaining $3 million of state Transformation Funds to leverage and secure significant federal matching funds for investing in statewide health IT infrastructure. These funds are being used to support OHA's vision of a statewide approach for achieving health IT-optimized health care. OHA-supported health IT infrastructure will connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

As we see the importance of supporting the CCO model and value-based care arrangements, OHA will continue to monitor and adapt to the environment. This includes exploring public/private partnerships and collaboratives with other organizations.

In 2015, Oregon passed legislation to align health IT efforts with health system transformation goals, formalize and support OHA's health IT efforts, improve OHA's ability to advance the necessary health IT to support CCOs and the spread of the coordinated care model. Oregon originally addressed health IT in HB2009 (2009) with the establishment of the Health IT Oversight Council (HITOC), setting forth a strategic, policy, and coordination role for OHA. HB2294 (2015) updates the health IT statute to account for changes since 2009 and has three major components:

1. Establishes the Oregon Health IT Program within OHA.

- Grants OHA authority to provide optional health IT services to support health care statewide (e.g., beyond the Medicaid program)
- Authorizes fees to cover the costs of operating OHA's health IT services. Fees would be charged to users of this program's service

2. Grants OHA flexibility in partnering with stakeholders and the ability to participate in partnerships or collaboratives that provide statewide health IT services. This is especially important where Oregon organizations are partnering to bring new statewide health IT services to Oregon, and allows OHA to participate and provide support, including:
   - Ability to vote on governance boards for such services, and
   - Ability to enter into agreements to support and provide funding for the appropriate Medicaid share of statewide HIT services.
3. Updates statute for Oregon's HIT Oversight Council (HITOC)
   - Aligns HITOC under the Oregon Health Policy Board and solidifies its role in providing strategic and policy recommendations and oversight on the progress of Oregon health IT efforts.

Since HB2294 has been in effect OHA has established the new HITOC formally under the Policy Board with a revised charter and new membership. In 2016 HITOC will focus on two priority policy topics: 1) behavioral health information sharing; and 2) achieving real-world interoperability. HITOC will participate in health IT strategic planning efforts over 2016-2017 to inform the next state health IT efforts. HITOC will continue in 2017-2022 as part of their oversight to monitor the environment and health IT efforts in the state.

In order to achieve the goals of a health IT-optimized health care system outlined above, the State will need to fill several roles:

The State will coordinate and support community and organizational health IT efforts.

- Recognizing that health IT efforts must be in place locally to achieve a vision of health IT-optimized health care, the State can support, facilitate, inform, convene and offer guidance to providers, communities and organizations engaged in health IT.

The State will align requirements and establish standards for participation in statewide health IT services.

- To ensure that health information can be seamlessly shared, aggregated, and used, the State is in a unique position to establish standards and align requirements around interoperability and privacy and security, relying on already established national standards where they exist.

The State will provide a set of health IT technology and services.

- New and existing state-level services connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care.

In particular, OHA's commitment to the CCOs in state-level health IT infrastructure includes the following:

- Statewide Direct secure messaging and CareAccord, offer a standards-based, HIPAA-compliant, common method of health information exchange, leveraging new requirements for certified EHRs and for hospital and providers seeking to meet meaningful use (funded, in part by CMS Medicaid Management Information System (MMIS) and CMMI State Innovation Model (SIM) funds).
- Bringing real-time hospital event notifications to all 60 Oregon hospitals contributing admission, discharge and transfer (ADT) data (both emergency department and inpatient data) to the Emergency Department Information Exchange (EDIE). CCOs, health plans, and provider clinics can subscribe to PreManage to access the EDIE data and better manage their populations who are high utilizers of hospital services and support care coordination across the health care system around emergency and inpatient hospital events (funded, in part by CMS MMIS and CMMI SIM funds).
- Technical assistance to support Medicaid providers with the adoption and meaningful use of certified EHR technology as well as support providers in submitting their clinical quality metrics electronically from providers' EHRs to meet meaningful use and OHA's CCOs clinical quality metrics reporting requirements (funded, in part by CMS Health Information Technology for Economic and Clinical Health (HITECH) funds).
- Developing new health IT services to launch in 2017 to support efficient and effective care coordination, analytics, population management and health care operations, including:
    - A statewide Provider Directory, critical to supporting health information exchange, analytics and population management, accountability efforts, and operational efficiencies (funded, in part by CMS HITECH funds).
    - A Clinical Quality Metrics Registry to capture clinical quality metrics from electronic health records (see Appendix C for CCO reporting requirements) (funded, in part by CMS HITECH and MMIS funds).
    - A Common Credentialing Program and database for the purpose of providing credentialing organizations access to information necessary to credential or re-credential all health care practitioners in the State.

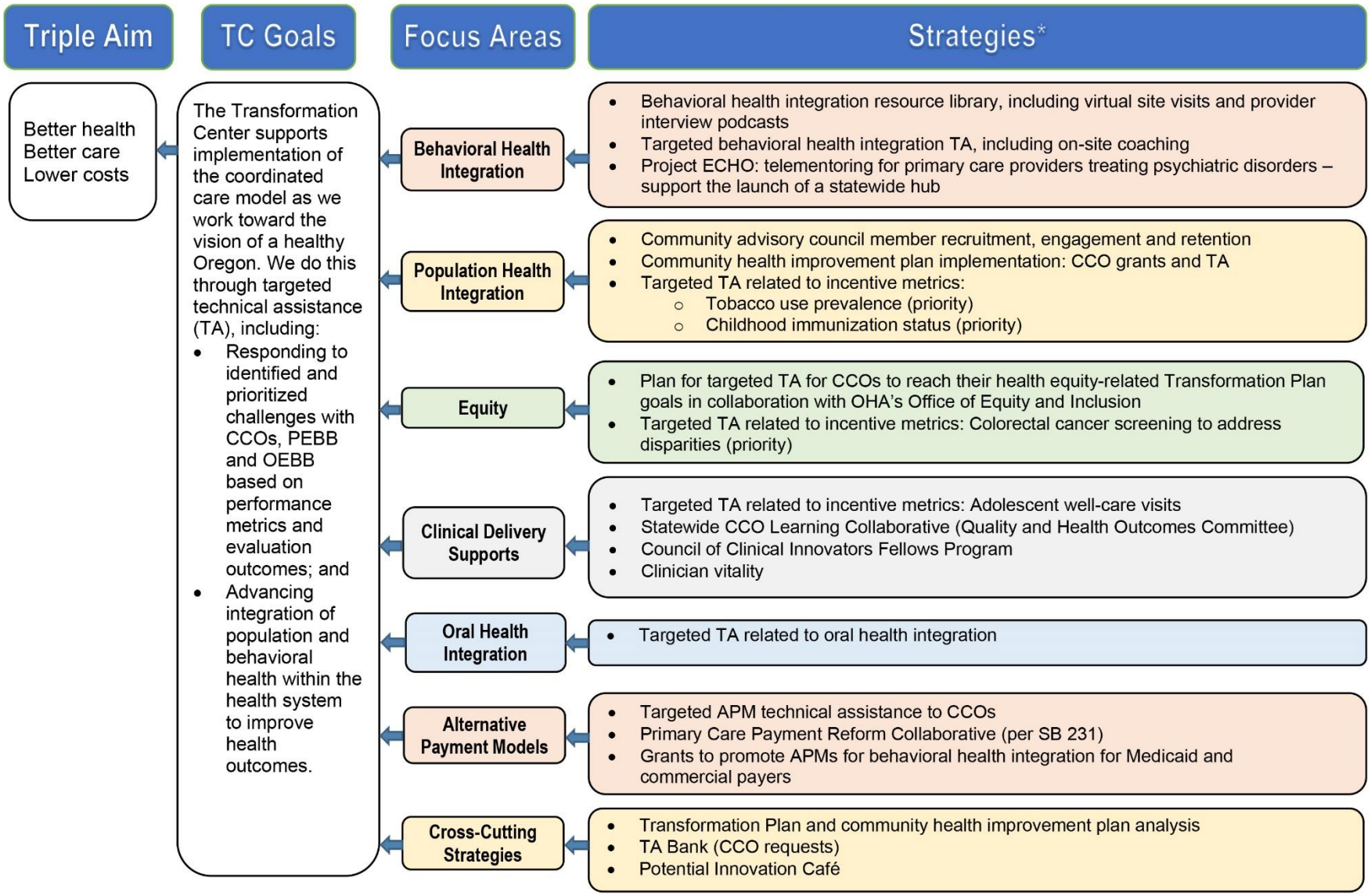
- Grant-funded initiatives to support telehealth and patient access to full clinical notes, including:
    - Launching telehealth pilots in five communities (funded, in part by CMMI SIM funds).
    - Supporting a telehealth resources and inventory website to link telehealth providers and purchasers (health plans, CCOs, etc.) to each other, through the Telehealth Alliance of Oregon (funded, in part by CMMI SIM funds).
    - Supporting an Oregon effort to promote OpenNotes to health care providers with EHRs not currently configured for OpenNotes, which allows full clinician notes to be available through an EHR's patient portal (funded, in part by CMMI SIM funds).
- Identifying and addressing barriers to behavioral health information sharing and care coordination. This work includes a 2016 behavioral health IT environmental scan and survey to identify the health IT tools, opportunities and challenges faced by Oregon's behavioral health providers; as well as support through a 2015-2017 $1.6 million grant from the Office of the National Coordinator for Health Information Technology (ONC) to improve care coordination between behavioral and physical health care. Through the project, OHA's subgrantee, Jefferson Health Information Exchange (JHIE), is focusing on consent management to enable coordination between primary care, behavioral health and emergency providers, by developing a common consent model that will be supported within the JHIE technology (funded, in part by the ONC Advance Interoperable Health IT Systems to Support Health Information Exchange Cooperative Agreement program).

New funding to Support Access to Health Information Exchange

Oregon intends to leverage new federal funding to support Oregon's Medicaid providers, including behavioral health, long-term care, and other social services, to connect to health information exchange (HIE) entities. In early 2016, CMS issued guidance about the availability of federal funding at the 90 percent matching rate for activities to promote HIE and encourage the adoption of electronic health record (EHR) technology by Medicaid providers to enable eligible professionals to meet meaningful use requirements. Oregon intends to explore using these funds to increase Medicaid providers' capability to exchange health information by supporting the costs of an HIE entity (e.g., regional HIEs) to onboard providers, with or without an EHR. Oregon is considering requiring HIE entities to meet minimum criteria to be eligible for support. Criteria have not yet been determined, but may include that the HIE entity uses standards-based or certified health IT; is interoperable and participates in statewide HIE connectivity (e.g., through Direct secure messaging); participates in Oregon's state-level provider directory (once it is available); reports to OHA's clinical quality metrics registry and public health registries as appropriate; and does not engage in practices that would result in health information blocking.

Attachment A: Transformation Center Driver Diagram

Transformation Center 2.0 (5/11/16)



**Strategies were developed in collaboration with: OHA leadership, Health Policy & Analytics Division, Innovator Agents, Quality Council*

Attachment B: Oregon Health Information Technology/ Health Information Exchange Aims and Objectives

Overarching aims and objectives	Strategies
1. Improved culture of HIT-optimized health care where providers and other stakeholders value and expect electronic access to shared information	• Assess the changing environment and convene stakeholders • Educate stakeholders regarding HIT's role in the changing healthcare environment • Share promising practices, positive outcomes and value • Promote policies that ensure HIT is incorporated into expectations for Oregon health care organizations
2. Increased alignment of standards to promote interoperability	• Promote alignment with federal and national standards where they exist and develop state standards or guidance where needed • Advocate for federal and national standards that are meaningful for Oregon stakeholders • Educate and provide guidance regarding specific standards in alignment with federal and national standards where possible • Encourage the collection, management, and use of discrete data
3. Improved distribution of financial burden for supporting HIT investments as payment models evolve	• Educate and promote value reimbursement for telehealth, including e-visits, telemedicine, and other resources • Promote HIT cost-consideration within payment models • Promote the use of alternative payment models that rely on, and support financial burden of, the use of associated HIT
4. Ensured protection of privacy and security of electronic health information	• Establish, promote and use policies and best practices that protect patient information • Provide resources to increase awareness, knowledge, and the means for ensuring privacy and security. • Support work to establish policies, processes, and documents to increase privacy and security of patient information • Support transparency in communicating to patients about providers' policies and safeguards for information • Educate patients on security measures around the provision of their health data

Goal 1 of "HIT-Optimized Health Care": Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver "whole person" care

- **Provider role in support of "HIT-Optimized Health Care":** have the technology capabilities and workflows to participate in care coordination, including: (1) Pursue meaningful use of HIT (particularly for those eligible for electronic health record (EHR) Incentive Programs); (2) Participate in care coordination and health information exchange that is inclusive of all members of the care team, including the patient

Goal 1: Aims and objectives	Goal 1: Strategies
1. Increased adoption of standards-based technology for data capture, use, and exchange	• Promote[38] participation in the EHR Incentive Program and standards that align with meaningful use and other quality incentive programs • Promote adoption of certified HIT and support those who may face challenges navigating the vendor arena • Promote and encourage streamlined processes to increase likelihood of adoption
2. Improved ability to capture, produce and use interoperable standards-based data in formats that are structured to be integrated and automated within EHRs and workflows	• Establish a "compatibility program" that sets baseline expectations for community, organizational and statewide HIT/health information exchange (HIE) efforts to ensure interoperability, privacy and security and to facilitate the sharing of information • [See Overarching Aims above]
3. Improved access to and sharing of meaningful patient information across organizational and technological boundaries	• Connect and support entities with existing HIT infrastructure by providing foundational and enabling HIT services (e.g., Provider Directory, hospital notifications) • Ensure all members of a care team have a means to participate in the basic sharing of information needed to coordinate care (e.g., CareAccord) • Promote statewide Direct secure messaging as a common baseline for HIE and promote other standards that enable interoperability across all systems of care • Promote information sharing and care coordination with behavioral health, dental, long-term care providers • Promote the ingestion of relevant patient data into the EHRs to increase the likelihood of its use • Pilot innovation (e.g., telehealth, behavioral health sharing)
4. Improved provider experience and workflows, reduced burden, and increased workforce capacity	• Provide guidance, information, and technical assistance • Identify and take action to remove barriers • Seek efforts that reduce administrative complexity and burden (e.g., Common Credentialing, align metrics) • Support efforts to increase workforce capacity

[38] Activities that "Promote" can include educating, outreach, informing, advocating, convening, providing guidance, as well as applying state levers such as contract requirements, policies, aligning reporting requirements, etc.

Goal 2 of "HIT-Optimized Health Care": Systems effectively and efficiently collect and use aggregated clinical data for quality improvement, population management, and incentivizing health and prevention

- **Systems' (e.g., CCOs, Health Plans) role/responsibility in support of "HIT-Optimized Health Care":** (1) Implement HIT tools for data collection, processing, and reporting; (2) Align clinical metric reporting requirements with meaningful use clinical quality measures; (3) Encourage and support meaningful use and health information exchange among contracted providers

Goal 2: Aims and objectives	Goal 2: Strategies
1. Improved use of HIT tools for data collection, analytics, and reporting	• Promote adoption of certified HIT and support providers who may face challenges navigating the vendor arena • Share promising practices, positive outcomes and value • Advocate for federal and national standards and oversight that are meaningful for Oregon stakeholders
2. Increased use of aggregated data, including clinical data for population management, quality improvement, and alternative payment methods	• Provide guidance, information, and technical assistance • Identify and take action to remove barriers • Support the appropriate collection and use of individual level clinical data where needed for more effective uses • Assess the changing environment and convene stakeholders • Support efforts to improve provider workflow to ensure accuracy and reliability of data • Support efforts to increase workforce capacity
3. Reduced reporting burden for data needed to support the coordinated care model across programs	• Align metrics and reporting across state programs with meaningful use specifications or other standards, ensuring metrics specifications are well-defined • Provide a clinical metrics data registry for Medicaid (CCO reporting and Medicaid EHR Incentive program) and, if valuable, expand registry to capture reporting for other programs

Goal 3 of "HIT-Optimized Health Care": Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers

- **Individuals' and families' role/responsibility in support of "HIT-Optimized Health Care":** (1) Expect providers to have electronic access to their relevant information; (2) Inform providers where they can access patient-generated information (e.g. personal health record); (3) Access their health records via available patient portals; (4) Communicate electronically with providers.

Goal 3: Aims and objectives	Goal 3: Strategies
1. Increased patient access to/use of their complete health records	• Promote participation in Meaningful Use, which requires eligible providers to give patients secure, electronic access to their health information. • Support innovations (e.g., Open Notes) • Educate patients on the benefits of accessing their health information
2. Improved ability for individuals to provide relevant information into their health records	• Assess changing environments and convene both provider and patient stakeholders • Share promising practices, positive outcomes, and value • Provide information regarding the legal liabilities of patient-uploaded data
3. Increased use of HIT by patients to engage providers (e.g., patient portals, e-visits, messaging, remote monitoring, etc.)	• Promote participation in Meaningful Use, which requires eligible providers to support electronic patient engagement via messaging • Promote payment policies that support electronic interactions between providers and patients • Encourage and support providers to educate and promote patient engagement in HIT • Educate patients regarding the use of HIT as a tool for engaging providers

Appendix B: Quality Strategy

Monitoring the gains we have made

Introduction

To monitor how well Oregon's coordinated care model is achieving its goals of access, quality, and outcome improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have a robust performance monitoring strategy and mechanisms to monitor and assess all Medicaid delivery systems (including Coordinated Care Organizations and Fee-For-Service).

As required by CFR 438.202(d), Oregon assesses how well the Coordinated Care Organizations (CCO) and Managed Care Organizations (MCO) are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees, and consumer satisfaction data described in Appendix C: Measurement Strategy. Oregon's evaluation plans, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries. Information on how Oregon will report to CMS on elements of the demonstration can be found in Appendix C: Measurement Strategy.

Oregon has developed a comprehensive program to assess all aspects of the delivery system, and CCO and MCO activities to determine quality improvement and contract compliance. This section describes the components of that program.

- **Quality structure**
  The Oregon Health Authority is comprised of subject matter experts in evidence based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency-wide committees that are responsible for oversight and planning. Underpinning the quality and health transformation elements are health equity and social determinants of health with key contributions at the leadership committee level.

Current Oregon Health Authority structure to support quality and access monitoring:

- Oregon Health Authority
  OHA Quality Council
  Oregon Health Policy Board

- Health Systems Delivery
  Quality and Health Outcomes Committee
  Health Evidence Review Committee
  Managed Care and CCO Collaborative
  Quality Management / Contract Compliance

- **Who is accountable for what**

  In an effort to drive innovation, improve health outcomes and maintain compliance with regulatory agencies the Oregon Health Authority is managing the substantial work through clear lines of responsibilities. Aligning programmatic expertise and skills with the appropriate quality activity supports the necessary detail needed to move healthcare forward. Specific delineation occurs for functions relating to quality and performance improvement; as well as quality assurance and compliance. Key attributes of accountability of quality structure (but not limited to):

  - Oregon Health Authority
    a. OHA Quality Council – monitor for the clinical quality performance, health transformation and quality improvement.
    b. Oregon Health Policy Board – develops strategic direction of health systems.

  - Health Systems Delivery (partnership committees with health delivery system and OHA)
    a. Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation.
    b. Health Evidence Review Committee – review and development of evidence based practices for all managed care entities, including Fee for Service (FFS).
    c. Managed Care and CCO Collaborative – monitors the client experience, primarily through complaints and grievance, appeals, and utilization trending.
    d. Quality Management / Contract Compliance - monitors managed care organizations and CCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud waste abuse).

- **Methods and resources for monitoring**

  Across the Oregon Health Authority quality programs, the agency utilizes multiple quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and LEAN principles are examples of proven methods of improvement. Ongoing development with these methods across the agency supports the transformation in the health system delivery through train the trainer models with CCOs and contractual relationships with FFS. Additional resources for monitoring include

robust data systems to drive a data-based decision culture. Key agency data systems include, but are not limited to, an all payer all claims database, performance monitoring through measures reporting, and CCO data dashboards from claims reporting. See Appendix C: Measurement Strategy for more detailed description of data sources.

- **Framework for quality**
  To monitor quality, the Oregon Health Authority will build upon the implemented seven focus areas across the health systems of Oregon. Continuing the progress in the focus areas, the Oregon Health Authority will intensify key focus areas – such as adding oral health to the existing primary care and behavioral health integration. Collaboratively working across the system the Coordinated Care Organizations, Managed Care Organizations and the Oregon Health Authority will support the framework through quality improvement in these focus areas. Focus areas are detailed in the following Improvement Strategies section.
- **Alignment with managed care regulations**
  Continuing on the pathway to achieve the triple aim, the Oregon Health Authority recognizes the need for alignment across all health delivery systems for quality. Increased focus in alignment will include programs in Medicare, Medicaid CCO and FFS systems, and federal improvement programs (e.g. Value Based Payment). Working with regional Quality Improvement Organizations (QIOs), OHA's External Quality Review Organization (EQRO) and Health Delivery Systems (CCOs, MCOs), the Oregon Health Authority will look for opportunities to align state efforts with federal direction in quality and transformation activities. While maintaining the state's program integrity of the gains in health transformation, the Oregon Health Authority will develop strategic alignment for quality programs to increase organizations' efficiency, improve burden on the health systems for reporting and communicate common thread goals that will continue Oregon's work in better health, better care and decreasing costs.

Improvement Strategies

Performance Improvement Projects (PIPs)

As per STC 25b.i, OHA will contractually require each CCO to address four of the quality improvement focus areas issues, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

Three of the focus areas will be conducted as performance improvement projects (PIPs) and one will be a focus study. One of the three required PIPs will focus on integrating primary care, oral and behavioral health, and will be conducted statewide. The quality improvement focus areas are:

1. Reducing preventable re-hospitalizations;
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community health workers, public health services, aligned federal and state programs;
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers;
4. Integration of health: physical health, oral health and/or behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care;
7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care; and
8. Addressing Social determinants of health.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. OHA encourages CCOs to address health equity throughout all of the PIPs and quality improvement focus areas.

Quality Management Plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance. These Quality Assessment and Performance Improvement (QAPI) plans are reviewed, along with documentation of the activities and studies undertaken as part of the Quality Management Plans (QMP) during both the certification process and ongoing EQRO reviews. The QAPI will be incorporated into the CCO's Quality Strategy and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. See the "Expectations of CCOs" section below for further details.

Performance Monitoring

Oregon has developed a comprehensive program to assess all aspects of the delivery system. This program involves routine analysis and monitoring of delivery system performance and

consumer satisfaction data, comprehensive on-site operational reviews, and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews (described below).

Monitoring

On-site operational reviews

Operational reviews are conducted on a regular basis. These reviews are designed to supplement other state monitoring activities by focusing on those aspects of CCO performance that cannot be fully monitored from reported data or documentation. These reviews focus on validating reports and data previously submitted by the CCO through a series of review techniques that include an assessment of supporting documentation and conducting a more in-depth review of the CCO's quality assurance activities.

On-going focused reviews

Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through the routine monitoring processes and grievance and appeal reporting. These reviews will also provide more detailed information on areas of particular interest to the state such as emergency department visits, behavioral health, utilization management, and data collection problems. Another example of a focused review is an on-going review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

Appointment and availability studies

The purpose of these studies is to review managed care and FFS provider availability/ accessibility and to determine compliance with contractually defined performance standards. To conduct these studies, state and External Quality Review Organization (EQRO) staff attempt to schedule appointments under defined scenarios, such as a pregnant woman requesting an initial prenatal appointment.

Marketing and materials review

Managed care contractors are contractually required to submit all marketing materials, marketing plans, and certain member notices to the state for approval prior to use. This process ensures the accuracy of the information presented to members and potential members.

Quarterly and annual financial statements

In order to monitor fiscal solvency of plans, plans are contractually required to submit Quarterly and Annual Financial Statements of Operations.

Network Adequacy

In accordance with the applicable Code of Federal Regulations, Oregon's 1115 demonstration Waiver, and Oregon's Medicaid Health Plan Contracts, the Oregon Health Authority ensures an adequate network capacity is available for clients served under Medicaid. Monitoring access and service delivery is an integral part of CMS oversight of the State, as well as State monitoring of the contracted health plans. A contractually required Delivery System Network (DSN) report and analysis is received yearly on July 1st. Subsequently, managed care contractors are required to update these reports any time there has been a material change in their operations that would affect adequate capacity and services, and upon OHA request. Resources used to assist with the review of these reports include, but are not limited to: plan-specific case mix reports, plan-specific race, ethnicity and primary language reports, plan-specific and OHA complaint/grievance/hearing reports, metric and utilization reports.

Credentialing

Managed care plans must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider's National Practitioner Data Bank profile. FFS providers are also enrolled through the state's Provider Enrollment Unit, which confirms that Medicaid, Medicare or other state agencies have not sanctioned providers. The Provider Enrollment Unit also checks providers' National Practitioner Data Bank Profile. Additionally, all credentialed providers must verify regularly through the Office of Inspector General and SAMHSA for compliance with conflict of interest standards.

Policy requirements include standards credentialing, privileging, conflict of interest compliance including time and interval of credentialing functions. CCOs must also work with OHA to assure proper credentialing of Mental Health Programs, associated providers and traditional health care workers. See Attachment A for a list of contractual elements and associated OARs.

Complaints and Grievances

On a quarterly basis, plans must submit a summary of all complaints registered during that quarter, along with a more detailed record of all complaints that have been unresolved for more than 45 days. A uniform report format has been developed to ensure that complaint data are consistent and comparable. OHA uses complaint data to identify developing trends that may indicate a problem in access, quality of care, and/or education. Complaint, grievance and appeals reports also identify FFS provider trends.

Equity

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain communities. These communities are often less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider. It is critical to address equity in these areas that impact a person's health. The connections among the CCO, its Community Advisory Council, community health workers, and local community health and community advocacy organizations will further this goal.

Through the Health Systems Division, Transformation Center, and the Office of Equity and Inclusion (OEI) will assist in developing a curriculum for CCOs and Medicaid providers that will include webinars, group training, individual coaching, information sharing, and technical assistance related to health equity. This would include topics such as:

- Language access services such as interpretation, translation, signage, web sites;
- Job descriptions, training, recruitment and retention of community health workers and other traditional health workers;
- Diversifying the health care workforce;
- Diversity and inclusion best practices;
- Diversifying community advisory boards;
- Including equity and diversity in CCO community health assessments and improvement plans;
- Cultural competence continuing education for all staff;
- Race, ethnicity, and language data collection, analysis, and reporting for quality improvement; and
- Community outreach and partnership with trusted culturally-competent community and faith-based organizations.

Compliance

Accountability Team Reviews

The OHA accountability teams meet monthly to review contract compliance issues across all delivery systems in aggregate and quarterly to review performance metrics.

On an annual basis, OHA prepares a compendium of plan-specific descriptive data reflecting their performance metrics. This analysis includes information on trends in plan enrollment, provider network characteristics, performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies, and other on-site survey findings, focused clinical study findings, and financial data. Each of the data files contribute to a profile for each plan, including a summary of plan strengths and weaknesses. These reports also provide a concise summary of critical quality performance data for each plan, as well as the EQRO's assessment of strengths and opportunities for improvement.

Each year, the state reassesses each plan's progress in addressing and improving identified problem areas. If any deficiencies are identified through the operational review, the plan will be issued a Statement of Deficiency (SOD), which specifically identifies areas of non-compliance. The plan will be required to submit a Plan of Correction (POC), which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up visits may be conducted as appropriate to assess the plan's progress in implementing its POC.

Fraud and Abuse

The plan must submit, in a timely manner, to the OHA Office of Program Integrity, Provider Audit Unit, suspected cases and Complaints of Fraud, Waste and Abuse made to or identified by the plan which necessitate a preliminary investigation. The plan must also submit the following information on an ongoing basis for each suspected or confirmed case of fraud, waste and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees, or any other source:

- The name, address, telephone number, provider and NPI number, of the individual or entity suspected of or confirmed to have committed the fraud or abuse;
- The source (name and contact information) that identified the fraud, waste or abuse, or noted as an anonymous source;
- The type of provider, entity, or organization that is suspected of or confirmed to have committed the fraud, waste or abuse;
- A description of the alleged or proven fraud, waste or abuse;
- Stage the research or investigation is in at the time of the report;

- The approximate dollar amount of the fraud, waste or abuse;
- Whether the complaint has been previously reported to OHA Office of Program Integrity Provider Audit Unit, Department of Justice Medicaid Fraud Control Unit, or other State agency or division;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the current case has been referred; and
- Other data or information as requested.

Concerns related to FFS provider networks are identified through ongoing Provider Services and Client Services reviews.

External Quality Review Organization (EQRO) Activities

OHA has contracted with an External Quality Review Organization (EQRO) to support monitoring of quality in the CCO delivery system. An external quality review is conducted annually for all 16 CCOs and remaining contracted Mental Health Organization. In compliance with Federal regulations, the scope of work includes all mandatory activities: compliance reviews every three years, validating health plan Performance Improvement Projects; and performance measure validation including information system capability assessment (ISCA), and preparing an EQRO Technical Report for each Medicaid managed care plan.

The contract also ensures the ability to negotiate optional activities, including encounter data validation, the conduct of Focused Studies and/or PIPs, PM calculations described above and beyond what the state and/or plans calculate, and administration and/or validation of consumer and provider satisfaction surveys.

Overview of External Quality Review Reports (2012-2015)

For the current 1115 Medicaid demonstration waiver by the Centers for Medicare & Medicaid Services (CMS), the EQR reports show the development of CCOs in the foundation and operations of CCOs to ensure quality, access and timeliness to care.

Areas of improvement since the launch of the CCOs have been in operational structure and systems to monitor and improve care. The following have been implemented over the last four years: development of community advisory councils, value-based payment arrangements, data systems to report gaps in care and utilization monitoring, population management programs, robust care management systems, use of community health workers, and strategies for integrating physical and behavioral health care.

While the gains by CCOs are remarkable, continued improvement is integral to a robust health system for ensuring quality for all Medicaid members. Specific areas of improvement will continue to be detailed for areas of network adequacy, integration of health systems to include

oral health and mental health, and refinement of delegation oversight accountability and monitoring.

As Oregon continues to move towards achieving the triple aim – improving the lifelong health of all Oregonians; increasing the quality, reliability and availability of care for all Oregonians; and containing the cost of care so it is affordable for everyone – monitoring and continuous improvement of the quality of services, access, and timeliness of services will be supported through the annual external quality review. For detailed reports from 2012-2015, please visit www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx.

Technical Report

The technical report provides a feedback loop for ongoing quality strategy directions and development of any technical assistance training plans. In addition to the Statement of Deficiencies and resulting Plans of Correction, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

Enforcement

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance and reports for monitoring. If a plan cannot meet a reporting deadline, a request for an extension must be submitted in writing to OHA. OHA will reply in writing as well, within one week of receiving the request. Plans that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: (1) contact OHA within one week with an acceptable extension plan; or (2) submit the information within one week.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. If these efforts are not producing results, a corrective action plan may be jointly developed and the plan monitored for improvement. More aggressive enforcement options that OHA may apply include restricting enrollment, financial penalties and ultimately, non-renewal of contracts.

List of conditions that may result in sanctions:

1. Fails substantially to provide Medically Appropriate services that the Contractor is required to provide, under law or under its Contract with OHA, to a Member covered under this Contract;

2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medical Assistance Program;

3. Acts to discriminate among Members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of Enrollment or refusal to reenroll a Member, except as permitted under the Medical Assistance Program, or any practice that would reasonably be expected to discourage Enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;

4. Misrepresents or falsifies any information that it furnishes to CMS or to the state, or its designees, including, but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this Contract, encounter data or other information related to care of services provided to a Member;

5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;

6. Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210 and this Contract;

7. Fails to comply with the operational and financial reporting requirements specified in this Contract;

8. Fails to maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services under this Contract;

9. Fails to maintain an internal Quality Improvement program, or Fraud and Abuse Prevention program, or to provide timely reports and data required under Exhibit B, Part 1 through Part 9 and Exhibit L, of the model contract;

10. Fails to comply with Grievance and Appeal requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, and record keeping and reporting requirements;

11. Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services required under this Contract;

12. Fails to follow accounting principles or accounting standards or cost principles required by federal or state laws, rule or regulation, or this Contract;

13. Fails to make timely Claims payment to Providers or fails to provide timely approval of authorization requests;

14. Fails to disclose required ownership information or fails to supply requested information to OHA on Subcontractors and suppliers of goods and services;

15. Fails to submit accurate, complete, and truthful encounter data in the time and manner required by Exhibit B, Part 8, Section 7;

16. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information;

17. Fails to comply with a term or condition of this Contract, whether by default or breach of this Contract. Imposition of a sanction for default or breach of this Contract does not limit OHA's other available remedies;

18. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations;

19. Fails to submit accurate, complete and truthful pharmacy data in the time and manner required by Exhibit B, Part 8, Section 7; or

20. Violates any of the other applicable requirements of 42 USC §1396b(m) or 1396u-2 and any implementing regulations.

Expectations for CCOs

As Oregon's health transformation journey continues to meet the triple aim, how systems of care are delivered are becoming part of day-to-day functions. The ongoing performance management, while creating a culture of innovation, will be the foundation to move CCOs forward. Goals for coming years will be; maintaining the gains in health transformation while increasing alignment of quality activities at the federal and state level. Decreasing the burden of reporting and ensuring compliance with federal regulations will be achieved through the CCO Quality Strategy. Rather than CCOs submitting Transformation Plans and QAPI, OHA will be requiring CCOs to submit, on an annual basis, a CCO Quality Strategy that will include elements of the QAPI, Transformation Plan and an annual Work Plan.

The CCO Quality Strategy will reflect an analysis of quality and transformation activities of the full prior calendar year. This analysis will provide CCOs the necessary picture to further determine gaps in health delivery, health improvement and cost containment. As gaps are defined, CCOs will determine interventions in alignment with CCO strategic plan to improve the quality of members care for their region. When developing interventions, CCOs will consider areas of transformation for the development of activities. CCOs will define in the annual work plan the interventions, measures of success and accountability of implementation of the determined interventions. The contract requirements (deliverables) will be updated annually for clear lines of understanding of format, due date, accountable review structure at Oregon Health Authority.

CCOs will be notified by October 2016 of the necessary elements of the CCO Quality Strategy that includes Health Transformation and QAP.

Standards for Managed Care Contracts

As required by CFR 438.204(g), Oregon must establish standards for all managed care contracts regarding access to care, structure and operations, and quality measurement and improvement. Attachment A on page 137 outlines each required component of the federal regulations and identifies the section of the model coordinated care organization, dental care organization, fully capitated health plan, and provider service organization contracts, and/or Operational Protocol where this requirement is addressed.

Review of Quality Strategy

The OHA Quality Strategy shall be reviewed annually by OHA. The OHA Quality Strategy review and update will be completed by December of each year and submitted to CMS, upon significant changes, in the subsequent quarterly report update.

The OHA Quality Council shall have overall responsibility to guide the annual review and update of the Quality Strategy. The review and update shall include an opportunity for both internal and external stakeholders to provide input and comment on the Quality Strategy. Key stakeholders shall include, but are not limited to:

- Addictions and Mental Health Planning and Advisory Council*
- Medicaid Advisory Committee*
- Health Systems Division Executive Team
- CCO Medical Directors
- FFS Contractors
- CCO Quality Management Coordinators
- Local Government Advisory Committee*
- DHS Internal Stakeholders
- OHA Internal Stakeholders
- Health Equity Policy Committee*

* *Committees including consumer representatives.*

The Quality Strategy and subsequent updates will be posted online for a two-week public comment period before they are submitted to CMS for approval. Final versions will be posted on the OHA website.

Attachment A: Contract Compliance

This table itemizes where the federal requirements of CFR 438.204(g) are addressed in the Medicaid model contracts.

Required component	Contract provision
438.206 - Availability of services • Delivery network, maintain and monitor a network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled. • Provide female enrollees direct access to women's health specialists. • Provide for a second opinion. • Provide out of network services when not available in network. • Demonstrate that providers are credentialed. • Furnishing of services, timely access, cultural competence.	Model Contract: • Exhibit B, Part 4, Subsection 3.a. • Exhibit G,1.b. • Exhibit B, Part 4, Subsection 2.m. • Exhibit B, Part 4, Subsection 3.a. (6) • Exhibit B, Part 4, subsection 3.b.(1) • Exhibit B, Part 4, subsection 3.a.(1)
438.207 - Assurances of adequate capacity and services • MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment. Submit the documentation in a format specified by the state at time of contracting and any time there is a significant change.	Model Contract • Exhibit B, Part 3.a.(1)
438.208 - Coordination and continuity of care • Each MCO must implement procedures to deliver primary care to and coordinate health care services to enrollees. • State must implement procedures to identify persons with special health care needs. Special health care needs are defined as: High health care needs, multiple chronic conditions, mental illness or substance use disorder and either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.	Model Contract: • Exhibit B, Part 4, 2.i. • Exhibit B, Part 4, 2.e.

Required component	Contract provision
• MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions. • State must have a mechanism to allow persons identified with special health care needs to access specialty care directly, (standing referral).	
438.210 - Coverage and authorization of services • Service authorization process.	Model Contract: • Exhibit M, subsection 7
438.214 - Provider selection • Plans must implement written policies and procedures for selection and retention of providers. • State must establish a uniform credentialing and recredentialing policy. Plan must follow a documented process for credentialing and recredentialing. • Cannot discriminate against providers that serve high risk populations. • Must exclude providers who have been excluded from participation in Federal health care programs.	Model Contract: • Exhibit B, part 4, 3.b.
438.218 - Enrollee information • Plans must meet the requirements of 438.10	Model Contract: • Exhibit N
438.224 - Confidentiality • Plans must comply with state and federal confidentiality rules.	Model Contract: • Ex. B, Part 4, Section 5.b.(3)
438.226 - Enrollment and disenrollment • Plans must comply with the enrollment and disenrollment standards in 438.56.	Model Contract: • Ex. B, part 3, subsection 6
438.228 - Grievance systems • Plans must comply with grievance system requirements in the Federal regulations.	Model Contract: • Ex. B, part 3, subsection 5
438.230 - Subcontractual relationships and delegation • Plan is accountable for any functions or responsibilities that it delegates. • There is a written agreement that specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor's performance is inadequate.	Model Contract • Exhibit D, section 18
438.236 - Practice guidelines • Plans must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically. • Guidelines must be disseminated. • Guidelines must be applied to coverage decisions.	Model Contract: • Ex. M, subsection 6

Required component	Contract provision
438.240 - Quality assessment and performance improvement program • Each MCO and PIHP must have an ongoing improvement program. • The state must require that each MCO conduct performance measurement, have in effect mechanisms to detect both underutilization and overutilization, have in effect a mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs. • Measure and report to the state its performance using standard performance measures required by the state. Submit data specified by the state to measure performance. • Performance improvement projects. Each plan must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the state the results of each project. • The state must review at least annually, the impact and effectiveness of the each program.	Model Contract: • Ex. B, Part 9
438.242 - Health information systems • Each plan must have a system in place that collects, analyzes, integrates, and reports data and supports the plan's compliance with the quality requirements. • Collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system. • The plan should ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the state and CMS.	Model Contract: • Exhibit B, Part 7

Appendix C: Measurement Strategy

Measurement Strategy Introduction

Framework for Measurement

Since the July 2012 extension of the 1115 demonstration, Oregon has sought to demonstrate the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon to achieve the demonstration goals of reduced Medicaid spending growth, and improved health care quality, access, and outcomes. Oregon utilizes community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of Medicaid beneficiaries in communities, as well as an active commitment to data and measurement.

As described in the narrative, Oregon intends to meet several key goals in the next five years, including:

- Build on Oregon's Medicaid delivery system transformation with a stronger, expanded 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 cure;
- Deepen focus on addressing the social determinants of health and improving health equity across all low-income, vulnerable Oregonians to improve population health outcomes;
- Commit to an ongoing sustainable rate of growth that includes a risk to Oregon receiving the federal funds if we fail to meet the 2 percent test and adopting a payment methodology and contracting protocol for CCOs that promotes increased investments in health-related services and advances the use of value-based payments; and
- Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

Oregon will accomplish these goals through a variety of strategies and quality improvement activities, described in the narrative and appendices, but also supported by a robust measurement strategy that will use financial incentives, multiple measure sets, and public transparency as mechanisms to drive improvement.

Improved Quality & Access

Oregon's focus on measurement and transparency as key components of the coordinated care model has resulted in strong improvements across the seven quality improvement focus areas originally identified in the 2012 waiver. Oregon has also successfully demonstrated that quality

and access for members has not been harmed despite transformation activities and the 2014 Medicaid expansion.

Under STC 52 and 54 of Oregon's 1115 demonstration waiver (2012 – 2017), OHA must conduct a quality and access test in each program year that the state achieves its cost control goal to determine whether the state's health system transformation efforts have caused the quality of care and access to care experienced by Medicaid beneficiaries to worsen. The test is passed if a composite score for the 33 quality and access metrics improves as compared to a historical baseline (2011).[39]

Table 1: Quality & Access Test results by year

Demonstration year	Number of measures included (of 37)[40]	Test score[41]
DY 12	25	114.3%
DY 13	28	58.4%

Through the coordinated care organization (CCO) incentive metrics program, Oregon has demonstrated improvements in a number of areas, including reductions in emergency department visits and increases in developmental screening, screening for alcohol and other substance use, and enrollment in Patient-Centered Primary Care Homes.[42]

Through the Hospital Transformation Performance Program (HTPP), Oregon is demonstrating increased medication safety, and stronger hospital-CCO coordination, as evidenced by measures such as follow-up after hospitalizations for mental illness.[43]

Evaluation results to date have indicated that health system transformation is meaningfully affecting patterns of care without negatively impacting key outcomes. See Evaluation Plan below for additional details.

Waiver Renewal

Measurement and evaluation are necessary to determine whether Oregon's health system transformation efforts and goal of advancing the Triple Aim is met. This appendix describes

[39] Methodology is documented in Oregon's 2012–2017 Accountability Plan, online at www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf

[40] Measures with multiple rates are treated as separate measures in the composite scoring, resulting in more than 33 quality and access test measures. For example, the measure Ambulatory Care: Outpatient and Emergency Department Utilization is treated as two measures for the purposes of the composite.

[41] The claims-based measures included in the composite were independently calculated and validated by a third party, with remaining non-claims-based measures calculated by OHA.

[42] Performance is publicly reported in semi-annual reports, online at www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

[43] Performance is publicly reported in annual reports, online at www.oregon.gov/oha/Metrics/Pages/Hospital-Reports.aspx

Oregon's robust measurement strategy, including the continued Quality and Access Test, the CCO and Hospital incentive metrics programs, data sources and validation, and commitments to transparent reporting. Most measurement activities are carried forward from the 2012-2017 waiver, reflecting updated focus areas and goals as part of the new waiver.

Oregon intends to measure quality of care, access to care, and health outcomes for individuals enrolled in CCOs and for the Oregon Health Plan population as a whole. The Oregon Health Authority intends to continue with a modified Quality and Access Test to ensure members are not being harmed as a result of Oregon's continued health system transformation, and will use multiple other measure sets for various monitoring, quality improvement, and incentive purposes.

In addition to continuing to utilize measures from the CMS adult and child measure sets, and CAHPS surveys, Oregon's measures will likely reflect the increased state and national focus on measure alignment, and enhanced focus on population health and health outcomes.

The measurement strategy will continue to evolve to support the following priority areas:

- Behavioral health and oral health integration;
- Social determinants of health;
- Public health priorities;
- CCO collaboration and coordination with other systems, such as early learning hubs, hospitals, and the Department of Human Services (DHS);
- Specific populations, including members with severe and persistent mental illness (SPMI) and dual eligibles; and
- Populations experiencing disparities, including, but not limited to, inequities by race, ethnicity, language, gender, age, and geography.

OHA will continue its incentive programs, for both CCOs and hospitals, using the pay for performance lever to continue to drive focus and quality improvement efforts across the health system. Both CCO and hospital programs will continue to be guided by the legislatively-established public committees, although changes to the program structure and specific measures are anticipated over time. See sections below for details on the CCO and hospital incentive programs.

This measurement strategy will also better support CCO quality improvement efforts, with an overall goal to improve the health of members and improve administrative burdens on CCOs through the alignment of metrics, performance improvement projects, and transformation activities. See Appendix B for additional details on quality improvement efforts.

Committees

Oregon's robust measurement strategy includes several public committees, legislatively charged with selecting measures used in the CCO and hospital incentive programs, as well as providing oversight for measurement alignment. Committees include:

CCO Metrics and Scoring Committee

Established in 2012, the Metrics and Scoring Committee is charged with reviewing data and relevant literature to determine which measure will be included in the CCO incentive program each year, as well as establishing the benchmarks and improvement targets for that year.[44]

Beginning in 2017, the Metrics and Scoring Committee will become a subcommittee of the Health Plan Quality Metrics Committee (HPQM - see below), and will select incentive metrics for CCOs from the master measure set selected by the HPQM Committee. However, the HPQM, when developing the master measure set, must take into account the recommendations of the Metrics & Scoring Committee.

Hospital Performance Metrics Advisory Committee

Established in 2013, the Hospital Performance Metrics Advisory Committee is charged with developing the hospital-specific metrics for incentive payments.[45] This Committee is comprised of members from diagnostic-related group (DRG) hospitals, Coordinated Care Organizations, and researchers, and recommends the measures for the hospital incentive program each year. The Committee also reviews data and relevant literature to establish benchmarks and improvement targets each year.

Health Plan Quality Metrics Committee

Legislatively established in 2015, the 15-member Health Plan Quality Metrics Committee (HPQM Committee) is charged with working collaboratively with the Oregon Educators Benefit Board (OEBB), the Public Employees' Benefit Board (PEBB), the Oregon Health Authority, and the Department of Consumer and Business Services (DCBS) to adopt health outcome and quality measures that are focused on specific goals and provide value to the state, employers, insurers, health care providers, and consumers.[46]

This Committee will convene in early 2017 and select an aligned set of health outcome and quality measures to be used for health benefit plans sold through the health insurance exchange, offered by PEBB and OEBB, and CCOs. State agencies are not required to adopt all of the measures selected by the Health Plan Quality Metrics Committee, but may not adopt any health outcome and quality measures that are different from the measures selected by the Committee.

[44] www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx
[45] www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx
[46] Oregon Senate Bill 440 (2015) www.oregon.gov/oha/analytics/APACDocs/Senate%20Bill%20440%20Enrolled.pdf

The Committee is charged with prioritizing measures that:

- Utilize existing state and national health outcome and quality measures, including measures adopted by CMS, have been adopted or endorsed by other states or national organizations, and have a relevant state or national benchmark;
- Are not prone to random variations based on the size of the denominator;
- Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden;
- Can be meaningfully adopted for a minimum of three years;
- Use a common format in the collection of the data and facilitate the public reporting of the data; and
- Can be reported in a timely manner and without significant delay so that the most current and actionable data is available.

Technical Advisory Workgroups (TAG)

OHA also staffs monthly workgroup meetings for both CCO metrics and HTPP metrics.47 These technical advisory group (TAG) meetings are public meetings, where all CCOs and DRG hospitals are invited to send representatives to participate in the discussion. TAG meetings focus on operationalizing selected measures, developing measure specifications, making recommendations to the Metrics and Scoring, and Hospital Performance Metrics Advisory Committee, and quality improvement strategies.

Measure Sets

In addition to the specific measure sets (described below) for the quality and access test, the CCO incentive measures, and the hospital incentive measures, Oregon intends to explore developing, validating, and reporting on measures that support the following:

- Quality improvement focus areas described in Appendix B
- Quality
- Access
- Population health and health outcomes
- Integration
- Behavioral health
- Oral health

[47] www.oregon.gov/oha/analytics/Pages/Hospital-Metrics-Technical-Advisory-Group.aspx and www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx

- Social determents of health
- Collaboration with other systems, particularly early learning and housing.

There are also several bodies of work that will inform Oregon's overall measurement strategy, including the CMS adult and child measure sets, the Child & Family Well-being Measures Workgroup, behavioral health mapping, and in-state and national measure alignment activities.

Oregon will continue to publicly report measures at the state and CCO, or hospital, level where appropriate. See Transparency section below.

Performance Measures for Children and Adults in Medicaid/CHIP

Oregon intends to continue its commitment to reporting on the CMS Adult Medicaid Quality Measures and CHIPRA Measures where possible, and where appropriate, for the entire population.

As a participant in both the Adult Medicaid Quality Grant and the Children's Health Insurance Program Reauthorization Act Quality Demonstration Program, Oregon has developed a deep understanding of these measures, and has developed capacity to report and analyze the data to identify opportunities to improve health care for Medicaid beneficiaries. One finding from this work is that the two measure sets artificially segment the population, which can limit a population health focus. Oregon intends to report these measures for the entire population where possible, unless it is clinically appropriate to use the age-segmentation.

Many of these measures may be included in other measure sets described below.

Child & Family Well-being Measures Workgroup

The Child & Family Well-being (CFWB) Measures Workgroup was created by the Joint Early Learning Council / Oregon Health Policy Board Joint Policy Subcommittee, which focused on identifying opportunities for coordination and integration between health and early learning system transformation efforts. The CFWB Workgroup was convened to provide recommendations for shared, cross-sector measures for child and family well-being in Oregon. [48]

The workgroup developed a 67-item child and family well-being measures library, as well as specific subsets of measures recommended for state level monitoring, and accountability measures that could be used as incentive or contract management measures with Coordinated Care Organizations and Early Learning Hubs. These measures, particularly the accountability measures, may be incorporated into future measure sets.

[48] www.oregon.gov/oha/analytics/Pages/Child-Family-Well-Being-Measures.aspx

Behavioral Health Mapping

The Oregon Health Authority has convened a technical advisory committee to help develop a behavioral health system mapping tool that will assist OHA and partners to assess public resource and service needs, while tracking resource and service delivery.[49]

The tool will enable the technical advisory committee to monitor and analyze system data to identify local areas with service gaps. Areas identified by the technical advisory committee may be appropriate for adoption into other monitoring or accountability measure sets.

Measure Alignment

There is growing interest in Oregon, and nationally, for measure alignment, and a developing understanding of measure fatigue. Both HB 2118 (2013) and SB 440 (2015, described above) created public committees charged with developing an aligned set of measures for public payers, and in 2016, CMS partnered with America's Health Insurance Plans to develop seven sets of clinical quality measures to support multi-payer alignment. Additional work from the Institute of Medicine and others provide important frameworks that Oregon will likely be incorporating into future measure development and selection.

Oregon is cognizant of the changing state and national landscape for quality measurement, and the need for parsimonious, aligned measure sets for Medicaid and other public payers (where possible). These conversations will affect measure selection in coming years, and measures proposed in this initial measurement strategy will likely change over time to address local and national movement. However, in the renewal period Oregon will have increased focus on selecting outcome measures and measures that reflect important aspects of health of Oregon Health Plan members.

Oregon is also particularly interested in ways in which the measure alignment conversation can overlap with CMS adult and child measures, and may be able to participate in future conversations determining which of the existing measures are essential to monitor state and national performance.

In addition, Oregon will monitor CMS and other national measure specifications to ensure implementation remains current and aligned. This includes updating measures to incorporate annual changes in HEDIS specifications, and potentially removing measures from measure sets described here if national measure stewards drop or significantly change measures.

Measure Development

Oregon is interested in a number of areas of measurement where national, standardized measures may not be available, or may need modification for Oregon's population or practice. Examples of this may include measures to address social determinants of health, such as developing a

[49] www.oregon.gov/oha/amh/Pages/bh_mapping.aspx

CCO-level measure for food insecurity screening, or housing, or transitioning existing claims-based measures to EHR-based measures, such as effective contraceptive use or alcohol and drug use screening (SBIRT).

As these measures are likely to be developmental and require testing before fully adopting them into the measurement framework, or incentive program(s), Oregon intends to establish a glide path for measure development and adoption, similar to California's Medi-Cal 2020 demonstration plan for testing innovative measures.[50]

Measures may be adopted as pay-for-reporting, or monitoring measures during the testing process, until they have been sufficiently vetted to be pay-for-performance metrics for CCOs or hospitals, or incorporated into the Quality & Access Test measure set. Developmental measures may be utilized in other processes, such as performance improvement project measures, where they can continue to be refined before being more formally adopted into pay-for-performance structures. The Metrics TAG workgroups described above will be critical partners in developing and testing innovative measures.

Quality & Access Test

This section lays out the details of the "quality and access test" that will be applied in each year of the demonstration that Oregon achieves its cost control goal to determine whether health system transformation has caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen.

Original Test (2012-2017)

In the previous demonstration period, Oregon's quality and access test consisted of two parts. In brief, part one of the quality and access test is a relatively simple comparison of program period quality and access to historical baseline levels of quality and access (2011). Part two is a more complex comparison of program period quality and access to a counterfactual level of quality and access that would exist had health system transformation not been undertaken. Part two of the test is only required if the state fails part one. Oregon fails the test for a given year if and only if it fails both part one and part two of the test. Failing the test would result in reductions in a portion of Designated State Health Program (DSHP) funding to the state, as described in the Standard Terms and Conditions.

Revised Test (2018-2022)

Oregon proposes continuing CMS and the state's agreement to an annual test to assess whether unadjusted metrics for quality and access have demonstrated improvement. Oregon proposes continuing a two part test, with modifications made to the original methodology to better reflect

[50] CA 1115 Waiver – PRIME Attachment Q – PRIME Projects and Metrics Protocol
www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf

the current state of health system transformation and the evolving measurement strategy (a summary of modifications is provided below).

Part One

A single "aggregate" indicator will be constructed using a number of "component" quality and access measures. A test result will be generated based on the differences between performance on this aggregate indicator in the current period (using the most recent full calendar year) and a baseline period (calendar year 2011). For component measures for which Oregon does not have a baseline period available, the earliest prior year available will be used as the comparative period instead.

Oregon will also explore a version of the quality and access test that compares performance on the aggregate indicator to performance in the prior year, rather than the historic baseline.

Oregon and CMS will agree on the initial component measures that will be used to construct the single quality and access aggregate indicator. Oregon will continue the original methodology for constructing the aggregate indicator developed under the 2012-2017 waiver which calculates a translated level of performance for each measure included in the aggregate indicator. Oregon is proposing 29 measures for the initial aggregate indicator (listed below); these proposed measures build on the original quality and access test measures, as well as the current CCO incentive measures.

OHA will calculate the results for the quality and access test, in conjunction with third party contractor(s) who may calculate some of the measures, and/or validate OHA's calculation of the test measures. This is similar to OHA's current approach for the CCO incentive measures, and ensures iterative production and review of the measures for the most robust results.

Table 2: Initial Proposed Quality & Access Test Measures

Proposed quality and access test measures	Current (2016) CCO incentive measure	Former Q&A test measure	New test measure
Adolescent well care visits	x	x	
Alcohol or other substance misuse (SBIRT)	x	x	
All-cause readmissions		x	
Ambulatory care: emergency department utilization	x	x	
Ambulatory care: avoidable emergency department utilization (Medi-Cal method)			x
Assessments for children in DHS custody	x		x
CAHPS: access to care	x	x	
CAHPS: medical assistance with smoking cessation		x	
CAHPS: satisfaction with care	x	x	
Child and adolescent access to primary care practitioners		x	

Proposed quality and access test measures	Current (2016) CCO incentive measure	Former Q&A test measure	New test measure
Childhood immunization status	x	x	
Colorectal cancer screening	x	x	
Comprehensive diabetes care: HbA1c testing	x	x	
Comprehensive diabetes care: HbA1c poor control	x	x	
Controlling high blood pressure	x	x	
Dental sealants on permanent molars for children	x		x
Depression screening and follow up plan	x	x	
Developmental screening in the first 36 months of life	x	x	
Effective contraceptive use among women at risk of unintended pregnancy	x		x
Follow-up after hospitalization for mental illness	x	x	
Immunization for adolescents		x	
Patient-Centered Primary Care Home enrollment	x	x	
Timeliness of prenatal care: prenatal care	x	x	
Timeliness of prenatal care: postpartum care		x	
PQI 01: diabetes, short term complication admission rate		x	
PQI 05: COPD admission rate		x	
PQI 08: congestive heart failure admission rate		x	
PQI 15: adult asthma admission rate		x	
Well child visits in the first 15 months of life		x	

Measure Inclusion/Exclusion

This approach relies on as broad a set of measures as possible, using measures for which data collection is already planned, because a broad set of measures encourage broad-based improvement and tends to increase the precision of the aggregate. CCO incentive measures are particularly attractive candidate measures, as the objectives of the CCOs should be aligned with those of the state as much as possible.

As measure sets are updated, new measures are developed, and measures are retired or adopted by the Health Plan Quality Metrics Committee and CCO Metrics and Scoring Committee, measures included in the aggregate indicator may shift. Oregon will keep the measure set the same to the extent possible, to ensure comparable results over time; however, allowing flexibility to remove measures if they are retired nationally, or to incorporate new measures that reflect care being provided in Oregon, will be important.

Measures in development that might also be included in the quality and access test by 2018 include a revised measure of electronic health record adoption across CCO provider networks, an opioid prescribing related measure, additional dental measures such as fluoride varnish or access to dental care, and behavioral health measures. Measures from the Hospital Transformation Performance Program may also be appropriate to include in the quality and access test.

In general, measures for which Oregon is already planning to collect data should be included in the aggregate indicator unless there is good reason to exclude the measure.

Good reasons to exclude a measure are:

- No data are available for that measure in the baseline, or prior year within the demonstration for comparison;
- Measure would contribute so much uncertainty to the aggregate that judgments about the aggregate would be affected;
- No benchmark is available;
- Lack of consensus at the state level about the value of the measure.

Measures may also be retired from the quality and access test if they are retired from other measure sets, such as HEDIS, or dropped by the national measure steward, or retired as a pay-for-performance metric by the public committees. This ensures that Oregon's measures remain aligned and reduces measurement burden on health plans, hospitals, and providers who might otherwise be required to continue reporting on a measure for quality and access test purposes that has otherwise been retired.

Passing the Test

Part one of the test is passed if the aggregate score for quality and access metrics, rounded to the nearest tenth of a percentage, is greater than zero percent.

Part Two

If Oregon does not pass part one of the test in any year to which it is applied, Oregon will undertake, and submit to CMS, a more detailed counterfactual analysis to determine whether quality and access have significantly diminished in a manner attributable to the state's efforts under the demonstration. Some or all of the counterfactual analysis may be addressed through Oregon's proposed evaluation activities, as described above.

If this analysis indicates a significant diminishment in quality and access under the demonstration in a given year, CMS will apply a reduction to the federal match claimed in the year immediately following the year for which the determination was made. Details of this reduction, as well as methodology and criteria for passing part two of the test are to be determined in conjunction with CMS.

Modifications to Original Q&A Test

- Change measurement period from state fiscal year to calendar year to better align with the CCO incentive measurement period (i.e., some measures are only available annually and on the calendar year).
- For new measures, allow baseline periods to be later than original CY 2011 baseline.

- Explore a version of the test that compares to a prior year, rather than historic baseline.
- Propose revisions to the measures included in the composite, as well as the flexibility to modify the measures further, depending on local measure development, strong performance, and prioritization/selection by public committees.

While not required in the 2012-2017 test period due to potential technical challenges and the increased risk of false-negative test results associated with a substantial increase in the number of comparisons, OHA will explore applying part one of the quality and access test to beneficiary subpopulations as one potential avenue for monitoring health equity and identifying potential disparities.

Regardless of any potential results from part one of the test by subpopulation, Oregon will address subpopulation analysis through its proposed evaluation activities (described in the Evaluation Plan) and its metrics reporting (described below).

CCO Incentive Measure Program

Established in the 2012 waiver, and corresponding state legislation, the CCO incentive program is a mechanism for focusing CCO efforts and driving continuous quality improvement. Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. Oregon's strategy has been to annually increase the percentage of CCO payment at risk for performance, providing a meaningful incentive to achieve significant performance improvement and affect transformative change in care delivery.

To date, the CCO incentive metrics program has been a success. CCOs show improvements in a number of incentivized areas, including reductions in emergency department visits, and increases in developmental screening, screening for alcohol and other substance use, and enrollment in Patient-Centered Primary Care Homes (PCPCHs). CCOs have made important strides in developing cross-sector relationships and systems to also improve care, such as coordination with the Department of Human Services to ensure children in foster care receive needed health assessments.

Oregon has learned that "what gets measured, gets managed." Measures selected as incentive measures have been incredibly powerful in driving quality improvement efforts, and have demonstrated broad reach, as CCOs work with providers to make improvements that affect their entire panel, not just Medicaid beneficiaries, as well as measure alignment happening across payers. Even measures potentially in development as *future* incentive measures have the ability to change the conversation, such as current work to develop a CCO-level measure of food insecurity screening.

Measure Selection

The CCO Metrics & Scoring Committee (described above), continues to select the annual incentive measures that will be tied to the quality pool, as required by STC 37b.ii. See Attachment A below for additional information on the CCO quality pool.

Many of the incentive measures that have been selected to date overlap with other, national measure sets, ensuring that the incentive program is aligned with existing state and national quality measures. Selected incentive measures also align with Oregon's quality improvement focus areas, and as health system transformation continues to deepen into the next phase, the incentive measures will evolve.

The Metrics & Scoring Committee will be selecting the 2017 incentive measures in the summer of 2016. The most current measure set is provided in the table below, as well as changes in the incentive measure set over time. Detailed measure specifications, technical documentation, and additional guidance are all published online.[51]

[51] www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

To ensure continuous quality improvement, the Committee has developed robust measure selection and retirement criteria to help guide measure selection each year, and continues to pursue measures that will help drive health system transformation.[52] Each year, the Committee will consider additional measures as potential incentive measures as priorities evolve and new measures are developed.

CCO incentive measures	2013	2014	2015	2016
Adolescent well-care visits	x	x	x	x
Alcohol or other substance misuse screening (SBIRT)	x	x	x	x
Ambulatory care: emergency department visits (per 1,000 mm)	x	x	x	x
CAHPS composite: access to care	x	x	x	x
CAHPS composite: satisfaction with care	x	x	x	x
Childhood immunization status				x
Cigarette smoking prevalence				x
Colorectal cancer screening	x	x	x	x
Controlling high blood pressure	x	x	x	x
Dental sealants			x	x
Depression screening and follow-up plan	x	x	x	x
Developmental screening (0-36 months)	x	x	x	x
Early elective delivery	x	x		
Diabetes: HbA1c poor control	x	x	x	x
Effective contraceptive use			x	x
Electronic health record adoption	x	x	x	
Follow-up after hospitalization for mental illness (FUH MI 7 day)	x	x	x	x
Follow-up for children prescribed ADHD medication	x	x		
Health assessments within 60 days for children in DHS custody	x	x	x	x
Patient-centered primary care home enrollment[53]	x	x	x	x
Timeliness of prenatal care	x	x	x	x

Benchmark Selection

The Committee also establishes annual benchmarks and improvement targets for each of the incentive measures. CCOs must meet either the benchmark or improvement target to be eligible for receiving funds from the quality pool. The Committee will continue to review measures annually to ensure CCO performance is not stagnating. CCOs will not be allowed to coast on early successes, or demonstrate improvement in just one area of transformation.

Current (2016) benchmarks and improvement targets are available online.[54]

[52] www.oregon.gov/oha/analytics/Documents/Measure_selection_criteria.pdf and www.oregon.gov/oha/analytics/Documents/MS_Committee_Measure_Retirement_Checklist.pdf

[53] The current CCO incentive measure looks at the percent of CCO members who are assigned to a recognized patient-centered primary care home. As the PCPCH program standards are changing, the measure will need to be modified to reflect the new tiers.

[54] www.oregon.gov/oha/analytics/CCOData/2016%20Benchmarks.pdf

The Committee reviews CCO performance data, improvement over prior year's performance, distribution of the quality pool, and emerging areas of need to help determine the right combination of incentive measures and benchmarks to help improve quality, access, and outcomes for Medicaid beneficiaries. Incentive measures will be added in subsequent years, and it is likely that other measures will be retired from the set.

Future Priorities

The Committee is also particularly interested in using the CCO incentive measure program structure to further health system transformation, by developing and adopting more transformational, and outcome-based measures, rather than traditional health care quality process measures, as well as exploring changes to the payment structure which would better support priority areas.

For example, the Committee is considering moving to a core and menu measure set, in which all CCOs would be incentivized for performance on the same core measures, but also have some flexibility to select additional incentive measures from a menu, based on local need and priority. The Committee will be developing this structure throughout 2016-17, for implementation as early as 2018 measurement.

The Committee is also interested in developing a measure, or mechanism, to more directly address health equity through the pay-for-performance program. This will also likely evolve throughout 2017 for implementation in a future measurement year.

Hospital Incentive Measure Program

Established in 2014, Oregon operates the Hospital Transformation Performance Program (HTPP), which issues incentive payments to participating hospitals for quality improvement efforts as determined by the hospital incentive measures. The HTPP is an integral aspect of health system transformation in Oregon. Oregon's vision for achieving the triple aim of better health, better care, and lower costs means that all aspects of the delivery system must coordinate their transformation efforts.

Hospitals are an essential part of Oregon's delivery system. In recognition of this, the Oregon Legislature mandated the creation of a hospital incentive measure program covering the 2013-2015 biennium. CMS approved the initial two years and an extension for a third year, under the 2012-2017 demonstration.

In 2015, the Oregon Legislature solidified the importance of hospitals in transforming the healthcare system by mandating the continuation of the HTPP for four additional years. In addition, the Legislature's extension recognized the vital and intertwined roles hospitals and CCOs play in transforming the delivery system and passed legislation that equally splits the incentive pool funding between hospitals and CCOs beginning in the third year (see Attachment A below for additional details on the hospital quality pool structure and distribution).

The implementation of the program has resulted in increased alignment and partnership work among hospitals, CCOs, primary care providers, and other community partners, particularly around three measures:

- *Screening, brief intervention, and referral to treatment (SBIRT) in the emergency department*. The inclusion of this measure in the HTPP has incentivized all of Oregon's DRG emergency departments to implement drug and alcohol screening, and complements the CCO incentive measure (focused on SBIRT in primary care). This required a significant investment by hospitals to change their emergency department workflows and technology to screen patients and track outcomes. OHA estimates that the HTPP SBIRT measure alone has resulted in a net savings of over $3.3 million (this is net of the $8.5 million per year HTPP incentive payments made for this measure).[55]
- Hospitals sharing emergency department (ED) visit information with primary care providers to reduce unnecessary ED visits by high utilizers. For many hospitals, this was a completely new process implemented because of the HTPP. Hospitals have made significant strides in increasing notifications to primary care providers since the first year of the program, and the HTPP has motivated partners like the Oregon Health Leadership Council to work with OHA to facilitate greater conversations among

[55] Gentilello et al (2005). Alcohol interventions for trauma patients treated in emergency departments and hospitals: a cost-benefit analysis. *Annals of Surgery*, 241, 541-550. Study estimates net cost savings at $89 per patient screened, or $330 for each patient offered an intervention. OHA applied the SBIRT-related cost savings to the first two years of data for the HTPP.

hospitals, CCOs, and primary care practices about the best processes to support this work.

- *Follow-up after hospitalization for mental illness*. This is both a CCO and hospital incentive measure and requires both systems to collaborate in order to be successful. Hospitals actively work with their local CCOs to ensure that they are successful on this measure and patients are able to attend their follow-up appointments after they are discharged from the hospital.

Additionally, the HTPP has resulted in collaboration between the Hospital and CCO Metrics Committees, hospital engagement in the Hospital Metrics Technical Advisory Group, coordination between CCOs and hospitals to achieve shared goals, and community partnerships to improve care. Hospitals and partners are engaged and invested in this work.

OHA is currently conducting an independent evaluation of the first two years of the HTPP, as required by CMS, to help demonstrate whether the HTPP is accelerating health system transformation among targeted providers, and whether the program is resulting in quality improvements. Results will be made available in June 2016.

Because of the foundational role that hospital quality improvement plays in moving transformation forward, Oregon proposes continuing the HTPP through the 2017-2022 demonstration period, transitioning the program from the initial structure to a program which is fully integrated and aligned with overall health system transformation goals. This section provides a summary of years 1-3 and OHA's proposal for the fourth year of the program, as well as the broader vision, which will continue to evolve with the Hospital Metrics Advisory Committee (described above), and partners.

Years 1–3 Domains and Measures

The Hospital Metrics Advisory Committee recommended eleven outcome and quality measures across six domains for the initial years of the program. The measures can also be captured in two overarching focus areas: hospital-focused, and hospital-CCO coordination-focused (see table below).

The Committee also recommended annual benchmarks and improvement targets for each of the hospital incentive measures. Hospitals must meet either the benchmark or improvement target to be eligible for receiving funds from the quality pool. Benchmarks and improvement targets are available online.[56]

To ensure continuous quality improvement, the Committee has adopted principles to help guide measure selection.[57] For future years of the program, the Committee will consider additional

[56] See Measures and Benchmarks Table document, www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx

[57] www.oregon.gov/oha/analytics/HospitalMetricsDocs/Hosp%20Perf%20Metrics%20Guiding%20Principles.pdf

measures as potential hospital incentive measures on an annual basis, as well as where to set the benchmark and improvement targets to ensure they provide stretch goals. Hospitals will not be allowed to coast on early successes from the first years of the program, or demonstrate improvement in just one domain or area of transformation.

Years 1–3 Domains and Measures

Focus area	Domains	Measures
Hospital focus	1) Readmissions	1. Hospital-wide all-cause readmission[58]
	2) Medication Safety	2. Hypoglycemia in inpatients receiving insulin 3. Excessive anticoagulation with Warfarin 4. Adverse drug events due to opioids
	3) Patient Experience	5. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Staff always explained medicines 6. HCAHPS: Staff gave patient discharge information
	4) Healthcare-Associated Infections	7. Central Line-Associated Bloodstream Infection (CLABSI) in all tracked units 8. Catheter Associated Urinary Tract Infection (CAUTI) in all tracked units
Hospital-CCO collaboration focus	5) Sharing ED Visit Information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits (two-part measure)
	6) Behavioral Health	10. Follow-up after hospitalization for mental illness 11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the emergency department (two-part measure)

Proposed Year 4

For the fourth year of the program that begins with the renewal demonstration, Oregon is proposing modifications to the domains to better reflect the focus of the program, and additional measures to further stretch hospital performance and improve quality.

Proposed Year 4 Domains and Measures

As shown in the table below, some of the initial measures have been realigned to make the aim for an overarching, community-focused program clearer. Two of the initial domains (medication safety and healthcare acquired infections) have been combined into a patient safety domain. While patient safety remains an important goal for all hospitals, this modification reduces the relative worth of these measures in terms of HTPP payment (see Attachment A for payment details) and shifts the emphasis to those measure which are more community-focused.

[58] OHA has proposed changing the readmission measure from all-cause to potentially preventable (PPR) for the third measurement year. This change is pending CMS approval.

One of the healthcare acquired infections measures (CLABSI), and two of the medication safety measures (Excessive anticoagulation with Warfarin and Adverse Drug Events due to opioids) have been removed, due to strong hospital performance in the initial years of the program.

Three new measures have been added, including C-difficile, opioid prescribed in the Emergency Department, and reducing c-sections (combined with a balancing measure of unexpected newborn complications).

Domains	Measures
1. Fostering effective care transitions	1. Potentially preventable readmissions 2. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Staff always explained medicines 3. HCAHPS: Staff gave patient discharge information
2. Improving patient safety	4. Catheter Associated Urinary Tract Infection (CAUTI) in all tracked units 5. C-difficile 6. Hypoglycemia in inpatients receiving insulin
3. Reducing avoidable ED visits	7. Emergency Department Information Exchange (EDIE): reducing emergency department re-visits
4. Coordinating behavioral health and substance Use Interventions	8. Follow-up after hospitalization for mental illness 9. SBIRT in the emergency department (two-part measure) 10. Safe opioid prescribing
5. Improving maternal health	11. Reducing c-sections/unexpected newborn complications

The Hospital Performance Metrics Advisory Committee will be reviewing Year 2 performance data and Year 3 preliminary data where possible to determine benchmarks for the Year 4 measures.

Proposed Year 4 Measurement Period

OHA also proposes changing the measurement period from the federal fiscal year (FFY) to the calendar year to further align with the CCO incentive measure program and ease administrative burden. The performance period for the fourth year will begin January 1, 2017 and end December 31, 2017.

During the three month interim period between the end of the third year (September 30, 2016) and the beginning of the year four measurement period (January 1, 2017), hospitals are expected to continue quality improvement efforts related to the HTPP measures. While hospitals will not report these data to OHA for payment on performance, they will still be expected to track and report these metrics. This gap period may also be used to collect any baseline data for the new measures as needed.

OHA will also use this time to meet with the Hospital Metrics Technical Advisory Group (described above) to discuss the metrics and finalize any changes to the specifications and reporting processes for Year 4.

While hospitals focus their efforts during Year 4, OHA will work with partners and the Hospital Performance Metrics Advisory Committee to identify additional focus areas for future years of HTPP and ensure that the program aligns with the broader goals of the demonstration.

HTPP Vision for Years 5 and Beyond

Oregon's vision for the Hospital Transformation Performance Program is a program that is fully integrated with the 1115 demonstration, furthers collaboration between hospitals and CCOs, and leads to achieving the triple aim.

Domains and Measures

Beginning in year 5 (January 1, 2018), the HTPP will include two measures sets: (1) the core measure set, and (2) the hospital-specific "menu" set. Similar to the CCO incentive measure program, these will be complemented by a challenge pool measure set, comprised of a subset of the most transformative domains and measures that are worth an additional incentive payment if benchmarks or improvement targets are achieved. See Attachment A below for additional details on the proposed payment structure.

- The core measure set will be comprised of domains and measures that are applicable to all hospitals. All hospitals would be expected to report on all domains and associated measures in this set. Payment would be contingent upon achieving either a benchmark or an improvement target.
- The hospital-specific menu set will include domains and measures from which hospitals would choose a specific number of measures, based on local priorities and need, and in accordance with parameters established by the Committee. Payment would be contingent upon achieving either a benchmark or an improvement target.
- The challenge pool will include the most transformative measures as selected by the Committee. Payment would be based on the dollars remaining after distribution of payments in the prior rounds, and contingent upon achieving either a benchmark or an improvement target.

This approach will hold hospitals accountable to a core set of domains and measures while allowing individual hospitals to identify locally relevant areas where they want to focus their quality improvement efforts. Hospitals would also be able to collaborate with their local CCOs on any hospital-specific measure that cut across the two systems. Additionally, this approach takes into account the differing service arrays offered at hospitals (e.g., a core metric focused on maternity care would be inappropriate as not all DRG hospitals in Oregon perform deliveries).

The core and menu set would be implemented incrementally, with additional measures added to both sets in each year, eventually including the maximal number of measures. As measures are removed due to high performance and new measures are introduced, hospitals would be paid for

reporting in the first year (to establish a baseline), but must achieve benchmarks or improvement targets to quality for payment in subsequent years.

Proposed measures for Year 5 and beyond are pending review with the Hospital Performance Metrics Advisory Committee.

Data Sources and Validation

The Oregon Health Authority will be responsible for collecting data on all measures selected, although CCOs and hospitals may be required to submit data according to specifications. Oregon will also work with contractors, including, but not limited to survey vendors and an external quality review organization to play a role in data collection and analysis where necessary. Oregon will also continue its robust measure validation process, both for the hospital and CCO incentive programs, but also for the quality and access test.

Data Sources

Oregon has developed many systems to collect data from plans and hospitals, and plans are required to have information systems capable of collecting, analyzing, and submitting required data and reports.

Data sources are described below. Data sources for specific measures are listed in the detailed specification sheets available online.[59]

Administrative Data – All CCOs and FFS providers are required to submit encounters to the Medicaid Management Information System (MMIS) and the All Payer All Claims data system (APAC). MMIS and APAC data provide a source of comparative information and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, monitoring and developing quality and performance indicators, studying special populations and priority areas, and cost-effectiveness analysis.

Oregon follows all federal regulations regarding claims submission and processing.

Clinical Data/Chart Review – CCOs may be required to conduct annual chart review on defined samples of their member population to determine measure compliance. OHA provides guidance and collects the data for analysis.

Community Health Assessment – CCOs are contractually required to submit the community health needs assessment to OHA. See Appendix B for additional details.

Electronic Health Records – Oregon is building CCO and provider capacity to report on measures from their electronic health records. CCOs work with their provider network to

[59] www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx and www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx

develop and extract reports from their EHRs, where possible aligning with Meaningful Use requirements. OHA is developing a clinical quality metrics registry which will enable electronic submission of EHR-based measures.

Member Satisfaction Surveys – Oregon, in conjunction with its external quality review organization, conducts statewide standardized surveys of patients' experience of care. These surveys allow for plan-to-plan comparisons. Plans are required to participate, as appropriate, in the performance of each survey. Survey results are shared with plans and reports are published on the OHA website, making them available to Medicaid beneficiaries to assist them in the process of selecting an appropriate plan.

Participating Provider Network Reports – Provider network reports are submitted by each plan and are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turnover.

Focused Clinical Studies – Focused clinical studies, conducted by the state and EQRO, usually involve medical record review, or surveys and focus groups. Plans and FFS providers are required to participate in mutually agreed upon focused clinical studies. Results of focus studies are distributed to plans and reports are published on the department website.

Race/Ethnicity Data – In MMIS, all claims and eligibility data can be tracked by race and/or ethnicity. Oregon currently collects information on member race, ethnicity, and language at enrollment – members are asked to self-identify. Ethnicity is currently defined as Hispanic/non-Hispanic. Oregon does not have data on multiple races. Additional information about race and ethnicity is also available through the CAHPS survey and from focused clinical studies.

Oregon historically has collected data only on preferred household language, but is in the process of moving to collecting individual preferred language.

The Oregon Health Authority and the Department of Human Services have adopted rules establishing uniform standards and practices for the collection of data on race, ethnicity, preferred spoken or signed and preferred written language, and disability status.[60]

Validation

The Oregon Health Authority will contract with an independent third party for assistance in measure validation as part of the quality and access test. To date, OHA has contracted with the Oregon Health Care Quality Corporation (Quality Corp) for assistance in this area. As a Robert Wood Johnson Foundation *Aligning Forces for Quality* grantee, Quality Corp is experienced in ensuring the production of transparent data and analytics that are highly valued and actionable.

OHA currently engages in rigorous, multi-directional, and ongoing validation activities with two contractors, as well as with the 16 CCOs and 28 DRG hospitals as part of the incentive

[60] ORS 413.161 collection of data on race, ethnicity, language and disability status www.oregonlaws.org/ors/413.161

programs. OHA and contractors independently produce measures and compare results, leading to identification of discrepancies and code.

CCOs and hospitals review data provided by OHA and compare to their own internal analysis, resulting in questions and corrections made if necessary. Both the hospital and the CCO incentive metrics program have established periods for final review and validation of data, prior to closing out the measurement year and paying for performance, to ensure quality and accuracy of results.

Validation also occurs as part of the external quality review organization activities, including the ISCA. See Appendix B for additional details. Oregon intends to continue robust validation activities to ensure accurate measurement throughout the 2017-2022 period.

Data Analysis

OHA is responsible for conducting data analysis for the measurement strategy. Where possible measures will be aggregated by CCO and by hospital, and analyzed for trends, issues, areas of concern and areas of innovative improvement. Data will also be analyzed by racial and ethnic groups, in addition to specific populations of interest (see below).

Where possible, measures will be analyzed and reported for the fee-for-service (FFS) population. Oregon is developing a dashboard to monitor performance measures for the FFS population, and additional monitoring and analysis is being explored as part of an FFS Access Project.

Data will be used to track program goals, address disparities, and drive quality improvement through the financial incentives, performance reporting, and rapid cycle feedback processes described in Appendix A. Data from selected measures will also be used to inform the evaluation questions described below.

Subpopulation Analysis

Where possible and appropriate, measures will be reported by race, ethnicity, language, disability, and where there is a diagnosis of serious and persistent mental illness (SPMI). Other subpopulations of interest include beneficiary language, individuals eligible for Medicare and Medicaid, and rural versus non-rural locations, as well as gender, and people with specific diagnoses (e.g., chronic conditions, substance use, experiencing homelessness, etc).

Evaluation questions will also be explored for populations of focus. See the Evaluation Plan above for additional details.

OHA will involve data analysts, internal and third party evaluators, the Office of Equity and Inclusion, and other external stakeholders as appropriate in defining additional subpopulations, and reviewing and interpreting any subpopulation analysis.

Reporting and Transparency

The Oregon Health Authority is committed to transparency in health system transformation efforts. Throughout the demonstration, Oregon has been improving its documentation and availability of publicly facing reports, as well as the user-friendliness of the reports. OHA will continue this emphasis throughout the renewal period.

Public Reporting

Since 2013, Oregon has been providing regular public reports on statewide and CCO performance on a suite of metrics. In the interest of advancing transparency, and providing Oregon Health Plan member with information about quality and access of care to help them make informed choices, OHA will continue publishing these reports.

Oregon will also publish an annual report on statewide and hospital performance on the hospital incentive metrics, as well as enhance its hospital reporting through price transparency projects.

At minimum, data will be reported publicly on an annual basis, however a subset of information or measures may be reported more frequently to track patterns of utilization and highlight potential issues with performance. Measures will be reported by CCO, by hospital, and in aggregate. Oregon will only publish data at aggregate levels that do not disclose information otherwise protected by law.

CCO Reporting

In addition to the semi-annual public reporting, Oregon has also developed a monthly metrics dashboard for reporting interim results to CCOs. This dashboard allows OHA and CCOs to have an ongoing conversation about metrics, including understanding specifications, identifying potential issues with performance and areas for improvement, and allow CCOs to make course corrects as needed to meet benchmarks or improvement targets.

These dashboards will continue throughout the renewal period.

Hospital Reporting

Unlike the CCO incentive measure program, the majority of hospital measures are reported by the hospitals directly. The information is collected by the Oregon Association of Hospitals and Health Systems (OAHHS) for initial validation, prior to its submission to OHA. As the data come directly from the hospitals, a monthly report on their performance is not provided. OHA provides quarterly reports for metrics that are produced by the state.

As part of its Hospital Reporting Program, Oregon produces quarterly reports on its acute care hospitals. These reports track key measures of hospital finances and utilization, including

profitability, charity care, bad debt, and inpatient, outpatient, and emergency department utilization.[61]

Additionally, under Oregon's Senate Bill 900 (2015), OHA is charged with posting median health care price data for the most common inpatient and outpatient hospital services. These reports are currently in development, but will increase price transparency, and potentially help Oregonians make better informed choices about health care.

Attachment A: Quality Pool

Financial incentives are a key strategy for stimulating quality and for moving the health system from a capitated payment structure to value-based purchasing. It is expected that over time, savings accruing from the restructuring of the delivery systems and improved models of care will allow reductions in capitation rates and the growth of incentive payments that reward outcomes rather than volume of services.

This attachment to Appendix C describes the CCO incentive program and hospital incentive program quality pool structures and distribution methodologies for the 2017–2022 demonstration period.

CCO Quality Pool Structure and Distribution

The Oregon Health Authority intends to continue its CCO incentive metrics program and quality pool, as established in 2012 (STC 37.b.ii). Originally, Oregon's strategy was to annually increase the percentage of CCO payment at risk for performance, from 2 percent of the global budget in 2013 to 5 percent in 2017.[62]

When the quality pool was established, OHA believed that unless CCOs had a meaningful percentage of their payment at risk for performance, they would be unlikely to take the steps necessary to achieve significant performance improvement and effect the transformative changes in the delivery system.

Quality Pool Size

Looking forward through 2022, OHA intends to cap the CCO quality pool size at 5 percent of the global budget (or, 5 percent of the actual paid amounts to the CCO for a given calendar year). This will ensure that the annual at-risk amount is not so large as to threaten the financial viability of a CCO should it not perform well relative to the established benchmarks and improvement

[61] www.oregon.gov/oha/OHPR/RSCH/pages/hospital_reporting.aspx

[62] The quality pool is financed at a set percent of the aggregate value of the per member per month (PMPM) CCO budget, not including several specific payments (the prior year's quality pool payments, the federal Health Insurers Fee, Targeted Case Management, and Hospital Reimbursement Adjustment payments). Additional details about the annual quality pool composition are available in the "reference instructions" online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

targets, while also being sufficiently large to prompt transformative changes and drive performance improvements.

Quality Pool Distribution

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

Quality pool award amounts will be determined through a two-stage process. In stage one, the maximum amount of dollars that a CCO is eligible for will be allocated based on performance on the incentive measures relative to the benchmarks and improvement targets established by the Metrics & Scoring Committee.

In stage two, any remaining quality pool funds that were not disbursed in stage one based on performance on the incentive measures (i.e., funds remaining if a CCO does not meet all benchmarks or improvement targets) will be distributed to CCOs that meet "challenge pool" criteria, as determined by the Metrics & Scoring Committee.

The Metrics & Scoring Committee will continue to examine the quality pool operation over time and annually re-evaluate the incentive measures, benchmarks and improvement targets, and challenge pool criteria.

The current stage one and two distribution mechanisms are described below; however these are under review with the Metrics & Scoring Committee and may be modified for future years, to better accommodate the core/menu measure set concept, and other priority areas, such as "must pass" measures related to health equity. The quality pool distribution methodology is documented online and updated annually.[63]

Stage One Distribution

Distribution based on performance on all incentive measures

For most of the current CCO incentive measures, the portion of available quality pool funds that a CCO receives is based on the number of measures on which it achieves either an absolute benchmark or demonstrates improvement over its own prior year's performance (improvement target). The benchmarks are the same for all CCOs, regardless of geographic region and patient mix.

CCO performance on these measures is treated on a pass/fail basis, and all measures are independent from one another. If the benchmark is met or the improvement target reached for a

[63] Quality Pool Reference Instructions, available online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

specific measure, the CCO receives all of the credit available for that measure, regardless of performance on other measures.

For the Patient-Centered Primary Care Home (PCPCH) enrollment measure, as long as it remains an incentive measure, performance is measured according to a tiered formula. The original formula:

$$\frac{(\text{\# of members in Tier 1}*1) + (\text{\# of members in Tier 2} * 2) + (\text{\# of members in Tier 3})*3}{\text{total number of members enrolled in the CCO} * 3}$$

The revised formula, updated to reflect new certification standards:

$$\frac{(\text{\# of members in Tier 1}*1) + (\text{\# of members in Tier 2}*3) + (\text{\# of members in Tier 3 + 4 + 5 }*3)}{\text{total number of members enrolled in the CCO} * 3}$$

The results of the tiered formula are added to the number of measures on which a CCO meets the benchmark or the improvement target, for the CCO's total score.

Since 2013, CCOs were required to meet three criteria to earn 100 percent of the quality pool funds for which they were eligible:

- Meet or exceed the benchmark or the improvement target on at least 75 percent of the incentive measures (i.e., 12 of 16); and
- Meet or exceed the benchmark or improvement target for the Electronic Health Record (ERH) adoption measure as one of the required 75 percent measures above; and
- Score at least 0.60 on the PCPCH enrollment measure using the tiered formula.

If CCOs did not meet the EHR adoption measure, or the PCPCH measure, the maximum payment they were eligible to receive was 90 percent.

Table 3: Current quality pool distribution

Number of benchmarks or improvement targets met	Percent of the quality pool payment for which the CCO is eligible
At least 12 (including EHR adoption) and (at least 60% PCPCH enrollment)	100%
At least 12 (not including EHR adoption) or (less than 60% PCPCH enrollment)	90%
At least 11.6	80%
At least 10.6	70%
At least 8.6	60%
At least 4.6	50%
At least 3.6	40%
At least 2.6	30%

Number of benchmarks or improvement targets met	Percent of the quality pool payment for which the CCO is eligible
At least 1.6	20%
At least 0.6	10%
Fewer than 0.6	No quality pool payment

In future years of the CCO incentive metric program (potentially beginning with CY 2018 measurement, and payments made in 2019), the Metrics & Scoring Committee is interested in moving to a core and menu set of measures, in which all CCOs would be held accountable for meeting benchmarks and improvement targets on the same measures (core set), but would also be able to select a specific number of measures from an approved list (menu set) based on their local priorities and need. As this will result in a consistent total number of incentive measures for all CCOs, the quality pool distribution during 2017–2022 will likely remain very similar to the tiered table above, but depending on the total number of measures across the core and menu sets, the specific number of measures in the tiers may shift.

The Committee may also choose to recommend that CCOs meet a higher percentage of all the measures to earn 100 percent of the quality pool funds for which they are eligible. For example, when the tiered distribution was originally established, there were 17 incentive measures (12 of 17 measures, plus PCPCH enrollment was roughly equivalent to meeting 75 percent of the measures to earn 100 percent of the funds). The Committee may choose to recommend CCOs must meet 90 or 100 percent of the measures to earn 100 percent of the funds.

These changes will be reflected in the annually updated Quality Pool Methodology documentation posted online.

Stage Two Distribution

Challenge Pool

In the second stage, remaining quality pool funds that have not been allocated to CCOs in stage one will become the 'challenge pool' – these funds will be distributed to CCOs that qualify based on the challenge pool criteria.

Historically, the challenge pool has been a subset of the incentive measures, those measures that the Committee believed were "most transformational." CCOs that performed well on those measures received both the stage one distribution, and any challenge pool dollars.[64]

Looking forward, the Committee is considering alternate ways to utilize the challenge pool, potentially selecting different measures, rather than a subset, to better incentivize areas of particular interest. For example, the Committee is considering a measure of health equity for

[64] Additional details about the challenge pool calculation and distribution to date are available in the "reference instructions" online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

future use in the challenge pool. These changes will be documented in the annually updated Quality Pool Methodology posted online.

During the second stage, all quality pool funds will be distributed; no quality pool funds will roll over into a subsequent year.

Hospital Quality Pool Structure and Distribution

The Oregon Health Authority intends to continue its hospital incentive metrics program and quality pool. This section describes the Hospital Transformation Performance Program (HTPP) funding and distribution methodology.

HTPP Funding

Unlike Delivery System Reform Incentive Payment (DSRIP) Programs, the HTPP is part of Oregon's 1115 demonstration. Rather than leveraging new funding mechanisms, the HTPP uses the existing Hospital Assessment Program that has been authorized in Oregon since 2004. HTPP spending is subjected to the total computable expenditures in the two percentage point reduction in the per capita growth rate of spending requirements (Oregon's 2 percent test) under the 2012–2017, and 2017–2022 demonstration.

In the first two years of the HTPP, funding is equivalent to the federal match rate of the state dollars generated by one percent of the Assessment. In the third year, and all subsequent years, funding is equivalent to the federal match rate of the state dollars generated by half of one percent of the Assessment. The other half of the one percent of the Assessment has been legislatively re-directed to contribute directly to funding the CCOs to further align the roles that hospitals and CCOs must play collaboratively in transforming the delivery system in Oregon. Hospitals will need to engage with CCOs directly in payment arrangements such as capitation, pay for performance, and other risk-based payment methodology in order to share in the CCO's funding.

HTPP funds have been capped by CMS at no more than $150 million per year and are therefore a small, but important proportion of those generated by Oregon's historical Hospital Assessment Program. Oregon's hospitals have historically qualified for increased Assessment-related reimbursements prior to the HTPP. HTPP provides an important mechanism for OHA to hold hospitals accountable for transforming and improving quality in order to qualify for a portion of these dollars. It is one of OHA's most important levers in engaging hospitals in quality improvement, and long-term funding is assured by the pre-existing Hospital Assessment Program.

Quality Pool Distribution

Quality pool payment is based on hospital performance on metrics recommended by the Hospital Performance Metrics Advisory Committee. Each hospital must meet benchmarks or improvement targets to earn funds associated with each measure. The size of payments to

individual hospitals will vary based on the amount of funds available from the Hospital Assessment Program, the measures achieved by an individual hospital, and hospital size.

All funds are distributed each year; there will be no carryover.

Years 1–3 Quality Pool Distribution

In the initial years of the program, quality pool distribution occurred in two phases. Phase 1 involves determining whether a hospital is eligible for a $500,000 floor payment, by achieving at least 75 percent of the measures for areas in which it operates. For example, if a hospital does not have an emergency department, measures related to emergency departments will not be included in the calculation of whether the hospital has met 75 percent of the measures.[65] Phase 2 involves allocating the remaining funds to hospitals based upon performance on individual measures.

Phase 1 Distribution

The first step in distributing the hospital quality pool funds involves determining the number of instances in which a hospital has achieved a measure. Hospitals achieving at least 75 percent of the measures will be allocated a $500,000 floor. Phase 1 allocation is pass/fail; hospitals cannot receive partial credit. Hospitals must achieve at least 75 percent of the measures to receive the floor payment. This impacts the amount remaining in the pool for Phase 2 allocation.

Example of Phase 1 floor allocation	
Total HTPP available funds	$150.0 million
Available funds – floor for 28 hospitals (assuming all achieve at least 75% of the measures) ($500,000 * 28)	$14.0 million
Remaining to earn in Phase 2 allocation (payment per measure achieved) (Total – floor)	$136.0 million

Phase 2 Distribution

The portion of Phase 2 quality pool funds that a hospital receives is based on the number of measures for which it submits data meeting OHA standards and for which it achieves an absolute benchmark or demonstrates improvement over its prior year performance. The benchmarks are the same for all hospitals, regardless of geographic region and patient mix.

Hospital performance on these measures is treated on a pass/fail basis and all measures are independent from one another. If a hospital meets the benchmark or improvement target for a specific measure, it receives all of the credit available for that measure, regardless of

[65] The exception is the follow-up after hospitalization for mental illness measure, for which all hospitals are eligible regardless of whether they operate in this area. In instances where a hospital does not have an acute psychiatric ward, OHA uses an attribution methodology in which Coordinated Care Organization performance is attributed to the hospital to further hospital-CCO collaboration.

performance on other measures. Once OHA has determined each hospital's level of performance against the benchmarks and targets, it will calculate the amount of funds each hospital will receive. The number of measures achieved by hospitals affects the "base amount" that each measure is worth after the Phase 1 allocation.

The proportions in the table below will be applied to hospital quality pool funds remaining after Phase 1. The proportions may shift if all measures are not achieved by at least one hospital. The base amount for each measure will then be allocated to the hospitals achieving that measure based on the proportion of total Medicaid discharges and total Medicaid inpatient days at each hospital that achieved the target: 50 percent based on Medicaid discharges and 50 percent based on Medicaid inpatient days.

Domains	**Measures**	**Share of available funds for Phase 2 distribution (Years 1–3)**
Readmissions	1. Hospital-wide all-cause readmission	18.75%
Medicaid Safety	1. Hypoglycemia in inpatients receiving insulin	6.25%
	2. Excessive anticoagulation with Warfarin	6.25%
	3. Adverse Drug Events due to opioids	6.25%
Patient Experience	4. HCAHPS: staff always explained medicines	9.38%
	5. HCAHPS: staff gave patient discharge info	9.38%
Healthcare-Associated Infections	6. CLABSI in all tracked units	9.38%
	7. CAUTI in all tracked units	9.38%
Sharing ED visit information	8. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	12.50%
Behavioral Health	9. Follow-up after hospitalization for mental illness	6.25%
	10. Screening for alcohol and drug use, brief intervention, and referral to treatment (SBIRT) in the emergency department	6.25%

Phase 2 Distribution Example for the Readmissions Measure

The table below provides an example of how the hospital quality pool distribution for the Readmissions measure worked in the initial years of the program in the following scenario:

- There are only three hospitals;
- The total available HTPP funding is $150,000,000; and
- Two of the three hospitals achieved at least 75 percent of the measures (meaning these two hospitals are allocated the floor payment of $500,000 each).

Example Total HTPP Funds available	$150,000,000
Number of hospitals achieving 75 percent of measures (eligible for floor allocation)	2
Phase 1 amount (floor allocation: $500,000*2)	$1,000,000
Funds remaining for Phase 2 Allocation (Total – floor)	$149,000,000

Readmissions	
Share of Available Funds	18.75%
Base Amount: total available to earn for measure (Share of funds*funds for Phase 2 allocation)	$27,937,500

Phase 2 allocation per hospital achieving measure (readmission example)									
Hosp	Achieved Measure?	Discharges		Days		Adjustment Factor (% discharges*0.5)+ (% days*0.5)		Amount earned for Measure (Total available for Measure * Adjustment Factor)	
		#	%	#	%				
A	Y	2,500	20%	8,000	21.05%	(20.0%*0.5)+ (21.05*0.5)=	0.21	$27,937,500 *0.21=	$5,866,875
B	Y	5,000	40%	10,000	26.23%	(40.0%*0.5)+ (26.32*0.5)=	0.33	$27,937,500 *0.33=	$9,219,375
C	Y	5,000	40%	20,000	52.63%	(40.0%*0.5)+ (52.63*0.5)=	0.46	$27,937,500 *0.46=	$12,851,250
Totals		12,500	100%	38,000	100%		1.00		$27,937,500

Proposed Future Quality Pool Distribution

Beginning in the fourth year, OHA proposes modifying the HTPP payment method to a three-phased structure that includes a challenge pool (similar to the CCO quality pool methodology). This will further incentivize quality improvement efforts focused on a subset of the most transformative HTPP measures and domains.

Phase 1: Floor Payment

OHA would retain the floor payment from the initial years of the program. A hospital is eligible for a floor payment of $500,000 by achieving at least 75 percent of the measures for which it is eligible. If a hospital does not achieve at least 75 percent of the measures, then its floor payment will be reallocated to the challenge pool.

Phase 2: Payment per Measure Achieved

Again, similar to the initial distribution, after the floor payments are allocated, the remaining funds will be allocated based on whether hospitals meet the benchmark or improvement targets on the measures. However, beginning in year four, funds not achieved by hospitals in Phase 2 will not be reallocated to the other hospitals or domains (as was done initially); instead, they will also be reallocated to the challenge pool.

The distribution formula will continue to be based on Medicaid discharges and Medicaid days, however, this will be rebased for CY 2015 or CY 2016, rather than the initial 12 months ending Sept 2012, which was used for the first three years of the program.

Phase 3: Challenge Pool

Any unclaimed funds from Phases 1 and 2 will be used for the challenge pool. The Committee will recommend a set (1–4) of the most transformative measures as the challenge pool measures. Additional measures outside of the core or menu set may also be considered for the challenge pool measures.

Hospitals achieving any of these measures will receive an additional incentive payment from the challenge pool funds.

Appendix D: Concept Paper on Increasing Use of Health-Related Services and Value-Based Payments

In 2012, under an amendment to its 1115 waiver, Oregon began the process of transforming its Medicaid delivery system by establishing Coordinated Care Organizations (CCOs), charging them with integrating and coordinating care and requiring them to meet key quality metrics, with financial incentives for achieving performance benchmarks. As contemplated by the waiver, CCOs receive an integrated global payment for each member, which provides CCOs with the flexibility to offer health-related services, in addition to health services, to improve care delivery and member health. The waiver also established an annual sustainable growth rate target of 3.4 percent for aggregate health care costs. To date, Oregon has succeeded in meeting this growth rate target and efforts to "bend the cost curve" remain a top priority for the State.

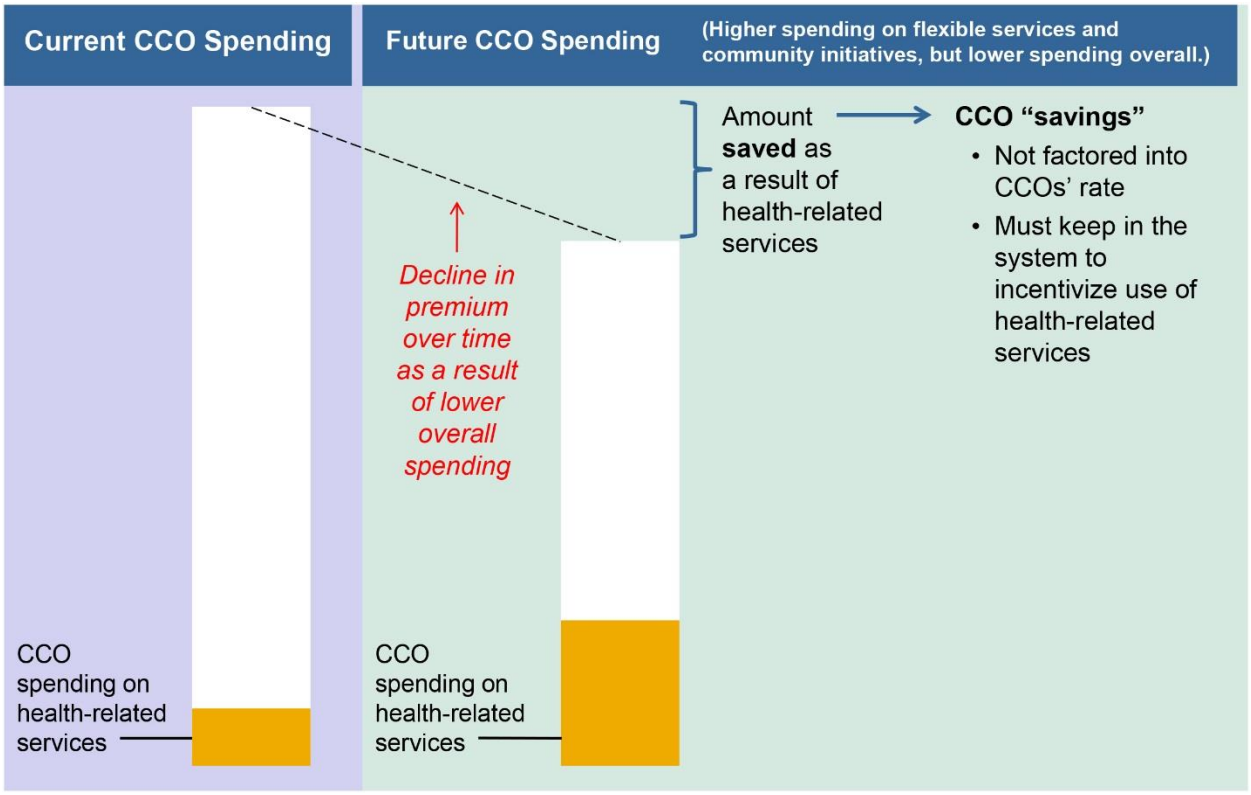
To continue meeting this growth rate target, Oregon has determined that additional actions are necessary to ensure that CCOs and the providers and community organizations with which they partner are positioned to drive the delivery of cost-effective, quality care and advance population health. Today, 16 CCOs provide services to more than one million Medicaid beneficiaries throughout the State. Some CCOs are using **flexible services** and **community benefit initiatives (CBIs)** to address member and community needs. Flexible services, specifically authorized through the current waiver, are cost-effective services offered instead of or as an adjunct to covered benefits (e.g., home modifications and healthy cooking classes). CBIs are community-level – as opposed to member-specific – interventions focused on improving population health and health care quality, such as investments in care management capabilities or provider capacity in line with the waiver's goals. Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. Flexible services have generally been funded through Medicaid capitation dollars while CBIs have generally been grant-funded. For the purposes of this paper, flexible services and CBIs are collectively referred to as "**health-related services**." Oregon seeks to increase the use of health-related services, which are essential to achieving the triple aim of better health, better care and lower costs – the core of the State's transformation goals.

Oregon has identified several barriers to achieving greater use of health-related services. Under the existing waiver, the costs of these services[66] cannot be counted as "medical" expenses in building the premium rate paid to CCOs, thereby inflating the CCOs' non-medical (administrative) expenses. In addition, when CCOs reimburse providers on a fee-for-service basis, there is no incentive – and no resources – to invest in health-related services. Moreover, as

[66] CBIs are not referenced in the current Waiver or the State's contracts with CCOs.

investment in cost-effective health-related services reduces utilization of state plan services (on which the capitated rate is based), CCO rates may decline over time. (This decline is referred to as "premium slide." See Figure 1 below.) As premium slide occurs, there is neither funding nor incentive for CCOs and providers to continue investing in these health-related services. While the waiver contemplates the flow of incentives outside the premium rates, CMS restricts the amount of payments that can be made outside of the capitated rate to no more than five percent.[67] Oregon's quality incentive program will reach this limit by the end of its current waiver period.

Figure 1. Depicting Premium Slide



As discussed below, Oregon seeks approval from CMS to amend its waiver and adjust its rate setting methodology to better support and incentivize the use of health-related services consistent with the intent of the waiver, the interest of CMS to promote value-based purchasing within managed care, and the need to assess the program's risk through the lens of actuarial soundness. The State also seeks CMS approval to amend its contracts with CCOs to require investment in health-related services through, among other things, use of value-based payment arrangements that support *provider* use of these services. The following proposals, when implemented together, should enable the State to continue meeting its growth rate targets. Accordingly, the State requests CMS approval to do the following:

[67] CMS requires that incentive payments not exceed 5% of the certified rates to managed care plans; see 2016 Medicaid Managed Care Rate Development Guide, September 2015, and 42 C.F.R. § 438.6.

1. **Include the costs of certain health-related services in the medical portion of CCOs' capitated rate.**
   STC 34(c) of the waiver currently requires the State to include the costs of flexible services in the administrative expense portion of the capitated rate. Oregon seeks to amend its waiver by removing STC 34(c), which would allow the costs of health-related services meeting the requirements of 45 C.F.R. § 158.150, "activities that improve health care quality," to be included in the medical portion of the CCO capitation rate. Doing so would allow the State to treat the costs of these services as benefit expenses for rate setting purposes, and would help prevent premium slide.[68] Oregon will also modify its rate setting methodology and amend its contracts with CCOs to reflect this change.

2. **Implement a reinvestment requirement to keep CCO savings in the system.**
   Oregon will further amend its contracts to require CCOs to reinvest savings that may be achieved through investment in health-related services. Such a reinvestment requirement could involve a medical loss ratio (MLR) standard of 88 percent – the MLR currently used for rate setting purposes – with a tiered corridor of 3 percent, where:

   a. CCOs that have an MLR *below* the 3 percent corridor (i.e., below 85 percent) must remit to the State the difference between their MLR and 85 percent; and

   b. CCOs that have an MLR *within* the 3% corridor (i.e., between 85 percent and 88 percent) may be eligible, depending on their performance on quality and cost measures, to retain some or all of the difference between their MLR and 88 percent, so long as the amount of the difference is reinvested in health-related services. Any portion of the difference that is not reinvested in such activities must be returned to the State. Such a reinvestment requirement enables some or all of the CCO's savings achieved to remain in the rates going forward (instead of being returned to the State) and be reinvested in members' care. The corridor could be tiered in a way that results in higher performing CCOs being allowed to retain a higher percentage of the difference than lower performing CCOs.

   For the purposes of calculating CCOs' MLRs to determine compliance with the State's MLR standard of 88 percent, spending on all health-related services would be included in the numerator (consistent with 42 C.F.R. § 438.8). Furthermore, given that spending on health-related services qualifying as "activities that improves health care quality" can be included in the base of the CCO capitation rate, any reinvestment in these services would *also* be included in the base and therefore remain in the system. CCOs with an MLR at 88 percent or above would not be subject to any remittance or reinvestment requirement. Oregon will work with CMS, CCOs and other stakeholders to develop this reinvestment requirement.

[68] Per the Medicaid and CHIP Managed Care Final Rule, "activities that improve health care quality" pursuant to 45 C.F.R. § 158.150 are included in the numerator of MLR calculations, which must be considered in developing the capitation rates (see 42 C.F.R. §§ 438.4, 8). As a result, once STC 34(c) is removed, there is no need for a waiver.

3. **Require CCOs to enter into value-based payment (VBP) arrangements with network providers.** Oregon's current demonstration calls for CCOs to adopt alternative payment methodologies to "align CCOs and their providers with health system transformation objectives." However, the State's CCO contracts do not require CCOs to enter into a minimum percentage of VBP arrangements, and at present, many CCO payments to providers are made through fee-for-services arrangements, which do not support provider investment in health-related services. Accordingly, Oregon will submit to CMS a VBP plan that describes how the State and CCOs will achieve a specific percentage of VBP payments by the end of the demonstration period. The plan will provide a clear definition of VBP that involves the sharing of risk (not just savings) and quality measures, describe how CCO contracts will be amended, and propose a schedule that ensures phased-in implementation over the course of the demonstration. The State will work with CCOs and providers to develop this VBP plan.

   In addition, Oregon may also require CCOs to have policies in place that instruct VBP-contracted providers to report their medical spending and revenue and invest a portion of any surplus on health-related services. Currently, a number of CCOs have subcapitation arrangements with network providers (e.g., primary care provider groups or hospitals) in which the CCOs pass a percent of their premium payments from the State directly onto the providers and the providers become the risk-accepting entities for the CCOs' members. While these arrangements may constitute value-based purchasing, many of these risk-accepting entities perform a mix of medical and administrative services and the breakdown of their spending has historically not been reported to the State. Requiring this breakdown to be reported would help ensure that CCOs and their provider partners are both investing in health-related services to ensure efficient use of resources and address the social determinants of health.

4. **Implement a CCO performance incentive program.** To further incentivize CCOs to utilize health-related services, Oregon will enhance the rate setting methodology to prevent premium slide and compensate CCOs identified as high performing (e.g., CCOs showing quality improvement and cost reduction). Two approaches to such an incentive program are described below. Both of these approaches would require the State to develop a mechanism for measuring CCO performance. Neither would replace the existing risk factor adjustments. Oregon will leverage, to the maximum extent possible, the existing cost and quality metrics included in the waiver.

   a. **Margin augmentation:** The State could develop rates with a profit margin range, such as 1 percent to 3 percent, as opposed to a fixed percentage of premium, which is used today. The margin percentage built into the rate would vary based on CCO-specific scoring within each rating region, where higher performing CCOs would receive higher percentages than lower performing CCOs for the following 12-month period.

b. **Base a portion of CCOs' capitated rate on quality and cost measures:** The State could develop a prospective adjustment to each CCO's rate based on the CCO's past performance on key quality and cost measures. To do this in a budget neutral manner, Oregon could set aside a portion of the capitated rate and allocate it to CCOs based on performance. For example, the State could assign scores to CCOs based on their performance in cost reduction and quality improvement; CCOs with high scores in *both* areas of measurement would be allocated more dollars than CCOs with lower scores.

While the details of measuring CCO performance still need to be developed, the overall goal is to incorporate an approach, like the three described above, in the State's rate setting methodology in a manner consistent with all Actuarial Standards of Practice and CMS and OACT guidance.

Actions Needed to Implement These Concepts

To implement the proposals described above, Oregon plans to take the following actions:

1. **Amend the 1115 Waiver.** The State proposes to amend its waiver so that costs of health-related services that meet the requirements of "activities that improve health care quality" pursuant to 45 C.F.R. § 158.150, are included in the medical portion of the CCO capitation rate. The State may also make technical and other adjustments to ensure that the policy programs contemplated in this paper are accurately reflected in the waiver. Oregon seeks approval of the proposals discussed above by December 2016.

2. **Amend its CCO contracts.** Oregon intends to amend its contracts with the CCOs to include the following:

    a. Requirements related to the collection of information on health-related services to determine whether the services meet the requirements of 45 C.F.R. § 158.150;

    b. Information on the reinvestment requirement and MLR standard;

    c. The requirement that a certain percentage of CCO payments to providers be made through VBPs (this will include a definition of VBP and a timeline for phasing in the requirement);

    d. The potential requirement that CCOs have policies in place that instruct VBP-contracted providers to report their medical spending and revenue and invest a portion of any surplus on health-related services; and

    e. Information on a CCO performance incentive program (i.e., a program involving margin augmentation or a performance-based adjustment to CCOs' rates).

3. **Amend State rules to include the costs of health-related services categorized as "activities to improve health care quality" in the medical portion of CCOs' rate**

and to define new terms as needed. Oregon intends to amend recently adopted State rules that define flexible services and prohibit them from being counted in the benefit costs portion of the capitated rate. The State will also include definitions for health-related services and community benefit initiatives.

4. **Enhance the rate setting methodology.** Working with CMS and OACT, the Oregon Health Authority (OHA) and its actuaries will enhance the CY 2016 rate setting methodology to incorporate the features of the approach described above in the CY 2017 methodology. OHA will continue to evaluate the risk of the program through the lens of actuarial soundness, ensuring that the rate setting methodology is consistent with all applicable CMS and OACT guidelines and Actuarial Standards of Practice.

Public Notice and Engagement

In January, the State met with the CCOs and State legislators to discuss and obtain feedback on the concepts described in this paper. In addition, interviews were conducted over a two and a half-month period with representatives from nine CCOs across the State. Between March and July, the State met with CMS and OACT to discuss drafts of the concept paper. This version of the concept paper reflects the feedback received from the CCOs, CMS, OACT and other stakeholders during these various discussions.

Appendix E: Integrating Health Care Delivery for Individuals Eligible for Both Medicare and Medicaid

Background

Focus on reform

OHA made a difficult decision not to participate in the national financial alignment demonstration in 2012 due to concerns that it would not have suited Oregon's unique marketplace. An in-depth analysis indicated that the demonstration was not likely to be financially viable for Oregon's CCOs and their affiliated Medicare Advantage plans. Oregon chose instead to focus on delivery system reforms underway in CCOs paired with Medicare/Medicaid administrative alignments without the proposed financial component of the financial alignment demonstration.

CCO CMS Alignment Workgroup

OHA developed a CCO CMS Alignment Workgroup that reports to the CCO Advisory Workgroup. The alignment workgroup focuses on opportunities to pursue administrative alignments and problem-solve care coordination issues. This group has been meeting regularly since 2013. The workgroup is a forum for OHA and DHS to work with CCOs, and their affiliated Medicare plans, serving individuals dually eligible for Medicaid and Medicare to get input on policies and to resolve issues that arise related to providing services to dually eligible members. The workgroup is also a forum for carriers to work together to share information and resources related to operating health plans that serve dually eligible individuals. The workgroup focuses on topics that have a Medicaid link, or are specific to dually eligible individuals, and not on general Medicare issues. The meetings have focused on communication strategies, mechanisms to address care coordination and care transitions, building linkages with Long-Term Services and Supports (LTSS) and Oregon's system of Aging and People with Disabilities programs, targeting outreach to minority and at-risk dual eligible populations, use of new Medicare billing codes to enhance preventive care for dual eligible beneficiaries, potential alignment for grievances and appeals, the integrated denial notice, and more.

The types of issues that are within the scope of this workgroup include:

- Issues relevant to serving dually eligible individuals, including the integration of Medicare and Medicaid benefits, and the coordination with external services such as Department of Human Service (DHS) long term care services for aged and physically

disabled individuals; services for individuals with intellectual or developmental disabilities; and mental health services not included in the CCO.

- Issues relevant to Medicare/Medicaid plans, including issues specific to Special Needs Plans (SNPs) and other areas of Medicare/Medicaid regulatory alignment and oversight.

OHA and DMAP held bi-weekly meetings from 2013-2015 to address issues related to dual eligibles and to problem solve challenges from the field for beneficiaries. In addition, they also developed a plan to address the identified issues using targeted approaches for systemic vs. onetime concerns. Additional meetings were held to bring in expertise with SHIBA and MMA Staff working on Medicare Part D and LIS issues, and joint presentations were provided around enhanced understanding of dual eligible systems and statewide issues.

Technical assistance

Recent implementation of our new ONE system in OHA included training for DHS staff on the new system to enhance their ability to provide supports to dual eligibles. OHA has made technical assistance available to CCOs for duals issues and developed the Duals Technical Assistance Tool to support a review of communication, population health management, health equity, care coordination, care transitions and administrative policies and supports.

Oregon held a complex care collaborative event in September 2015 ("Engaging Beneficiaries with Medicaid and Medicare and Long-Term Services and Supports: Strategic Approaches and Partnerships") and is planning another event ("Care Coordination to Improve Health for High Need Members Across the Lifespan: Aging and Disability") for September 2016. These events serve as an opportunity to focus on improving health outcomes for OHP members with dual eligibility and complex care needs, support the spread of innovative complex care models and successes throughout Oregon, and promote information sharing and networking.

CCO progress to date

As reported by CCOs regarding their affiliated plans in November 2015, the majority of Oregon's affiliated Medicare Advantage plans are aligning the following with their CCO for dual eligible members: care coordination planning across plans, care transitions planning across plans, sharing health risk assessment/client risk identification across plans. Plans that are the same parent company as the CCO are also integrating claims processing, provider network information to members, and in some cases providing one single ID card. Oregon has two CCOs that have no specific MA affiliation in place and do not report work toward coordinating care for duals members with MA plans.

Oregon added new care coordination elements and reporting requirements to dual eligible special needs plan (DSNP) MIPPA contracts for 2016 and 2017. OHA has been working closely with Oregon's current DSNP plans on which metrics will be reported by each plan and used to develop an Oregon statewide DSNP report beginning in 2017.

Evaluation

Oregon began a project in 2015 to bring APAC data and Medicaid data together to inform a statewide evaluation of duals in coordinated care. We have engaged the OHSU Center for Healthcare Effectiveness with us in that work. Oregon joined the CMS BCN IAP to assist us with the project and recently added a super-utilizer analysis to the project. We anticipate having better data integration to allow us to take a deeper dive into duals work and help inform legislative and policy initiatives going forward.

Pre-Implementation Outreach: Proposed Dual Eligibles Outreach Project, May–September 2016

OHA is interested in increasing the number of Dual Eligible Medicare/Medicaid beneficiaries enrolled in CCOs rather than Fee for Service (FFS). Working with contracted community assistors, OHA will conduct targeted outreach to approximately 26,000-27,000 FFS Duals Eligible Beneficiaries. OHA will develop letters, flyers and talking points using information gathered from previously conducted dual eligible focus groups as well communication messages from other states working to enhance dual communications on coordinated / integrated care. Messages will inform members about coordinated care and the added benefit for the member.

Letters will go to members in their identified primary language and a selection form and postage-paid return address envelop will be included in each letter. Mailings will be staggered over the project period of May–September so that outreach can be staggered.

Follow-up calls will be conducted to answer questions and provide enrollment assistance. If members aren't reached on the first attempt, outreach will be scheduled for a different day or another time in which the member can be reached.

Processes for ensuring smooth and efficient enrollment for those choosing to enroll in a CCO will be developed. Where possible, community connections will be used to help identify or locate any members for whose mail is returned or invalid phone numbers, i.e. such as outreach to community organizations serving vulnerable seniors or homeless populations.

Appendix F: Federal Authority to Continue and Enhance Oregon's Health Care Transformation

July 2017–June 2022

Requested new Waiver and Expenditure (CNOM) authorities or changes to existing authorities					
Issue	**Change needed-Medicaid**	**Applicable federal Medicaid law or regulation**	**Current 1115 Demonstration**	**Potential 1115 Demonstration amendment or change to Special Terms and Conditions (STC)**	**Potential State Plan action**
Value-based payment methodologies	Ability to: • Require a specific percentage of CCO payments to network providers to be made through value-based payment (VBP) arrangements. • Implement a CCO performance incentive program	42 CFR § 438.6	Value-based payment authority in place, but lack authority to require CCOs to meet a standard.	**Waiver authority, as follows:** Waiver of 42 CFR § 438.6, to the extent necessary, to allow the state to require a specific percentage of CCO payments to network providers be made through value-based payment (VBP) arrangements.	NA
Global budget • Health-related services and Risk arrangements	• CCOs are expected to have comprehensive risk contracts. • State is considering potential options for risk-sharing arrangements.	42 CFR § 434.20 and 21–basic HMO and PHP rules and contract requirements SSA § 1902(a)(30): Payments must be consistent with efficiency, economy, and quality of care.	• CCOs are expected to have comprehensive risk contracts. • Flexible services are included as administrative costs to CCOs.	**Waiver authority, as follows:** Waiver of federal statute and regulation under SSA § 1902(a)(30); 42 CFR § 434.20, 42 CFR § 438.6(c) and 42 CFR § 438.6(b) to the extent necessary, in order to include flexible, in-lieu of, services as reimbursable at the medical services payment	NA

		42 CFR § 438.6(b)–comprehensive risk contracts		rate rather than as administrative costs.	
Global budget • Financial solvency, including reinvestments	• Financial solvency requirements–State is considering brokering re-insurance or stop-loss insurance.	42 C.F.R. § 434.50–protection against insolvency 42 CFR § 438.116–solvency standards	• CCOs are expected to meet state financial solvency requirements • Reinvestment of savings not required	**Waiver authority, as follows:** Waiver of federal statute and regulation under 42 C.F.R. § 434.50 and 42 CFR § 438.116, to the extent necessary, to allow the state to require CCOs to reinvest a portion of savings achieved through investment in health-related services.	NA
Hospital Transformation Performance Program (HTPP)	Extension of CNOM authority through June 2020	SSA § 1115(a) - Costs not otherwise matchable	HTPP is approved and in place, but due to expire prior to the end of this waiver renewal. If maintained, we seek authority to continue through June 2020 at the same level of expenditure	**Amendment to current CNOM authority, as follows:** Expenditures - Hospital Transformation Performance Program (HTPP): Beginning July 1, 2017, through June 30, 2020, expenditures for incentive payments to participating hospitals for adopting initiatives for quality improvement of the Oregon health care system and the measurement of that improvement. The expenditures are limited to $150 million total computable for each demonstration year. HTPP expenditures are	**NA**

				further limited pursuant to Section XI.	
Tribal Uncompensated Care Program	Authority to: Extend the Tribal Uncompensated Care Program (UCCP) to extend payments to Tribal providers for certain services previously not funded under the OHP. The Uncompensated Care Program was established to broaden the numbers of services that can be reimbursed by Medicaid funds, thereby allowing other health care funding streams to be used toward the goal of eliminating health disparities in this population.	SSA § 1115(a) - Costs not otherwise matchable	UCCP is approved and in place. The state wishes to continue the program in the renewal	**Amendment to current CNOM authority, as follows:** To extend the uncompensated care program through the 2017-2022 renewal period	**NA**
Care Coordination for individuals residing in institutions for mental diseases (IMDs)	Authority to: • Provide or ensure provision of case management/care coordination services to residents of IMDs to ensure a smooth medical care transition to housing in the community. • Apply the program to those with IMD stays that do not qualify as short-term	42 CFR §438.3(e), 42 CFR § 435.1009 and 42 CFR § 435.1010 - Regulations pertaining to providing Medicaid benefits to incarcerated individuals and prohibiting FFP 42 CFR §438.3(e) – new managed care regulations at 42 CFR §438.3(e) rule provides that states may make a capitation payment for enrollees with a	NA	**Waiver and CNOM authority, as follows:** Waiver of federal regulation to the extent necessary, and to authorize federal financial participation for the state to serve individuals residing in institutions for mental diseases (IMDs) with case management/ care coordination services during the final 30 days prior to discharge from the institution. Expenditures for costs of measures necessary to	NA

		short-term stay in an Institution for Mental Disease to address access concerns for inpatient psychiatric and substance use disorder services.		ensure case management/care coordination to the population.	
Care Coordination for pre-adjudicated incarcerated individuals in local or regional correctional facilities (not state penitentiaries) for up to 30 days of the initial incarceration period	Authority to: • Provide or ensure provision of case management/care coordination services to pre-adjudicated inmates of local or regional correctional facilities in order to ensure continuity of care while the individual is incarcerated. • Medical services outside case management/care coordination would not be provided.	42 CFR § 435.1009 and 42 CFR § 435.1010 Regulations pertaining to providing Medicaid benefits to incarcerated individuals SSA § 1115(a) - Costs not otherwise matchable	NA	**Waiver and CNOM authority, as follows:** Waiver of federal regulation to the extent necessary, and to authorize federal financial participation for the state to serve pre-adjudicated incarcerated individuals with case management/care coordination services for up to 30 days of the initial incarceration. Expenditures for costs of measures necessary to ensure case management/care coordination to the population.	NA
Social Determinants of Health - Supportive Housing Grants for Coordinated Health Partnerships	Authority to: • Allow the state to pay for rent for transitional housing for up to 60 days for patients leaving an acute care setting who require health care services.	SSA - § 1905(a) SSA § 1115(a) - Costs not otherwise matchable	NA	**Waiver and CNOM authority, as follows:** Waiver to allow limited rental assistance Expenditures for costs of grants to foster	**NA**

	• Provide one-time grants to local entities to: ○ Engage in homelessness prevention for a targeted population of Medicaid-eligible and enrolled high-risk individuals ○ Support care coordination and other services not available through other authorities to eligible individuals ○ Support transitional services from inappropriate non-institutional settings to more appropriate community setting ○ Expand Health Information Technology (HIT) opportunities to new providers			collaboration and coordination among CCOs, hospitals, community-based organizations, Tribes, Indian health entities, housing authorities, county and city agencies and public health agencies to assist eligible individuals with specific supportive housing services for which federal financial participation is not otherwise provided. Such investments serve to ensure housing security and avoid negative health impacts of homelessness or inappropriate housing for identified at-risk Medicaid and CHIP-eligible populations.	
Psychiatric telephonic consultation line pilot for adults and older adults	Federal financial participation (FFP) for Psychiatric telephonic consultation line pilot for adults and older adults to address Oregon's limited access to prescribing psychiatric clinicians.	SSA § 1905(a)	OPAL-K in place for kids with state GF. State wishes to expand to adults with federal participation**.**	**CNOM authority, as follows:** Expenditures for a real time, psychiatric, telephonic consultation program to help address the significant shortage of prescribing psychiatric physicians in Oregon.	State Plan amendments as appropriate

Allow doulas to provide services within the doula's scope of practice without supervision of an existing licensed medical provider	Ability to provide payments to doulas as certified, but unlicensed, providers under the OHP	1905(a)(6); 42 CFR 440.60	Doulas are among certified traditional health workers, who must be under the supervision of a licensed practitioner to be eligible for payment.	**Waiver** authority as follows: Waiver of federal regulation to the extent necessary to ensure doulas are able to practice and be reimbursed independent of supervisory regulations.	NA
Eligibility/enrollment • Mandatory • Auto • Choice of plan • Lock-in	Change to allow dually eligible individuals to disenroll from CCOs without cause at any time	42 CFR § 431.51–freedom of choice 42 § 438.52–choice of plan 42 CFR § 438.50(f)(2)–equitable distribution of enrollees 42 CFR §438.6–contract requirements 42 CFR §438.10–required information, including available providers	State has a w*aiver in place (of 42 CFR 431.51)* to allow mandatory managed care enrollment, auto-enrollment without choice of plan, and lock-in for Medicaid-eligible populations, including for those dually eligible for Medicaid and Medicare. State will continue to provide choice among providers in plan.	**Amendment to description of current Waiver authority, as follows:** Add to the current waiver under 42 CFR 438.56(c) the authority to allow Dual Eligible individuals to disenroll from CCOs without cause at any time	NA
Selected state designated health programs (DSHP)	Ability to receive federal financial participation (FFP) for certain state-funded health care programs	SSA § 1115(a)	Approved and in place with a sunset of June 30, 2017.	**CNOM authority, as follows:** Expenditures for a limited amount of expenditures for approved designated state health programs	NA

				(DSHP). Subject to approval by the federal Office of Management and Budget, these costs can be calculated without taking into account program revenues from tuition or high risk pool health care premiums.	
Facilitate Care Coordination and Care Coordination resources and access for American Indians and Alaska Natives (AI/AN), including primary care case management PCCM.	Ability to work with tribes, urban Indian populations and tribal health entities to ensure efficient and effective care coordination services for AI/AN individuals in Oregon Ability to require CCOs to contract with Indian Health Service (IHS), tribal and urban Indian health entities (I/T/Us)	SSA § 1905(a) § 1902(a)(1) 42 CFR 431.50	NA	**STC s only –** requiring state collaboration with AI/AN population and health entities, and delivery system changes, as necessary, including re-establishment of PCCM program for Tribes**,** and requirement for CCOs to contract with AI/AN entities	Add PCCM to current Delivery System
Expand Nurse Home Visiting services	Ability to improve access to early intervention services that can improve health outcomes and social-emotional well-being for at-risk families and children, ranging from prenatal support to age five.	SSA § 1905(a)	NA	NA	Using a State Plan Amendment, expand the use of Targeted Case Management codes that allow for nurse home-visiting programs (including those focused on social services, care coordination, and wraparound services) to directly bill Medicaid for a defined set of services. This change would allow CCOs to help categorize family supportive services as "health-related" services and be eligible for reimbursement. Billable

					codes would also allow for gathering of sufficient data and metrics that can be used to track process measures related to nurse home-visiting services across CCOs.
Increase access to Targeted Case Management services	Ability to extend Targeted Case Management services to CCO members	SSA § 1905(a)			Retain existing Targeted Case Management (TCM) programs as State Plan benefits, offered through county public health programs and available to CCO members upon referral.

Citations from the Code of Federal Regulations (CFR) and the Social Security Act

References to 42 CFR § 438	Other CFR references	Social Security Act references
• 42 CFR § 438.2–Definitions • 42 CFR § 438.6– Contract requirements; actuarial soundness; entities eligible for comprehensive risk contracts; certification of MCO data for rate setting; services not covered under state plan • 42 CFR §438.10–Required information, including available providers • 42 CFR § 438.12 Provider discrimination prohibited • 42 CFR § 438.50(f)(2)–Equitable distribution of enrollees • 42 § 438.104–Marketing activities • 42 CFR § 438.116–Solvency standards • 42 CFR §§ 438.204–Elements of state quality strategies • 42 CFR § 438.206 – Availability of services and credentialed providers; responsibilities of health care professionals • 42 CFR § 438.207–Assurances of adequate capacity • 42 CFR § 438.208–Coordination/ continuity of care • 42 CFR § 438.209–Direct access to specialists • 42 CFR § 438.210–Coverage and authorization; communications with clients; EQRO requirements • 42 CFR § 438.240 (a)(2)–PIP topics • 42 CFR §§ 438.608 and 610–program integrity • 42 CFR § 438.228–Grievance systems • 42 CFR § 438.240–Quality assessment and program performance improvement • 42 CFR § 438.416–Managed care reporting requirements • 42 CFR § 438. 6, 10, 56, 100, 102, 104, 210, 224, 228, 400-424, 702, 706, 708–Member communications	• 42 C.F.R. § 430– Grants to states for Medical Assistance programs • 42 CFR § 431.51–Freedom of choice; funds from units of government • 42 CFR § 434.20 and 21–Basic HMO and PHP rules and contract requirements • 42 C.F.R. § 434.50–Protection against insolvency • 42 CFR § 417.479(i)–Physician incentive requirements (422.208-Medicare) • 42 CFR §422.128, 208, 210; 42 CFR § 431. 200, 211, 213, 214, 220, 230–Communications • 42 CFR § 431.53	• SSA § 1902(a)(10)(A)–Services required • SSA § 1902(a)(10)(B)–Amount, duration and scope • SSA § 1902(bb)–Payments to FQHCs/RHCs • SSA § 1905(a)–Services eligible for reimbursement • SSA § 1115(a)–costs not otherwise matchable (CNOM) authorities • SSA § 1915(b)

Appendix G: Budget Neutrality

Calendar year	Neutrality ceiling	Actual/projected expenditures	Surplus/deficit
Original Waiver Period			
1994 Actual	$ 390,951,750	$ 346,190,634	$ 44,761,116
1995 Actual	$ 818,988,036	$ 827,254,935	$ (8,266,899)
1996 Actual	$ 892,465,451	$ 885,011,152	$ 7,454,299
1997 Actual	$ 1,040,624,108	$ 895,762,310	$ 144,861,798
1998 Actual	$ 1,224,165,720	$ 1,051,592,807	$ 172,572,913
Jan-99	$ 112,450,962	$ 95,260,442	$ 17,190,520
Total Original Waiver	$ 4,479,646,027	$ 4,101,072,280	$ 378,573,747
First Waiver Extension (beginning February 1999)			
1999 Actual (Feb - Dec)	$ 1,236,961,227	$ 1,071,151,312	$ 165,809,915
2000 Actual	$ 1,448,108,685	$ 1,275,376,104	$ 172,732,581
2001 Projection (1)	$ 1,602,109,256	$ 1,398,528,881	$ 203,580,375
Jan-02	$ 152,138,992	$ 132,715,597	$ 19,423,395
Total First Waiver Extension	$ 4,439,318,160	$ 3,877,771,894	$ 561,546,266
Second Waiver Extension (beginning February 2002)			
2002 Actuals (Feb to Sept)	$ 1,253,756,577	$ 1,051,310,479	$ 202,446,098
OHP2 Waiver Amendment			
DY 1 (FFY 03 Actual)	$ 1,987,913,110	$ 1,542,201,604	$ 445,711,506
DY 2 (FFY 04 Actual)	$ 2,093,044,450	$ 1,494,082,316	$ 598,962,134
DY 3 (FFY 05 Actual)	$ 2,278,562,238	$ 1,733,929,530	$ 544,632,708
DY 4 (FFY 06 Actual)	$ 2,454,368,136	$ 1,558,038,076	$ 896,330,060
DY 5 (FFY 07 Actual)	$ 2,588,680,697	$ 1,488,456,119	$ 1,100,224,578
Total Second Waiver	$ 11,402,568,631	$ 7,816,707,645	$ 3,585,860,986
OHP2 Waiver Extension			
DY 6 (FFY 08 Actual)	$ 3,047,303,332	$ 1,980,350,291	$ 1,066,953,041
DY 7 (FFY 09 Actual)	$ 3,210,937,225	$ 1,857,765,840	$ 1,353,171,385
DY 8 (FFY 10 Actual)	$ 3,882,351,591	$ 2,275,008,353	$ 1,607,343,238
DY 9 (FFY 11 Actual)	$ 4,521,446,161	$ 2,847,833,594	$ 1,673,612,567
DY 10 (FFY 12 Actual)	$ 3,717,258,708	$ 2,034,387,873	$ 1,682,870,835
Total OHP2 Waiver Extension	$ 18,379,297,017	$ 10,995,345,951	$ 7,383,951,066
OHP2 Waiver Extension			
DY 11 (SFY 13 Actual)	$ 5,489,605,375	$ 3,035,739,903	$ 2,453,865,472
DY 12 (SFY 14 Actual)	$ 6,169,664,585	$ 4,572,687,190	$ 1,596,977,395
DY 13 (SFY 15 Actual)	$ 10,258,848,642	$ 6,024,979,658	$ 4,233,868,984
DY 14 (SFY 16 Actual/Projection)	$ 11,134,048,316	$ 6,578,825,705	$ 4,555,222,611
DY 15 (SFY 17 Projection)	$ 11,324,289,719	$ 6,563,632,982	$ 4,760,656,737
Total Waiver Extension	$ 44,376,456,637	$ 26,775,865,438	$ 17,600,591,199

OHP Waiver Renewal			
DY 16 (SFY 18 Projection)	$ 11,805,785,434	$ 6,827,114,449	$ 4,978,670,985
DY 17 (SFY 19 Projection)	$ 12,441,523,499	$ 7,038,290,715	$ 5,403,232,784
DY 18 (SFY 20 Projection)	$ 13,233,748,982	$ 7,342,548,481	$ 5,891,200,501
DY 19 (SFY 21 Projection)	$ 14,078,410,420	$ 7,660,930,957	$ 6,417,479,463
DY 20 (SFY 22 Projection)	$ 14,979,145,600	$ 7,994,022,481	$ 6,985,123,119
Total Waiver Renewal Request	$ 66,538,613,935	$ 36,862,907,083	$ 29,675,706,852
Cumulative Total	**$ 150,869,656,984**	**$ 91,480,980,770**	**$ 59,388,676,214**

Appendix H: Budget Neutrality - Projection of Expenditures for the Title XIX Program Demonstration Years 2011–2020

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
EXPENDITURE LIMIT (CEILING)										
MEMBER MONTHS										
Base Member Mos										
AFDC (Parent, Caretaker, Relative)	2,253,369	2,253,883	775,343	736,838	652,414	738,719	721,748	730,409	739,174	748,044
PWO	157,919	182,746	258,696	207,435	167,382	160,916	162,728	164,681	166,657	168,657
CMO (Children's Medicaid Program)	1,803,966	1,984,180	4,167,270	4,196,755	4,116,925	4,077,516	4,077,516	4,126,446	4,175,963	4,226,075
Old Age Assistance	422,934	438,634	466,345	492,289	515,502	535,687	556,843	563,525	570,287	577,130
Aid to Blind/Disabled	982,751	1,009,099	991,201	975,434	981,879	999,290	1,010,421	1,022,546	1,034,817	1,047,235
Foster Care & SAC	227,611	224,620	228,623	238,472	236,863	235,089	236,150	238,984	241,852	244,754
New ACA Adults	-	1,748,385	4,810,790	5,353,971	4,769,101	4,512,264	4,484,962	4,538,782	4,593,247	4,648,366
BCCP	9,968	10,886	7,707	4,673	3,285	3,144	2,685	2,717	2,750	2,783
Total Base	5,858,518	7,852,433	11,705,975	12,205,867	11,443,351	11,262,625	11,253,053	11,388,090	11,524,747	11,663,044
Expansion Member Mos										
General Assistance										
Parents	256,428	126,456								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	7,618	2,955								
FHIAP - Non-Medicaid										
Total Expansion	264,046	129,411								
Total Member Months	**6,122,564**	**7,981,844**	**11,705,975**	**12,205,867**	**11,443,351**	**11,262,625**	**11,253,053**	**11,388,090**	**11,524,747**	**11,663,044**
ALLOWED PER MEMBER PER MONTH COSTS (PMPM)										
Base Populations PMPM										
AFDC (Parent, Caretaker, Relative)	$ 504.08	$ 529.80	$ 553.83	$ 578.95	$ 605.22	$ 632.45	$ 660.91	$ 690.65	$ 721.73	$ 754.21
PWO	$ 1,917.16	$ 2,018.86	$ 2,117.88	$ 2,221.76	$ 2,330.74	$ 2,444.95	$ 2,564.75	$ 2,690.42	$ 2,822.25	$ 2,960.54
CMO (Children's Medicaid Program)	$ 734.70	$ 768.80	$ 798.32	$ 828.98	$ 860.81	$ 893.52	$ 927.47	$ 962.71	$ 999.29	$ 1,037.26
Old Age Assistance	$ 658.53	$ 721.39	$ 786.23	$ 855.19	$ 928.47	$ 966.54	$ 1,006.17	$ 1,047.42	$ 1,090.36	$ 1,135.06
Aid to Blind/Disabled	$ 2,179.61	$ 2,419.85	$ 2,673.57	$ 2,946.88	$ 3,241.11	$ 3,406.41	$ 3,580.14	$ 3,762.73	$ 3,954.63	$ 4,156.32
Foster Care & SAC	$ 887.03	$ 934.56	$ 977.06	$ 1,021.43	$ 1,067.77	$ 1,108.35	$ 1,150.47	$ 1,194.19	$ 1,239.57	$ 1,286.67
New ACA Adults		$ 522.00	$ 559.88	$ 600.50	$ 644.07	$ 689.15	$ 737.39	$ 789.01	$ 844.24	$ 903.34
BCCP		$ 2,631.69	$ 2,750.12	$ 2,873.87	$ 3,003.20	$ 3,138.34	$ 3,279.57	$ 3,427.15	$ 3,581.37	$ 3,742.53
Expansion Population PMPM										
General Assistance										
Parents	$ 391.86	$ 658.53								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	$ 352.72	$ 352.72								
FHIAP - Non-Medicaid										
TOTAL EXPENDITURES LIMIT										
Base Populations Expenditures										

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
AFDC (Parent, Caretaker, Relative)	$ 1,135,878,246	$ 1,194,107,213	$ 429,408,215	$ 426,592,360	$ 394,854,001	$ 467,202,832	$ 477,010,471	$ 504,456,976	$ 533,484,051	$ 564,182,265
PWO	$ 302,755,989	$ 368,938,590	$ 547,887,084	$ 460,870,786	$ 390,123,923	$ 393,431,574	$ 417,356,638	$ 443,061,056	$ 470,347,718	$ 499,315,795
CMO (Children's Medicaid Program)	$ 1,325,373,822	$ 1,525,437,584	$ 3,326,814,986	$ 3,479,025,960	$ 3,543,890,209	$ 3,643,342,096	$ 3,781,773,765	$ 3,972,570,829	$ 4,172,998,066	$ 4,383,538,555
Old Age Assistance	$ 278,514,726	$ 316,426,181	$ 366,654,430	$ 421,000,630	$ 478,628,142	$ 517,762,913	$ 560,278,721	$ 590,247,356	$ 621,818,133	$ 655,077,178
Aid to Blind/Disabled	$ 2,142,013,908	$ 2,441,868,215	$ 2,650,045,257	$ 2,874,486,946	$ 3,182,377,846	$ 3,403,991,449	$ 3,617,448,639	$ 3,847,564,511	$ 4,092,318,353	$ 4,352,643,775
Foster Care & SAC	$ 201,897,787	$ 209,920,867	$ 223,378,389	$ 243,582,455	$ 252,915,206	$ 260,560,893	$ 271,683,491	$ 285,392,303	$ 299,792,484	$ 314,917,629
New ACA Adults			$ 2,693,465,107	$ 3,215,059,586	$ 3,071,634,881	$ 3,109,626,736	$ 3,307,166,129	$ 3,581,144,386	$ 3,877,802,847	$ 4,199,054,942
BCCP		$ 28,648,577	$ 21,195,174	$ 13,429,595	$ 9,865,512	$ 9,866,941	$ 8,805,645	$ 9,311,567	$ 9,848,768	$ 10,415,461
Total Base	$ 5,386,434,478	$ 6,085,347,228	$ 10,258,848,642	$ 11,134,048,316	$ 11,324,289,719	$ 11,805,785,434	$ 12,441,523,499	$ 13,233,748,982	$ 14,078,410,420	$ 14,979,145,600
Expansion Population Expenditures										
General Assistance										
Parents	$ 100,483,876	$ 83,275,070								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	$ 2,687,021	$ 1,042,288								
FHIAP - Non-Medicaid										
Total Expansion	$ 103,170,897	$ 84,317,357	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures										
General Assistance										
Adults/Couples										
FHIAP - Existing										
FHIAP - Non-Medicaid										
Total Non-Allowable Expansion	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Annual Expenditure Limit	**$ 5,489,605,375**	**$ 6,169,664,585**	**$ 10,258,848,642**	**$ 11,134,048,316**	**$ 11,324,289,719**	**$ 11,805,785,434**	**$ 12,441,523,499**	**$ 13,233,748,982**	**$ 14,078,410,420**	**$ 14,979,145,600**
Cumulative Expenditure Limit	**$ 45,444,191,787**	**$ 51,613,856,371**	**$ 61,872,705,013**	**$ 73,006,753,329**	**$ 84,331,043,048**	**$ 96,136,828,482**	**$108,578,351,981**	**$ 121,812,100,963**	**$ 135,890,511,383**	**$ 150,869,656,983**
ACTUAL & PROJECTED EXPENDITURES (WITH WAIVER)										
MEMBER MONTHS										
Base Populations Member Months										
AFDC (Parent, Caretaker, Relative)	2,253,369	2,253,883	775,343	736,838	652,414	738,719	721,748	730,409	739,174	748,044
PWO	157,919	182,746	258,696	207,435	167,382	160,916	162,728	164,681	166,657	168,657
CMO (Children's Medicaid Program)	1,803,966	1,984,180	4,167,270	4,196,755	4,116,925	4,077,516	4,077,516	4,126,446	4,175,963	4,226,075
Old Age Assistance	422,934	438,634	466,345	492,289	515,502	535,687	556,843	563,525	570,287	577,130
Aid to Blind/Disabled	982,751	1,009,099	991,201	975,434	981,879	999,290	1,010,421	1,022,546	1,034,817	1,047,235
Foster Care & SAC	227,611	224,620	228,623	238,472	236,863	235,089	236,150	238,984	241,852	244,754
New ACA Adults	-	1,748,385	4,810,790	5,353,971	4,769,101	4,512,264	4,484,962	4,538,782	4,593,247	4,648,366
BCCP	9,968	10,886	7,707	4,673	3,285	3,144	2,685	2,717	2,750	2,783
Total Base	5,858,518	7,852,433	11,705,975	12,205,867	11,443,351	11,262,625	11,253,053	11,388,090	11,524,747	11,663,044
Expansion Member Months										
General Assistance										
Parents	256,428	126,456								
Adults/Couples										
FHIAP - Existing										
FHIAP - Medicaid	7,618	2,955								
FHIAP - Non-Medicaid										
Total Expansion	264,046	129,411	-	-	-	-	-	-	-	-
Non-Allowable Expansion Population Member Months										
General Assistance										
Adults/Couples	532,651	244,489								
FHIAP - Existing	2,477	972								

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
FHIAP - Non-Medicaid	44,588	17,134								
Total Non-Allowable Expansion	579,716	262,595	-	-	-	-	-	-	-	-
Total Member Months	**6,702,280**	**8,244,439**	**11,705,975**	**12,205,867**	**11,443,351**	**11,262,625**	**11,253,053**	**11,388,090**	**11,524,747**	**11,663,044**
PER MEMBER PER MONTH COSTS (PMPM)										
Base Population PMPM										
AFDC (Parent, Caretaker, Relative)	$ 295.27	$ 316.81	$ 520.15	$ 535.31	$ 582.81	$ 602.63	$ 623.12	$ 644.31	$ 666.22	$ 688.87
PWO	$ 1,174.82	$ 1,056.49	$ 977.26	$ 1,203.37	$ 1,399.13	$ 1,446.70	$ 1,495.89	$ 1,546.75	$ 1,599.34	$ 1,653.72
CMO (Children's Medicaid Program)	$ 204.21	$ 223.51	$ 214.42	$ 233.81	$ 239.38	$ 247.52	$ 255.94	$ 264.64	$ 273.64	$ 282.94
Old Age Assistance	$ 232.31	$ 305.23	$ 316.04	$ 358.88	$ 350.76	$ 362.69	$ 375.02	$ 387.77	$ 400.95	$ 414.58
Aid to Blind/Disabled	$ 984.34	$ 1,099.88	$ 1,049.16	$ 1,174.02	$ 1,215.36	$ 1,256.68	$ 1,299.41	$ 1,343.59	$ 1,389.27	$ 1,436.51
Foster Care & SAC	$ 491.68	$ 605.19	$ 634.80	$ 644.52	$ 676.76	$ 699.77	$ 723.56	$ 748.16	$ 773.60	$ 799.90
New ACA Adults		$ 580.69	$ 569.47	$ 580.82	$ 647.48	$ 669.49	$ 692.25	$ 715.79	$ 740.13	$ 765.29
BCCP	$ 3,066.43	$ 2,958.74	$ 2,655.02	$ 1,360.52	$ 2,327.37	$ 2,406.50	$ 2,488.32	$ 2,572.92	$ 2,660.40	$ 2,750.85
Expansion Population PMPM										
General Assistance	$ -	$ -	$ -							
Parents	$ 382.35	$ 327.81	$ 353.38							
Adults/Couples	$ -	$ -	$ -							
FHIAP - All Title XIX										
FHIAP - Existing	$ -	$ -	$ -							
FHIAP - Medicaid	$ 171.94	$ 147.41	$ 158.91							
FHIAP - Non-Medicaid	$ -	$ -	$ -							
Non-Allowable Expansion Population PMPM										
General Assistance	$ -	$ -	$ -							
Adults/Couples	$ 818.76	$ 701.96	$ 756.71							
FHIAP - Existing	$ 366.41	$ 314.14	$ 338.65							
FHIAP - Non-Medicaid	$ 407.37	$ 349.26	$ 376.50							
TOTAL EXPENDITURES (Member Months x PMPM)										
Base Population Expenditures										
AFDC (Parent, Caretaker, Relative)	$ 665,357,818	$ 714,049,690	$ 403,296,504	$ 394,433,856	$ 380,235,735	$ 445,174,231	$ 449,735,614	$ 470,609,823	$ 492,452,502	$ 515,305,070
PWO	$ 185,527,167	$ 193,070,042	$ 252,814,222	$ 249,620,744	$ 234,189,258	$ 232,797,177	$ 243,423,188	$ 254,720,337	$ 266,541,206	$ 278,911,454
CMO (Children's Medicaid Program)	$ 368,391,830	$ 443,484,857	$ 893,534,287	$ 981,223,087	$ 985,499,603	$ 1,009,266,760	$ 1,043,599,445	$ 1,092,022,669	$ 1,142,710,515	$ 1,195,725,661
Old Age Assistance	$ 98,252,220	$ 133,886,140	$ 147,384,288	$ 176,673,743	$ 180,818,921	$ 194,288,318	$ 208,827,262	$ 218,518,089	$ 228,656,573	$ 239,266,555
Aid to Blind/Disabled	$ 967,359,925	$ 1,109,887,765	$ 1,039,930,976	$ 1,145,182,423	$ 1,193,339,308	$ 1,255,787,757	$ 1,312,951,152	$ 1,373,882,580	$ 1,437,640,214	$ 1,504,363,550
Foster Care & SAC	$ 111,912,157	$ 135,937,770	$ 145,129,519	$ 153,700,910	$ 160,298,718	$ 164,508,230	$ 170,868,694	$ 178,798,269	$ 187,096,707	$ 195,778,725
New ACA Adults	$ -	$ 1,015,277,287	$ 2,739,593,547	$ 3,109,687,128	$ 3,087,883,870	$ 3,020,915,625	$ 3,104,714,945	$ 3,248,814,768	$ 3,399,599,902	$ 3,557,348,016
BCCP	$ 30,566,217	$ 32,208,805	$ 20,462,260	$ 6,357,688	$ 7,645,415	$ 7,566,036	$ 6,681,139	$ 6,990,624	$ 7,316,100	$ 7,655,616
Total Leverages	$ 186,166,774	$ 230,730,998	$ 17,058,017	$ 98,072,388	$ 55,609,340	$ 76,840,864	$ 76,840,864	$ 76,840,864	$ 76,840,864	$ 76,840,864
Total Base	$ 2,613,534,108	$ 4,008,533,354	$ 5,659,203,620	$ 6,314,951,967	$ 6,285,520,167	$ 6,407,144,998	$ 6,617,642,303	$ 6,921,198,023	$ 7,238,854,583	$ 7,571,195,511
Expansion Population Expenditures										
General Assistance										
Parents	$ 89,271,730	$ 45,140,938								
Adults/Couples										
FHIAP - All Title XIX										
FHIAP - Existing										
FHIAP - Medicaid	$ 1,521,803	$ 529,677								
FHIAP - Non-Medicaid										
Total Expansion	$ 90,793,533	$ 45,670,615	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Allowable Expansion Population Expenditures										
General Assistance										
Adults/Couples	$ 313,969,297	$ 148,120,151								

	Actual DY 11 SFY 13	Actual DY 12 SFY 14	Actual DY 13 SFY 15	Projection DY 14 SFY 16	Projection DY 15 SFY 17	Projection DY 16 SFY 18	Projection DY 17 SFY 19	Projection DY 18 SFY 20	Projection DY 19 SFY 21	Projection DY 20 SFY 22
FHIAP - Existing	$ 933,153	$ 326,655								
FHIAP - Non-Medicaid	$ 16,509,812	$ 5,738,428								
Total Non-Allowable Expansion	$ 331,412,262	$ 154,185,234	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hospital Transformation Performance Program										
Tribal Uncompensated Care Program										
DSHP FFP (STC 55)	$ -	$ 230,000,000	$ 122,654,457	$ 68,092,578	$ 68,000,000	$ -	$ -	$ -	$ -	$ -
DSHP State Share	$ -	$ 134,297,987	$ 93,121,582	$ 36,330,000	$ 40,800,000	$ -	$ -	$ -	$ -	$ -
DSHP Total Computable	$ -	$ 364,297,987	$ 215,776,039	$ 104,422,578	$ 108,800,000	$ -	$ -	$ -	$ -	$ -
Continued Federal Investment to further advance Healthcare System Transformation										
						$ (2,344,272,268)	$ (2,344,272,268)	$ (2,344,272,268)	$ (2,344,272,268)	$ (2,344,272,268)
Annual Actuals/Projected Expenditures	**$ 3,035,739,903**	**$ 4,572,687,190**	**$ 6,024,979,658**	**$ 6,578,825,705**	**$ 6,563,632,982**	**$ 6,827,114,449**	**$ 7,038,290,715**	**$ 7,342,548,481**	**$ 7,660,930,957**	**$ 7,994,022,481**
Cumulative Actuals/Projected Expenditures	**$ 30,691,781,378**	**$ 35,264,468,568**	**$ 41,289,448,226**	**$ 47,868,273,931**	**$ 54,431,906,913**	**$ 61,259,021,361**	**$ 68,297,312,076**	**$ 75,639,860,557**	**$ 83,300,791,514**	**$ 91,294,813,995**
Annual Budget Neutrality Margin	**$ 2,453,865,472**	**$ 1,596,977,395**	**$ 4,233,868,984**	**$ 4,555,222,611**	**$ 4,760,656,738**	**$ 4,978,670,985**	**$ 5,403,232,784**	**$ 5,891,200,501**	**$ 6,417,479,463**	**$ 6,985,123,119**
Cumulative BN Margin	**$ 14,566,243,635**	**$ 16,163,221,030**	**$ 20,397,090,014**	**$ 24,952,312,625**	**$ 29,712,969,363**	**$ 34,691,640,348**	**$ 40,094,873,131**	**$ 45,986,073,632**	**$ 52,403,553,096**	**$ 59,388,676,214**

Appendix I: Title XXI Allotment

Template for States Using CHIP Funds	Actual DY 11 (SFY 2013)	Actual DY 12 (SFY 2014)	Actual DY 13 (SFY 2015)	Actual/Projection DY 14 (SFY 2016)	Projection DY 15 (SFY 2017)	Projection DY 16 (SFY 2018)	Projection DY 17 (SFY 2019)	Projection DY 18 (SFY 2020)	Projection DY 19 (SFY 2021)	Projection DY 20 (SFY 2022)
State's Allotment	$ 143,895,447	$ 152,919,671	$ 193,533,316	$ 211,330,598	$ 222,120,237	$ 233,460,749	$ 245,380,258	$ 257,908,328	$ 271,076,027	$ 284,916,012
Funds Carried Over From Prior Period(s)	$ 82,821,577	$ 77,230,788	$ 61,338,237	$ 105,180,173	$ 143,062,824	$ 180,869,041	$ 233,460,748	$ 245,380,257	$ 257,908,327	$ 271,076,026
SUBTOTAL (Allotment + Funds Carried Over)	$ 226,717,024	$ 230,150,459	$ 254,871,553	$ 316,510,771	$ 365,183,061	$ 414,329,790	$ 478,841,006	$ 503,288,585	$ 528,984,354	$ 555,992,038
Reallocated Funds (Redistributed or Retained that are Currently Available)										
TOTAL (Subtotal + Reallocated funds)	$ 226,717,024	$ 230,150,459	$ 254,871,553	$ 316,510,771	$ 365,183,061	$ 414,329,790	$ 478,841,006	$ 503,288,585	$ 528,984,354	$ 555,992,038
State's Enhanced FMAP Rate	73.71%	74.08%	74.68%	92.26%	98.12%	97.87%	97.11%	79.63%	73.88%	73.88%
COST ACTUALS/ PROJECTIONS OF APPROVED CHIP PLAN - (CHIP 0-300%)										
Benefit Costs										
Insurance payments										
Managed care	$ 126,678,193	$ 153,873,286	$ 148,292,397	$ 118,508,563	$ 121,561,770	$ 114,083,389	$ 116,272,134	$ 121,668,091	$ 127,314,464	$ 133,222,874
Member Months	$ 907,493	1,080,484	890,388	$ 795,961	758,468	688,402	678,539	686,681	694,922	703,261
per member/per month rate	$ 175.44	$ 187.46	$ 220.62	$ 219.97	$ 236.79	$ 244.84	$ 253.17	$ 261.78	$ 270.68	$ 279.88
Fee for Service	$ 32,528,290	$ 48,671,833	$ 48,148,418	$ 56,580,080	$ 58,037,786	$ 54,467,349	$ 55,512,332	$ 58,088,548	$ 60,784,321	$ 63,605,200
Total Benefit Costs	**$ 159,206,483**	**$ 202,545,119**	**$ 196,440,815**	**$ 175,088,643**	**$ 179,599,556**	**$ 168,550,738**	**$ 171,784,466**	**$ 179,756,639**	**$ 188,098,785**	**$ 196,828,074**
Benefit Costs										
Insurance payments	$ 24,131,320	$ 12,279,473								
Managed care										
Member Months	89,989	47,347								
per member/per month rate	$ 268.16	$ 259.35								
Fee for Service										
Total Benefit Costs for Kids Connect	**$ 24,131,320**	**$ 12,279,473**								
Administration Costs										
Personnel	$ 1,365,490	$ 790,477	$ 323,135	$ 454,314	$ 293,106	$ 463,177	$ 472,064	$ 493,971	$ 516,896	$ 540,884
General administration	$ 5,689,544	$ 3,293,654	$ 1,346,393	$ 1,892,978	$ 1,221,277	$ 1,929,906	$ 1,966,932	$ 2,058,214	$ 2,153,731	$ 2,253,681
Contractors/Brokers (e.g., enrollment contractors)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Claims Processing	$ 4,324,051	$ 2,503,177	$ 1,023,258	$ 1,438,662	$ 928,171	$ 1,466,728	$ 1,494,869	$ 1,564,242	$ 1,636,836	$ 1,712,798
Outreach/marketing costs	$ 36,272	$ 1,567,650	$ 1,075,904	$ 538,790	$ 1,000,000	$ 1,034,000	$ 1,069,156	$ 1,105,507	$ 1,143,095	$ 1,181,960
Other	$ 1,397,680	$ 7,035,504	$ 10,035,008	$ 6,741,101	$ 4,812,978	$ 4,976,619	$ 5,145,824	$ 5,320,782	$ 5,501,689	$ 5,688,746
Total Administration Costs	**$ 12,813,037**	**$ 15,190,462**	**$ 13,803,698**	**$ 11,065,845**	**$ 8,255,532**	**$ 9,870,431**	**$ 10,148,845**	**$ 10,542,717**	**$ 10,952,246**	**$ 11,378,069**
10% Administrative Cap	$ 20,370,867	$ 23,869,399	$ 21,444,153	$ 19,454,294	$ 19,955,506	$ 18,727,860	$ 19,087,163	$ 19,972,960	$ 20,899,865	$ 21,869,786
Federal Title XXI Share	$ 144,582,785	$ 170,388,516	$ 154,441,084	$ 172,447,594	$ 184,314,020	$ 174,616,338	$ 176,666,342	$ 151,535,377	$ 147,058,902	$ 153,822,698
State Share	$ 51,568,055	$ 59,626,536	$ 52,359,989	$ 13,706,894	$ 3,541,068	$ 3,804,831	$ 5,266,969	$ 38,763,979	$ 51,992,129	$ 54,383,445
TOTAL COSTS OF APPROVED CHIP PLAN	**$ 196,150,840**	**$ 230,015,054**	**$ 210,244,513**	**$ 186,154,488**	**$ 187,855,088**	**$ 178,421,169**	**$ 181,933,311**	**$ 190,299,356**	**$ 199,051,031**	**$ 208,206,143**

Benefit Costs for Demonstration Population #16 (FHIAP Children - Group 0-200% FPL)											
Insurance payments	$ 817,583	$ 462,334									
Managed care											
Member Months	7,099	2,720									
per member/per month rate	$ 115.17	$ 169.96									
Fee for Service											
Total Benefit Costs for Waiver Population #16	**$ 817,583**	**$ 462,334**									
Benefit Costs for Demonstration Population #16 (FHIAP Children - Individual 0-200% FPL)											
Insurance payments	$ 781,778	$ 449,899									
Managed care											
Member Months	3,583	1,374									
per member/per month rate	$ 218.19	$ 327.44									
Fee for Service											
Total Benefit Costs for Waiver Population #16	**$ 781,778**	**$ 449,899**									
Benefit Costs for Demonstration Population #20 - FHIAP Children ESI (200%-300% FPL)											
Insurance payments	$ 33,498	$ 15,508									
Managed care											
Member Months	233	117									
per member/per month rate	$ 143.77	$ 132.55									
Fee for Service											
Total Benefit Costs for Demonstration Population #20 - FHIAP ESI	**$ 33,498**	**$ 15,508**									
Total Demonstration Benefit Costs (Waiver Pop. #16 & #20)	**$ 1,632,859**	**$ 927,741**									
Administration Costs											
Personnel	$ 288,167	$ 87,818									
General administration	$ 1,200,696	$ 365,907									
Contractors/Brokers (e.g., enrollment contractors)	$ -	$ -									
Claims Processing	$ 912,528	$ 278,089									
Outreach/marketing costs	$ -	$ -									
Other (specify)	$ -	$ -									
Total Administration Costs	**$ 2,401,391**	**$ 731,814**									
10% Administrative Cap	$ 181,429	$ 103,082									
Federal Title XXI Share	$ 2,973,645	$ 1,229,357									
State Share	$ 1,060,604	$ 430,198									

TOTAL COSTS FOR HIFA DEMONSTRATION	**$ 4,034,249**	**$ 1,659,555**								
Total Combined Administration Cost of SCHIP State Plan										
Administration Costs										
Personnel	$ 1,653,657	$ 878,295	$ 323,135	$ 454,314	$ 293,106	$ 463,177	$ 472,064	$ 493,971	$ 516,896	$ 540,884
General administration	$ 6,890,240	$ 3,659,561	$ 1,346,393	$ 1,892,978	$ 1,221,277	$ 1,929,906	$ 1,966,932	$ 2,058,214	$ 2,153,731	$ 2,253,681
Contractors/Brokers (e.g., enrollment contractors)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Claims Processing	$ 5,236,579	$ 2,781,266	$ 1,023,258	$ 1,438,662	$ 928,171	$ 1,466,728	$ 1,494,869	$ 1,564,242	$ 1,636,836	$ 1,712,798
Outreach/marketing costs	$ 36,272	$ 1,567,650	$ 1,075,904	$ 538,790	$ 1,000,000	$ 1,034,000	$ 1,069,156	$ 1,105,507	$ 1,143,095	$ 1,181,960
Other (specify)	$ 1,397,680	$ 7,035,504	$ 10,035,008	$ 6,741,101	$ 4,812,978	$ 4,976,619	$ 5,145,824	$ 5,320,782	$ 5,501,689	$ 5,688,746
Total Administration Costs	**$ 15,214,428**	**$ 15,922,276**	**$ 13,803,698**	**$ 11,065,845**	**$ 8,255,532**	**$ 9,870,431**	**$ 10,148,845**	**$ 10,542,717**	**$ 10,952,246**	**$ 11,378,069**
Confirm										
10% Administrative Cap	$ 20,552,296	$ 23,972,481	$ 21,826,757	$ 19,454,294	$ 19,955,506	$ 18,727,860	$ 19,087,163	$ 19,972,960	$ 20,899,865	$ 21,869,786
HIFA Demonstration Waiver Budget										
Allotment Expenditure Analysis	**State Fiscal Year 11 (SFY 2013)**	**State Fiscal Year 12 (SFY 2014)**	**State Fiscal Year 13 (SFY 2015)**	**Actual/Projection DY 14 (SFY 2016)**	**Projection DY 15 (SFY 2017)**	**State Fiscal Year 16 (SFY 2018)**	**State Fiscal Year 17 (SFY 2019)**	**State Fiscal Year 18 (SFY 2020)**	**State Fiscal Year 19 (SFY 2021)**	**State Fiscal Year 20 (SFY 2022)**
Prior Period Adj - Program Costs	**$ 1,488,772**	**$ (1,916,802)**	**$ (9,856,394)**	**$ (574,459)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Prior Period Adj - Admin. Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Prior Period Adj - Fed Title XXI Share Collections	**$ 1,101,713**	**$ (1,412,373)**	**$ (7,320,576)**	**$ (1,610,778)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Other Adjustments/Client-Related										
TOTAL CURRENT PROGRAM COSTS (State Plan + Demonstration)	**$ 201,673,861**	**$ 229,757,807**	**$ 200,388,119**	**$ 185,580,025**	**$ 187,855,088**	**$ 178,421,169**	**$ 181,933,311**	**$ 190,299,356**	**$ 199,051,031**	**$ 208,206,143**
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$ 226,717,024	$ 230,150,459	$ 254,871,553	$ 316,510,771	$ 365,183,061	$ 414,329,790	$ 478,841,006	$ 503,288,585	$ 528,984,354	$ 555,992,038
Total Federal Title XXI Program Costs (State Plan + Demonstration)	$ 148,658,140	$ 170,202,483	$ 149,690,027	$ 170,836,812	$ 184,314,020	$ 174,616,338	$ 176,666,342	$ 151,535,377	$ 147,058,902	$ 153,822,698
Reporting period difference due to timing between CMS 21 Reporting and FHIAP Reporting	$ 828,096	$ (1,390,261)	$ 1,353	$ 2,611,135	$ -	$ -	$ -	$ -	$ -	$ -
Unused Title XXI Funds Expiring (Allotment or Reallocated)						$ 6,252,704	$ 56,794,407	$ 93,844,881	$ 110,849,426	$ 117,253,328
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	**$ 77,230,788**	**$ 61,338,237**	**$ 105,180,173**	**$ 143,062,824**	**$ 180,869,041**	**$ 233,460,748**	**$ 245,380,257**	**$ 257,908,327**	**$ 271,076,026**	**$ 284,916,011**

Appendix J: Public meeting notices

NEWS RELEASE: April OHPB meeting

3/30/2016
Oregon Health Policy Board to meet April 5 in Portland at OHSU

Media contact: Alissa Robbins, Media inquiries, 503-490-6590, alissa.robbins@state.or.us
Additional contacts: Jeff Scroggin; Meeting information or accommodation; 971-273-6844; jeffrey.scroggin@state.or.us

The Oregon Health Policy Board will hold its monthly meeting April 5 at the OHSU Center for Health and Healing in Portland. The board will hear an update on Oregon's 1115 Waiver with the Centers for Medicare and Medicaid Services (CMS), and discuss primary, preventive and chronic care. The board may take action or provide guidance on these topics. Public testimony regarding Oregon's 1115 Waiver with CMS is encouraged and will be heard during the meeting, beginning at 11:35 a.m.

When: Tuesday, April 5, 8:30-11:45 a.m.

Where: OHSU Center for Health & Healing, 3033 SW Bond Ave., third floor, Room 4. The meeting also will be available via live web stream. A link to the live-stream and a recording of the meeting will be posted on the board's meeting page. Members of the public can also call in to listen by dialing 1-888-808-6929, participant code 915042#.

Agenda: Director's report, board protocols discussion; Public Health Advisory Board charter approval; health system transformation and primary care; Oregon's 1115 Waiver discussion; public testimony regarding Oregon's 1115 Waiver; other public testimony.

For more information on the meeting, visit the board's meeting page. You also can learn more about Oregon's Waiver renewal process and find documents on the board's website.

The meeting site is accessible to people with disabilities. To request alternate formats, sign language interpreters, physical accessibility, or other reasonable accommodation, call the Oregon Health Authority at 1-800-282-8096 at least 48 hours before the meeting.

# # #

NEWS RELEASE: May OHPB meeting

4/29/2016
Oregon Health Policy Board to meet May 3 at OHSU in Portland
Includes presentation on Oregon's waiver renewal with CMS and public input opportunity

Media contact: Alissa Robbins; OHA External Relations; 503-490-6590; alissa.robbins@state.or.us
Additional contacts: Jeff Scroggin; Meeting information or accommodation; 541-999-6983; jeffrey.scroggin@state.or.us

The Oregon Health Policy Board will hold its monthly meeting May 3 in Portland. The meeting will be held at the OHSU Center for Health and Healing.

The board will hear an update on Oregon's 1115 waiver with the Centers for Medicare and Medicaid Services (CMS). Public testimony about the waiver is encouraged and will be heard during the meeting, beginning at 10:45 a.m.

When: Tuesday, May 3, 8:30-11:45 a.m.

Where: OHSU Center for Health & Healing, 3033 SW Bond Ave., third floor, Room 4. The meeting also will be available via live web stream. A link to the live-stream and a recording of the meeting will be posted on the board's meeting page. Members of the public also can call in to listen by dialing 1-888-808-6929, participant code 915042#.

Agenda: Director's report; behavioral health town halls update; Workforce Committee Liaison update; Oregon's 1115 Waiver discussion; public input opportunity on Oregon's waiver renewal; OHPB priorities discussion; public testimony.

For more information on the meeting, visit the board's meeting page.

More information and documents about Oregon's Waiver renewal process are available on the OHPB website.

The draft waiver renewal application for public comment will be posted Monday, May 2.

The meeting site is accessible to people with disabilities. To request alternate formats, sign language interpreters, physical accessibility, or other reasonable accommodations, call the Oregon Health Authority at
1-800-282-8096 at least 48 hours before the meeting.

# # #

NEWS RELEASE: May Medicaid Advisory Committee Meeting/ Waiver Hearing

Oregon Medicaid Advisory Committee to meet May 25 in Salem

May 13, 2016

Contact: Alissa Robbins, 503-490-6590 (media inquiries)
Oliver Droppers, 503-507-2990 (meeting information and accommodation)

What: The monthly public meeting of the Medicaid Advisory Committee.

When: Wednesday, May 25, 9:30 a.m. to 12:30 p.m.

Where: Oregon State Library, Room 102/103, 250 Winter St., NE, Salem. The meeting will also be available via webinar at https://attendee.gotowebinar.com/register/5672779983090523140. The public also may join by a listen-only conference line at 888-398-2342, access code 3732275.

Details: Oregon Health Authority staff will present an update on Oregon's 1115 Waiver renewal including a brief presentation on the proposed Coordinated Health Partnership concept. The committee will hear formal public comments after the waiver presentation.

Also at the meeting Bruce Austin, MD, OHA's dental director, will discuss OHA's Oral Health Strategic Plan. The Oregon Health Authority has charged the Medicaid Advisory Committee with developing a framework for defining and measuring oral health access for Oregon Health Plan members.

For more information on the 1115 Waiver renewal, see the draft renewal application at www.oregon.gov/oha/OHPB/Documents/Oregon%27s%20Draft%20Waiver%20Application.pdf For more on the Coordinated Health Partnership concept, see pages 23-32 in the application.

OHA is accepting public comment on the draft waiver through June 1. Comments may be submitted to Janna.Starr@state.or.us, or through an online survey at www.surveymonkey.com/r/QP7W23N.

For webinar information, meeting minutes, reports and updates, please visit the Committee's website at www.oregon.gov/oha/OHPR/MAC/Pages/index.aspx.

# # #

Tribal Meetings and Consultations:

March 30, 2016 - 11:00 AM - 12:00 PM
Tribal Roundtable/Workgroup
500 Summer Street NE, Room 137 A-D, Salem, Oregon
Plus phone and webinar

Overview of the 1115 Waiver and request for input

April 4, 2016 - 11:00 AM - 12:00 PM
Tribal Roundtable
500 Summer Street NE, Room 137 C, Salem, Oregon
Plus phone and webinar

Overview of the 1115 Waiver and request for input

April 8, 2016 - 11:00 AM - 12:00 PM
Tribal Roundtable
500 Summer Street NE, Room 473, Salem, Oregon
Plus phone and webinar

April 18, 2016 – 3:45 PM – 4:30 PM
Northwest Portland Area Indian Health Board Quarterly Board Meeting
17500 Nez Pierce Road
Lewiston, Idaho

Agenda included discussion of 1115 waiver renewal and care coordination activities.

April 28, 2016 - 11:00 AM - 12:00 PM
Tribal Roundtable
500 Summer Street NE, Room 160, Salem, Oregon
Plus, available via phone and webinar

Overview of the 1115 Waiver, timeline, and request for input

May 5, 2016, 9:00 AM – 4:00 PM
Tribal Consultation
500 Summer Street NE, Room 137 A-D, Salem, Oregon
Facilitators: Tribal representative & Lynne Saxton

Agenda

- Tribal Priorities List (specialty care access)
- Care Coordination Contract
- 1115 waiver renewal application
- Details of the 1115 Waiver and request for input

May 26, 2016, 9:00 AM – 4:00 PM
OHA Tribal Monthly Meeting
500 Summer Street NE, Room 137 A-D, Salem, Oregon
Facilitators: Tribal representative & Lynne Saxton

Agenda included 1115 waiver check-in, review of waiver details, and request for input

May 27, 2016, 9:00 AM – 4:00 PM
Tribal Consultation
SB 770 Quarterly Health & Human Services Cluster Meeting
350 Winter Street NE, Room 260, Salem, Oregon 97301
Labor & Industries Building (DCBS)
Also accessible via conference line

Agenda

- OHA Public Health
- 1115 waiver renewal update
- Care coordination update
- 1515 update
- Program update from Aging and People with Disabilities
- DCBS and Tribal Premium Sponsorship

June 15, 2016, 1:00 PM -4:00 PM
OHA Tribal Monthly Meeting
500 Summer Street NE, Salem, OR Human Services Building, Room 166
Also accessible via conference line

Agenda included discussion of care coordination, 100% FMAP, tribal priorities.

June 20, 2016, 9:00 AM – 4:00 PM
Tribal Consultation
500 Summer Street NE, Room 137 A-D, Salem, Oregon
Facilitators: Tribal representative & Lynne Saxton

Agenda

- Tribal Priorities (specialty care access)
- Care Coordination Contract (review final contract)
- 1115 Waiver Renewal Application
- 1915(i) waiver

- Details of the 1115 Waiver and request for input

Post Award Public Meeting:

Oregon's Post-Award Public Forum, December 11, 2012

# # #

Tribal Consultation Notices

Tribal consultation letter request for comments posted on waiver webpage 3/16/2016 and updated on 4/16/16 https://www.oregon.gov/oha/OHPB/Documents/request-for-comments.pdf. Hard copies of the letter were sent to the Tribes.

4/8/16 email from Karol Dixon, OHA Tribal Affairs Director, to Tribal Health Leaders
From: Dixon Karol L
Sent: Friday, April 08, 2016 12:05 PM
To: teemantm@burnspaiute-nsn.gov; IMontiel@ctclusi.org; vfaciane@ctclusi.org; kellelittle@coqulletribe.org; mstevenson@cowcreek.com; SStanphill@cowcreek.com; kelly.rowe@grandronde.org; tresa.mercier@grandronde.org; peggy.ollgaard@ihs.gov; rkfrost@klm.portland.ihs.gov; scott.powell@klm.portland.ihs.gov; narajam@aol.com; mwatkins@naranorthwest.org; jfinkbonner@npaihb.org; lgriggs@npaihb.org; lbird@npaihb.org; MarciM@ctsi.nsn.us; carol.prevost@ihs.gov; deborah.alvarez@ihs.gov; caroline.cruz@wstribes.org; SandraSampson@yellowhawk.org; LindaHettinga@yellowhawk.org; JimWallis@yellowhawk.org; TimGilbert@yellowhawk.org; rod049@yahoo.com; mingersoll@ctclusi.org; brendameade@coquilletribe.org; dlcourtney5431@msn.com; reyn.leno@grandronde.org; don.gentry@klamathtribes.com; dpigsley@msn.com; garyburke@ctuir.org; austin.greene@wstribes.org; jarvis.kennedy@burnspaiute-nsn.gov; justinquaempts@ctuir.org; cheryle.kennedy@grandronde.org; raymond.tsumpti@wstribes.org; dave.fullerton@grandronde.org
Cc: Saxton Lynne <LYNNE.SAXTON@dhsoha.state.or.us>; Coyner Lori A <LORI.A.COYNER@dhsoha.state.or.us>
Subject: Save the Dates, OHA Tribal Consultation & other OHA meetings

Tribal Health Leaders,

Please save the dates for the attached Tribal Consultation and OHA meeting schedule. The Health Cluster (770) includes DHS and DCBS, and is included on this list.

We are still nailing down dates for the OHA Tribal Monthly Meetings in April and June. An updated schedule will be sent when those dates are finalized. In the meantime, please note the May 5 and June 20 Tribal Consultation dates. As discussed in the 4/1 letter to Jackie Mercer and copied to all Tribes, OHA looks forward to a discussion on how to proceed with the Care

Coordination Contract, how to ensure specialty care access and the 1115 waiver renewal application. If you have any questions, please contact me.

4/28/16 email from Karol Dixon, OHA Tribal Affairs Director, to Tribal leaders

From: Dixon Karol L
Sent: Thursday, April 28, 2016 2:15 PM
To: teemantm@burnspaiute-nsn.gov; IMontiel@ctclusi.org; vfaciane@ctclusi.org; kellelittle@coquilletribe.org; mstevenson@cowcreek.com; SStanphill@cowcreek.com; kelly.rowe@grandronde.org; tresa.mercier@grandronde.org; peggy.ollgaard@ihs.gov; rkfrost@klm.portland.ihs.gov; scott.powell@klm.portland.ihs.gov; narajam@aol.com; mwatkins@naranorthwest.org; jfinkbonner@npaihb.org; lgriggs@npaihb.org; lbird@npaihb.org; DonBJr@ctsi.nsn.us; carol.prevost@ihs.gov; deborah.alvarez@ihs.gov; caroline.cruz@wstribes.org; michael.collins@wstribes.org; SandraSampson@yellowhawk.org; LindaHettinga@yellowhawk.org; JimWallis@yellowhawk.org; TimGilbert@yellowhawk.org; rod049@yahoo.com; mingersoll@ctclusi.org; brendameade@coquilletribe.org; dlcourtney5431@msn.com; reyn.leno@grandronde.org; don.gentry@klamathtribes.com; dpigsley@msn.com; garyburke@ctuir.org; austin.greene@wstribes.org; jarvis.kennedy@burnspaiute-nsn.gov; justinquaempts@ctuir.org; cheryle.kennedy@grandronde.org; raymond.tsumpti@wstribes.org; Lecatsas Allyson
Cc: Saxton Lynne; WESTFALL Margarit; Johnson Julie A; Coyner Lori A; Busek Rhonda J; Dixon Karol L
Subject: Please RSVP for the OHA Tribal Consultation 05.05.2016

For the Tribal Consultation next week…

To ensure we have lunch for everyone, please RSVP to Margarit Westfall, Margarit.WESTFALL@state.or.us, by Tuesday morning and let her know if you have any special requirements. I've added "voting buttons" to this message, so if you have Outlook you may be able to just hit "yes" or "no".

The draft agenda is copied here – please let me know if you have any suggestions, additions, etc. I'm gathering and creating the materials and will send it out in an email Monday. In addition, following a request from the meeting with THDs last week, OHA staff will provide brief summaries of each topic.

OHA Tribal Consultation
500 Summer Street NE, Room 137 A-D, Salem, Oregon
May 5, 2016, 9:00 AM – 4:00 PM
Facilitators: (any volunteers? tribal representative) & Lynne Saxton

Agenda

Blessing
Introductions – tribal leaders, tribes, state officials
Review agenda
Topics will have a brief background/summary of the issues provided in person

1. Tribal Priorities List (specialty care access)
- List will be distributed beforehand and available at meeting
- Review prioritization and adjust as needed

2. Care Coordination Contract
- OHA provide a summary of RFP and what is included

NOON: Working Lunch

3. 1115 waiver renewal Application..... Lori Coyner, State Medicaid Director
- Draft Tribal narrative distributed 04/25 & at 04/28 OHA meeting
- Draft application distributed 05/02
- Comments to OHA by 06/01/2016
- State to submit waiver renewal request to CMS on ~06/03/2016

6/13/16 and 6/17/16 emails from Karol Dixon, OHA Tribal Affairs Director, to Tribal leaders

From: Dixon Karol L
Sent: Friday, June 17, 2016 1:33 PM
To: rod049@yahoo.com; mingersoll@ctclusi.org; brendameade@coquilletribe.org; dlcourtney5431@msn.com; reyn.leno@grandronde.org; don.gentry@klamathtribes.com; dpigsley@msn.com; garyburke@ctuir.org; austin.greene@wstribes.org; jarvis.kennedy@burnspaiute-nsn.gov; justinquaempts@ctuir.org; cheryle.kennedy@grandronde.org; raymond.tsumpti@wstribes.org; umanion@gmail.com; teemantm@burnspaiute-nsn.gov; vfaciane@ctclusi.org; imontiel@ctclusi.org; kelly.rowe@grandronde.org; tresa.mercier@grandronde.org; DonBJr@ctsi.nsn.us; brendab@ctsi.nsn.us; dpigsley@msn.com; SandraSampson@yellowhawk.org; LindaHettinga@yellowhawk.org; JimWallis@yellowhawk.org; TimGilbert@yellowhawk.org; austin.greene@wstribes.org; caroline.cruz@wstribes.org; michael.collins@wstribes.org; deborah.alvarez@ihs.gov; carol.prevost@ihs.gov; brendameade@coquilletribe.org; kellelittle@coquilletribe.org; SStanphill@cowcreek.com; dcourtney@cowcreek.com; deberhardt@cowcreek.com; martha.decker-hall@klm.portland.ihs.gov; george.lopez@klamathtribes.com; rkfrost@klm.portland.ihs.gov; narajam@aol.com; mwatkins@naranorthwest.org; alecatsas@naranorthwest.org; sbonnell@naranorthwest.org; peggy.ollgaard@ihs.gov; Dean.Seyler@ihs.gov; jfinkbonner@npaihb.org; lgriggs@npaihb.org; lbird@npaihb.org; Laura.Herbison@ihs.gov; Judith.Adams@ihs.gov; Shana Radford
Cc: Saxton Lynne; Johnson Julie A; WESTFALL Margarit
Subject: RE: OHA Tribal Consultation 06.20.2016 - updated draft agenda
Attachments: OHA Tribal Consultation Agenda 06.20.2016 v6.docx; Tribal Priority List

Per discussion at the 6/15 Tribal monthly meeting, an updated Tribal Priority List is attached. A new column is timeline/deadline. A worksheet in the excel file was developed as option for Monday to determine the numbered priorities. Printed copies of both the list and the prioritization exercise will be available on Monday.

Discussions with Sandy added two items to the list:
Data from KEPRO on utilization by county
Traditional Health Workers / Peer Support Specialists

If there are other items to be added, please let me know.

From: Dixon Karol L
Sent: Monday, June 13, 2016 1:21 PM
Subject: OHA Tribal Consultation 06.20.2016 - updated draft agenda

Attached is an updated draft agenda for the Tribal Consultation for next Monday, June 20. Attached are two documents on Public Health Modernization. Other topics had attachments in the email Julie sent on Friday for the OHA Tribal Monthly Meeting. If you have any questions or suggestions, please let me know.

Tribal leader review of waiver language: 6/3/16 email from Karol Dixon, OHA Tribal Affairs Director, to Tribal leaders

From: Dixon Karol L
Sent: Friday, June 03, 2016 3:05 PM
To: teemantm@burnspaiute-nsn.gov; Vicki Faciane; Iliana Montiel; Kelly Rowe; Tresa Mercier; DonBJr@ctsi.nsn.us; brendameade@coquilletribe.org; dpigsley@msn.com; TimGilbert@yellowhawk.org; JimWallis@yellowhawk.org; LindaHettinga@yellowhawk.org; SandraSampson@yellowhawk.org; austin.greene@wstribes.org; caroline.cruz@wstribes.org; michael.collins@wstribes.org; deborah.alvarez@ihs.gov; brendameade@coquilletribe.org; kellelittle@coquilletribe.org; Sharon Stanphill - GO \ Health & Wellness Director; dcourtney@cowcreek.com; deborah.alvarez@ihs.gov; martha.decker-hall@klm.portland.ihs.gov; rkfrost@klm.portland.ihs.gov; Jackie; mwatkins@naranorthwest.org; alecatsas@naranorthwest.org; sbonnell@naranorthwest.org; peggy.ollgaard@ihs.gov; jfinkbonner@npaihb.org; Lisa Griggs; Laura Bird; Laura.Herbison@ihs.gov; rod049@yahoo.com; mingersoll@ctclusi.org; brendameade@coquilletribe.org; dlcourtney5431@msn.com; reyn.leno@grandronde.org; don.gentry@klamathtribes.com; dpigsley@msn.com; garyburke@ctuir.org; austin.greene@wstribes.org; jarvis.kennedy@burnspaiute-nsn.gov; justinquaempts@ctuir.org; cheryle.kennedy@grandronde.org; raymond.tsumpti@wstribes.org; umanion@gmail.com
Cc: Saxton Lynne; Coyner Lori A; STARR Janna
Subject: Oregon 1115 Waiver AI/AN language -- final review
Attachments: AIAN waiver with lb edits 6-2-16 to state.docx; AIAN waiver with lb edits 6-2-16 to state clean.docx

Tribal Health Leaders,
Following up from our meetings last week, a quick update and review of the 1115 waiver application https://www.oregon.gov/oha/healthplan/pages/waiver.aspx.

Attached is both a red line and a clean version of the AIAN section.

For retroactive eligibility, there is not a change. Oregon does provide 3 months retroactive eligibility and does not employ this "waiver". It was approved when we thought we might need it during ACA implementation, and we have chosen to keep it in the event we would need that exception again.

Regarding the SUD waiver, that is a separate application and will be discussed on 06/15 at the OHA Tribal monthly meeting, and again on 06/20 at the Tribal Consultation.

Please send any final comments for the 1115 wavier by noon on Tuesday

If there is an official representative from your Tribe that is not on this email, or if you have any questions, please let me know.

Appendix K: Stakeholder Survey and Public Comment Logs

Survey of Stakeholders on Oregon's Waiver Renewal

Summary

Stakeholders were asked to participate in a survey composed of seven questions to inform the Oregon Health Authority about key elements of the waiver. The survey included questions about overall support for the CCO model, housing support services, social determinants of health, opportunities to slow the growth in health care costs and care coordination for people who are dually eligible. The survey also asked respondents for any other feedback or suggestions. A total of 67 responses were received from named respondents

Methodology

The survey was shared via multiple channels. It was sent to OHA's Health System Transformation e-bulletin list, which includes stakeholders who have subscribed to OHA news over the years. It was forwarded by staff and stakeholders. Additionally, a link was posted to the Waiver Renewal Website and was mentioned in public forums.

Demographics

Respondents were required to enter their name and optionally asked their organization. Thirty-one respondents provided their organizational affiliation. Of those that provided a response their affiliation was with:

- 4 local governments
- 5 health systems/providers
- 9 Non-Profit Community Service Providers
- 1 CCO
- 2 CCO Community Advisory Councils
- 4 Consumer advocates
- 3 Provider associations
- 1 Advocacy organization
- 1 Health Plan

Question 1: Proposal to Continue the CCO Model

"Oregon's overall goal for this waiver is to continue the coordinated care model in Medicaid for another five-year period. Using the coordinated care model, individuals, their health plans and providers are able to focus on primary care, prevention and managing chronic conditions, which results in better health at lower costs. What do you think of the proposal to continue the coordinated care model for another five-year period?"

- 66 respondents
- 53 were supportive of continuing the CCO model
    - 9 out of those were conditionally supportive with conditions such as:
        - Increased accountability and transparency
        - Increased peer support
        - More support for food, housing and other social determinants of health
        - Increased expertise in the CCO model among OHA leadership
        - Increased use of performance metrics/stricter penalties
        - Continued partnership with Public Health, Area Associations on Aging
        - Use of data to drive expansion of the CCO model to other populations
        - Assurance that CCOs are non-profit entities
        - Stricter board membership
- 2 respondents disapproved of continuation
- 6 respondents did not indicate support or disapproval

Question 2: Improving Transitions of Care & Housing Support

"How would improving transitions of care and improving housing support and services help to improve health outcomes in your community?"

- 51 respondents
- 50 respondents wrote positively about housing support and transitions of care, one expressed concern that this was out of scope for CCOs
- 19 mentioned improvements to physical health outcomes
- 11 mentioned improvements in behavioral health outcomes
- 1 mentioned improvements in dental health outcomes
- 10 mentioned the importance of housing to social support and/or safety
- Other themes included reduction in health care costs, achievement of CCO metrics, contribution to Community Health Improvement Plan goals, reduction in involvement

with the justice system, and the need to utilize and strengthen community partnerships to implement transitions and housing programs.

Question 3: Suggestions for improving Social Determinants of Health

"Social determinants of health are socioeconomic conditions that have an important factor in an individual's health status. Do you have specific suggestions for improving social determinants of health in your community?"

54 total Respondents, who mentioned focusing on the following:

- Domestic Violence (3)
- Employment (4)
- Housing/Supportive Housing (12)
- Transportation (2)
- Education (3)
- Early Childhood services (3)
- Parks and Recreation (1)
- Public Health (2)
- Area Agencies on Aging (2)
- Increased access to addictions treatment/on-demand addictions treatment (3)
- Reimbursement for Traditional Health Workers/community health workers/Peers (4)
- Prevention of unintended pregnancy (2)
- "Prescriptions" for healthy food (4)
- Mobile primary care clinics/"doc in a box" (2)
- Alternative payment methodologies to pay for social services/partnership development and Care coordination by community partners (12)
- Adjust Durable Medical Equipment restrictions(1)

Question 4: Opportunities to slow growth in health care costs

"What are the biggest opportunities for slowing the growth in health care costs to achieve this goal, assuming we retain it in the next waiver?"

53 respondents, who mentioned focusing on the following:

- Coordinated care model (6)
- Prescription drugs (4)

- Investment in access to preventive medicine/primary care (11)
- Access to Mental Health Services (2)
- Tobacco prevention (1)
- Access to Addictions Treatment/on demand addictions treatment (3)
- Access to housing (2)
- Peer support (2)
- Reduce Emergency room use (6)
- Reduce unintended pregnancies (1)
- Address intimate partner violence (1)
- Expand partnerships with community based organizations (8)
- Treat cases of Hepatitis C virus in Oregon (1)
- Home-based palliative care (1)
- Combine CCOs/Local Public Health agencies (2)
- Single Payer Health Care (4)

Question 5: Better care coordination for Dually Eligible individuals

"Do you think this proposal will help provide better coordination of care for dually eligible individuals?"

56 Respondents:

- Yes: 37 respondents (66%)
- No: 5 respondents (9%)
- Not Sure: 14 respondents (25%)

Question 6: Suggestions for increasing access for dually eligible individuals

"Do you have other suggestions for ensuring dually eligible individuals have access to the coordinated care model?"

38 Respondents focused on themes of:

- Synchronization/alignment of Medicaid and Medicare providers and services
- CCOs must show their value first/Must prove they are stable first

- CCOs would need to serve older adults with as much skill as Medicare providers
- Access to behavioral health services needs to improve in Medicare
- Community Health Worker/Traditional Health Worker Outreach to engage this population

Question 7: Other feedback/suggestions

"Do you have any other feedback or suggestions for this waiver? Additionally, do you have any feedback or suggestions regarding advancing Oregon's health system transformation?"

38 Respondents focused on themes of:

- Gratitude for increased access to care in Oregon
- Integration of social services/community engagement
- Positive feedback re: care coordination for pre-adjudicated jail inmates, juveniles need same consideration
- Carving Pre/postnatal Home visiting out of global budget is appropriate
- Substance Use Disorder section needs to include recovery supported housing
- PEBB/OEBB should move into CCO model
- Need further consideration of rural hospitals
- Need more attention to DME
- Traditional Health Workers
- More transparency into CCO finances
- Focus on equity and inclusion
- Re-visit the prioritized list
- Focus on population health
- Disseminate information about learnings from this model more effectively (consider a searchable database)
- Consider one CCO for whole state

Public Comment Logs

High Level Topical Breakout of Waiver Comments

Quick View of the Numbers

Comments/ Questions by Group or Source	Number of Meetings or Commenters	Number of Comments
Tribal meetings/consultations	10	33
Public Meetings (MAC; OHPB) Oregon Health Policy Board Medical Advisory Committee	 2 2	 27 27
Other Meetings (various organizations and agencies)	69	59
Legislative Committee Meetings	4	12
Written	Written only	77
Letters of support	Written only	24
Online Survey	Online only	67
TOTAL	**87 - Meetings** **101 - Written** **67 - Survey**	**326**

Numbers of Comments/Questions by Topical/Area and Sub-Area

Total comments/questions by topic/area and sub-area	
Behavioral health integration; oral health integration; other service integration (e.g. TCM)	**27**
• Behavioral health	**20**
• Oral health	1
• Targeted case management	4
• Durable medical equipment	2
PCPCH, HIT, Transformation Center	**14**
• Transformation Center	9
• HIT	3
• PCPCH	2
Outcome-based metrics, value-based payments and incentives; evaluation	**30**
• Metrics and outcomes	20
• Incentives	6
• Cost	4
Social determinants; housing, homelessness, CHP Pilot; incarceration	**94**
• CHP eligible population	17
• CHP CCO roles	11
• CHP partners/diversity	18
• CHP and other new funding	10
• Hepatitis C	9
• Incarcerated individuals	5
• Domestic and sexual violence	13
• CHP Service Menu	11
Flexible – Health-related services; global budget; 2% test; sustainable growth rate	**59**
• Flexible Services-Health Related Services	34
• DSHP 2	2
• Funding and billing	18
• Savings	5
Dual eligibles; Long-Term Services and Supports (LTSS)	**16**
• LTSS integration into Transformation	9
• Dual eligible opt-out	5
• CHP participation	2
Equity; Traditional Health Workers (THWs)	**22**
• Equity	10
• THWs	12
Indian health care	**16**
• CHP	1
• STCs	1
• Contracting with CCOs	5
• UCCP	2
• 100% FMAP	3
• Other care coordination	1
• Other	3

Total comments/questions by topic/area and sub-area	
General Waiver	**48**
• Public process and endorsements	2
• General information about the demonstration	11
• STCs	1
• Prioritized list	2
• Ongoing policy and operations	8
• Letters of general support	24
Total comments	**326**

Presentations and Meetings							
Date	**Time**	**Meeting**	**Number in attendance**	**Presenting**	**Who was in attendance**	**Location/logistics**	**What was discussed (major themes and questions)**
5/29/2015	1:00 pm–4:00 pm	Oregon Hospital Performance Metrics Advisory Committee	13	Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff; Guest presenters	421 SW Oak St, Portland (Oak Room, first floor) and by phone/webinar	Hospital Transformation Performance Program
6/26/2015	1:00 pm–4:00 pm	Oregon Hospital Performance Metrics Advisory Committee	14	Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff; Guest presenters	Clackamas Community College – Wilsonville Training Center, Room 210, 29353 SW Town Center Loop East, Wilsonville, OR 97070 plus phone	Hospital Transformation Performance Program; 1115 demonstration and extension of the program
7/10/2015	1:00 pm–4:00 pm	Oregon Hospital Performance Metrics Advisory Committee	17	Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff; Guest presenters	421 SW Oak St, Portland (Oak Room, first floor) and by phone/webinar	Hospital Transformation Performance Program; 1115 demonstration and extension of the program
8/11/2015	10:00 am – Noon	Oregon Hospital Performance Metrics Advisory Committee	12	Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff; Guest presenters	Committee members and staff only - via webinar	Hospital Transformation Performance Program; 1115 demonstration and extension of the program
9/17/2015		WVCH, Bill Guest	1	Leslie Clement	WVCH CEO: Bill Guest		
9/21/2015		EOCCO, Robin Richardson and Sean Jessup	2	Leslie Clement	EOCCO: Robin Richardson and Sean Jessup	Code: 815-8922	
9/22/2015		Health Share, Janet Meyers	1	Leslie Clement	HSO CEO: Janet Meyers	Public, listen-only line*	
9/23/2015		Care Oregon, Erinn Fair Taylor	1	Leslie Clement	Care Oregon: Erinn Fair Taylor		
10/23/2015	1:00 pm–4:00 pm	Oregon Hospital Performance Metrics Advisory Committee	9	Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff	via webinar only	Hospital Transformation Performance Program; 1115 demonstration current program
11/20/2015	1:00 pm–4:00 pm	Oregon Hospital Performance Metrics Advisory Committee		Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff	Clackamas Community College – Wilsonville Training Center, Room 210; 29353 SW Town	Hospital Transformation Performance Program

						Center Loop East, Wilsonville, OR 97070	
11/24/2015	11:00 am	OAHHS	5	Lori Coyner	OAHHS Policy Committee, Lori Coyner	Phone	HTPP as part of waiver
12/7/2015	11:00 am	OAHHS	6	Lori Coyner	OAHHS Policy Committee, Lori Coyner	Phone	HTPP as part of waiver
12/17/2015	11:00 am	OAHHS	6	Lori Coyner	OAHHS Policy Committee, Lori Coyner	OAHHS Office	HTPP as part of waiver
12/17/2015	10:30 am – Noon	SUD Stakeholder Advisory	Approx. 25	Lori Coyner	SUD Advisory Council Members, State Staff	Salem -- HSB 137 + Webinar	How SUD systems improvement might fit with the 1115 Demonstration
12/18/2015	1:00 pm– 4:00 pm	Oregon Hospital Performance Metrics Advisory Committee	17	Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff; Guest presenters	Clackamas Community College – Wilsonville Training Center, Room 210; 29353 SW Town Center Loop East, Wilsonville, OR 97070	Hospital Transformation Performance Program
1/11/2016	2:30 pm– 4:30 pm	SUD Stakeholder Advisory	Approx. 25	Leslie Clement	SUD Advisory Council Members, State Staff	Salem -- HSB 137 + Webinar	Planning for 2017 SUD Amendment to 1115 Demonstration
1/13/2016		House HC		Lori Coyner, Sara Kleinschmit	Oregon's House Health Care Committee (legislators)	Salem; Legislature	
1/15/2016		OAHHS	6	Lori Coyner	OAHHS Policy Committee, Lori Coyner	Phone	HTPP as part of waiver
1/21/2016		Meeting with legislators	3	Lori Coyner, Optumas by phone, Manatt in person	Rep. Greenlick; Sen. Bates; Sen. Monnes-Anderson	By phone	Flexible services and global budget
1/21/2016	1:30 pm– 3:30 pm	Meeting with CCO CEOs	15–20	Lori Coyner, Optumas by phone, Manatt in person	CCO CEOs, Lori Coyner, Optumas and Mannat consultants	Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	Flexible services and global budget proposals for 1115 Demonstration
1/21/2016		Help C treatment in OHP patients		Lori Coyner, Jim Rickards, BethAnne Darby, Ann Murray			Darby, Coyner, Rickards, Murray re: Hep. C Treatment in Oregon Medicaid patients
1/22/2016	1:00 pm– 4:00 pm	Oregon Hospital Performance Metrics Advisory Committee	16	Lori Coyner, Sara Kleinschmit	Oregon Hospital Performance Metrics Advisory Committee;	Clackamas Community College – Wilsonville Training Center, Room 210; 29353 SW Town	

					OHA staff; OAHHS staff; Guest presenters	Center Loop East, Wilsonville, OR 97070	
1/29/2016	11:00 am	OAHHS	6	Lori Coyner	OAHHS Policy Committee, Lori Coyner	421 SW Oak St, Portland	Hospital Transformation Performance Program; 1115 demonstration
2/1/2016		House HC		Lori Coyner, Leslie Clement	Oregon's House Health Care Committee (legislators)	Salem; Legislature	Planning and assignments for 2017 SUD Amendment to 1115 Demonstration
2/8/2016	9:00 am–3:00 pm	CCO Quality and Health Outcomes Committee	Approx. 45	Lori Coyner	QHOC	Room 137 A-D Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	Overview of Waiver renewal
2/18/2016	1:30 pm–3:30 pm	Meeting with CCO CEOs	15–20	Lori Coyner	CEOs from all CCOs	Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	General waiver, dual-eligibles, housing, flexible services
2/26/2016	1:00 pm–2:00 pm	Oregon Hospital Performance Metrics Advisory Committee	17	Lori Coyner, Sarah Bartelmann	Oregon Hospital Performance Metrics Advisory Committee; OHA staff; OAHHS staff; Guest presenters	Clackamas Community College – Wilsonville Training Center, Room 210; 29353 SW Town Center Loop East, Wilsonville, OR 97070	Hospital Transformation Performance Program; 1115 demonstration
2/29/2016	3:00 pm–4:30 pm	SUD Stakeholder Advisory	Approx. 25	Karen Wheeler	SUD Advisory Council Members, State Staff	Salem - HSB 137 + Webinar	Planning and assignments for 2017 SUD Amendment to 1115 Demonstration
2/9/2016	9:00 am–2:30 pm	QHOC	Approx. 45	Sarah Bartelmann	Quality and Health Outcomes Committee	Salem - HSB 137 and via phone	1115 demonstration metrics and incentive measures
3/10/2016	11:00 am	OAHHS	6	Lori Coyner	OAHHS Policy Committee, Lori Coyner	421 SW Oak St, Portland	HTPP as part of waiver
3/17/2016	1:30 pm–3:30 pm	Meeting with CCO CEOs	15–20	Lori Coyner	CEO from all CCOs	Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	General waiver, dual-eligibles, housing
3/18/2016	11:00 am – Noon	Rates workgroup	Approx. 20	Lori Coyner	CCO representatives; State staff	421 SW Oak St, Portland	Flexible services and global budget
3/24/2016		Cascade Aids Project staff	3	Lori Coyner	Meet with Tyler TerMeer & Peter Parisot of Cascade AIDS Project		Waiver input, general

3/28/2016	3:00 pm–4:30 pm	SUD Stakeholder Advisory	Approx. 25	Karen Wheeler	SUD Advisory Council Members, State Staff	Salem - HSB 137 + Webinar	Planning and assignments for 2017 SUD Amendment to 1115 Demonstration
3/28/2016		OBA Health Policy Committee		Jeremy Vandehey			Waiver - generally
3/30/2016	11:00 am – Noon	Tribal Roundtable	Approx. 20	Lori Coyner, Karol Dixon	Tribal and Urban Health representatives and Health Directors; OHA staff	Salem - HSB 473 + Webinar	Overview of Waiver renewal; social determinants of health; tribal care coordination
4/4/2016	11:00 am –Noon	Tribal Roundtable	Approx. 10	Lori Coyner, Leslie Clement, Karol Dixon	Tribal and Urban Health representatives and Health Directors; OHA staff; Governor's office staff	Salem - HSB 473 + Webinar	Overview of Waiver renewal; social determinants of health; tribal care coordination; tribal contracting opportunities and CCO coordination
4/5/2016	8:30 am–Noon	Oregon Health Policy Board	25 signed in, in-person (40 in attendance); 2 on the host line; 7+ on participant call-in line; 70+ clicks on the Web stream	Lori Coyner, Leslie Clement,	Oregon Health Policy Board; general public	OHSU Center for Health & Healing 3303 SW Bond Ave, 3rd floor Rm. #4; and by phone and live stream	Overview of 1115 renewal proposal. focusing on social determinants of health and OHA draft proposals for addressing supportive housing needs statewide
4/6/2016	3:00 pm–4:00 pm	Medicaid Advisory Committee Meeting	Approx. 25	Lori Coyner	Medicaid Advisory Committee; general public	Human Services Building; Room 137 D; Salem and via webinar for members and phone for public	Overview of 1115 renewal proposal. focusing on continuation of integration under Transformation and social determinants of health
4/6/2016	9 am	Central City Concern	6	Leslie Clement, Oliver Droppers	Central City Concern leadership	At their main office-Portland	Key components of the waiver
4/8/2016	10:00 am – 11:00 am	Tribal Roundtable	Approx. 20	Lori Coyner, Karol Dixonl	Tribal and Urban Health representatives and Health Directors; OHA staff	Salem - HSB 473 + Webinar	N
4/11/2016	2:00 pm–3:00 pm	CCO Behavioral Health Directors	Approx. 20	Mike Morris	CCO BH Directors; state staff	Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	Behavioral health sections of waiver; supportive of concepts; suggested language in the WrapAround and ACT codes for care coordination.

4/13/2016	2:00 pm–4:00 pm	Oregon Consumer Advisory Council	Approx. 20	Mike Morris	Oregon Consumer Advisory Council; state staff	Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	Behavioral health concepts; enthusiastic about concepts and strongly recommend that peer support specialists be a provider type to provide the services included in those concepts.
4/14/2016	9:00 am	Oregon Health Leadership Council		Jeremy Vandehey, Leslie Clement, Lynne Saxton			Overview, waiver presentation, status
4/18/2016	3:45 pm	NPAIHB-Board Meeting	Approx. 20	Karol Dixon	Tribal Health Directors	NPAIHB (Meeting in Lewiston, ID)	Overview, waiver renewal
4/20/2016		OBC Health Leadership Council		Jeremey Vandehey, Lynne Saxton			Waiver
4/21/2016	12:30 pm –2:30 pm	Meeting with CCO CEOs	15–20	Lori Coyner	CEO from all CCOs	Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	General waiver, dual-eligibles, housing, flexible services
4/22/2106	9:00 am–Noon	Metrics and Scoring Committee	15–20	Lori Coyner, Sarah Bartelmann	Metrics and Scoring Committee (9 members) and public	Clackamas Community College, Wilsonville, OR and phone	Waiver and quality pool incentives program including metrics
4/22/2106	1:00 pm–3:00 pm	Hospital Performance Metrics Advisory Committee	15–20	Lori Coyner, Sarah Bartelmann	Hospital Metrics Advisory Committee (9 members) and public	Clackamas Community College, Wilsonville, OR and phone	Waiver and HTPP incentive program including metrics
4/24/2016	10:00 am – 11:00 am	Meeting with Cascade AIDS Project	3	Lori Coyner	Tyler TerMeer, Pater Parisot, Lori Coyner	421 SW Oak St. Suite 875: Lincoln Building	Waiver renewal and Housing proposal. Organization interested in participating in Housing advisory
4/25/2016	2:30 pm–4:30 pm	SUD Stakeholder Advisory	30	Karen Wheeler	SUD Stakeholder Advisory; State staff	Salem - HSB 352 and via phone	SUD amendment planning and 1115 Renewal timelines for comment
4/25/2016		OBA meeting		Jeremy			
4/25/2016		Quality Health Outcomes Committee	40	Lori Coyner	CCO Medical Directors	Salem and phone	General waiver and public comment timeline
4/26/2016	1:00 pm–3:00 pm	Ombuds Advisory Council		Janna Starr	Ombuds Advisory Committee; general public	Salem - HSB 160 and via phone	General waiver, dual-eligibles, housing, flexible services

4/27/2016	9:00 am–Noon	Medicaid Advisory Committee Meeting		Lori Coyner	MAC	Oregon State Library, Room 102/103; and via webinar	Request for letter of support from MAC
4/27/2016		OAHHS		Jeremy Vandehey			
4/28/2016	4:00 pm–5:00 pm	Tribal Roundtable	Approx. 25	Lori Coyner, Karol Dixon	Tribal representatives, Indian Health Service and Urban Indian Providers, State staff	Human Services Bldg. 500 Summer St. NE, Salem, Oregon; and via phone	Overview of waiver, questions and discussions from previous meetings, CHP Pilots
4/28/2016		Association of Community Mental Health Programs		Mike Morris			Behavioral health concepts
4/28/2106		CareOregon		Lori Coyner	CCO CEO	Phone	Flexible services, CHP, Value-based payments, behavioral health
4/29/2016	10:30 am	Association of Oregon Counties, Housing Committee		Lori Coyner	AOC Housing Committee Members	AOC-1201 Court St., Salem, OR	Coordinated Health Partnerships (CHP) housing supportive services pilot proposal in the waiver request.
4/29/2016		WVCH CCO		Lori Coyner	CCO CEO	Phone	Flexible services, MLR
4/29/2016		Eastern Oregon CCO		Lori Coyner	CCO CEO	Phone	Flexible services, MLR, value based payments, primary care, CHP
4/29/2106		HealthShare of Oregon		Lori Coyner	CCO CEO	Phone	Sustainable rate of growth, flexible services, CHP, behavioral health
5/2/2016		Meeting with legislator		Jeremy Vandehey			
5/3/2016		OHLC meeting		Jeremy Vandehey			
5/3/2016		WOAH CCO		Lori Coyner	CCO CEO	Phone	HIT, CHP, flexible services, sustainable rate of growth
5/3/2016		OHPB meeting		Lori Coyner			
5/3/2016		AOCMHP		Jeremy Vandehey			
5/4/2016		NGA check-in		Jeremy Vandehey, Lori Coyner			
5/4/2016	2:00 pm	HSCO meeting	Approx. 35	Lori Coyner, Jeremy Vandehey	HSCO Members, Sen. Monnes-Anderson, Governor's Office, state staff	HSCO -11740 SW 68th Pkwy. Portland, OR 97223	Demonstration renewal, funding, CHP Pilots, dual eligibles
5/5/2016	9:00 am–4:00 pm	Tribal Consultation	Approx. 40	Lori Coyner, Jeremy Vandehey	Tribal representatives, Indian Health Service and Urban Indian Providers,	Human Services Bldg. 500 Summer St. NE,	Demonstration renewal and its impact on native peoples-UCCP, CHP Pilots, care coordination,

					Indian Health Service federal staff, Governor's Office, State staff	Salem, Oregon; and via phone	Tribal consultation, CCO relationships, etc.
5/6/2016		JCC meeting		Jeremy Vandehey			
5/19/2016		CCO CEO meeting		Lori Coyner			
5/19/2016		Coalition of Local Health Officials		Veronica Guerra, Cate Wilcox, Jeston Black	Counties		Targeted Case Management in waiver
5/23/2016		Senate HC		Lori Coyner			
5/24/2016		House HC		Lori Coyner			
5/24/2016		OHCS Housing subcommittee		Lori Coyner	Presented with Kenny LaPoint, Oregon Housing and Community Services Department and Amanda Saul, Enterprise Community Partners		Housing and CHP
5/23/2016		Full e-board		Lori Coyner			
5/25/2016		Medicaid Advisory Committee		Veronica Guerra; Oliver Droppers			
5/26/2016		Tribal Monthly meeting		Lori Coyner, Karol Dixon	Tribal members		Language in waiver, 100% FMAP, contracting with CCOs
5/27/2016		Tribal 770 Meeting		Lori Coyner, Karol Dixon, Lynne Saxton	Tribal members, DHS agency, public health		Waiver update and public comment period, language in waiver regarding tribal issues.
5/31/2016		Ombuds Advisory Council		Veronica Guerra			Waiver renewal update
5/31/2016		Oregon Primary Care Association		Lori Coyner	OPCA staff and Exec Dir		Social determinants of health, CHP, risk adjusting, value base payment in primary care, rural health
5/31/2016	3:00 pm	OPCA		Lori Coyner			
6/15/2016		Tribal Monthly meeting	15-20	Lori Coyner, Karol Dixon	Tribal members		100% FMAP, CHP moving forward
6/20/2016		Tribal Consultation	20-30	Lori Coyner, Karol Dixon, Lynne Saxton	Tribal members		waiver update

Public and Tribal Meetings: Comments and Questions

Question or comment	Response
March 30, 2016 - Tribal Workgroup/Roundtable	
Outcome based metrics, value-based payments and incentives; evaluation	
1. Will CCOs still be receiving incentive payments under the renewal?	The state plans to continue the CCO incentive program with an expanded focus on outcome metrics. See pages 22-24 and Appendix C for additional information.
Tribal and Native health care - general	
2. Will the Special Terms and Conditions (STC) revisions proposed by Tribes in 2015 be included in the new waiver?	OHA walked through the proposed STCs with tribes during numerous meeting and consultations. Tribal representatives provided edits which were incorporated in final language. See pages 42-44 of waiver proposal.
April 4, 2016 - Tribal Roundtable	
Tribal and Native health care - CCOs	
3. There are 36,000 AI/AN individuals with the HNA designation in the MMIS system and 52% are in CCOs.	N/A: comment only.
4. In Coos & Curry Counties, the Tribes have been working with the CCO for years, and 3-4 years ago Tribes collaborated to train CCOs	N/A: comment only.
5. Will contracting with CCOs be easier for Indian health providers and clinics?	The state will facilitate this process, including developing appropriate contracting forms and addenda. OHA walked through the proposed STCs and waiver narrative with tribes at numerous meetings and consultations. Tribal representatives provided edits which were incorporated into final waiver language.
Tribal and Native health care – Care coordination	
6. Will Indian care coordination be part of the waiver?	OHA walked through the proposed STCs and waiver narrative with tribes during numerous meetings and consultations. Tribal representatives provided edits which were incorporated into final waiver language. The waiver addresses the state's support and intention to work with the AI/AN population on all of the care coordination options. See pages 42-44.
General waiver	
7. Does the waiver just apply to CCOs, or FFS, too?	The waiver primarily applies to managed care and CCOs; however, tribal health issues are included in the waiver narrative and proposed STCs. The Prioritized List of Health Services, which is a standing waiver component, applies to FFS and CCOs.

April 8, 2016 - Tribal Roundtable	
Tribal and Native health care – CCOs	
8. Will Indian individuals still be exempt from required enrollment in CCOs?	The state is asking for those eligible for both Medicare and Medicaid, dual eligibles, to be mandatorily enrolled under the renewal, but this will not include AI/ANs or AI/AN dual eligibles.
9. Will OHA require CCOs to contract with tribal clinics and use the "Indian Addendum?	OHA intends to require CCOs to contract with I/T/Us and negotiate in good faith, and will look at using a version of the addendum. OHA walked through the proposed waiver language with tribes during numerous meetings and consultations. Tribal representatives provided edits which were incorporated into final waiver language. See pages 42-44.
Tribal and Native health care – Care coordination	
10. The state should consider agreements through an IGT with IHS for care coordination under the new CMS guidance for 100% FMAP	As a result of engagement with tribes, care coordination principles have been included in the waiver (see pages 42-44). Care coordination will be more fully addressed in STCs, in development. The specific methodology is not a waiver-specific issue and will be addressed operationally.
Tribal and Native health care – 100% FMAP for Referred Services	
11. Does 100% FMAP for referred services apply to Long-term services and Supports (LTSS)	The 100% FMAP applies to LTSS as long as provided by or referred through IHS or Tribal Health entities. This is not a waiver-specific issue (will be addressed operationally) but OHA will work with tribes on 100% FMAP decisions and implementation.
12. Does 100% FMAP for referred services apply to Non-emergency medical transportation (NEMT)?	The 100% FMAP applies to non-emergency medical transportation as long as provided by or referred through IHS or Tribal Health entities. This is not a waiver-specific issue but OHA will work with tribes on 100% FMAP decisions and implementation. To be addressed operationally.
Tribal and Native health care – Uncompensated Care (UCCP)	
13. Will UCCP go forward in the waiver?	UCCP is addressed in the waiver request and will continue going forward. See pages 42-44.
14. Will the UCCP payment system be improved (administratively burdensome now)?	Authority and methodology addressed in request (see pages 42-44). Other issues to be addressed operationally. New staff will be in place at OHA to assist with this effort.

April 28, 2016 - Tribal Roundtable	
Tribal and Native health care – CCOs	
15. Will Tribal members be moved to opt-out enrollment?	AI/AN individuals will continue to be exempt from auto-enrollment in CCOs and be allowed to opt in or out of CCOs.
16. The Transformation Center has been available to provide TA to CCOs but not to Tribal health entities. Why?	The Transformation Center has not reached out to the Tribes for learning collaboratives. Will expand to include tribes including as part of Coordinated Health Partnership pilots.
17. If the Tribes had formed their own CCO like they had wanted to, they would have had access to the Transformation Center, right? Still they would like to be included in these opportunities without having to go through a CCO.	This is not a waiver-specific issue and will be addressed operationally.
Outcome-based Metrics, Value-based payments and Incentives; Evaluation	
18. Maybe we should put GPRA measures in place in the STCs with respect to Tribes and the Transformation Center.	OHA will take this recommendation into consideration as the STCs are developed.
Social determinants; Housing, homelessness, Coordinated Health Partnership Pilots, Incarceration	
19. Is there a targeted population for the CHP?	OHA has defined the CHP target population as those with repeated incidents of avoidable emergency use or hospital admissions; two or more chronic conditions; mental health and/or substance use disorders; currently experiencing homelessness; and/or individuals who are at risk of homelessness, including low-income seniors eligible for Medicare and Medicaid, and Indian Health Services (IHS), Tribal, and Urban Indian program constituents; and, individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail). The population will be further refined during discussions with CMS, local CHP needs, and from recommendations from a CHP advisory committee.
20. Will CHP dollars flow only to the CCOs?	OHA is requesting federal funding to support and develop CHPs. CCOs will receive the funding but will be required to distribute some portion of the funding to CHP partners. As a result of tribal engagement, tribes were added as a potential lead entity for CHPs. See pages 33-34.
21. How can we pay for the CHP pilots, which are voluntary, and keep having savings?	We expect the CHP pilots to contribute to savings by helping people avoid more expensive hospitalizations and other services due to housing instability.
22. Regarding the CHP pilots, what about smaller rural communities where there is no available housing?	OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. Will be further addressed by CHP advisory committee and through community partnerships.

23. We should add additional partners, like Habitat for Humanity, and look into grants that might get actual housing in place. Services and housing need to go hand-in-hand.	OHA will address this with the CHP advisory committee and at the local CHP level.
General Waiver	
24. Will the 1915 waivers and plans still be in place? Don't they do these supportive housing services?	Request takes into consideration existing 1915 plans and seeks to coordinate and ensure, on an individual basis, non-duplication of services among the 1915 waivers and plans and the 1115 demonstration. The 1915 waivers and plans will remain in place and do provide some supportive housing services, but they are often limited. We want to offer these services under the 1115 demonstration in order to serve a broader population than served under 1915 waivers.
May 5, 2016 - Tribal Consultation	
Tribal and Native health care – CCOs	
25. We are saying the waiver narrative that we will require CCOs to "offer" contracts to I/T/Us. "Offer" is not a strong enough term, as it does not imply completion of a contract.	Tribes provided specific language that was incorporated in the waiver narrative.
26. Also with respect to contracts, there should be timelines and a resolution pathway.	Agreed, this may not be language that can be included in the waiver itself, but these principles will be included as procedures are developed. OHA will collaborate with I/T/U partners to more fully address.
27. Do providers who provide services under a CCO have to provide services for any Medicaid-eligible person? (Lack of Tribal FFS access)	Access issues are addressed throughout the waiver renewal application and will continue to be addressed operationally.
Behavioral Health Integration; Oral Health integration; other service integration (e.g. TCM)	
28. Are we considering the new IMD flexibility that is in the Final Managed Care Rule from CMS?	OHA is seeking flexibility to provide a level of care coordination to our IMD residents in Oregon as part of the CHP homelessness prevention and care transitions domain. Additionally, OHA is currently working to develop an SUD waiver that addresses IMD services.
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
29. Will Tribes have an opportunity to take the lead in any of the CHPs?	Based on tribal feedback and consultation, tribes have been included as potential leads for the CHP. See pages 33-34.
Flexible – Health-related Services; Global Budget; 2% test; Sustainable growth rate	
30. Is there any way to bill flexible services under Fee-for-Service?	OHA will investigate the potential tribal IGT to help fund health related services. This particular issue would not require waiver authority.
31. Flexible services are very good for diabetes treatment, per the results of a grant project at NARA. Would be good to get funding to continue this project, as the funding has run out.	OHA will investigate the potential tribal IGT to help fund health related services. This particular issue would not require waiver authority.

Dual Eligibles; Long-term Services and Supports (LTSS)	
32. Will Long-Term Services and Supports (LTSS) be addressed in the waiver, and if not, we should start discussing it for the future.	LTSS are not directly addressed in the waiver renewal.
General waiver	
33. Do providers who provide services under a CCO have to provide services for any Medicaid-eligible person? (Lack of Tribal FFS access)	Access issues to be addressed throughout the waiver renewal application, as well as operationally.
April 5, 2016 - Oregon Health Policy Board	
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
34. Given the Counties' and Cities' experience with supported housing services, why are CCOs targeted as lead agencies for the project?	Under the waiver, CCOs are the delivery system for the vast majority of Oregon Health Plan members. However, CHPs will be required to engage local county agencies in the pilots as described in application.
35. Can't these types of Housing supportive services already be provided by CCOs?	These services can be provided through use of health-related (flexible) services. However, additional financial support and focus is needed to deepen the efforts to engage the larger community to support high risk CCO members.
36. There are many incarcerated individuals at risk of homelessness. Around the country, 50% of incarcerated individuals have high needs and no social supports.	The state is requesting of CMS to approve the provision of care coordination services for those who are pre-adjudicated during an initial 30-day period of incarceration.
37. The OHPB took a vote to affirm the Housing and Health direction taken by OHA and the waiver renewal request	N/A: action only.
38. Concern expressed about Hepatitis C patients with HIV not getting needs met under new CMS guidance	OHA is currently undertaking several efforts to address hepatitis C treatment. These efforts include the following: • OHA requested Coordinated Care Organizations' (CCOs) hepatitis C treatment coverage criteria in February 2016. • Receipt, compilation and analysis of CCOs hepatitis C treatment coverage criteria was completed in April 2016 by OHA. • OHA is currently working with CCOs to align coverage criteria with the Fee-For- Service population criteria in response to CMS letter 172. • Oregon's Pharmacy and Therapeutics Committee is scheduled to review hepatitis C in September 2016 • The Medicaid Advisory Committee will have a stakeholder subcommittee to address HepC drug access and treatment issues.

Outcome-based Metrics, Value-based payments and Incentives; Evaluation	
39. Current (OHSU) evaluations of Transformation and coordinated care showing cost is down 15 percent more than in the commercial market; quality and incentive measures show improvement statewide.	N/A: comment only.
40. Challenge to CCOs: Rate-setting methodologies that do not support moving away from counting widgets to paying for quality. Suggest we stay with our innovations in payment while respecting CMS' needs for counting things.	N/A: comment only.
Equity; Traditional Health Workers (THWs)	
41. Is the use of Community Health Workers (CHWs) targeted for improvement in the new waiver?	OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission. See pages 46-47 for more information.
May 3, 2016 - Oregon Health Policy Board	
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
42. Regarding Coordinated Health Partnerships (CHP) – You said Medicaid dollars cannot be used for capital construction. We had heard there were four other states using Medicaid in that way.	Although Medicaid does not allow federal dollars to be used for capital investments, OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. This modification was made as a result of public comment (see page 34).
43. Could a CCO theoretically invest in capital construction without using Medicaid funding?	A CCO could invest in capital construction without using Medicaid funding.
44. Is OHA collaborating with the state housing authority?	OHA is collaborating with the state housing authority as addressed in the waiver request.
45. Oregon Coalition on Domestic and Sexual Violence (28 non-profit organizations): One of the greatest social determinants of health is domestic and sexual violence, and Oregon has one in ten incidence of sexual assault against women.	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal. CHPs will have the ability to clearly define the populations they would like to target based on regional needs that could include sexual violence victims. See pages 28-29.
Social determinants; Hepatitis C; HIV/AIDS	
46. Hepatitis C: Ambassador Project (education and advocacy project for those with Hepatitis C and Lung Cancer): Those with Hepatitis C are being denied care by CCOs. There are 95,000 people with Hepatitis C in Oregon, 18,000 of them depending on the waiver and 60 percent have a behavioral health issue.	Not a waiver-specific issue at this time. OHA is currently undertaking several efforts to address hepatitis C treatment. These efforts include the following: • OHA requested Coordinated Care Organizations' (CCOs) hepatitis C treatment coverage criteria in February 2016.

		• Receipt, compilation and analysis of CCOs hepatitis C treatment coverage criteria was completed in April 2016 by OHA. • OHA is currently working with CCOs to align coverage criteria with the Fee-For- Service population criteria in response to CMS letter 172. • Oregon's Pharmacy and Therapeutics Committee is scheduled to review hepatitis C in September 2016. • The Medicaid Advisory Committee will have a stakeholder subcommittee to address hepatitis C drug access and treatment issues.
47.	Hepatitis C: OHSU-Infectious Diseases, AIDS Integrated System of Care: In dealing with Hepatitis C, we can learn from AIDS about screening and ongoing care. We should also be looking at other states. OHSU is looking at other models.	Not a waiver-specific issue at this time. OHA is currently undertaking several efforts to address hepatitis C treatment. These efforts include the following: • OHA requested Coordinated Care Organizations' (CCOs) hepatitis C treatment coverage criteria in February 2016. • Receipt, compilation and analysis of CCOs hepatitis C treatment coverage criteria was completed in April 2016 by OHA. • OHA is currently working with CCOs to align coverage criteria with the Fee-For- Service population criteria in response to CMS letter 172. • Oregon's Pharmacy and Therapeutics Committee is scheduled to review hepatitis C in September 2016.
48.	Hepatitis C treatment parallels our Behavioral Health treatment in the waiver. It has just been in the past few years that effective treatment has become available, but individuals still cannot get it if they are not severe enough.	Not a waiver-specific issue at this time. OHA is currently undertaking several efforts to address hepatitis C treatment. These efforts include the following: • OHA requested Coordinated Care Organizations' (CCOs) hepatitis C treatment coverage criteria in February 2016. • Receipt, compilation and analysis of CCOs hepatitis C treatment coverage criteria was completed in April 2016 by OHA. • OHA is currently working with CCOs to align coverage criteria with the Fee-For- Service population criteria in response to CMS letter 172. • Oregon's Pharmacy and Therapeutics Committee is scheduled to review hepatitis C in September 2016. • The Medicaid Advisory Committee will have a stakeholder subcommittee to address hepatitis C drug access and treatment issues.
49.	Hepatitis C People are being hurt. Oregon has 2 times the infection rate from liver disease as the rest of the country. No attention is being paid. CMS needs to establish a standard of care and treatment without using the excuse of cost. "We have a conflagration and can't afford a fire hose."	Not a waiver-specific issue at this time. OHA is currently undertaking several efforts to address hepatitis C treatment. These efforts include the following: • OHA requested Coordinated Care Organizations' (CCOs) hepatitis C treatment coverage criteria in February 2016. • Receipt, compilation and analysis of CCOs hepatitis C treatment coverage criteria was completed in April 2016 by OHA. • OHA is currently working with CCOs to align coverage criteria with the Fee-For- Service population criteria in response to CMS letter 172.

	• Oregon's Pharmacy and Therapeutics Committee is scheduled to review hepatitis C in September 2016. • The Medicaid Advisory Committee will have a stakeholder subcommittee to address hepatitis C drug access and treatment issues.
50. HIV/AIDS Hepatitis C organization: There is a great need for co-treatment of HIV/AIDS and Hepatitis C. 21 percent of people infected with HIV are co-infected with Hepatitis C, and these people have a 50 percent greater mortality than those who are not co-infected.	Not a waiver-specific issue at this time. OHA is currently undertaking several efforts to address hepatitis C treatment. These efforts include the following: • OHA requested Coordinated Care Organizations' (CCOs) hepatitis C treatment coverage criteria in February 2016. • Receipt, compilation and analysis of CCOs hepatitis C treatment coverage criteria was completed in April 2016 by OHA. • OHA is currently working with CCOs to align coverage criteria with the Fee-For- Service population criteria in response to CMS letter 172. • Oregon's Pharmacy and Therapeutics Committee is scheduled to review hepatitis C in September 2016. • The Medicaid Advisory Committee will have a stakeholder subcommittee to address hepatitis C drug access and treatment issues.
Flexible – Health-related Services; Global Budget; 2% test; Sustainable growth rate	
51. Flexible services are a challenge due to the lack of billing codes.	With the waiver renewal, we are planning to have 3 "buckets" of expenditures: 1) medical encounters and claims, 2) health-related services, and 3) administrative costs. Health-related services will be included in developing the medical portion of the CCO global budgets. CCO financial templates will be further refined to capture health related services with input from OHA finance, OHA actuaries, CCOs and CMS.
PCPCH, HIT, Transformation Center	
52. Will the Transformation Center still be providing learning opportunities and technical assistance to CCOs?	The Transformation Center will continue to provide technical assistance and will take steps toward more focused TA, prioritizing the highest needs of CCOs in the waiver renewal period.
53. Yamhill County CCO is a good example where the Transformation Center grant was a great help.	N/A: comment only.
Outcome-based Metrics, Value-based payments and Incentives; Evaluation	
54. Will the state use MLR calculations to allow possible reinvestments?	OHA proposes to implement a reinvestment requirement that could involve a MLR standard of 88% with a tiered risk corridor of 3%. Those with an MLR below the 3% corridor (i.e., below 85%) must remit to the State the difference between their MLR and 85%. Those with an MLR within the 3% corridor (i.e., between 85% and 88%) may be eligible to retain some or all of the difference between their MLR and the 88% as long as it is reinvested in cost-effective health-related services.

55. Has OHA discussed the MLR with the Insurance Division?	OHA has not specifically involved the insurance division in the development of the MLR guidance. However, OHA has included guidance from federal regulation, CMS, and an audit by Office of Inspector General. Additionally, OHA does monitor CCO solvency.
56. Hepatitis C: Quality measures should be included around Hepatitis C	The Metrics and Scoring Committee has statuary authority to establish CCO incentive metrics. Metrics and Scoring Committee meetings are public and public testimony on metrics is welcome. Additional quality metrics for which OHA is accountable are established through negotiation with CMS.
Equity; Traditional Health Workers (THWs)	
57. CCOs have not been active partners in using Traditional Health Workers (THWs) to help address these domestic and sexual violence issues, leaving it to private and outside funding.	OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission.
General waiver	
58. Oregon Law Center: Supportive of the CHP efforts as well as the continuation and focus of the Transformation Center. Looks forward to discussing the changes for dual eligibles.	N/A: comment only.
59. Concern about the Prioritized List –"creaking with age". The funding line continues to go down. EPSDT treatment is outside the list, and there are co-morbidity issues. It may be time to look at "medical necessity" as the standard.	To support Health System Transformation, OHA will continue to maintain current language that restricts coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one.
60. We need better coordination between OHA as the single state Medicaid agency and DHS and other state agencies involved with Medicaid and CHIP clients.	Ongoing coordination and collaboration supported by the waiver request.
April 6, 2016 - Medicaid Advisory Committee	
Behavioral Health Integration; Oral Health integration; other service integration (e.g. TCM)	
61. Suggests adding some specification in the waiver around the expansion of oral health access.	OHA is interested in further thoughts from the Medicaid Advisory Committee about oral health access. Will be further addressed operationally and in planning.
62. What is OHA looking for in terms of outcomes from the partnership with the Oregon Early Learning Council (ELC) to provide in-home nurse visits? Does this affect discussions around the integration of Maternal Case Management and Targeted case Management?	OHA will partner with Public Health and counties to expand access to nurse home visiting programs and improve access to early intervention services that can improve health outcomes and social-emotional well-being for at-risk families and children from prenatal to age five. OHA is requesting to continue to carve out TCM services from the CCO global budget. Oregon plans to continue to convene the existing workgroup to develop strategies to coordinate TCM services with other CCO provided services.
63. Will there be any improvements in access to hearing, vision or other devices with this waiver renewal?	At this time, these particular issues have not been included in the waiver renewal.

Outcome-based Metrics, Value-based payments and Incentives; Evaluation	
64. Given the expanded definition of flexible services under the term "health-related services", and given the increased emphasis on the social determinants of health, increasing health equity, and fully integrating behavioral health care, what are the strategies for accomplishing those goals and what incentive targets and metrics will be used to measure success?	We are working to expand, improve and identify the appropriate incentives, outcomes and metrics that will enhance both the CCOs' ability to effectively provide flexible services and the state's ability to evaluate and continually improve the strategy.
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
65. Can you talk more about what the housing piece would look like in terms of using Medicaid funding for housing for members?	The state is looking at what we might be able to offer through Medicaid to support people in getting and keeping a place to live, in order to contribute to their overall health and help them avoid acute care needs and hospital stays. We cannot provide outright rent or funds for housing purchase, but we hope to support services that will help individuals to find and keep housing, such as case management and peer counseling. CCOs can also provide housing services as Flexible Services.
66. Will the definition of care coordination be changed under the waiver renewal?	We are interested in expanding the concept and usage of care coordination principles to address individuals in transition to and maintaining residence in community housing in order to help them avoid health problems from housing insecurity. No change to existing case management or care coordination services are being proposed in the waiver renewal.
67. There is interest in knowing the extent of collaboration with the Department of Corrections.	OHA was working closely with other state agencies and partners to develop the Coordinated Health Partnership proposal.
68. Will there be any improvements in access to hearing, vision or other devices with this waiver renewal?	At this time, these particular issues have not been included in the waiver renewal.
69. How can the state address the problem of Home Care Workers not being able to assist their clients when they are in the hospital? This affects continuity and quality of care.	Not a waiver-specific issue at this time. There are some current efforts to improve this situation under the 1915(i) state plan, rather than the 1115 demonstration.
Flexible – Health-related Services; Global Budget; 2% test; Sustainable growth rate	
70. What is being changed in rate-setting to accommodate the new definition of flexible services, and how will that impact the development of the global budgets for CCOs?	As a result of feedback, OHA has provided more clarification around health related services (see pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. Spending on health related services would be included in the numerator in MLR calculations. CCO spending on health-related services is to be included in the base of the CCO capitation rate, any reinvestment

	in these types of services would also be included in the base and therefore would remain in the system.
Equity; Traditional Health Workers (THWs)	
71. We need specific details on movement towards outcomes based metrics. As we move in this direction, we should ensure that we do not inadvertently exclude equity	OHA is committed to reporting on all measure sets, where possible, by race, ethnicity, language, disability, and for other vulnerable populations (e.g., gender, age, geography, etc). Additionally, the metrics & scoring committee has been working on developing methodologies to define metrics that address social determinants of health and health equity. As a result of public comment, OHA has incorporated an 8th focus area for the Performance Improvement Projects to address social determinants of health. OHA encourages CCOs to address health equity throughout all of the PIPs and quality improvement focus areas. See page 127 for the revised language.
Dual Eligibles; Long-term Services and Supports (LTSS)	
72. Is there consideration of an integrated Medicare-Medicaid Plan similar to the financial or administrative alignment demonstrations for dual eligible beneficiaries?	OHA is proposing to automatically enroll dual eligibles into CCOs with the option of opting out. No other changes to the dual eligible coverage is included in the waiver renewal. Other LTSS have not been included in the waiver renewal at this time.
73. Will there be any provisions related to LTSS benefit coordination in the waiver?	OHA is proposing to automatically enroll dual eligibles into CCOs with the option of opting out. Other LTSS have not been included in the waiver renewal at this time. There are ongoing discussions and development of LTSS/OHP strategies for coordination.
General waiver	
74. Will the Fee-for-Service population and service delivery system continue to decrease during the next waiver renewal period?	OHA will continue to offer coordinated care on a statewide basis. Certain populations and individuals will continue to be exempt from enrollment in CCOs such as American Indians and Alaska Natives, those with complex needs or requiring continuity of care that may not be available in their local area through a CCO.
75. The MAC would like a review of a completed draft of the waiver request prior to submission.	A complete draft will be presented during the MAC's April 27 meeting.
April 27, 2016 - Medicaid Advisory Committee (MAC)	
Outcome-based Metrics, Value-based payments and Incentives; Evaluation	
76. Provider Admin. costs have gone up with Transformation	OHA is trying to address this through metrics. For example, CCOs need to provide incentive dollars back to providers. OHA will require CCOs to enter into value based payment arrangements with network providers. At a later time, we can have a discussion with the MAC on value-based payment arrangements.

Dual Eligibles; Long-term Services and Supports (LTSS)	
77. With respect to the LTSS populations and the CHPs, has OHA interacted with DHS?	OHA has been engaged in inter-agency and inter-departmental planning. Through CMS' Innovator Accelerator Program (IAP), OHA is looking at a mix of services and working to ensure that services are provided effectively under the Section 1915 programs.
78. Seniors and people with disabilities and their providers often are not aware the individuals are eligible for supportive services. Education and information is needed, and we should not assume computer access for all people.	N/A: comment only.
79. Will the 1115 renewal contain provisions for inclusion of Long-term services and supports (LTSS)?	OHA is proposing to automatically enroll dual eligibles into CCOs with the option of opting out. Other LTSS have not been included in the waiver renewal at this time.
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
80. It is good to hear about the focus on social determinants of health. Cost-savings may be a challenge as we address "upstream" determinants.	N/A: comment only.
81. Will the waiver address veterans with behavioral health needs?	Veterans are a not specifically mentioned in the waiver renewal, but they could be included as a target population under the CHP pilots given risk of homelessness.
Flexible – Health-related Services; Global Budget; 2% test; Sustainable growth rate	
82. You mentioned barriers to CCO flexible services. What are some examples?	Currently, flexible services are reimbursed at an administrative rather than a medical rate. There has been minimal use of flexible services during the current waiver period which OHA is seeking to expand.
83. Will there be additional attention to flexible services and population-based health?	OHA is emphasizing the use of health related services to target social determinants of health. Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and target social determinants of health.
Equity; Traditional Health Workers (THWs)	
84. Are we continuing to push on using traditional health workers (THWs) more broadly, and on diversity initiatives?	OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission. The metrics & scoring committee has been working on developing methodologies to define metrics that address social determinants of health and health equity.
85. Do we have before and after results for Transformation and diversity?	We stratify the Transformation metrics by ethnicity, as well as behavioral health needs and disability. This information is tracked by CCO and is publically available.

General waiver	
86. Is the state allowed to move the line on the Prioritized List?	The Health Evidence Review Commission has the general authority to move the funding line. During the 2012 waiver renewal, CMS required the state not lower the funding line below a certain condition/treatment level, even though there may be technical changes to the lines and placement.
April 11, 2016 - CCO Behavioral Health Directors	
Behavioral Health Integration; Oral Health integration; other service integration (e.g. TCM)	
87. Supportive of the behavioral health sections of the waiver that were presented.	N/A: comment only.
88. Suggested that language in the WrapAround and ACT codes might help to describe care coordination.	OHA will consider this request.
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
89. Interested in how to maximize Medicaid match and optimize services.	Renewal request will contain: • Supportive housing options and services; • Care coordination services for Oregon State Hospital patients, homeless patients leaving acute care facilities and for pre-adjudicated individuals in county jail; • Care transitions from acute settings back to the community; and • Expansion of OPAL K concept to adults.
April 13, 2016 - Oregon Consumer Advisory Council	
Behavioral Health Integration; Oral Health integration; other service integration (e.g. TCM)	
90. Enthusiastic about the behavioral health waiver concepts	N/A: comment only.
91. Strongly recommended that peer support specialists be a provider type that can provide the services in the concepts	OHA is making an effort to include peer support specialists as a provider type in a variety of proposals included in the waiver renewal.
April 21, 2016 - Coordinated Care Organization - CEO Meeting	
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
92. Is CMS funding outside of HUD guidelines (e.g. in terms of limits on percentages of certain populations in a housing unit)	HUD guidelines generally do not affect Medicaid funding, per se, except to the extent OHA supportive housing services and HUD housing may intersect. The residents and providers may be subject to HUD guidelines and also receive Medicaid-funded services under Medicaid guidelines. Will be addressed to the extent necessary to ensure compliance.
93. Is OHA maximizing Housing Authority Dollars?	Planned and currently occurring, but not specified in request. OHA is working closely with the Department of Housing and Community Services.
94. How does the CHP proposal fit with flexible services?	Through the Coordinated Health Partnership, Oregon is taking an important step in addressing an aspect of social determinants of health. In addition, flexible services

	and community benefit initiatives can be used by CCOs to address other social determinants of health.
95. Where will additional funding for these Housing initiatives come from?	We are requesting Federal Financial Participation funds and waiver benefits for housing services.
96. Will the CHP pilot be an element of the Global Budget for CCOs?	OHA is looking at a pilot that will be grant-based. CCOs would be the lead entity in their communities/regions and manage the grants.
97. How will we know that the funds go for housing for targeted populations?	OHA will not be funding housing, per se, but the supportive services that help people remain in their homes. Medicaid funds cannot be used for construction or purchase of housing or for long-term rental support.
98. Will people with FFS, or open card Medicaid coverage, have access to the CHP program? For example, many dually eligible individuals are not members of CCOs and need supportive housing or transition services.	OHA anticipates that individuals not currently enrolled in CCOs but are served through fee-for-service may be eligible for the CHP pilot program.
99. Will the CHP pilot cover the I/DD population?	It is not planned that the CHP will cover the I/DD population because that population is covered for supportive housing through Section 1915 waivers and state plans.
Flexible – Health-related Services; Global Budget; 2% test; Sustainable growth rate	
100. Will there be increased funding for flexible services?	Flexible services are a part of the waiver renewal request. It would involve more flexibility and improved rates. We are also working to expand, improve and identify the appropriate incentives, outcomes and metrics.
101. What else (other than CHP) does the state want to fund under DSHP?	We are looking at investing some Behavioral Health dollars, some Housing General Fund dollars, and potentially some State Hospital dollars. OHA is working on the plan now. The state want to ensure some targeted populations, such as the pre-adjudicated jail population and those in residence at OHS, are enrolled in OHP and have access to services to help them transition to and stay in the community.
Dual Eligibles; Long-term Services and Supports (LTSS)	
102. Suggested the state take a serious look at health care for the dually eligible population.	OHA is proposing to automatically enroll dual eligibles into CCOs with the option of opting out. Other LTSS have not been included in the waiver renewal at this time. Ongoing work around best practices with respect to dual eligibles will continue.
April 26, 2016 - Ombuds Advisory Council	
Outcome-based Metrics, Value-based payments and Incentives; Evaluation	
103. There need to be strong metrics to hold CCOs accountable, particularly in serving high-risk individuals such as those with HIV/AIDS.	High risk individuals are the target population of CHPs. Individuals with HIV/AIDs may be part of the CHP population but are not called out specifically.
Equity; Traditional Health Workers (THWs)	

104. Will there be additional attention to the use of Traditional Health Workers (THWs) in the waiver renewal?	Yes, OHA is interested in seeing CCOs have more THWs on their panels. THWs would also be included in the provider network for the Coordinated Health Partnerships (CHP) pilot.
105. The Office on Equity and Inclusion (OEI) has a tip sheet on hiring THWs.	N/A: Comment only.
106. Will CCOs be mandated to include THWs on their provider panels?	There is no current plan to require CCOs to contract with THWs.
May 31, 2016 - Ombuds Advisory Council	
107. Would someone who is blind and homeless be included in the CHP program?	Each local CHP may set parameters around the population(s) they would like to serve, depending on regional needs. However, a person with a disability who is homeless would likely be eligible for services through a 1915 waiver and therefore not part of the CHP target population.
108. Thanks to OHA for transparency in posting all comments and questions, not just summaries.	N/A: Comment only.
109. Is there anything new happening with NEMT or emergency transportation in the waiver?	There are no new provisions related to transportation in the renewal. CCOs are provided dollars within their global budgets to cover non-emergency Medical Transportation. Transportation issues can be addressed within the context of CHPs.
110. Oregon has saved the federal government millions and millions of dollars since the waiver started in 1994; yet they are still concerned about "setting a precedent" with some of our renewal requests. We may need the help of our congressional delegation to help CMS understand that Oregon is a good investment and Oregon Medicaid saves lives as well as money. Encouraged all Advisory members to contact their federal delegation and tell them that the waiver must be renewed and it must be renewed as soon as possible.	We have been working with CMS to try to get an approval as quickly as possible, but some of our requests may potentially require additional discussions.
111. Many, many people in Portland are being evicted in "mass evictions". The city has turned over all homelessness services to the county effective July 1. Concern that collaboration will not happen. Hopes CHP can help with collaboration and with stopping evictions.	CHP will be able to work with tenants who may be at risk of eviction. We have had many conversations with community partners, and these are still occurring. We have had positive feedback from counties that are already doing this kind of work. The state will hold the CHP leads responsible for outcomes and collaboration.
112. To what extent are pediatric patients called out in the waiver?	They are not specifically called out, but in terms of CHPs, a local CHP could decide on pediatric goals for their housing outcomes. OHA is proposing to expand nurse home visiting programs to fill the gaps of care for at-risk families and children from prenatal to age five. In OHP overall, pediatric measures need to be revisited.
113. We do not see anything in the waiver about partnering with education or higher education in the CHPs. They could be instrumental in emphasizing healthy behaviors.	CHPs will have the flexibility to address a variety of issues and populations based on regional needs.

114. Regarding integration, when clients call their CCO about dental issues, they are told to call the DCO. It is the same with Mental Health services. Are we doing more in this waiver to ensure integration?	Oral and behavioral health integration are occurring at a slower pace than anticipated. We are working to develop new metrics on integration outcomes.
115. The housing initiative is great! We have not seen a large use of flexible benefits by CCOs. It would be good to engage consumers in evaluating how the waiver is being implemented. A survey was recently done in Portland that asked people what they thought a healthy community looks like. Found that people needed a lot of training and advocacy to fully use the system.	N/A: Comment only.
116. The biggest challenge is the CCOs. They do not use their Consumer Advisory Councils to the degree they should and thus, do not understand how consumers feel about their service delivery.	N/A: Comment only.
117. At the Health Forum Conference this week, Judge Ed James (Multnomah Co.) said that the most important things that happen to a patients happen between the ED and ongoing treatment. Post-ED stability is all-important.	N/A: Comment only.
118. Is the Transformation Center running out of money and going away in September?	The Transformation Center will continue after the SIM grant ends because it is an important part of health system transformation.
119. Traditional Health Workers are underutilized	OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission.
120. The Ombuds Advisory Council would like to see more emphasis on client engagement.	N/A: Comment only.
April 29, 2016 - Association of Oregon Counties-Housing Sub-Committee	
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
121. Regarding the request for case management-care coordination services for pre-adjudicated inmates for 30, days: why 30 days?	The average stay in a county or local jail for any inmate is 12-15 days, and 61.5% of the individuals in jail are pre-adjudicated and awaiting trial.
122. Regarding the Coordinated Health Partnerships (CHP) pilot proposal: Will CCOs be centralized in each CHP area and will the coordinator of the CHP for that area be located there?	To be incorporated in operational planning and for the consideration of the CHP Advisory Group.
123. Will the state mandate CCOs to do the CHP pilots?	The state will issue a request for proposals, and will allow CCOs and tribes to submit proposals. The grants will be for five years.
124. Is transportation part of the CHP vision? It is a social determinant of health, as well.	There are no specific transportation goals, but local CHPs may choose to address it as a targeted issue, if it is an identified need of the community.
125. Sometimes people, including families, just need a 30 day rental so they can get out of a treatment facility or off the streets while they find permanent housing? Will there be anything for them in the CHPs?	OHA is aware that temporary shelter services are in short supply. This could be a targeted issue for local CHPs.
126. AOC is working on a Housing Survey of counties. Thus far, 29 of the 36 counties had responded.	N/A: Comment only.

General waiver	
127. Would OHA like an endorsement of the request from this committee?	OHA would welcome any endorsements or letters of support.
128. How long does the state expect the CCO model to last?	We don't see the CCO model changing since it has been successful and is producing cost savings.
May 4, 2016 - Human Services Coalition of Oregon (HSCO)	
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
129. How would we get past the law forbidding FFP for inmates? Would they also be able to collect SSI?	We will ask for a waiver of the law and regulations to provide care coordination services for the initial 30 days of incarceration in a local jail. This would only apply to OHP. SSI has separate provisions for incarceration.
130. Would this apply to inmates on Work Release, too?	If someone were placed in a work release facility prior to being adjudicated, the 30-day waiver would apply. If the person were on home release or full community release pending trial, FFP would be available without the waiver.
131. If a CCO cannot meet the social determinant or equity metrics, can the state require them to partner with communities?	With the 5-year funding, there will be a requirement for building coalitions and establishing outcomes for community health which will have to involve the whole community. Through their Community Health Improvement Plans, CCOs have equity metrics, and the metrics and scoring committee is expanding this focus.
132. Are there CHP strategies for immigrant communities?	Local CHPs will be required to reach out to all groups within their community and may target immigrant communities where there is an identified need.
133. Regarding the CHP Pilots, if funding is available to all 16 CCOs, how does that work where there are 2 CCOs in an area?	Where there are two CCOs in a region, OHA would need to work directly with CHP advisory group.
Flexible – Health-related Services; Global Budget; 2% test; Sustainable growth rate	
134. Some CCOs are already working with agencies to address lowering residential treatment admissions and address acute care transitions (e.g., Central City Concern). Will there be language in the waiver to encourage increased use of flexible services	Yes, the enhanced use of flexible health-related services will continue to be an emphasis.
Dual Eligibles; Long-term Services and Supports (LTSS)	
135. What are we doing about Dual Eligibles?	We are looking at ways we can provide improved care coordination for dual eligible and are proposing an opt-out auto-enrollment strategy in the renewal request.
General waiver	
136. Describe the Governor's role in the waiver renewal.	The Governor is the state official required to submit Oregon's waiver renewal request. Governor Brown is highly committed to seeing that the renewal is approved and the hard work of Health System Transformation is preserved.

137. Regarding the funds CMS gave us for the last renewal, will they do it in a similar way this time? It was important to the state budget.	Yes, we want to continue the current model which holds down costs and for which the federal investment was so important. We will be requesting Federal Financial Participation to support CHPs. Now we are seeking to support a new local infrastructure to address the social determinants of health through the Coordinated Health Partnerships (CHP) pilot program which we also expect to move the system forward and ultimately decrease costs.
May 19, 2016 Coalition of Local Health Officials Meeting	
138. Will the TCM carve out be able to pass the 2% cost increase if the program is expanded?	TCM is currently under the 2% test and will remain as such in the current waiver renewal.
139. How will the TCM carve out affect current CCO/County MOUs on home visiting?	Any existing contracts between the CCOs and county health and mental health providers will remain in place. The TCM carve out will impact the payment of TCM services that are being provided at the county level since CCOs will not be the payer for those services (as previously discussed).
140. Is there a reason community benefit definition is limited to "improved healthcare quality?" Will that include spending on population health work?	The community benefit definition will be modified in the final waiver proposal. It does include spending on population health.
141. Is it possible to expand Healthy Home statewide? How does the 2% growth number affect this?	Any county wishing to expand the Healthy Home program will need to consult with the Oregon Health Authority to determine if the expansion will fit within the 3.4% sustainable rate of growth. If a county wanted to pursue an expansion and there is not a substantial impact on aggregate health care cost growth, a state plan amendment could be pursued to enable expansion of the Healthy Home Program among other counties that are interested.
May 31, 2016 – Oregon Primary Care Association - Call	
Outcome-based Metrics, Value-based payments and Incentives; Evaluation	
142. Overall, the waiver is going in the right direction with social determinants.	N/A: comment only.
143. There are not a lot of social determinants in the measurement strategy. Recommend that SDH outcomes be developed for pilots, though there will be pushback from CCOs on SDH metrics.	The metrics & scoring committee has been working on developing methodologies to define metrics that address social determinants of health and health equity
144. Particularly interested in social determinants and the effect of the CHP strategy on equity and early childhood.	N/A: comment only.
145. Concern about small providers taking on risk through value-based methodologies.	The shift to value based payment VBP arrangements will require CCOs and providers to assume increased risk. The requirements for VBP will be phased in throughout the 5 year waiver to allow small providers time to build capacity.
146. Concerned that "Community benefit" – examples seem claims-based.	OHA modified the waiver language to provide more clarity for the community benefit initiatives mentioned in the waiver renewal.

147. Definition of health related services says they will improve "health care quality" – instead of "health quality".	OHA modified the waiver language to provide more clarity for the health related services proposal in the waiver renewal.
148. Who makes the decisions in CCOs about where to invest reinvestment dollars?	CCOs and OHA, in collaboration, will determine the activities in which funds should be reinvested.

Presentations to Oregon Legislative Committees

Question or comment	Response
January 13, 2016 - House Interim Health Care Committee – Oregon State Legislature	
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
149. How will the housing initiative affect the 3.4% growth limitation with the expenses of housing?	State cannot purchase housing or pay rent. The state believes the supportive services will contribute to our savings and not be detrimental.
General waiver	
150. Does anti-discrimination language need to be built into the waiver	The state is still subject to all federal law that is not explicitly exempted by the waiver, and anti-discrimination mandates apply to all of our programs.
151. Is this submittal routine, or are there risks?	We are trying to get the waiver submitted and approved before the next federal administration comes in, as this can often cause delays and obstacles with CMS approvals.
May 23, 2016 - Senate Interim Health Care Committee – Oregon State Legislature	
Social determinants; Housing, homelessness, CHP Pilot; Incarceration	
152. We hope the housing programs will continue in the waiver and be successful.	N/A: Comment only
153. If CMS has approved using funding in correctional settings in another state, it should be approved for Oregon.	N/A: Comment only
Behavioral Health Integration; Oral Health integration; other service integration	
154. We hope the SUD expansion will continue in the waiver and be successful.	N/A: Comment only
Flexible – Health-related Services; Global Budget; 2% test; Sustainable growth rate	
155. Will there still be a Global Budget?	The global budget will remain as one of the critical elements of the waiver.
Equity; Traditional Health Workers (THWs)	
156. Is there a request to let Doulas practice without supervision?	The state has requested to waive the supervision requirement for doulas.
General Waiver	
157. Can you give some examples of feedback you have received on the waiver? Things not there that people want? Things there people don't want?	We have heard a lot from Tribes about care coordination challenges, access to specialty services and being potential leads in the CHPs. We have made adjustments to the waiver in each of those areas to include tribal requests.

Question or comment	Response
158. The waiver request has improved over the past couple of months. Agreed that we need to get approval as early as possible, but we should not give up our very important goals. CMS should be more ready to engage in shared savings.	Yes, timing and shared savings are still very much in discussion with CMS.
May 23, 2016 - Joint Interim Sub-Committee on Human Services (Emergency Board) – Oregon State Legislature	
General waiver	
159. Agree with direction of waiver and the quest for early approval. Shared savings is important.	N/A: Comment only
160. Need to publish a Fact Sheet for CMS, our state leaders and the public telling about all we have accomplished under OHP	N/A: Comment only
May 24, 2016 - House Interim Health Care Committee – Oregon State Legislature	
General waiver	
161. Kudos to OHA and Housing and Community Services for working together so well on the Coordinated Health partnerships. Hope it is successful.	N/A: Comment only

Written Comments (by date and source)

Commenter and Comments	Response
162. **5-1-16 Lindsey Hopper, JD, MPH, Vice President of Medicaid; PacificSource Health Plans; direct: 541-706-5066** ● CHP Pilots should have a specific rural focus ● Transportation problems should be addressed ● Would like "safe harbors" for CCO spending on housing-related activities. ● Best practices would be helpful ● Need to allow for some kind of capital investment ● Behavioral health services: expand psych telephonic services to all age groups; change "telephonic" to "in-person and remote"; build feedback loop for OPAL-K providers; address SUD for ages 10-21; add autism treatment to ECHO project; allow time for behavioral health integration to develop without ROI metrics ● Metrics and Hospital Transformation: Address statistical soundness when number of patients is small in a measure; look at outcome measures through CHIP/Transformation Plan grants and not just numeric scores. ● PCPCH: flexibility is needed; integrate pharm benefits	CHPs will look different in rural and urban areas and will be dependent on regional needs identified by the CCO and its partners. CHPs will be available to be developed statewide. OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. At this time, OHA is proposing to expand psychiatric telephonic services to adults and already offers services to children and adolescents. The development of CHPs will allow the development of a pool of funds from private partners for capital investment. In a future amendment, OHA intends to request a substance use disorder amendment to the 1115 demonstration.

Commenter and Comments	Response
• HIT/HIE: Base HIE should include direct messaging; require HIE if one is available; designate funding for regional HIT adoption • Housing: permit pooling of resources to fund housing and non-medical transportation • Flexible Services: Create workgroup with CCOs for evaluating flex services	Federal dollars from CMS and from US Department of Housing and Urban Development can both be used to support the CHPs and CHPs will be encouraged to seek funding through partners. However, the funding must be used for defined purposes. For example, Medicaid funding may not be used to build housing or pay for rent. OHA is pursuing statewide Direct Secure Messaging as a strategy for basic connectivity across the care team, regional HIEs and the state; however there are currently some barriers to free-flow of different types of files through Direct Secure Messaging for some EHR vendors. OHA expects to leverage new federal HIE funding to support onboarding costs to HIEs, including regional HIEs, for Medicaid providers that have typically faced barriers including behavioral health, long term care, dentists, and others. CCOs are provided dollars within their global budgets to cover Non Emergency Medical Transportation. Transportation issues will be addressed within the context of CHPs. Flexible services and community benefit initiatives are defined in the flexible services concept paper for the waiver. Further refinement will occur in negotiations with CMS and in discussions with CCOs.
163. **5-26-16 -- Lynn Knox, Health Care Partnerships Coordinator; Oregon Food Bank; lknox@orgonfoodbank.org; 503-853-8732** Flexible services Food insecurity as a social determinant - Explicit encouragement to incorporate these program into a global budget, flexible services or community benefit funding. • Screening for food insecurity • Data • Diabetes education and prevention • On-site nutrition & gardening resources	To help address this issue, an incentive measure is currently being assessed around food insecurity. This measure may be tested in the future.
164. **5-27-16 -- Naaman Córdova-Muenzberg, Executive Director; SAFE of Columbia County; 503-397-7110, Ext. 11 naamancm@safeofcolumbiacounty.org, www.safeofcolumbiacounty.org/**	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal.

Commenter and Comments	Response
Interpersonal violence ● Flexible Services ● Explicitly call out as Social Determinant of Health ● Empower CCOs to partner with advocates and non-clinical providers o Primary prevention o Effective screening	
165. **5-27-16 -- Elizabeth "Lisa" Norton, MSW; Executive Director; My Sisters' Place; 541-574-9424; www.mysistersplace.us** Interpersonal violence ● Flexible Services ● Explicitly call out as Social Determinant of Health ● Empower CCOs to partner with advocates and non-clinical providers o Primary prevention o Effective screening	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal. Social determinants of health have been further defined on pages 26-27.
166. **5-27-16 -- Susan Stoltenberg, Executive Director; Impact NW** Interpersonal violence ● It is critical we invest in Traditional Health Workers, advocates and other non-clinical service providers who are connected to and based in their communities and experienced in providing trauma-informed care. ● CCOs must be explicitly encouraged to use Flexible Services to fund advocacy services for survivors of intimate partner violence ● The Waiver must explicitly list intimate partner violence as a social determinant of health to be addressed ● The Medicaid Waiver must empower CCOs to partner with advocates: community-based non-clinical providers who have Triple Aim impact.	As outlined in the waiver proposal on pages 46-47, OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission. As a result of public comment, OHA has added a reference to encourage CCOs to support trauma informed care and services through the CHPs. See page 29 of the waiver proposal. The CCOs are able to work with the community and providers to define flexible services that are needed in their community. CHPs in the waiver provide an additional mechanism for CCOs to partner with advocates and community-based non-clinical providers.
167. **5-27-16 -- Susan Stoltenberg; Executive Director; YWCA of Greater Portland; PO Box 4587, Portland, OR 97208** Interpersonal violence ● The Waiver must explicitly list intimate partner violence as a social determinant of health to be addressed, as currently CCOs are not prioritizing this as an important issue, despite its well documented health effects and costs.	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal. The CCOs are able to work with the community and providers to define flexible services that are needed in their community.

Commenter and Comments	Response
● CCOs must be explicitly encouraged to use Flexible Services to fund advocacy services for survivors of intimate partner violence. ● It is critical we invest in Traditional Health Workers, advocates and other non-clinical service providers who are connected to and based in their communities and experienced in providing trauma-informed care. ● Effective screening	As outlined in the waiver proposal on pages 46-47, OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission.
168. **5-28-16 -- OHSU - Family Medicine at Richmond; Brian Frank MD, Assistant Professor; Family Medicine OHSU; 3930 SE Division Street Portland, OR 97202; 503-418-3900** Flexible Services ● Food insecurity as a social determinant of health ● OHA should support clinics' efforts to improve access to fresh, healthful foods and decrease food insecurity by explicitly emphasizing inclusion of these efforts in the Medicaid waiver; and incorporating them into a global budget, allowing flexible services and community benefit funding.	To help address this issue, an incentive measure is currently being developed around food insecurity. The measure may be further tested.
169. **5-28-16 -- Kathleen Marvin, Executive Director; Tillamook County Women's Resource Center** Interpersonal violence ● Oregon cannot afford to continue to ignore domestic and sexual violence as a social determinant of health. intimate partner violence is listed as one of the five core social determinants of health to be addressed by The Center for Medicare and Medicaid Innovation's (CMMI) new Accountable Health Community Model (AHC) ● It is critical we invest in Traditional Health Workers, advocates and other non-clinical service providers who are connected and based in their communities. ● It is a shame that CCOs are not partnering with advocates and Traditional Health Workers on their care teams with Medicaid dollars. The Medicaid Waiver must empower CCOs to partner with advocates: community-based non-clinical providers who have proven Triple Aim impact. ● Effective screening	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal. As outlined in the waiver proposal on pages 46-47, OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission. CHPs in the waiver provide an additional mechanism for CCOs to partner with advocates and community-based non-clinical providers.
170. **5-30-16 -- Melanie Taylor Prummer, M.A. Executive Director; Battered Persons' Advocacy; 541-957-0288** Interpersonal violence	The CCOs are able to work with the community and providers to define flexible services that are needed in their community. As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal

Commenter and Comments	Response
● CCOs must be explicitly encouraged to use Flexible Services to fund advocacy services for survivors of intimate partner violence. ● The Waiver must explicitly list intimate partner violence as a social determinant of health to be addressed, as currently CCOs are not prioritizing this as an important issue, despite its well documented health effects and costs. ● The Medicaid Waiver must empower CCOs to partner with advocates: community-based non-clinical providers who have Triple Aim impact. ● Additionally, partnerships between advocates and healthcare offers one of the most exciting and largest potentials for primary prevention of this social determinant of health. ● Effective screening - Despite this opportunity healthcare is still not adequately addressing this social determinant of health.	violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal. CHPs in the waiver provide an additional mechanism for CCOs to partner with advocates and community-based non-clinical providers.
171. **5-31-16 -- Stephanie Irving, Executive Director; Helping Hands Against Violence; PO Box 441, Hood River, OR 97031; 541-386-4808** Interpersonal violence ● To address social determinants of health, CCOs and healthcare providers should partner with advocates, who have the experience and knowledge to provide best practice services to survivors, and can assist with care coordination and case management, amongst core advocacy services such as safety planning, motivational interviewing, empowerment model services, access to housing, and legal advocacy, and other supportive services. ● The Medicaid Waiver must empower CCOs to partner with advocates: community-based non-clinical providers who have Triple Aim impact. ● Effective screening	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal. CHPs in the waiver provide an additional mechanism for CCOs to partner with advocates and community-based non-clinical providers.
172. **5-31-16 -- Kent Benner, MD; BJ Cavnor; Mark Loveless, MD; Steve Nemirow; Lorren Sandt; Andrew Seaman, MD; Rob Shinney; Atif Zaman, MD** A transformative solution to treat, and cure, patients with viral Hepatitis C (HCV) in the collaborative spirit of existing and future 1115 Demonstration Waivers. A five year project proposal: ● Rate-setting ● Access ● THWs ● Rules and Practices – OHA and CCOs ● Action Plan	There does not appear to be any specific waiver of federal law needed to enhance access to drug therapies. Proposed waiver language does address a carve-out request for breakthrough therapies outside of Oregon's 2 percent test of controlling costs (see page 52). OHA is currently undertaking several efforts to address hepatitis C treatment. These efforts include the following: ● OHA requested Coordinated Care Organizations' (CCOs) hepatitis C treatment coverage criteria in February 2016. ● Receipt, compilation and analysis of CCOs hepatitis C treatment coverage criteria was completed in April 2016 by OHA.

Commenter and Comments	Response
• Coalitions • Sustainable value-based payment systems • Possible IAP assistance from CMS	• OHA is currently working with CCOs to align coverage criteria with the Fee-For- Service population criteria in response to CMS letter 172. • Oregon's Pharmacy and Therapeutics Committee is scheduled to review hepatitis C in September 2016. • The Medicaid Advisory Committee will oversee a sub-committee of advocates to address Hepatitis C access issues.
173. **5-31-16 -- Rachel Simpson, Ombuds Advisory Council member** OHP does not provide the types of durable medical equipment (DME) people really need to live a productive life in the community. For example, how does someone with special needs get a lift to get them in and out of bed or their wheelchair? Medicare rules are too stringent.	There does not appear to be any specific waiver of federal law needed to enhance DME benefits. Benefits for individuals with disabilities are also available through the 1915(i) and 1915(k) options.
174. **5-31-16 -- Siobhan Mahorter, Business Development Manager; Karen Kalaijian, Medical Policy Director; Nurse-Family Partnership | National Service Office; 206-715-4035** • The Medicaid Waiver must include IPV as a social determinant of health. Maternal and Child health should be a priority for social determinants. • NFP can help Oregon improve Care Coordination for high-risk pregnant women and their families. • Would like to participate in future Learning Collaboratives on maternity and child health services. • Would like to see the reporting burdens minimized on home visitors • OHP should expand flexible health-related services to include family supportive services • Want NFP better-integrated and to expand referrals and revenue for home visitors.	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal. To address maternal and child health, OHA is proposing to expand nurse home visiting services through a State Plan Amendment. Though the expansion does not require waiver authority, we have included a mention in the waiver proposal (see page 41). The CCOs are able to work with the community and providers to define flexible services that are needed in their community. CCOs have the flexibility to define health related services and may choose to include family supportive services. The reporting burdens on home visitors will be reviewed as the program is expanded. This is an operational issue that does not require waiver authority but may involve federal and state regulations.
175. **5-31-16 -- Sarah H. Keefe, Health Systems Program Coordinator; Oregon Coalition Against Domestic and Sexual Violence** Interpersonal violence	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal.

Commenter and Comments	Response
• The Medicaid Waiver must include IPV as a social determinant of health • It must bolster CCOs ability to incentivize providers to address this social determinant of health through partnering with community-based domestic and sexual violence advocates through Flexible Services • OHA must insist on adopting best practice interventions for survivors, as well as investing in primary prevention, such as universal education models around healthy relationships.	
176. **5-31-16 -- Lisa McMahon; Oregon Foster Youth Connection; Program Director; Children First for Oregon; PO Box 14914, Portland, OR 97293** • Youth move a lot. Care (mental health & physical health) needs to be consistent and available throughout all their moves. • Too many youth are waiting for health care services, and too many providers are waiting to be reimbursed. • One youth shared that she didn't have enough choice in who she saw for health care or if she could see a specialist.	There does not appear to be any specific waiver of federal law needed to address this issue. Currently, the CCOs are already engaged in this issue and have an incentive measure around timely health services for foster youth. OHA and Metrics and Scoring Committee identified health care for foster youth a priority by including this as one of 17 incentive measures for CCOs.
177. **5-31-16 -- Jon Bartholomew, Government Relations Director; AARP Oregon; 9200 SE Sunnybrook Blvd., #410; Clackamas, OR 97015; 1-866-554-5360** • Supportive of health related services not being in administrative costs. • Encourage OHA and the CCOs to focus on in the future is the role of family caregiving in the overall health of Oregonians. Caregiving has an impact on the three elements of the Triple Aim. o Caregiver Respite o Caregiver Training o Support groups • Impact on caregivers own health is an issue, and it affects them and the ones for whom they care.	There does not appear to be any specific waiver of federal law needed to address the caregiver issue. This issue is in the purview of Aging and People with Disabilities.
178. **6-1-16 -- Jim Moorefield, Executive Director; Willamette Neighborhood Housing Services; 257 SW Madison Ave., Ste. 113; Corvallis, OR 97333** Supportive of CHP particularly	N/A: comment only.
179. **6-1-16 -- Coalition for a Healthy Oregon (COHO); Ruth Rogers Bauman, President** Integrated budgets • Continue to employ flexible spending strategies at local level.	The CCOs are able to work with the community and providers to define and employ flexible services that are needed in their community. The integrated global budget, as described by Oregon statute (ORS 414.025), is a total amount established prospectively by the Oregon

Commenter and Comments	Response
• Clearly define "integrated budget" CHP – • Concerned about the expectations for CCOs. While CCO funds cannot be used to build brick-and-mortar housing, the metrics outlined in the waiver request indicate that CCOs would be responsible for providing housing. • The current lack of available affordable housing could place CCOs in an untenable position • Will there be additional services that are not now funded? • Are community Benefits a new service? • Can we unify the federal funds received by CMS and the federal funds received by the US Department of Housing and Urban Development? • We believe the outlined process for calculating the MLR and using it as an additional force for continued community investments is unnecessary and puts our transformation efforts at risk. • Makes it difficult to build any reserves by limiting the incentive to make large savings • Confusion around if "Health Related Services" are in the hard MLR. • Suggest removing section 2.b and section 4 from page 40 of the waiver application as the requirements would effectively push us back to a fee-for-service model of care delivery. • A committee modeled after the metrics and scoring committee may be necessary to evaluate all new metrics around social determinants. • Like the cap rate carveouts. Suggests the state consider adding oncology drugs to this list as well. Concerned about short timelines for new programs	Health Authority to be paid to a CCO for the delivery of, management of, access to and quality of the health care delivered to members of the CCO. As a result of feedback, OHA has incorporated this definition into the waiver on page 48 and Appendix D. Although Medicaid does not allow federal dollars to be used for capital investments, OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. This modification was made as a result of public comment (see page 34). Federal dollars from CMS and from US Department of Housing and Urban Development can both be used to support the CHPs and CHPs will be encouraged to seek funding through partners. However, the funding must be used for defined purposes. For example, Medicaid funding may not be used to build housing or pay for rent. OHA is requesting approval from CMS to cover services across three domains -- homelessness prevention/transitions of care, housing transition services, and tenancy sustaining services. Many of these services are not currently covered under the 1115 waiver. OHA is requesting that they be covered under the waiver renewal. The community benefit initiatives are a category within health related services (as well as flexible services) and are intended to meet community needs and to improve population health. CBI is not a new service but rather a more defined service when combined with flexible services. OHA proposes to implement a reinvestment requirement that could involve a MLR standard of 88% with a tiered risk corridor of 3%. Those with an MLR below the 3% corridor (i.e., below 85%) must remit to the State the difference between their MLR and 85%. Those with an MLR within the 3% corridor (i.e., between 85% and 88%) may be eligible to retain some or all of the difference between their MLR and the 88% as long as it is reinvested in cost-effective health-related services. Waiver

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	narrative has been modified based on feedback on pages 49-50 and Appendix D. Spending on health related services would be included in the numerator in MLR calculations. CCO spending on health-related services is to be included in the base of the CCO capitation rate, any reinvestment in these types of services would also be included in the base and therefore would remain in the system. CMS Managed Care Regulations require the state to implement an MLR beginning 2018. The proposed use of MLR is consistent with federal regulations and OIG recommendations. The metrics & scoring committee has been working on developing methodologies to define metrics that address social determinants of health and health equity. CHPs will be phased in over 5 year period with payments based on process measures in year 2-3 and moving to outcomes. Year 1 will involve planning and proposal development.
180. **6-1-16 -- Innovative Housing, Inc.; Sarah Stevenson, Executive Director** ● Support CHP; recommend grants to existing, experienced affordable and supportive housing/homeless providers that work with CCOs. Or allow affordable housing providers to apply as the lead applicant. ● Concerned that CCOs and Tribes lack a thorough understanding of the current housing landscape ● All 3 domains may not be appropriate for some communities ● Populations need to be more clearly defined (dual eligibles?) ● Recommend a housing stakeholder workgroup at OHA ● What would the 60 days of rental assistance look like – What if CCOs lose track of the person? ● Recommend .88 MLR ● More clarification of health related services	CCOs are Oregon's health care delivery system. Any request for federal Medicaid funds must include CCOs as part of the strategy. CCOs will work with existing affordable housing providers as the leads. Tribes will also be able to apply as a lead. Lead entities for the CHP will be expected to partner with local housing providers to help build an understanding of the housing situation in the region (see page 34). OHA believes that the three domains identified in the CHP proposal will have the largest impact for at risk populations targeted through the pilots. All CHPs will be expected to provide services across the three domains. CHPs will have the ability to clearly define the populations they would like to target based on regional needs. See pages 28-29.

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	As a result of feedback, OHA will convene a CHP advisory group to provide recommendations for program implementation. See pages 31-32. CCOs will be expected to coordinate care for individuals transitioning from acute care settings and requiring in home throughout the entire 60 day period. OHA is proposing a medical loss ratio (MLR) standard of 88% – the MLR currently used for rate setting purposes. See pages 49-50 and Appendix D. As a result of feedback, OHA has provided more clarification around health related services (see pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health.
181. **6-1-16 -- Enterprise; Amanda Saul, Senior Program Director; Pacific Northwest Enterprise Community Partners** ● Enterprise supports the Coordinated Health Partnerships (CHP) concept and the partnership with affordable housing providers. We recommend providing grants to a team of existing, experienced affordable and supportive housing and homeless providers that work with CCOs to provide identified housing services to the CCOs' members. ● All 3 domains may not be appropriate for all communities ● More clearly define target populations for CHP (dual eligibles?) ● Recommend a housing stakeholder workgroup at OHA ● What would the 60 days of rental assistance look like – What if CCOs lose track of the person? ● Recommend .88 MLR ● More clarification of health related services; Clarify that Flexible Funds can be used for physical housing improvements as well, such as mold remediation and air conditioners.	OHA believes that the three domains identified in the CHP proposal will have the largest impact for vulnerable populations targeted through the pilots. All CHPs will be expected to provide services across the three domains. OHA has defined the CHP target population as those with repeated incidents of avoidable emergency use or hospital admissions; two or more chronic conditions; mental health and/or substance use disorders; currently experiencing homelessness; and/or individuals who are at risk of homelessness, including low-income seniors eligible for Medicare and Medicaid, and Indian Health Services (IHS), Tribal, and Urban Indian program constituents; and, individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail). As a result of feedback, OHA will convene a CHP advisory group to provide recommendations for program implementation, including enrollment. See pages 31-32.

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● Use consistent language throughout as it relates to "affordable housing providers" (rather than "local" or "area housing providers" ● Add "affordable housing providers" to p. 26 second paragraph beginning "The final design and implementation details…" ● P28 chart – numbers appear to be duplicative and may overstate cost savings. ● Make more explicit examples of things that would be funded through this project ● Edit chart p. 31 (see letter) ● Who would be responsible for enrolling participants in the pilot project, and how would they enroll? ● Remove "transitional" on p. 26, Coverage of Homelessness Prevention	CCOs will be expected to coordinate care for individuals transitioning from acute care settings throughout the entire 60 day period. OHA is proposing a medical loss ratio (MLR) standard of 88% – the MLR currently used for rate setting purposes. As a result of feedback, OHA has provided more clarification around health related services (see pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health.
182. **6-1-16 -- Oregon Primary Care Association; Laura Etherton** ● Define health-related services that will be in medical rates ● Will be interested to see details on CCO reinvestment requirements and performance incentive programs, and hope they can help increase use of health-related services in Oregon's communities. ● To ensure that both the CCOs and their provider partners are investing in health-related services, we would suggest streamlining reporting to focus on reporting on health-related services. ● Encourage OHA to ensure system-wide behavioral health integration and reflect that through payment and contractual relationships. ● Need a recovery-based model of care ● Concern about risk and value-based payments ● Articulate what risk-sharing means in this context, ● If it includes both upside risk and downside risk, and how it would relate to primary care practices of different sizes or areas of focus. Small clinics may not be able to assume risk, for example, but are a critically important component of Oregon's health workforce. ● Recommend clear and direct guidance regarding qualities of a PIP or focus study, including: the PIP evaluation and review process, public outreach components, and a description of how lessons from individual PIPs will be shared to forward knowledge among CCOs.	As a result of feedback, OHA has provided more clarification around health related services (see pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. OHA proposes to implement a reinvestment requirement that could involve a MLR standard of 88% with a tiered risk corridor of 3%. Those with an MLR below the 3% corridor (i.e., below 85%) must remit to the State the difference between their MLR and 85%. Those with an MLR within the 3% corridor (i.e., between 85% and 88%) may be eligible to retain some or all of the difference between their MLR and the 88% as long as it is reinvested in cost-effective health-related services. Through this waiver renewal and other efforts OHA will encourage a continued focus on behavioral health integration. To build a recovery-oriented service system and seamless transitions in treatment and recovery, OHA intends to request a substance use disorder amendment to the 1115 demonstration (see page 16). The shift to value based payment arrangements will require CCOs and providers to assume increased risk. OHA intends to align with federal

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• Urge OHA to clarify how the proposed revisions to the PCPCH enrollment measure would change over the five years of transformation to create incentives for CCOs and practices to attain the highest levels of PCPCH certification.
• For improving social determinants of health and health equity:
  • Ensure that primary care providers are included as provider partners in Coordinated Health Partnerships,
  • Clarify how CCOs with overlapping service areas will take part in the CHPs
  • Define strategies and metrics that capture how these programs support housing transitions and sustain tenancy for households as well as individuals
  • Define a method to screen for risk of homelessness
  • Provide complementary services that can stabilize this population, particularly if housing cannot be attained for the target population, such as evidence-based supportive employment, education, food, and other services
  • Maximize the value of the intervention by helping households renew their eligibility for Medicaid and keeping this population within the Coordinated Health Partnership safety net even if they would otherwise administratively or financially churn out of Medicaid
  • Provide direct support to individual patients such as motivational interviewing.
  • In some areas, multiple entities provide similar services to a shared patient population. CHPs will also face this challenge of increasing access to services while reducing duplication of services. We urge OHA to provide technical assistance and guidelines for community organizations and partners to manage these limited resources wisely, while ensuring easy access to services.
• Clarify health-related services to focus on "improved health", not "improve health quality".
• Risk adjustment methodology should be adjusted for social determinant of health risk factors.
	guidelines that require small practices to build capacity. The Transformation Center can assist in building capacity through work with the CCOs.
	
	The 1115 waiver outlines the quantity and focus areas for Performance Improvement Project (PIP). The review process and reporting deliverables are outlined in the CCO contract. Implementation plans for PIPs are variable to the organization, community of implementation, and topic selection.
	
	The Oregon Health Authority relies upon the expertise of stakeholders on the CCO Metrics and Scoring Committee to advise us on the technical specifications and implementation of CCO metrics. OHA will look to these advisors and other stakeholders as the PCPCH Enrollment metric is revised to reflect changes in the PCPCH Standards.
	
	To improve social determinants of health and health equity, CHPs will be have the flexibility to define the populations they would like to target (as long as they meet minimum criteria required by OHA) and work with local partners to address regional needs. Providers participating in the CCO provider network will be engaged in CHP efforts. The CHP advisory group, included in the proposal as a result of feedback, will help develop CHP program specifics. OHA has started to analyze data from the Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) that looked at those who were homeless or residing in a shelter, or at-risk of being homeless. OHA will work with the CHP advisory group and other government agencies to develop a method to screen those at-risk of homelessness. The CHPs will seek to reduce duplication of services for Medicaid beneficiaries.
	
	As a result of feedback, OHA has made further edits to clarify that health related services are activities that improve health care quality. See pages 48-49.

183. **6-1-16 -- SASS (Sexual Assault Support Services)** Interpersonal violence	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal.

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• CCOs must be explicitly encouraged to use Flexible Services to fund advocacy services for survivors of intimate partner violence. • The Waiver must explicitly list intimate partner violence as a social determinant of health to be addressed, as currently CCOs are not prioritizing this as an important issue, despite its well documented health effects and costs. • The Medicaid Waiver must empower CCOs to partner with advocates: community-based non-clinical providers who have Triple Aim impact. • Additionally, partnerships between advocates and healthcare offers one of the most exciting and largest potentials for primary prevention of this social determinant of health. • Effective screening - Despite this opportunity healthcare is still not adequately addressing this social determinant of health.	
184. **6-1-16 -- Jackie Yerby, Executive Director; PROGRAM; Bradley Angle; jackiey@bradleyangle.org** Interpersonal violence • The Waiver must explicitly list intimate partner violence as a social determinant of health to be addressed, as currently CCOs are not prioritizing this as an important issue, despite its well documented health effects and costs. • CCOs must be explicitly encouraged to use Flexible Services to fund advocacy services for survivors of intimate partner violence. • It is critical we invest in Traditional Health Workers, advocates and other non-clinical service providers who are connected to and based in their communities and experienced in providing trauma-informed care. • Effective screening	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal.
185. **6-1-16 -- Oregon Association of Area Agencies on Aging & Disabilities. (O4AD) PO Box 2777, Salem, OR 97308; 503-463-8692; info@o4ad.org; www.o4ad.org** • Oregon's health system will need to define stronger incentives rather than attempting to recreate systems already in place and define disincentives for failing to utilize the network of expertise, experience and community access that exists locally. • Area Agencies on Aging working in this field can offer expertise, experience and program development to aid in these goals and will be a critical partner in the CHP pilot project.	CHPs may select to involve other entities and organizations that serve the targeted populations selected by individual regions. Other entities could include those focused on diversity, disabilities, aging, youth, etc. CHPs will include the following entities: • CCOs • Tribes • County agencies • Corrections • Health providers • housing entities • local hospitals

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• Studies show that disability is a significant cause of homelessness. • In order to help individuals with disabilities attain stable housing, the housing has to be able to meet the needs of the individual living with their disability as well as the supportive services provided. • Defining stronger mandates for CCOs to build partnerships with community based organizations including Area Agencies and programs to increase investment in health related services and social determinants of health is necessary. • During the initial period of integration within the 1115 waiver, the outcome of training and support for senior and disability mental health services for community mental health centers was added to the overall goals of integration. • In order to achieve successful mental health services in communities around the state, coordination with long term services and supports for individuals with disabilities is essential. **Dual Eligible Opt-out** • This change for these individuals will require careful and well planned coordination with the Aging and Disability network in order to meet the needs of the individuals served. • Seek input from advocates and consumers, factor cultural planning into the proposal to make this change and work closely with the ADRC (Aging and Disability Resource Connection), SHIBA (Senior Health Insurance Benefits Assistance) program, and field offices within APD and the Area Agency network to implement this proposed change. **Health Information Technology Infrastructure** • Navigation between data systems will allow community partners the ability to identify key opportunities for intervention and support of CCO goals. • Insuring that systems provide for easier sharing and common data will enhance stronger coordination and identification of key intervention points. • Real time access to data by community partners will continue to improve strategies to strengthen services and supports that will help meet overall outcomes and goals in health system transformation.	• other entities serving or advocating for the targeted population OHA will coordinate with agencies focused on aging and disabilities to make the proposed change around dual eligibles opt out. OHA has several efforts to ensure HIT infrastructure can support sharing data between CCOs, providers, and community partners. In particular related to the aging and people with disabilities populations, OHA is launching a pilot to bring real-time hospital event notifications to APD/AAA field offices - connecting to the same system (PreManage) in use by CCOs in many regions. OHA recognizes the value of data sharing across entities including LTSS organizations, and will work with CMS to provide new funding to connect and onboard LTSS providers and others to health information exchange systems.
186. **6-1-16 -- Brian T. Rogers, MD, Director; Institute on Development & Disability; Oregon Health & Science University** • NICH and OCCYSHN programs would like to be part of CHP to focus on outcomes for children.	CHPs may select to involve other entities and organizations that serve the targeted populations selected by individual regions. Feedback received indicates that other entities could include those focused on diversity, disabilities, aging, youth, etc. CHPs will include the following entities:

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• The Executive Summary includes "Expand the behavioral health services integration through partnerships with counties, corrections, and community based-programs." There is no mention of partnerships with health care institutions or organizations. While a great deal of behavioral health is provided in the community, many of our most vulnerable youth receive behavioral health at health care institutions or organizations. These institutions and organizations are well positioned to provide truly integrated care. • In Executive Summary, we propose that the language in the 2017 Waiver recognize and reflect the state's commitment to children and adolescents with medical complexity, chronic health conditions, and special health care needs given that these youth represent our most vulnerable Oregonians.	• CCOs • Tribes • County agencies • Corrections • Health providers • housing entities • local hospitals • other entities serving or advocating for the targeted population OHA seeks to focus on strengthening partnerships with counties, corrections, and community based programs as well as health care organizations such as hospitals. Individual CHPs will develop partnerships at the local level and will be able to shape those partnerships to best address care transitions and homelessness. In a future amendment, OHA intends to request a substance use disorder amendment to the 1115 demonstration, which will help strengthen partnerships with health care institutions and organizations as well. See page 16 for more information about the SUD amendment. To target at-risk children, OHA is proposing to expand the nurse home visiting program through a State Plan Amendment. Separate from the waiver, OHA will continue existing programs targeting at-risk children.
187. **5-31-16 -- Family Care Health; Jeff Heatherington, Chief Executive Officer** • What is the expectation for CCOs as the leads? • If there are multiple CCOs in an area, which leads? • Don't agree with the need to establish CHPs to do what CCOs are already doing • How will CCOs pay for CHP services? Global budgets? Will CHPs be responsible for paying for services and if so, how will CHPs be funded? • Should ask to provide long-term rental assistance, up to 12 months • Lack of housing a barrier • Need clarification on CCO responsibilities for health related services and community benefits. • Support tracking health related services separately • Support reinvestment component but not based on a target MLR	CCOs will be expected to coordinate with partners to provide services to target populations across the three domains. OHA is requesting federal funding to support and develop CHPs. CCOs will receive the funding but will be required to distribute some portion of the funding to CHP partners. CCOs will be able to use health related services to provide additional funding to CHPs. Additionally, OHA will seek to have housing supports and services be billable waiver benefits. Pilots will be funded for four years with initial funding tied to meeting process measures and in later years moving to payments based on outcomes.

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• Support rewarding high CCO performance. When will this start? • Support excluding high cost drugs from rate setting. • Explain on p. 51 "Provide expenditures to cover providers that do not comply with disenrollment restrictions on enrollees" • Is the OPAL-K for adults an actual waiver request? Supportive. • Support SUD amendment coming up. But disappointed to see the substance use disorder amendment isn't in this waiver application. • Are Global Budget and "Integrated" budget the same? • Will the Global budget still be used? • State should explore how to increase interpreters for CCOs and collect data. • Support waiving the doula supervisión request • Support THW expansion • All CCOs should invest in HIT so that interoperability will be achieved throughout the state. • What is happening with Nurse Home Visiting? • Regarding the use of flexible services, clarify and distinguish between individual and community based "health-related services"	As a result of feedback, we have added a CHP advisory committee to the waiver renewal. This committee will make recommendations and decisions regarding CHP program. See pages 31-32. OHA is proposing to allow rental assistance for a period of 60 days to individuals requiring health care services while transitioning from an acute care setting into the community. Medicaid dollars may not be used for long-term rental assistance. OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. CCOs have the freedom to offer health related services (flexible) services, in addition to covered health services, to improve care delivery and member health. Flexible services, specifically authorized through the current waiver, are cost-effective services offered instead of or as an adjunct to covered benefits (e.g., home modifications and healthy cooking classes). Community benefit initiatives are community-level interventions focused on improving population health and health care quality (see appendix D). The definition of Community Benefit Initiative has been clarified based on public comment on page 48 and Appendix D. OHA proposes to implement a reinvestment requirement that could involve a MLR standard of 88% with a tiered risk corridor of 3%. Those with an MLR below the 3% corridor (i.e., below 85%) must remit to the State the difference between their MLR and 85%. Those with an MLR within the 3% corridor (i.e., between 85% and 88%) may be eligible to retain some or all of the difference between their MLR and the 88% as long as it is reinvested in cost-effective health-related services. The expenditure authority reference under the existing authorities that will continue going forward is to allow payment for services rendered to an individual who should have been disenrolled at a certain time. All proposals within the waiver renewal will be implemented at the start of the waiver renewal period, July 1, 2017. However, the CHPs will not

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	be formed and underway until July 1, 2018 to allow an RFP process and development of CHPs. Oregon would like to expand the OPAL-K concept for adults. The proposal for expansion of the program does not require a waiver of federal law and can be pursued through existing authorities granted to the state. As a result of public comment, all references to an integrated budget have been replaced with the term integrated global budget. The global budget will continue to be used by the CCOs. OHA is proposing to expand nurse home visiting services through a State Plan Amendment to address maternal and child health.
188. **5-31-16 -- Oregon Pediatric Improvement Partnership & Oregon Pediatric Society** ● Please add language to waiver that includes a focus on children and adolescents. ● Supportive of housing pilots and social determinants work – concerned about the use of "vulnerable" ● A primary barrier that still exists, and is not explicitly addressed in these strategies, is the remaining siloed and differentiated contracts that exist within a CCO that carve out care, particularly behavioral health. ● Waiver heavily emphasizes building behavioral health providers. Should enhance behavioral health services that are provided within the primary care setting ● Need to improve the coordination and collaboration between service lines that exist in a CCO, specifically between physical health and behavioral health. ● Support expanding Access to Psychiatric Clinicians through Telephone Consultation. ● Refine and advance coordinated care model through expanded PCPCH program, HIT and Transformation Center. ● Home visiting supported. ● Move to More Outcomes Based Metrics for Measuring Performance and Quality Incentives ● Support flexible services ● More transparency in rate-setting needed	The waiver includes a focus on children through the expansion of the nurse home visiting program. Separate from the waiver, OHA will continue existing programs targeting at-risk children and adolescents. Additionally, CHPs will have the ability to define the populations they would like to target, including families with children, based on regional needs and the broad criteria for the population included in the proposal. The term vulnerable has been removed from the discussion of CHPs. OHA will work with the CHP advisory committee to further refine the definition of the target population - added to waiver on pages 31-32. OHA is currently engaged in various efforts to help further behavioral health integration. The following are focused on developing strategies to improve behavioral health integration and behavioral health workforce: • Oregon Health Policy Board's Healthcare Workforce Committee • Behavioral Health Information Sharing Advisory Group • Transformation Center • Certified Community Behavioral Health Clinics • Health Information Technology Oversight Council and Behavioral Health HIT Environmental Scan

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• Support value-based payments – helpful in serving CYSHCN (children and youth with special health care needs) • Availability of a workforce in a given community is dependent on appropriate payment – need a better-trained BH workforce	
189. **6-1-16 -- Coalition of Local Health Officials (CLHO)** Clarify definition of community-benefit initiatives under "health-related services" in the waiver renewal document • Identify future opportunities in the waiver renewal process for CCOs and PH to meet the social determinants goals of the waiver renewal. • A strong, clear, definition of "community benefit initiatives" that is supportive of population–based initiatives within the 1115 waiver renewal will allow for innovative partnerships to improve the health of the population. Recommendations: • Clarify the language in the TCM expansion section of the waiver document to include prenatal and programmatic expansions like the Healthy Homes program. • Expansion of the preventative TCM programs must accompany an allowance for growth beyond the 2% limitation and should be based on past record of savings. These programs are small within the Medicaid budget and expansion to new programmatic areas without allowing for growth would be very challenging. • If TCM programs will truly be "carved out" of the CCO Model we will want language in the CCOs' contracts to share data and still make the programmatic improvements that were envisioned with the integration proposed in the initial waiver. • The language in the waiver renewal document has some confusing and conflicting language in the TCM expansion section. • In 2015, the Legislature passed HB 3100, which amended ORS 431.416 and required the Local Public Health Authorities to coordinate with Coordinated Care Organizations. Including language in the 1115 Waiver that will support those partnerships is imperative and will assist Local Public Health Authorities to meet that obligation.	The community benefit initiatives are a category within health related services (previously defined as flexible services) and are intended to meet community needs. As a result of public comment, language has been clarified in the waiver proposal page 48 and Appendix D. As a result of feedback, OHA has provided more clarification around health related services (pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. OHA worked with CCOs in 2015 to improve transparency throughout the rate setting process. The full rate certification and CCO rates are posted on the OHA website. TCM is currently under the 2% test and will remain as such in the current waiver renewal. If there are plans for expansion, TCM programs and counties will need to have conversations with OHA to inform us about their plans for growth. Any county wishing to expand the Healthy Home program will need to consult with the OHA to determine if the expansion will fit within the 3.4% sustainable rate of growth. If a county wanted to pursue an expansion and there is not a substantial impact on aggregate health care cost growth, a state plan amendment could be pursued to enable expansion of the Healthy Home Program among other counties that are interested. OHA plans to continue to convene the existing workgroup to develop strategies to coordinate TCM services with other CCO provided services. Through the CHPs, CCOs will be expected to partner with local public health departments. See pages 33-34.
190. **6-1-16 -- CareOregon; Erinn Fair-Taylor, Director of CCO Partnership and Development; 315 SW Fifth Ave. Ste 900; Portland, OR 97204**	Through the Coordinated Health Partnership, Oregon is taking an important step in addressing an aspect of social determinants of health.

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• Will the waiver cover other social determinants than housing? • Where there are 2 CCOs, who would lead the CHP? • Do CCOs have to be lead – may be other entities that are appropriate and want to apply • How does the lack of housing affect the program? • Are CCOs already equipped to coordinate the care of the incarcerated population, or is this new capacity that each CCO will need to develop? • Suggests flexibility in the "opt-in/opt-out provisions of CHP (direct benefits v. care coordination) • When considering where to invest resources to expand use of electronic health records, or to improve health information exchanges, CareOregon requests that an emphasis be placed on the behavioral health setting. • Encourage more CCOs to leverage community partnerships in social service arenas. • CareOregon would support efforts that would help train our community partners to provide trauma informed care, and become more familiar with the contractual relationships that support coordinated work. • Along with VBPs, CareOregon requests that the OHA consider more ways for CCOs to be flexible with "pay-for-performance" (P4P) dollars. Currently, CCOs must use P4P funds to come up with new APMs to implement within the CCOs provider network. This hurts smaller CCOs with slimmer margins by limiting community investment. • What will happen to the dual eligible beneficiary that lives in an area with two CCOs? • What will happen to the dual eligible beneficiary that is currently assigned to one CCO, but belongs to a D-SNP affiliated with different CCO? • CareOregon would caution against applying this new policy proposal in manner that disrupts the managed care the dually eligible individuals are already receiving. • Supports the expansion of the role of the Transformation Center through further implementation of Project ECHO, OPAL-K and future substance abuse disorder work. CareOregon has found value in the technical assistance and shared learning opportunities provided by the Transformation Center, and look forward to building upon this beneficial relationship in the future. • Requests that the Transformation Center be tasked with helping CCOs navigate the barriers to care coordination that accompany restrictive federal regulations (e.g. HIPAA and the Fair Housing Act)	In addition, flexible services and community benefit initiatives can be used by CCOs to address other social determinants of health. Where there are two CCOs in a region, OHA would need to work directly with CHP advisory group and develop guidance. The advisory group has been developed as a result of feedback. See pages 31-32. Only CCOs or tribes have been identified as potential leads for the CHP. As a result of feedback, OHA has added language to encourage CHPs to collaborate with foundations and organizations to earmark funds for capital investments. See page 34. With the support of partner organizations and funding through CHPs, CCOs will be equipped to coordinate the care of the incarcerated population. OHA will provide supports through the Transformation Center. Individuals eligible for Medicaid coverage in Oregon can decide to participate in a pilot project and opt out at any time; individuals will be provided with information about their enrollment options to make an "informed choice." OHA expects to leverage new federal HIE funding to support onboarding costs to HIEs, including regional HIEs, for Medicaid providers that have typically faced barriers including behavioral health, long term care, dentists, and others. In addition, OHA will be conducting a scan and survey to assess the use of HIT in behavioral health settings in Oregon, which will inform further HIT efforts. Currently, a portion of incentive pool dollars (P4P dollars), must be paid to providers. However, that proportion has not been specified giving CCOs flexibility in how those dollars are spent. As a result of public comment, OHA has added a reference to encourage CCOs to support trauma informed care and services on page 29.

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• Encourages the Transformation Center to provide technical assistance to CCOs that are working to coordinate with ELHs in areas with multiple CCOs and overlapping geographic boundaries. • Any proposal that might change the way in which the surplus margin is calculated should take into account the unique challenges that each CCO may face within regional health care transformation. Specifically, critical access hospitals in rural areas often limit a CCO's ability to implement new ways to be cost effective when compared to urban areas. • CareOregon is in support of removing Targeted Case Management (TCM) from managed care capitation payments at this time. CareOregon also requests that delegation of Maternity Case Management program responsibilities align with the TCM delays.	Dual eligibles that live in an area with two CCOs will be enrolled using the same process as other members, which is based on previous enrollment, enrollment of other members on the case, and CCO area capacity limit. Added to waiver on page 53. Dual eligibles that are enrolled in a D-SNP will be assigned to the affiliated CCO. As a result of public comment, added to waiver on page 53. OHA will implement the dual eligible enrollment change over time and work closely with CCOs to minimize the impact to members. There does not appear to be any specific waiver of federal law needed to address the barriers to care coordination that accompany restrictive federal regulations. This issue, in particular that around 42 CFR Part 2, is already being addressed through other ongoing work within OHA. Through the Transformation Center's TA bank, CCOs can currently receive technical assistance around early learning. Support can be provided to build collaboration between local early learning hubs and CCOs. Capitation rate setting includes an adjustment for use of critical access hospitals. Specifics around how MLR is adjusted for use of critical access hospitals can be addressed during development of the guidance for value based payment arrangements and MLR.
191. **6-1-16 – Haven - Serving Victims of Domestic Violence and Sexual Assault; Tara L. Koch, Executive Director; PO Box 576; The Dalles, OR 97058** • To address social determinants of health, CCOs and healthcare providers should partner with advocates, who have the experience and knowledge to provide best practice services to survivors, and can assist with care coordination and case management, amongst core advocacy services such as safety planning, motivational interviewing, empowerment model services, access to housing, and legal advocacy, and other supportive services. • The Medicaid Waiver must empower CCOs to partner with advocates: community-based non-clinical providers who have Triple Aim impact.	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal.

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• Effective screening	
192. **6-1-16 -- Housing Alliance; Allison McIntosh** • Very supportive of CHP • Want OHA to give CHPs flexibility	CHPs will have the flexibility needed to define the populations they would like to target based on regional needs.
193. **6-1-16 -- Health Share of Oregon; Janet L. Meyer, Chief Executive Officer** • Any increase in funding through increased federal match for the CCBH program should be invested in those communities where CCBH development is most active and where community based provider organizations are most engaged in implementing the new model. • We hope the OHA is considering acting as a statewide hub for ECHO to be used in ways beyond psychiatric prescribing. • Recommend adding an 8th allowable PIP focus area to address social determinants of health and a 9th to address health equity. • Health Share operates at a 91-92% MLR and supported the 85% target MLR in the new federal Medicaid managed care rules. We recommend eliminating as much subjectivity as possible by clearly defining eligibility criteria for retaining some funding under the target MLR proposal. • CCOs are leaders in value-based payment (VBP) arrangements. However, the system cannot sustain a minimum percentage of such payment arrangements without 1) a concrete definition of VBPs and 2) a reasonable amount of time to pursue, acquire, and transition to such VBPs. • The OHA does not require consistent financial reporting across CCOs, so incentive programs based on quality and cost measures are troubling. • The success of community health partnerships will require an increase in CCO enrollment for the dual eligible members. If the "opt out" option is not implemented, we ask that the OHA also become a member participant to represent dual eligible. • Would like more clarity on how inclusion of these activities in rate setting will impact regional rate setting if CCOs in the same region have substantially different proportions of spending in these areas. • Urge the OHA to actively commit to pursuing the fundamental building blocks of a robust health information exchange. Examples of these building blocks include the development and implementation of a statewide provider directory and methodologies for patient identification and attribution.	In October 2015 Oregon was awarded a 1-year planning grant to prepare an application for the Certified Community Behavioral Health Clinic (CCBHC) demonstration, a two-year federal demonstration program that begins in January 2017. During the planning grant year Oregon must identify at least two organizations meeting the federal CCBHC criteria and develop a prospective payment system to reimburse CCBHCs for required services provided by these organizations. OHA is currently working on an advisory committee comprised of stakeholders from across Oregon to develop the application. OHA is not requesting additional waiver authority or funding for this program since it is being funded through a separate federal demonstration program and is outside of the scope of the 1115 demonstration. OHA is currently refining the financial reporting requirements within Exhibit L which is used across CCOs to report financials. As a result of public comment, OHA has incorporated an 8th focus area for the Performance Improvement Projects to address social determinants of health. OHA encourages CCOs to address health equity throughout all of the PIPs and quality improvement focus areas. See page 127 for the revised language. OHA will work with its actuarial firm to assess the regional impacts of the program. OHA is exploring opportunities to make Project ECHO available to primary care providers statewide on a variety of topics. OHA proposes to implement a reinvestment requirement that could involve a MLR standard of 88% with a tiered risk corridor of 3%. Those with an MLR below the 3% corridor (i.e., below 85%) must remit to the

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• EDIE (and PreManage) is the first step toward this, but we have a long way to go. • Expanding access to traditional health workers (THWs) is a priority for Health Share. We have recently engaged researchers to help determine the best payment methodology to sustain this workforce. • OHA currently requires CCOs to use qualified and certified HCIs, but there are still not enough to cover the need. CCOs have asked for this language to be removed from the CCO Contract until there is a sufficient workforce to meet the needs of our membership. • It is not realistic or reasonable to suggest that doula care can affect the disproportionate rate of preterm birth, low birth weight and infant mortality that some communities of color face. To assert that they can have an impact on infant mortality rates is unfair to doulas and unfounded. • Health Share opposes the request to waive the requirement that doulas be supervised by licensed medical providers. The purpose of the oversight by a licensed practitioner is not to instruct or direct the work of the doula, but to ensure that the care the doula provides is coordinated with the rest of the maternity care team. • Even if CCOs are required to offer to contract, IHS providers have little incentive to contract with CCOs, since CCOs are already required to reimburse them as network providers.	State the difference between their MLR and 85%. Those with an MLR within the 3% corridor (i.e., between 85% and 88%) may be eligible to retain some or all of the difference between their MLR and the 88% as long as it is reinvested in cost-effective health-related services. OHA intends to align with existing federal guidance (e.g., MIPS and APMs) to develop definitions of value based payment arrangements. Implementation of value based payment arrangements will be phased in over the waiver renewal period. If Opt Out option for dual eligible does not move forward, the suggestion to include duals as FFS in CHP is noted and will be assessed. OHA is committed to pursuing the building blocks of a robust health information exchange infrastructure across Oregon, beyond the Emergency Department Information Exchange and PreManage bringing real-time hospital notifications to CCOs, practices and hospitals statewide. OHA will launch a critical component of this infrastructure, a statewide Provider Directory, in 2017. While Oregon has myriad health information exchange efforts in place within some regions and organizations, many gaps remain. OHA's Health Information Technology Oversight Council (HITOC) will revised Oregon's strategic plan over the next year or so, and explore partnership opportunities to ensure we have the infrastructure needed to support CCOs and health system transformation. OHA will continue to support the training and use of traditional health workers and health care interpreters. OHA will review CCO contracts to ensure the language supports this goal, yet recognizes that the workforce is still being expanded. In combination with other efforts, doulas are a part of Oregon's overall strategy to improve birth outcomes funded by Medicaid by addressing health inequities in Oregon's birth outcomes. The proposed change to waive the doula supervision requirement is a result of discussions with the doula workgroup and will remain in the waiver proposal.

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	As a result of tribal consultation, OHA added the provision to require CCOs to contract with willing providers. See pages 42-44
194. **5-28-16 -- Primary Health of Josephine County; Roylene Dalke, Chief Executive Officer** ● Have focused on behavioral health integration under transformation ● Encourage more attention to trauma-affected children ● Supportive of CHP to assist with trauma recovery	As a result of public comment, OHA has added a reference on page 29 to encourage CCOs to support trauma informed care and services.
195. **6-1-16 -- Oregon Association of Hospitals and Health Systems (OAHHS); Andrew S. Davidson, President and CEO** ● Hospital members have begun committing to community solutions to address our state's significant behavioral health challenges and appreciate the potential opportunity presented in the waiver to continue the development of local solutions. ● Urge OHA to recognize hospitals ongoing implementation of VBP involving both Medicare and Commercial ● Extremely supportive of HTPP	The HTPP program included in the waiver renewal acknowledges hospitals commitment to address behavioral health challenges.
196. **5-31-16 -- Sharon Brigner, MS, RN Deputy Vice President, State Advocacy; PhRMA; 202-835-3489** ● Oregon should finalize its proposal to ensure meaningful access to emerging therapies o Exclude Hep C, cystic fibrosis drugs, biologics, and behavioral health drugs from sustainable growth rate o Make newly approved drugs available (e.g. Hepatitis C; Cystic Fibrosis) o Cover all covered outpatient drugs as medically necessary ● PhRMA seeks additional information and engagement with OHA regarding proposed value-based methodologies o What will be mandated? o Want to ensure access to care o Concerned about how OHA will measure efficacy of value-based payments ● PhRMA seeks additional information and engagement with OHA regarding rate-setting methodologies o Wants to ensure that changes to CCOs rate-setting methodologies do not diminish access or quality of care	Given the unpredictability of emerging high-cost drug therapies and their rapidly rising share of health care spending, OHA recommends that high cost, emerging therapies such as drugs for Hepatitis C and Cystic Fibrosis and biologics are excluded from the sustainable rate of growth calculations. OHA will require CCOs to enter into value based payment arrangements with network providers. OHA intends to align with existing federal guidance (e.g., MIPS and APMs) to develop definitions of value based payment arrangements. OHA will ensure that value based payment arrangements improve outcomes, access, and reduce waste in the healthcare system. The waiver continues the state test for quality and access used to ensure access and quality of care are not diminished (see appendix C). If health related services are included in the medical portion of the rate, investment in these services will increase and not decrease the MLR. See concept paper in appendix D for further discussion.

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o Concerned about how health-related services being calculated in medical rate will impact rate calculation and MLR	
197. **5-31-16 Coco Yackley, private citizen (OHSU)** ● Quality metrics for OHA should be published and produced publicly in the same manner as CCO quality metrics. Suggested metrics: o 90% of clients receive enrollment/re-enrollment confirmation within x days. This speaks to the pace of the central office able to manage enrollments o x% of clients re-enrolled within 60 days of having lost coverage. This speaks to the ease of the system to enroll. o % of client records age 18+ that have all REAL-D fields completed o % of claims submitted within 30 days of visit. This puts pressure on the 'overall system' to get claims in quickly so we have more accurate tracking to performance ● Allow for controlled studies with marijuana -- The number of medicinal products with marijuana are only going to explode in numbers over the coming years. Combine that with the disturbing numbers concerning opiate additions and chronic pain management therapies, it seems like Oregon is in a prime position to assist CMS with real research in this area of marijuana products such as topical rubs as alternative to other prescription drugs. OHSU has excellent research capabilities. We have all the correct pieces to support proper 'trusted' research in this area. If not Oregon, then who?	OHA is developing a new quarterly report to the legislature focused on CCOs and health system transformation. As part of this report, OHA intends to include metrics related to enrollment, eligibility, renewal, and other process improvements such as call wait time, application backlog, etc. The first of these reports will be published in mid-July. OHA is also developing better ways to monitor claims submission dates and identify areas for improvement based on dates as well as claim type, although OHA notes that CCOs have 6 months from date of service to submit claims as per their contracts. Marijuana controlled studies are outside of the scope of the 1115 waiver renewal.
198. **6-1-16 -- KEPRO – 777E. Park Dr. Harrisburg, PA 17111** ● Concerned that the change to an "opt-out" system will have unanticipated implications to the OHP. ● The dual populations, currently being managed in the open-card system, includes some of the most difficult to manage patients and would demand considerably more costs from CCO global budgets, limiting an organization's ability to continue local care delivery innovations. ● The team of care coordinators and network of clinicians have been working with this population for several years and are uniquely in tune with their care needs. ● Each year KEPRO's efforts to manage this population have created additional savings for OHP and through these savings have created additional access for more than 30,000 members.	OHA is proposing to automatically enroll dual eligibles into CCOs with the option of opting out. There are various state and national studies that show improvements in dual eligible outcomes, reduced inpatient hospital stays and readmissions after enrolling dual eligible beneficiaries into managed care.

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● Drastic shifts in their OHP placement could undermine advances made in treating and stabilizing their conditions.	
199. **6-1-16 -- Oregon Region Providence Health and Services; James L. Mason, Ph. D. Chief Diversity Officer; 4400 NE Halsey Street, Suite 595, Portland, Oregon 97236** ● Would like to see more specific language referencing populations with disparate outcomes. "Vulnerable" is too broad and "the result will be more generic, and race blind/neutral strategies which will lead to fewer culturally appropriate service innovations and programs." ● We need better data on the health outcomes of linguistically, ethnically, racially diverse groups, including refugees and immigrants.	In 2015, OHA implemented the REAL +D data legislation that is intended to collect standardized race, ethnicity, language and disability status data at a disaggregated level to unmask inequities in health outcomes between and within populations/groups. This data will be helpful in identifying differences in health outcomes between racially, ethnically, and linguistically diverse groups. As a result of public comment, the term vulnerable has been removed from the waiver. OHA will work with the CHP advisory committee to further refine the definition of the target population - added to waiver on page 31.
200. **6-1-16 -- Alberto Moreno, Co-Chair; Kayse Jama, Co-Chair; Oregon Health Equity Alliance; 240 N Broadway, Suite 115, Portland OR, 97007** ● Urge OHA to prioritize development of metrics and data collection in this area to inform the targeting of interventions and the evaluation of their effectiveness. ● Recommend a greater articulation of an 'Equity Strategy' as an amendment to the renewal request. ● Look forward to working with OHA to create a plan to develop a strategy on health equity that includes immigrants and refugees, linguistically diverse, people with disabilities, and other vulnerable populations. We urge a greater focus on it in Appendix C. ● Recommend a greater integration of THWs in Oregon's plan for health transformation.	OHA's is committed to reporting on all measure sets, where possible, by race, ethnicity, language, disability, and for other vulnerable populations (e.g., gender, age, geography, etc). Additionally, the metrics & scoring committee has been working on developing methodologies to define metrics that address social determinants of health and health equity. In 2015, OHA implemented the REAL +D data legislation that is intended to collect standardized race, ethnicity, language and disability status data at a disaggregated level to unmask inequities in health outcomes between and within populations/groups. This data will be helpful in identifying differences in health outcomes between racially, ethnically, and linguistically diverse groups. OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission.
201. **6-1-16 -- Kristina Narayan, Policy and Research Coordinator; Asian Pacific American Network of Oregon** ● APANO recommends a greater articulation of an 'Equity Strategy' as an amendment to the renewal request, including that includes immigrants and refugees, linguistically diverse, people with disabilities, and other vulnerable populations.. We urge a greater focus on it in Appendix C.	OHA is committed to reporting on all measure sets, where possible, by race, ethnicity, language, disability, and for other vulnerable populations (e.g., gender, age, geography, etc). Additionally, the metrics & scoring committee is interested in addressing social determinants of health and health equity.

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• Additionally we urge the OHA to explore how CBI and flexible services can orient toward a more patient-centered service model. • We urge OHA to prioritize development of metrics and data collection in this area (specific to housing and supportive services) to inform the targeting of interventions and the evaluation of their effectiveness.	Health related services (flexible services) are cost-effective, patient-centered services offered to individuals instead of or as an adjunct to covered benefits (e.g., a child has asthma and there is a need for mold removal in the home). The definitions have been clarified as a result of public comment (see pages 48-49 and Appendix D). OHA intends to conduct a robust evaluation of the CHP and will develop metrics and reporting requirements in collaboration with the CHP advisory group.
202. **5-12-16 -- WOAHCCO; Phil Greenhill, Executive Director** • Very supportive of waiver in general, and especially housing initiatives, but concerned that funding may not be adequate to ensure success. • Concerned about HIE and the overall management of PHI - suggests an interpretation from CMS pertaining to a similar status as the ACO's and the Data Use Agreement structure they operate under. Concerned about meeting the letter of the law. • Concern about MLR. Will it move us backwards toward FFS?	OHA is working to determine the appropriate level of funding for the CHP. OHA agrees that legal and policy requirements such as HIPAA and 42 CFR Part 2 (requiring specific patient consents related to addiction treatment) can create barriers to health information exchange and management of protected health information. OHA has endeavored to make resources available related to behavioral health information sharing, and has provided comment to SAMHSA on new rules related to 42 CFR Part 2 related to the QSOA provisions that can be used by CCOs to ensure appropriate sharing of PHI. CMS Managed Care Regulations establish an MLR beginning 2018. The proposed use of MLR is consistent with federal regulations and the recommendations from an audit by Office of Inspector General. Discussions are underway with CCOs to avoid unintended consequences such as promoting FFS payment models.
203. **5-25-16 -- Klamath County Juvenile Department; Dan Golden, Director** • OHP coverage for initial mental health assessments for youth in juvenile detention • OHP upon release. If we could do that, we could screen youth into mental health and A&D treatment regularly, and they would be less at risk when they get out.	OHA will explore whether the CHP target population should include pre-adjudicated juveniles. Included in waiver on page 30. Incarceration does not prevent an individual from being found to be Medicaid eligible or from remaining enrolled in Medicaid. Additionally, state Medicaid agencies must accept applications from incarcerated individuals. Though an incarcerated individual can remain enrolled and be found Medicaid eligible, they currently are unable to receive Medicaid covered services and no FFP may be claimed for services to inmates of a public institution. The waiver renewal requests that

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	preadjudicated individuals are able to receive care coordination and case management services at a minimum while incarcerated.
204. **5-19-16 -- Wasco County Youth Services; 202 East Fifth Street; The Dalles, OR 97058; 541-506-2660; Molly Rogers, MJM, Director** Sent recommendations of 2015 Juvenile Justice Task Force	OHA will explore whether the CHP target population should include pre-adjudicated juveniles. Included in waiver on page 30.
205. **6-1-16 -- Jack Howard, Union County Commissioner; Phone 541-963-1001; Cell 541-786-7142** Supportive of CHP program and the potential effect on county jails and their populations. Concern that data show that adjudication referrals are peaking "well past" 30 days in Union County. Suggests that services may be needed up to 60 days.	OHA analysis support the request for 30 days of care coordination services for pre-adjudicated individuals. At this time, OHA is not considering adjusting the timeframe to 60 days. OHA will perform further data analysis to assess time of adjudication referrals.
206. **5-18-16 -- Eastern Oregon Coordinated Care Organization (EOCCO); PO Box 40384; Portland, OR 97240; Sean Jessup, Director Medicaid Programs; 503-265-4748** Would like OHA to include all Oregon hospitals in the HTPP program, specifically the rural Type A/B and Critical Access hospitals in Oregon that are currently excluded from participation. Would like the target MLR eliminated and/or reconsider the reinvestment provision. Concerned that OHA would like to set an MLR higher than 85% with reinvestment requirements. Support value-based payments, but with flexibility for smaller practices, critical access and others.	OHA will not be able to include rural Type A and B hospitals in the HTPP program because they are exempt from the provider tax, which is a requirement to participate in the program. OHA proposes to implement a reinvestment requirement that could involve a MLR standard of 88% with a tiered risk corridor of 3%. Those with an MLR below the 3% corridor (i.e., below 85%) must remit to the State the difference between their MLR and 85%. Those with an MLR within the 3% corridor (i.e., between 85% and 88%) may be eligible to retain some or all of the difference between their MLR and the 88% as long as it is reinvested in cost-effective health-related services. More information can be found on pages 48-50 and in Appendix D. OHA intends to align with existing federal guidance (e.g.,MIPs and APMs) to develop definitions of value based payment arrangements. Implementation of value based payment arrangements will be phased in over the 5 year waiver renewal period to allow for small practices to develop capability.
207. **5-27-15 -- Julia Lager-Mesulam, LCSW Partnership Project Director** ● Did not see the current Targeted Case Management Program that exists for those living with HIV included in the document ● As a TCM HIV provider wants to make sure that this is included – great savings through viral suppression	OHA is proposing to continue to carve out the TCM program from the global budget. Counties can continue to administer and operate TCM programs under the existing FFS system.

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208. **5-3-16 -- Autism Society of Oregon; Tobi Rates, Executive Director** ● The EPSDT waiver should be removed ● Necessary services must be made available for treatment of all EPSDT-diagnosed conditions.	To support Health System Transformation, OHA intends to continue to maintain current language that restricts coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one.
209. **5-27-16 -- Oregon Law Center; Beth Englander, State Support Unit Attorney; 522 SW 5th Ave., Suite 812 Portland, OR 97204; 503-473-8321** ● The application does not sufficiently address how the goals of the 1115 demonstration waiver program and Oregon's health care transformation goals are met by the continued use (and very strict application) of the OHP Prioritized List ● The approval of the Prioritized List appears inconsistent with §1115 of the Social Security Act if the state cannot provide such evidence ● Continued use of the Prioritized List appears to contradict the state's goals and strategies towards achieving Transformation. ● If the continued use of the Prioritized List of Services is approved, it should require expanded coverage and variances where services are medically necessary. ● The application should be explicit that additional "flexible services" or "health related services" must comply with constitutional and Medicaid due process procedures (i.e. denial of services) and other quality assurance safeguards.	CMS's 1115 waiver website allows states to use demonstrations to demonstrate and evaluate policy approaches such as Oregon's prioritized list. Removal of the prioritized list would cause a budget impact that could result in the removal of optional Medicaid benefits such as prescription drugs, durable medical equipment, outpatient mental health and substance abuse treatment, etc. Additionally, provider rates could be lowered, which could create access issues for Medicaid patients. The prioritized list allows the state to efficiently spend state and federal dollars on a set of services proven to improve population health. Services paired below the funding line generally treat conditions with a less serious impact on health and/or no effective treatment. The comorbidity rule allows these conditions to be treated when treating them would improve a funded condition. OHP provides a Member Services Line for recipients, a Nurse Advice line for providers, and an appeals process by which recipients and their providers can address concerns about coverage of services under the prioritized list. The HERC ranks effective preventive services near the top of the List and its methodology also raises the priority of conditions for which treatment would minimize the consequence of a disease once it has developed (tertiary prevention). HERC staff has coordinated with metrics staff to ensure that the prioritized list does not create a barrier to attainment of performance measures. The HERC has recognized that the list is limited in that it deals with discrete condition-treatment pairs. Therefore, it is working increasingly to address the broader context of a patient's care by including statements on multisector interventions as well as looking at specific conditions such as obesity which are related to a large number of discrete health conditions.

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	OHA, including the HERC, must comply with nondiscrimination provisions of the ACA and the ADA. The HERC has addressed issues where the list could be construed to discriminate based on various factors including age and expected length of life. The HERC's prioritization criteria specifically raise the priority of conditions with a large impact on healthy life, which in effect raises the priority for disabling conditions. Disabilities advocates were fully engaged in the creation of the prioritized list
210. **6-1-16 -- Paul Terdal; 503-984-2950; 700 NW Macleay Blvd, Portland, OR 97210** EPSDT – Early and Periodic Screening Diagnosis and Treatment ● Oregon should remove the EPSDT flexible language from the waiver. It serves to keep needed care from children ● If the clause isn't removed, it should be clarified to better confirm Congressional intent, with the following conditions: ● If service is above the line EPSDT applies, with no caps on amount, duration and scope. Coverage of care must be based on individualized determinations and correct or ameliorate standard. ● If service is below the line, parents or providers may appeal and receive service based on individualized determination of medical necessity. Oregon must provide a simple appeal process, with the right by parents to judicial review, guaranteeing coverage of service based on individualized determination of medical necessity. HERC - Health Evidence Review Commission HERC has several insurance industry representatives, and no bonafide consumer representatives. The HERC membership clause in Oregon's section 1115(a) waiver should be clarified to specify: ● No more than one HERC member may be an executive, employee, or board member of an insurance company or CCO ● Consumer Representatives must be bonafide consumer representatives who are either (a) Medicaid recipients, or the parents or guardians of Medicaid recipients; or (b) representatives of non-profit advocacy organizations representing the needs of Medicaid consumers	To support Health System Transformation, OHA intends to continue to maintain current language that restricts coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one. The HERC member composition in the waiver references what appears in Oregon Revised Statutes. Any changes to these requirements would have to be initiated through the legislative process.
211. **5-25-16 -- Allcare Health; Doug Flow, Chief Executive Officer**	OHA is proposing to allow rental assistance for a period of 60 days to individuals transitioning from an acute care setting into the community.

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• Are there other creative ideas that could help give CCOs tools to help those in need? One idea might be to allow for up to 12 months of rental assistance (with reviews done every 90 days). • How exactly is the "accountability framework" going to work? • In Southern Oregon there simply isn't enough affordable and transitional housing. To make this work we are going to need to build new structures. Will there be flexibility for CCOs to invest in the front end of housing projects to get building going (land, construction, etc…)? • With such a large needed coalition (demonstrate partnership and commitment among county and city government, local health departments and housing agencies, hospitals, affordable housing providers, and supportive housing service providers etc…) what happens if you have one bad actor? Are these all the right players to be at the table? How do you manage such a diverse group when you touch a myriad of communities? • How will the CHPs work when there are multiple CCOs in a region? How will funding be distributed? • Is there a way to break down some of the federal barriers between CMS and HUD especially when it comes to funding of projects? • Can we include in the waiver the ability to share information between housing assistance and the CCOs to see which of our members have housing and which members are in need of housing? • Consider holding off on including specific metrics to be measured until a committee like the Metrics and Scoring Committee can meet to develop meaningful, measurable and transformational metrics. • There is no mention of the Community Health Improvement Plans (CHIPs) which allows our members to help guide our CCO to invest in programs to improve the health of our communities. This was a vital part of the waiver process in 2012 and could help in your current negotiations. • There is no mention of the Transformation Plans done by the CCOs which show that the CCO model can deliver on what it promises. • Page 3 of the draft waiver: this would be a great place to mention metrics which show improving health for our OHP members. • Page 5: this would be a great place to mention some CCOs are also helping break down silos in other sectors (educational HUBs, social services, etc…). • Page 22 at the top: how do the metric menus get selected? • In the preamble to the waiver demonstrations project on Page 23, we would recommended adding "Children" to the list of targets and "transportation" as a tool	At the moment, the state is not considering an extended timeframe for this group. OHA will work with CMS and the CHP advisory group to develop accountability mechanisms. Although Medicaid does not allow federal dollars to be used for capital investments, OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. This modification was made as a result of public comment (see page 34). CHP leads will be responsible for coordination with all partner entities participating in the CHP. CHPs may select to involve other entities and organizations that serve the targeted populations selected by individual regions. Other entities could include those focused on diversity, disabilities, aging, youth, etc. CHPs will include the following entities: • CCOs • Tribes • County agencies • Corrections • Health providers • housing entities • local hospitals • other entities serving or advocating for the targeted population Where there are multiple CCOs in a region, OHA would need to work directly with CHP advisory group and develop guidance. The advisory group has been developed as a result of feedback. See pages 31-32. As a result of feedback, OHA will convene a CHP advisory group to provide recommendations for program implementation. See pages 31-32. Federal dollars from CMS and from US Department of Housing and Urban Development can both be used to support the CHPs and CHPs will be encouraged to seek funding through partners. However, the

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needed to make this housing project work (this is especially critical to rural communities). ● Page 54: the evaluation is missing a great deal of the successes accomplished by the CCOs, including, but not limited to, merging dental and mental health inside the CCOs, Non-Emergent Medical Transportation, local governance, the CHIPs, the Community Advisory Councils, quality metrics improvements, nearly seamlessly bringing on half a million people on to OHP without an interruption of care, work with Education HUBs, etc. ● Clearly define an integrated budget (or global budget) explaining CCOs have local controls needed to put resources in the right places to improve the health of the communities we serve o One suggestion would be to have a definition of terms at the beginning of the document to help avoid any confusion in the future and make the document more accessible to the public. ● Use much clearer language explaining both flexible services and community benefit spending will be included in the 85% MLR (a definition of terms might help with this as well). ● Remove 2.b. on page 40. This is overly complicated, takes away needed CCO flexibility and could have unintended consequences. ● Remove 4 on page 41. This creates more confusion and seems to be encouraging the old "Fee for Service" way of thinking when it comes to rates. ● Create a metrics and scoring committee to identify standards in measuring successes in investments in the social determinants of health. ● Commit to working with more providers around Alternative Payment Methodologies (APMs) but do not force providers into value based payments. Providers are just getting comfortable with APMs and we need to keep getting community buy in to the new "pay for value" model before we force them to readjust to a new funding scheme. ● We very much support adjusting the Oregon Medicaid rate of growth cap of 3.4% when considering items the state or CCOs cannot control such as FQHC rates and high cost, emerging drug therapies. We would ask that you, along with hepatitis C drugs and biologics, also call out new oncology drugs as well.	funding must be used for defined purposes. For example, Medicaid funding may not be used to build housing or pay for rent. OHA will support the health information technology (HIT) component of CHPs by building upon the current physical health-centric health information sharing infrastructure to support data exchange between the partners involved, including between corrections, social services, CCOs and health care providers. See page 32 OHA will reference all of the work under the 2012 waiver, including Health Transformation Plans and Community Health Improvement Plans, to inform our efforts and areas for improvement as we move into HST 2.0. Waiver authority is not required to pursue this work. Key accomplishments of the current demonstration, including metrics improvements, are highlighted in the historical narrative portion of the application. CHPs will have the ability to clearly define the populations they would like to target based on regional needs. CHPs will look different in rural and urban areas and will be dependent on regional needs identified by the CCO and its partners. The integrated global budget, as described by Oregon statute (ORS 414.025), means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization. As a result of feedback, this definition has been added to the proposal (see page 48). As a result of feedback, OHA has provided more clarification around health related services (see pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. Spending on health related services would be included in the numerator in MLR calculations. CCO spending on health-related

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	services is to be included in the base of the CCO capitation rate, any reinvestment in these types of services would also be included in the base and therefore would remain in the system. To further Health System Transformation, OHA will retain proposed language around the target MLR standard and the CCO performance incentive program. The CCO metrics & scoring committee is interested in addressing social determinants of health and will inform metrics in this area. OHA will continue to work with CCOs to support them in moving towards value based payment arrangements. Federal guidance encourages a movement in the direction of value based payment arrangements and OHA will implement strategies to move the state towards the national progression. The definition of emerging "high cost drugs" still needs specificity. OHA will explore adding oncology drugs.
212. **Lane County Board of Commissioners; Faye Stewart, Chair** ● Urges the OHA to provide a definition of community benefit that includes those population health strategies that are demonstrated to impact the health of the community- it should not be equated with only health care quality, but should instead include the important work that public health and others are doing to address social determinants and improve the health of the population.	As a result of feedback, OHA has provided more clarification around health related services (see pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health.
213. **Multnomah County; Deborah Kafoury, Chair** ● Include existing networks (county-funded network of social service CBOs and Area Agencies of Aging) in CHP pilot. ● Add clearer incentives for population management, not just high-need patient management. ● Explicitly call out Health Equity needs to address highest prevalence conditions for racial/ethnic groups; add mechanism to track disparities across CCO outcomes by race/ethnicity. ● CHP - add specific requirements to engage and fund community partners and counties.	CHPs may select to involve other entities and organizations that serve the targeted populations selected by individual regions. As a result of public comment, community based organizations or other entities could include those focused on diversity, disabilities, aging, youth, etc. See page 34. Through the waiver renewal, OHA seeks to further address the social determinants of health through the CHP pilot and an emphasis on flexible services. Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health.

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• An expected percentage of funds should be passed through partners already on the ground. • Provide CCOs/stakeholders with clear direction to ensure THWs/CHWs can be paid for their work without moving CCOs back to FFS. • Dual eligibles - ensure auto enrollment process doesn't break alignment between plans when consumer's plans are already aligned. • Require a set portion of savings be earmarked for public health services and prevention strategies that benefit Medicaid members. • Define HIE entities and regional entities; secure messaging may be more appropriate for provider organizations (pg 15-16) • Resolve the problem with CCO data pertaining to race, ethnicity, and language. • Include "culturally specific providers" as a category in 2nd paragraph, Appendix A, pg 8. • Include "culturally competent" in last sentence, 1st paragraph to describe delivery (Appendix A, pg 9). • Include more mandates for metrics that are driven by public health; require stronger partnerships between CCOs, Local Public Health Authorities, and Area Agencies on Aging. Call out DHS as key partner helping to implement waiver. • Attachment B - clarify who's responsible: CCOs or health plans. • Goal 2, Aims and Objectives #1 (pg 22) include better demographic data collection and coordination between CCOs and Medicaid program. • Goal 3, Aims and Objectives #1 (pg23) add language about "equitable" patient access across languages. • Add deadlines throughout document to ensure accountability • Appendix D Concept Paper - define "provider" and include public health agencies as providers. • Page 3, #3 - include Local Public Health Authorities together with network providers.	OHA is committed to reporting on all measure sets, where possible, by race, ethnicity, language, disability, and for other vulnerable populations (e.g., gender, age, geography, etc). Additionally, the metrics & scoring committee has been working on developing methodologies to define metrics that address social determinants of health and health equity. As a result of public comment, OHA has incorporated an 8th focus area for the Performance Improvement Projects to address social determinants of health. OHA encourages CCOs to address health equity throughout all of the PIPs and quality improvement focus areas. See page 127 for the revised language. It is not completely clear where exactly to make edits on pages 8 and 9 of Appendix A. As a result of feedback, OHA will convene a CHP advisory group to provide recommendations for program implementation. See page 31-32. OHA is requesting federal funding to support and develop CHPs. CCOs will receive the funding but will be required to distribute some portion of the funding to CHP partners. OHA will implement the dual eligible enrollment change over time and work closely with CCOs to minimize the impact to members. Through the CHPs, CCOs will be expected to partner with local public health departments (see pages 33-34). However, funds will not necessarily be earmarked or required for reinvestment in public health services. OHA added further description on HIE and OHA's commitment to statewide Direct secure messaging as providing basic connectivity across the state. In particular, HIE entities include several regions and organizations in Oregon who have invested in data sharing infrastructure (many of which support Direct secure messaging as one component) – such as Jefferson HIE associated with 5 CCOs and several regions and

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	the Regional Health Information Collaborative associated with IHN CCO. The HIT Aims and Objectives (Attachment B of Appendix A) for Goal 2 indicates a critical role that "systems" play in supporting HIT-optimized health care. In this context, we refer to "systems" to mean both CCOs and health plans." The HIT Aims and Objectives are under review by HITOC as part of updating Oregon's HIT Strategic Plan. OHA will include your comments in its work with HITOC (e.g., related to demographic data and coordination, and equitable patient access to health records across languages). OHA will work with CMS to develop accountability mechanisms. Public health agencies may be providers in the context of health related services or community benefit initiatives.
214. **Saving Grace; Janet Huerta, Exec Director** Interpersonal violence ● CCOs must be explicitly encouraged to use Flexible Services to fund advocacy services for survivors of intimate partner violence. ● The Waiver must explicitly list intimate partner violence as a social determinant of health to be addressed, as currently CCOs are not prioritizing this as an important issue, despite its well documented health effects and costs. ● The Medicaid Waiver must empower CCOs to partner with advocates: community-based non-clinical providers who have Triple Aim impact. ● Additionally, partnerships between advocates and healthcare offers one of the most exciting and largest potentials for primary prevention of this social determinant of health. ● Effective screening - Despite this opportunity healthcare is still not adequately addressing this social determinant of health.	As a result of public comment, we have made modifications to the waiver proposal. CHPs will have the flexibility to address interpersonal violence under the homelessness prevention/ transitions of care domain. See page 29 of the waiver proposal

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215. **Washington County, Dept. of Health and Human Services; Marni Kuyl, Director** ● Clarify/define community benefit and "activities that improve health care quality." ● Allow TCM programs to growth beyond 2% limit; specify that TCM expansion includes prenatal and expansion of programs such as Healthy Homes. ● Require CCOs to engage and fund community partners and counties. ● Add language about payment structures for THWs outside of FFS. ● Require set funds be earmarked for reinvestment in public health services and prevention. ● Require stronger partnerships between CCOs, Local Public Health Authorities, and Area Agencies on Aging. ● Include LPHAs in CCO value-based payment arrangements.	As a result of feedback, OHA has provided more clarification around health related services (see pages 48-49 and Appendix D). Health related services collectively refers to flexible services and community benefit initiatives (CBIs). Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. TCM is currently under the 2% test and will remain as such in the current waiver renewal. If there are plans for expansion, TCM programs and counties will need to have conversations with OHA to inform us about their plans for growth. Any county wishing to expand the Healthy Home program will need to consult with the OHA to determine if the expansion will fit within the 3.4% sustainable rate of growth. If a county wanted to pursue an expansion and there is not a substantial impact on aggregate health care cost growth, a state plan amendment could be pursued to enable expansion of the Healthy Home Program among other counties that are interested. OHA plans to continue to convene the existing workgroup to develop strategies to coordinate TCM services with other CCO provided services. Through the CHPs, CCOs will be required to engage counties, local public health departments, and community partners. OHA is requesting federal funding to support and develop CHPs. CCOs will receive the funding but will be required to distribute some portion of the funding to CHP partners. OHA will continue to support the training and use of traditional health workers including supporting the Traditional Health Worker Commission and working with them to explore payment structures outside of FFS. Through the CHPs, CCOs will be expected to partner with local public health departments (see pages 33-34). However, funds will not necessarily be earmarked or required for reinvestment in public health services.

General Letters of Support

1. **5-18-16 -- Oregon Health Leadership Council; Greg Van Pelt, President**
   General Letter of Support
2. **5-18-16 -- Eastern Oregon Coordinated Care Organization (EOCCO); Kevin Campbell, CEO; PO Box 40384; Portland, OR 97240**
   General Letter of Support
3. **5-19-16 -- Oregon Health Care Association (OHCA); Jim Carlson, CEO; 11740 SW 68th Parkway, Ste. 250; Portland, OR 97223; 503-726-5260**
   General Letter of Support
4. **5-19-16 -- Association of Oregon Community Mental Health Programs (AOCMHP); Cherryl Ramirez, Executive Director**
   General Letter of Support with encouragement to continue with the strong behavioral health and social determinants of health focus.
5. **5-20-16 -- Providence Health & Services; Dave Underriner, Chief Executive 4400 N.E. Halsey St., Building 2 Suite 599; Portland, OR 97213**
   General Letter of Support
6. **5-20-16 -- Health Share of Oregon**
   - Adventist Health
   - CareOregon
   - Central City Concern
   - Clackamas County
   - Kaiser Permanente
   - Legacy Health
   - Multnomah County
   - Oregon Health & Science University
   - Providence Health & Services
   - Tuality Healthcare
   - Washington County

   General Letter of Support
7. **5-24-16 -- Lane County Board of Commissioners; Faye Stewart, Chair**
   General Letter of Support
8. **5-25-16 -- Medicaid Advisory Committee; Janet E. Patin, MD; Karen Gaffney, MS; Co-Chairs; 500 Summer Street, NE; Salem OR 97301**
   General Letter of Support
9. **5-25-16 -- Allcare Health; Doug Flow, Chief Executive Officer**
   General Letter of Support
10. **5-26-16 -- Trillium Community Health Plan; Chris Ellertson, Chief Executive Officer**
    General Letter of Support – described Trillium successes
11. **5-31-16 -- Family Care Health; Jeff Heatherington, Chief Executive Officer**
    General Letter of Support
12. **6-1-16 -- Willamette Neighborhood Housing Services; Jim Moorefield, Executive Director; 257 SW Madison Ave., Ste. 113; Corvallis, OR 97333**
    General Letter of Support

13. **6-1-16 -- Linn Benton Health Equity Alliance; Karen Levy, Chair**
    General Letter of Support
14. **6-1-16 -- Coalition of Local Health Officials (CLHO); Morgan Cowling, MPA, Executive Director**
    General Letter of Support
15. **6-1-16 -- Oregon Nurses Association; Jenn Baker, Director of Health Policy and Government Relations**
    General Letter of Support. ONA encourages CCOs to further innovate and look to social determinates of health, like housing and food insecurity, and applauds the efforts outlined in the waiver that will move Oregon in that direction.
16. **6-1-16 -- KEPRO; 777 E. Park Dr. Harrisburg, PA 17111**
    General Letter of Support (one comment on dual eligibles)
17. **6-1-16 -- Coalition for a Healthy Oregon (COHO)**
    General Letter of Support
18. **6-1-15 -- PacificSource Community Solutions - Jessica Sayers, Medicaid Contract Manager**
    General Letter of Support
19. **6-1-16 -- OCHIN**
    General Letter of Support – especially supportive of CHP and HIT improvements in waiver (OCHIN has served as Oregon's Regional Extension Center, and through that program supported small practices across the state in onboarding to certified EHR technology)
20. **6-1-16 -- Housing Alliance; Allison McIntosh**
    General Letter of Support
21. **6-1-16 -- Oregon Opportunity Network; Ruth Adkins, Policy Director**
    General Letter of Support - Focus on Supportive Housing initiative
22. **6-1-16 -- Washington County; Department of Health and Human Services — Office of the Director; Marni Kuyl, RN, MS; Robert Wood Johnson Executive Nurse Fellow; Director, Department of Health and Human Services; 155 N First Avenue, Suite 160, MS 5, Hillsboro, OR 97124-3072**
    General Letter of Support
23. **6-1-16 -- Oregon Association of Hospitals and Health Systems; Andrew S. Davidson; President and CEO**
    General Letter of Support
24. **6-2-16 -- Kaiser Permanente; Daniel J. Field, Executive Director, Community Benefit and External Affairs; 500 N.E. Multnomah Street, Suite 100, Portland. OR 97232-2099**
    General Letter of Support