

HB 2086 Report #2: Structural Needs for Behavioral Health System Transformation

Barriers, Risk Sharing, Data, Medicaid Demonstration, and Other Issues



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EXECUTIVE SUMMARY

HB 2086 was passed by the legislature and signed into law by Governor Brown in 2021. In conjunction with HB 5024 (Oregon Health Authority Budget Bill), HB 2086 supports a framework for transforming Oregon's behavioral health system by establishing and incentivizing outcome measures designed to improve system accountability and performance across agencies and providers. The need to establish common outcomes and supporting incentives is transformational by aligning the efforts of multiple agencies and entities for individuals who are involved with multiple systems. This report is the second in a series required by HB 2086 to inform the legislature on the progress of implementation, with a focus on:

- Barriers to applying the quality metrics and incentives developed by the Behavioral Health Committee to contracts with coordinated care organizations and counties;
- Data infrastructure needs to implement the quality metrics and incentives and recommendations for facilitating risk-sharing agreements; and
- Recommendations for counties to share in the costs of a hospitalization at the Oregon State Hospital (OSH).

Status of the Behavioral Health Committee

HB 2086 created the Behavioral Health Committee to establish quality metrics and incentives for the behavioral health system. Committee members (Attachment A) were recruited in alignment with the statutory membership framework and selected with intentional focus on applicants with lived experience, people from Oregon communities most impacted by health inequities, individuals that advance equity and social justice, and those with diverse expertise and experiences that would benefit the Committee. The Committee has been meeting weekly with plans for ongoing meetings as needed through 2022. From the first meeting, committee members have expressed a need to see the system "recreated at the cellular level."

Barriers to Applying Metrics and Incentives

Enabling Alignment with Existing Payor Incentive Structures

The current Medicaid Waiver that guides Oregon's relationships with Coordinated Care Organizations (CCOs) specifies that the Medicaid Metrics and Scoring Committee has authority to select the metrics and incentives for CCOs. The proposed 2022-2027 Waiver would establish the Health Equity Quality Metrics Committee, which is envisioned to work in conjunction with the Metrics and Scoring Committee with a focus on ensuring CCO metrics and incentives are aligned with OHA's 10-year strategic health equity goals.

HB 2086 requires OHA to identify legislative changes or changes to Oregon's 1115f OHP (Oregon Health Plan) Demonstration Waiver that would enable application of metrics and, potentially, incentives developed by the Committee to contracts with CCOs. Options being considered to enable the Behavioral Health Committee to implement a metrics and incentives program within CCO contracts include:

- Establish a formal process for the Behavioral Health Committee to co-create behavioral health metrics with the Metrics and Scoring Committee within the proposed changes to the 2022-2027 waiver, and explore potential statutory changes to ORS 414.638.
- Initially establish unmatched incentives. Incentives that do not require federal matching funds would not require CMS approval and could be achieved through changes to CCO contracts. This option would rely entirely on state general funds.
- Take advantage of unutilized incentive potential. OHA is in the process of research and policy analysis to further determine how additional funding may be available or applicable for CCO incentives. Federal law limits incentives to 105% of approved

capitation payments; Oregon CCO incentives in 2021 were at 104.25%, which calculates to \$45 million remaining incentive capacity.

Community Behavioral Health and Other Community Partners

HB 2086 requires OHA to identify legislative changes or changes to the waiver needed to apply the metrics and incentives developed by the Committee in contracts with counties. OHA has not identified any operational barriers or legislative changes needed to establish metrics or an incentives program within contracts with counties or agreements with Tribes.

OHA also has not identified barriers to implementation of behavioral health metrics and incentives with other potential community partners (such as private healthcare, courts, social services, law enforcement, etc.).

Data Infrastructure Needs

Current data collection and reporting infrastructure issues also create barriers to implement the quality metrics and incentive programs envisioned in HB 2086 in several ways. To best implement the Committee's recommended metrics and incentives, investments are needed to support data infrastructure elements including: Health Information Exchanges; Community Information Exchanges; Behavioral Health Data Warehouses; Electronic Health Records; ability to disaggregate data by Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation - Gender Identity (SOGI); and the ability to measure the activities or outcomes of individuals who are represented in multiple data systems. The data infrastructure will benefit from coordination with communities and people that these investments are intended to serve.

Oregon State Hospital Cost Sharing

The rising number of aid and assist patients committed to the Oregon State Hospital has outpaced the hospital's bed capacity and greatly impacted the hospital's ability to serve other populations, including people under civil commitment. Delays in admissions have resulted in significant delays in needed care along with multiple court contempt actions. The hospital's capacity challenges are exacerbated when individuals who are deemed ready to return to community placements languish at the hospital because the courts and the counties refuse to authorize community placements. Preventing individuals from returning to community and limiting their ability to reside in their most integrated settings is in direct conflict with Oregon's agreement with the Federal Department of Justice (Oregon Performance Plan) and the Americans with Disabilities Act.

OHA will be crafting draft legislation for the 2022 session designed to incentivize counties to provide community-based services and supports rather than hospital care for individuals who no longer need to occupy a hospital bed. Several other states charge counties for days spent at their state hospitals when the individuals no longer need hospital care and have found this approach motivates communities to find community placements more quickly. To its credit, the 2021 legislature has provided substantial investments to strengthen community-based supports.

INTRODUCTION

[HB 2086](#) was passed by the legislature and signed into law by Governor Brown in 2021. In conjunction with HB 5024 (Oregon Health Authority Budget Bill), HB 2086 supports a framework for transforming Oregon's behavioral health system by establishing and incentivizing outcome measures designed to improve system accountability and performance across agencies and providers.

This report is the second in a series required by HB 2086. It directs OHA to report as follows:

(2) No later than December 31, 2021, the Oregon Health Authority shall report to the Legislative Assembly, in the manner provided in ORS 192.245:

(a) Identified barriers, including legislative changes or changes to the demonstration project under section 1115 of the Social Security Act, that are needed to apply the quality metrics and incentives developed by the committee to contracts with coordinated care organizations and counties;

(b) The authority's specific needs for data infrastructure to implement the quality metrics and incentives and recommendations for facilitating risk-sharing agreements within the health care delivery system to achieve the goals of the quality metrics; and

(c) Recommendations for counties to share in the costs of a hospitalization at the Oregon State Hospital for a patient beginning 30 days after a county is notified that the patient no longer needs hospital level care.

STATUS OF THE BEHAVIORAL HEALTH COMMITTEE

OHA developed a state-wide recruitment approach for Committee members. More specifically, OHA staff leveraged existing relationships to increase awareness and inform community members of the opportunity with the Committee. Staff also meaningfully engaged with communities that are historically and currently unrepresented in directing public policy and those communities systemically impacted by health inequities.

Applications for Committee membership were received by September 10, 2021. HB 2086 required specific types of representation while also allowing the OHA Director to make additional appointments. The criteria for Committee members included applicants with behavioral health lived experiences, those representing communities impacted by health inequities, individuals who advance equity and social justice, and people with knowledge (including learned experiences and diverse ways of gaining knowledge) of the behavioral health system and responses.

A portion of these demographics among Committee members is described in Attachment A. The Membership Document also includes two other key demographics: the majority of members' work or current experiences are not limited to the Portland Metro area, and only 33% of members are in paid executive positions. In addition, this is the first time that many of the members are participating in a community-based OHA

committee. In combination, these features are critical to advance transformation and equity through this initiative.

The Committee started its work on November 15, 2021 and meets weekly to accomplish its goals. To begin the process of establishing quality metrics and incentives, the Committee has begun identifying and refining outcomes that will be correlated to the metrics and incentives. These outcomes are in addition to those required by HB 2086. The outcomes in statute include:

- Improve timely access to behavioral health care;
- Reduce hospitalizations;
- Reduce overdoses;
- Improve the integration of physical and behavioral health care; and
- Ensure individuals are supported in the least restrictive environment that meets their behavioral health needs.

Members first discussed concepts that they desire to be imbedded in the behavioral health system and then prioritized those concepts under certain themes. Those themes, and an example of a concept for each, are described below, though these examples are not an exhaustive list. The Committee is translating those concepts as outcomes through group work that will inform the metrics and incentives.

- **Workforce:** Adequate funding for service providers including increased funding for those serving people with the highest needs and increased wages (wages can increase retention, which allows for continuity of care for clients and increases individual and program outcomes);
- **Client satisfaction and engagement:** Participants of behavioral health supports are satisfied with the system as a whole (this is driven by those receiving services and supports and made equitable to disrupt the white dominant normative);
- **Access and services:** Increase and improve access to services and interventions for people impacted by the legal system including those suspended/disenrolled during incarceration;
- **Maximize care and support/minimize harm:** Supportive housing, which is conducive to positive growth and change, is available including for individuals exiting incarceration and OSH; and
- **Data:** Providers do not ask for irrelevant information and focus on “what is happening now.”

From the first meeting, committee members have expressed a need to see the behavioral health system “recreated at the cellular level.”

The Behavioral Health Committee started its work by crafting a statement that describes the purpose of a Behavioral Health System. That purpose statement continues to be refined. As of this report, it states:

The purpose of any behavioral health system is to continually evolve its services through meaningful and compassionate engagement with those who are most impacted by the system, to minimize suffering and maximize possibility, potential, and well-being, to promote and support individual and

community agency and connection, to provide care that is linguistically appropriate alongside racial and cultural specific practices of healing and thriving, to thoughtfully and sustainably remove barriers so that all people may live their lives with hope and dignity.

As the Committee's work continues to define, prioritize, and evaluate outcomes that will be used to inform the quality metrics and incentives, reflections on the purpose statement and values including transformation and equity are continuous to ensure that meaningful change is made to the system. The current work of the Committee puts members on track to provide their initial report for establishing metrics and incentives on February 1, 2022. In part, that report will describe a framework that will be used to select metrics and incentives that aim to move towards the outcomes included in HB 2086 and those prioritized by the Committee.

BARRIERS TO APPLYING METRICS AND INCENTIVES

Barriers and Opportunities with the 2022-2027 Medicaid Waiver and CCOs

The Oregon Health Authority (OHA) is currently applying to the Centers for Medicare & Medicaid Services (CMS) for a new five-year Medicaid waiver (2022-2027 Medicaid Waiver), also known as the 1115 OHP (Oregon Health Plan) Demonstration. The purpose of the waiver is to allow Oregon's Medicaid program to operate in a manner which waives elements of existing federal Medicaid law to improve its program in Oregon through innovation; as such, it is a critically important tool for the transformation needed to create an equitable system of behavioral healthcare. Specific to the Medicaid waiver, HB 2086 requires OHA to identify legislative changes or changes to the new five-year waiver to apply metrics and incentives developed by the Committee to contracts with coordinated care organizations (CCOs).

Both the current and 2022-2027 Medicaid waivers specify that different entities have the authority to develop metrics that are used to determine incentives for CCOs. The current waiver provides the Metrics and Scoring Committee (MSC) as the sole authority to establish metrics used to determine financial incentives for CCOs. That authority is also enshrined in ORS 414.638. The 2022-2027 waiver gives responsibility for establishing metrics and associated incentives to the newly formed Health Equity Quality Metrics Committee (HEQMC), which will work closely with the MSC. For adopting this process, OHA is in its last stages of finalizing the waiver proposal, and that proposal will be submitted in February 2022. Though, there are specific opportunities that will support the established metrics and incentives by the Committee as described below.

Formalizing Proposed Metrics and Incentives

Because the current waiver, the new waiver proposal, and statute provide authority to different committees for CCO metrics and incentives, OHA is strategically evaluating the most optimal, sustainable, and long-term plan to implement the metrics and incentives established by the Committee for CCOs as envisioned by HB 2086. OHA staff and leadership are discussing the feasibility of adding the Committee into the CCO metrics and incentives process of the 2022-2027 waiver proposal. Such a change in the waiver proposal may be complex due to the proposal being nearly completed but warrants

further discussion. This new process would also require statutory changes to ORS 414.638.

Separately, OHA is also exploring various mechanisms where the Committee would inform the responsible committees of their recommended metrics and incentives that are specific to behavioral health. These metrics and incentives would be used as proposals during the formal metrics and incentives selection process. Metrics and incentives, as well as outcomes, for behavioral health are unique. The Committee having the opportunity to leverage lived experiences and expertise to inform these provisions is one approach that can enhance selection efforts for the behavioral health system.

Implementing Unmatched Incentives

Should the Committee and OHA want to implement incentives not matched by federal funds, CMS would not have jurisdiction over that program and the unmatched arrangement would therefore not be subject to the provisions of Section 1115 of the Social Security Act. The incentives would need to be paid 100% by state general funds, and no federal funds could be claimed. Such an approach would require contract adjustments between OHA and CCOs to administer the metrics, incentives, and data requirements, separate from and in addition to the Medicaid-matched contracts currently in effect with CCOs but there are no legislative or Medicaid barriers to implementing a program of incentives utilizing state general funds

Exploring Additional Funding through Matched Incentives

The Behavioral Health Committee could design separate incentives, using the same or different measurements, to be offered as additional options for CCOs. However, 42 CFR § 438.6 (Special contract provisions related to payment) stipulates that incentive payments may not exceed 105% of approved capitation payments.

In 2021, the CCO quality incentive program was funded at 104.25%, which would limit any new behavioral health metric valuation to no greater than 0.75% of approved capitation payments. Currently this would equate to approximately \$45 million per year in additional incentives to CCOs. In order to leverage these additional funds, OHA is exploring the opportunity to utilize this additional funding. OHA will complete research and policy analysis to further determining the availability and applicability of these funds as additive incentives.

One option for increasing this amount is to consider implementing a withhold model. However, any withholds are required to be actuarially sound. Also, changes would be needed in Oregon's budgeting process to create a withhold-based incentive program, plus the Legislature would need to make a one-time investment to fund this model.

Health Equity and Social Determinants of Health

The 2022-2027 waiver includes several proposals relating to health equity funding and investments in social determinants of health. In addition, the Committee has adopted a set of values including equity and addressing systemic factors to assist in their evaluations of outcomes, metrics, and incentives. This provides the opportunity for the Committee to align equity efforts with the waiver proposal by increasing the focus on health equity and successfully addressing inequities.

For example, the 2022-2027 waiver includes housing navigation services to address housing loss to improve social determinants of health and healthcare accessibility.

While housing navigation is limited, the Committee has discussed proactively providing housing for behavioral health. The provision of supportive housing is well-evidenced to better improve behavioral health more than conventional treatment, decrease more intensive levels of care, and disrupt incarceration with Lane County as a local example.

One example of a related equity measurement that may be considered by the Committee could include returns to OSH or incarceration, which would complement the 2022-2027 waiver. Opportunities for accomplishing this and other health equity metrics and incentives will require further analysis of formalizing proposed recommendations and leveraging funding as described.

Barriers Related to Counties

HB 2086 also requires OHA to identify barriers to operationalizing metrics and incentives via contracts with counties. These contracts primarily use state general funds and federal block grant monies through County Financial Assistance Agreements and a Community Financial Assistance Agreement (CFAA) with the Warm Springs Tribe.

OHA has not identified additional operational barriers nor legislative changes needed to apply metrics and incentives developed by the Committee to the CFAAs. OHA, Counties, and the Tribes have broad authority to negotiate financial assistance agreements, and there is no currently known barrier to supporting a quality metrics and incentive program through those agreements.

DATA INFRASTRUCTURE NEEDS

HB 2086 authorizes a process to establish coordinated actions by multiple agencies and entities in support of improved care and outcomes for people in Oregon who have complex behavioral health needs. The data infrastructure needed to support this effort requires thoughtful design and consideration of the people these investments are intended to serve. Typically, individuals want their health care providers to have their health information and share it with other providers for care coordination. Though retelling one's life story including behavioral health experiences can be traumatic. Also, the ways in which we describe people can affect how they are treated. Clinical records can include highly sensitive data, such as past and sometimes outdated issues and diagnoses, or notes related to disagreements and conflict with past providers. OHA will need to approach the collection, sharing, use, and reporting of data for HB 2086 by placing the individuals at the center and with the leadership of community voices, particularly from those with lived experience and people from communities who historically and currently experience health inequities.

General Data Infrastructure Challenges

The barriers related to data as described below have been identified as general obstacles to existing analyses that create challenges for implementing metrics and incentives. OHA often faces barriers when conducting analyses which measure the activities or outcomes of individuals who are represented in multiple data systems. Neither OHA nor the state has a defined protocol to support person identification conflicts among its systems.

This limitation produces particularly negative impacts on efforts to promote the use of Race, Ethnicity, Primary Language, and Disability (REALD) information when evaluating program impact on equity. The inability to match individuals and their corresponding

demographic information across systems leads to an outmoded approach in which individual systems are each expected to collect complete and accurate REALD data, rather than making efficient use of data available across systems to meet reporting needs. HB 3159, the Data Justice Act, is designed to mitigate this issue, but will take several years to be fully implemented and operational.

Person identification issues that occur within OHA data systems are further compounded when metrics require integration with other state systems. These complications are the result of both an unclear authority to request or access data, and a lack of tools to support the ongoing integration of cross-agency data. Though metrics are yet to be selected, it is reasonable to anticipate that the Behavioral Health Committee may identify metrics which incentivize changes in the legal system (including e-courts, Law Enforcement Data System), Department of Corrections, Department of Education, Employment Department, and Oregon Youth Authority. Historically, connecting the OHA's administrative data systems to data from the legal system has been difficult at best and is often not permissible due to statutory prohibitions.

The application of meaningful quality metrics and incentives is inherently limited by the overall data literacy of patients, providers, analysts, and leaders. This limiting factor has been identified by the State Chief Data Officer, who notes that:

Data is integral to all aspects of State government, from the administration and evaluation of programs, to funding and policy decisions. However, without active stewardship and governance, data can quickly become a greater burden, forcing users to slog through redundant, obsolete, or trivial data to access what they need, or replicating harmful and biased practices through the use of low quality or decontextualized data. In order to build our capacity to manage and utilize data strategically, Oregon needs to establish effective data governance, apply appropriate data justice and equity frameworks to our work, and work to build a culture of data literacy to transform data into meaningful insights.¹

Data Systems

Oregon's existing health care data infrastructure brings some opportunities to support behavioral health quality metrics and incentives, as well as risk-sharing arrangements, but some gaps remain.

Medicaid Management Information System (MMIS): OHA's best and most complete source of behavioral health data are the administrative claims and encounter data contained in the Medicaid Management Information System (MMIS). However, this system represents only those approximately one in four people living in Oregon who receive their health care through the Oregon Health Plan.

Measures and Outcomes Tracking System (MOTS): The Measures and Outcomes Tracking System (MOTS) is an important source of supplemental behavioral health data for Medicaid as well as services paid for through the SAMHSA block grant or state general funds. However, there are significant data quality concerns related to completeness, accuracy, and utility. OHA is undertaking a multiyear project to modernize MOTS. These efforts are expected to greatly improve the flexibility and

¹ See https://www.oregon.gov/das/OSCI0/Documents/68230_DAS_EIS_DataStrategy_2021_v2.pdf for more information

interoperability of the MOTS data but collecting high quality data will also require a well-defined data collection framework which holds partners accountable for providing timely and accurate information, as well as mechanisms for ensuring compliance.

Electronic Health Records (EHRs):² Approximately 65% of state-licensed behavioral health programs have adopted an Electronic Health Records (EHR) system. However, only a third have fully implemented their EHRs, meaning the other two-thirds retain some paper processes. Many agencies have found their EHR does not adequately support their needs. For example, behavioral health providers receive funding from a variety of sources, which have significant reporting burdens that EHRs often do not support.

Federal financial incentives for EHRs primarily serve hospitals and physical health providers, so behavioral health agencies have had limited access, which has likely contributed to these challenges. Only 13% of behavioral health agencies that are not part of a large physical health organization have participated. Their average incentive payments have been a fraction of the average for physical health provider payments. Participation rates are higher for CMHPs and CCBHCs.

Behavioral health providers use more than 50 different EHRs and therefore face information-sharing challenges. For Oregon behavioral health agencies not part of a large physical health organization, the top EHR vendors are Credible, Qualifacts, Netsmart, and Epic.

Behavioral health agencies have expressed the need for financial support, shared learning opportunities, and education to help them select and implement EHRs. In particular, agencies need clarification and support around 42 CFR Part 2 and its implications.

Sharing information across the behavioral health and health care system: Health Information Exchange (HIE): Individuals with behavioral health needs often fall through the cracks in our health care system and thus may face poor health outcomes or lower quality of care. Sharing information across behavioral health and physical health care systems can support better outcomes and coordinated care.

Health information exchange tools can provide real-time access to patient information at the point of care, promoting safer and better-informed clinical decisions, especially when it is easily accessible within the clinician's workflow. HIE can support referrals, notifications about critical health events, and access to prescription or other important clinical patient information, as well as provide important information for managing risk-sharing arrangements.

Behavioral health providers' use of health information exchange has been improving, but still lags behind physical health care providers. Most behavioral health providers continue to rely heavily on faxing. Those providing substance use disorder treatment face additional restrictions and consent requirements under 42 CFR Part 2.

Health information exchange tools include:

² Data shared on EHR and HIE use are from the 2019 HITOC Data Report: https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/2019HITReport_HIEOverview_TwoWorlds_Combined.pdf

- **EDIE/Collective Platform:**³ Oregon has made major strides in sharing real-time information about when a person goes into the emergency department (ED), or is admitted or discharged from a hospital, through Oregon’s Emergency Department Information Exchange (EDIE) and the Collective Platform. This system connects data from all Oregon hospitals to providers, skilled nursing facilities, state programs, all CCOs, and many major health plans across Oregon. Nearly all CCBHCs and the vast majority of CMHPs participate, as do nearly all Assertive Community Treatment (ACT) Teams, and about a third of behavioral health agencies with state-licensed programs. This system has been particularly important for behavioral health agencies. This tool allows an agency to be notified when their client is admitted, to share care guidelines with EDs, and follow up after hospital discharge. Some agencies use the data to improve their programs and manage populations where they carry financial risk.
- **Reliance eHealth Collaborative**⁴ is a regionally based health information exchange that provides a community health record and other tools to support sharing of health information for care coordination, managing populations and risk-sharing arrangements, and other uses. Reliance is primarily funded by CCOs, health plans, and hospitals, and includes many behavioral health agencies in its regions (Central, Southern, Gorge, and Southern Coast in particular). In 2019, about a third of CMHPs and CCBHCs participated in Reliance.
- **Digital Divide: National and EHR-Based Networks**⁵ have enabled many large organizations to share comprehensive clinical information on individuals with other treating providers. However, these networks are not accessible to many smaller or diverse types of providers. Today, providers on dominant EHR vendors (like Epic) can participate in national or EHR-based networks (such as Epic CareEverywhere, Carequality, Commonwell, and eHealthExchange) which provide access to a considerable amount of information, integrated into a provider’s EHR workflow. Although some behavioral health EHRs participate in these networks (like Netsmart) and some behavioral health agencies use dominant EHR vendors (often if they are integrated with a physical health component), many agencies’ EHRs do not participate in these networks, which perpetuates a digital divide.

Addressing Social Determinants of Health: Community Information Exchange (CIE)⁶: An increasingly important component of Oregon’s health care system is addressing social determinants of health, such as food and housing insecurity. Research has shown that what improves a person's health is often what happens

³ See overview: <https://orhealthleadershipcouncil.org/wp-content/uploads/2021/09/Collective-Platform-Leveraging-Health-Information-Technology-in-Oregon.pdf> and <https://orhealthleadershipcouncil.org/edie/> for more information

⁴ See <https://www.reliancehie.org/> for more information

⁵ See “HIE in Oregon: A Tale of Two Worlds” starting on page 32:

https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/2019HITReport_HIEOverview_TwoWorlds_Combined.pdf

⁶ See OHA’s CIE informational webpage, <https://www.oregon.gov/oha/HPA/OHIT/Pages/CIE-Overview.aspx>

outside of a medical setting. Community Information Exchanges (CIEs) help providers, CCOs, behavioral health agencies, community-based organizations, and others connect individuals to social services and supports that can address social determinants of health.

CIEs are networks that electronically connect health care, human and social service partners. CIEs include a shared resource directory, "closed-loop" referrals, reporting, and optional social needs screening and other tools. CIEs are developing rapidly throughout the state, sponsored by CCOs, health plans, and other organizations. Behavioral health agencies can use a CIE to screen individuals, identify social supports, refer for services, and be notified when those services are provided. CIEs typically focus on social supports but in some cases include referrals for behavioral health services as well.

Managing Risk-Sharing Agreements: To manage new risk-sharing arrangements, organizations need clear information about attributed patients/clients where they carry risk, transparent information about accountability metrics and financial incentives or risks, and information to manage care including care goals, plans of care, and information about risks and social factors that impact health outcomes. Health care organizations typically have significant resources to manage these arrangements, including population management and analytics tools, integrated data from outside sources, care management tools that can use data to trigger workflows, and dedicated analytics workforce. However, counties and many behavioral health agencies often do not have specific systems, funding, or workforce to support risk-sharing agreements.

OHA Data Systems for Reporting, Metrics, and Outcomes Measurement

OHA has several data systems and sources that can be leveraged for reporting, metrics, and outcomes measurement related to behavioral health.

- As noted above, OHA's current Measures and Outcomes Tracking System (MOTS) collects data on publicly funded behavioral health services but is outdated and insufficient for reporting. Efforts are underway to modernize this system, improve and streamline reporting requirements, provide data back to behavioral health agencies about their clients, and develop a data warehouse to gather data across different sources. Improving EHR sophistication among behavioral health agencies can allow for automated reporting and significantly reduce burden for providers.
- Medicaid claims data can be used for assessing some components of behavioral health care utilization for Oregon Health Plan Members. Providers and CMHPs report through MOTS and other routes additional information to either augment Medicaid claims data or report on services provided outside of Medicaid coverage. Improving this data collection is part of the modernization efforts.
- All Payer All Claims data can be used for assessing behavioral health care utilization for Commercial payers and Medicare.
- Hospital and emergency room discharge data are reported to OHA for all hospital visits, regardless of payer. These data could be used to assess reduction of hospital/ED visits.

Significant gaps remain in data available to OHA. For example, OHA lacks data on services not publicly funded (e.g., private insurance, grant funded, or private pay).

Some smaller publicly funded programs are exempt from some required reporting. Reducing legal system involvement is a promising outcome from HB 2086 investments, but OHA has limited access to data from the legal system. OHA lacks comprehensive race, ethnicity, language, disability (REALD) and sexual orientation and gender identity (SOGI) data, although some data are collected for individuals participating in publicly funded programs and Medicaid.⁷

Additional Data Questions and Issues

Metrics and risk sharing arrangements are still to be defined, so the specific data requirements and system supports needed cannot yet be fully determined. However, investments in behavioral health agency EHRs, HIE, and CIE, as well as gaining access to legal system data, will be important, regardless of the precise program design.

Additional issues to address regarding data systems to support behavioral health include:

Data justice and decolonization: It will be important to disaggregate data by population served, to assess whether programs are reducing or perpetuating health inequities. Communities of color and Tribal communities must have a voice in how data are used and ensure that data are not used against them.

Human-centered data collection and use: Designing data collection that recognizes potential stigma and avoids inequitable access will be important. Some screening questionnaires required for services can contain difficult and personal questions and are more accessible for individuals from white, dominant culture backgrounds. Outdated diagnoses and issues can persist in health records and can impact how people are treated by providers and impact the care they receive. Better system coordination and data sharing can leverage existing data where appropriate and reduce trauma and burden on individuals, but do not address concerns about how patient data are used.

Accessible systems and diverse, culturally appropriate workforce: Individuals seeking diverse providers and culturally-appropriate care often face challenges due to the shortages in Oregon's health care and behavioral health workforce. In addition, individuals often need to access their own health information through a providers' patient portal, other web-based access to systems, or by downloading their data into a patient/consumer app. For individuals who primarily speak languages other than English, who lack broadband or smartphones, or face other barriers, these systems may be inaccessible.

RISK-SHARING AGREEMENTS

Successful implementation of risk-sharing agreements, or other value-based payment (VBP) models, is predicated on the evaluation of quality metrics and usage of incentives to promote outcomes which drive toward health system goals. Often these goals are expressed as the achievement or prevention of certain clinical dispositions among a patient population.

⁷ The Data Justice Act (HB3159 (2021)) requires OHA to establish annual REALD/SOGI data collection from all providers and payers, which will be implemented several years in the future.

While some of this information is gathered as claims information, many key elements are unaccounted for within the traditional billing model. For this reason, both Medicaid and non-Medicaid domains would benefit from the integration of clinical data through interoperable data feeds from Health Information Exchanges (HIE). Integration of HIE data is expected to require the deployment of modernized data warehousing solutions – some of which are currently underway – and would also greatly benefit from the establishment of a single statewide HIE.

Among the Medicaid population, the adoption rate of new risk-sharing or VBP models is typically slow. The Medicaid policy landscape has changed rapidly since the initial MMIS implementation in 2009, and new strategies for risk sharing with providers and performance evaluation often require costly changes to data systems. The cost of these changes can be traced to the fact that the base-level MMIS was designed primarily for claims reimbursements. Change orders that have been purchased to support the implementation and management of VBP models often handle basic program activities (patient attribution, Per-member Per-month payment generation), but struggle to produce a user-friendly experience that supports both community providers and agency staff in managing these programs. Extensive manual data management and manual reporting is often required to fully operate the program due to the lack of systematic capabilities for VBP administration, reporting, and analytics.

In November 2021, OHA completed a Medicaid Information Technology Architecture State Self-Assessment (MITA SS-A) with the help of contractor NTT Data. As part of this exercise, NTT produced a roadmap document to inform OHA's ongoing Medicaid Enterprise System (MES) Modularization efforts. After examining existing information technology, and conducting interviews with program subject matter experts, NTT recommended that OHA implement a configurable VBP module for OHA/ODHS Medicaid Fee-For-Service (FFS) operations in order to streamline quality measurement, policy changes, patient attribution, payment, reporting, and analytics for current and prospective VBP and risk sharing programs.

With respect to the establishment of risk sharing relationships outside of its FFS program, OHA is implementing both a Behavioral Health Data Warehouse (BHDW) and a behavioral health data collection application to replace its existing Measures and Outcomes Tracking System (MOTS). Together, these tools will support the collection of client outcome information. Once implemented, this combined data infrastructure will provide a foundation upon which behavioral health contracts can successfully operationalize more advanced risk sharing concepts. Modernization of key infrastructure and the deployment of an improved data collection application will guarantee the availability of information necessary to support outcomes-based payments.

OHA seeks to improve data available in these modern data platforms through integration of data from other state sources such as the Medicaid Enterprise System, and the Oregon State Hospital Electronic Health Record system. As identified above, connection to other state data sources – especially those related to the legal system – is desirable but faces obstacles related to the demonstration of authority.

OREGON STATE HOSPITAL COST SHARING

The relentless increases in admission orders to the Oregon State Hospital for aid and assist patients has outpaced the hospital's bed capacity. OSH has been unable to provide timely care for people referred to the hospital and is facing numerous contempt findings.

At the same time, courts and counties frequently fail to return an aid and assist patient to the community, despite OSH notifying the court (as required by [ORS 161.370](#)) that the person no longer needs a hospital level of care. Thus, many people who do not need a hospital level of care still take up OSH beds. One of the drivers of this problem is that OSH is a "free" resource for the counties. Counties are incentivized to send and keep their residents at OSH, because the costs of caring for such residents is transferred to the state upon admission to OSH. During a Behavioral Health Committee meeting, members of the Behavioral Health Committee identified two additional related challenges:

- Counties do not currently have adequate resources to support people in their communities
- There is an extreme lack of accessible and affordable housing for OSH patients before and after they reside at OSH.

In 2019, 60% of OSH clients were experiencing homelessness prior to admission and that pattern continues.⁸ Committee members also pointed out how being admitted into OSH can disrupt a housing achievement that might have been forthcoming before entering into OSH. Without accessible and affordable housing, individuals who exit OSH cannot readily achieve stability through housing, which compounds the likelihood of a continuous cycle of state custody.

The 2021 legislature made significant investments in community supports and services, including many that will have positive impacts for people, increasing options for hospital diversions as well as timely and effective transitions back to community placements:

- \$130M in infrastructure investments for residential treatment and housing
- \$21M in specific aid and assist funding for counties
- \$121M in funding for Certified Community Behavioral Health Clinics
- \$15M in funding to support enhanced mobile crisis and 988 call center requirements
- \$80M in supports to strengthen behavioral health workforce

Other State Models

OHA has contracted with a national expert to identify potential pathways for counties to share in the costs of a hospitalization at the Oregon OSH for a patient beginning 30 days after a county is notified that the patient no longer needs hospital level care. The contractor's work will include identifying models that other states have implemented and looking at success factors and outcomes to determine an approach that may suit Oregon.

Recommendation on Cost Sharing

⁸ See <https://www.oregonlive.com/pacific-northwest-news/2019/05/oregon-mental-hospital-is-worlds-most-expensive-homeless-shelter-state-health-director-says.html> for more information.

OHA will be recommending legislation to require courts and counties to take a person back into the community within 30 days after OSH has determined that the person no longer needs a hospital level of care. The legislation should require counties to pay for the full cost of the person's care at the state hospital if the county does not transport the person back to the county within 30 days of OSH's notice to the court that the person does not need a hospital level of care.

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the OHA Communications Unit at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us

BEHAVIORAL HEALTH COMMITTEE: MEMBERSHIP

VOTING MEMBERS

Voting Members include representation types required by House Bill 2086 and additional appointments made by the Oregon Health Authority Director as permitted by statute.

	NAME	REPRESENTATION
1	Ana Day	Child/Family Behavioral Health Provider
2	Carol Dickey	Advocate for <i>Caring Systems</i>
3	Cherryl Ramirez	Community Mental Health Program Representative
4	Des Bansile	Youth Peer Supports and Advocate
5	Hakimi Thang	Mental Health Peer Support Specialist
6	Jill Archer	Behavioral Health Leader (CCO)
7	Jordan Shin	Behavioral Health Provider and Supervisor
8	Jorge Ramírez García	Behavioral Health Equity, Program, and Research Expert
9	Kat Hendrix	Behavioral Health Advocate
10	KC Lewis	Mental Health Rights Attorney
11	Kerri Melda	Mental Health and Disability Advocacy Leader
12	Megan Torres	Behavioral Health and Harm Reduction Provider
13	Mike Marshall	Addiction Recovery Advocate
14	Nick Chaiyachakorn	Young Adult Peer
15	River McKenzie	Community Behavioral Health Provider and Trans/Gender Diverse Community Advocate
16	Robin Henderson	Behavioral Health Systems Leader
17	Sabrina Garcia	Behavioral Health Program Leader
18	Shaun Parkman	Public Health Professional
19	William Barnes	Community Advocacy Expert
20	Current Vacancy	<i>Tribal Government to be represented at a future date</i>
21	Current Vacancy	<i>To be appointed at a future date</i>
22	Current Vacancy	<i>To be appointed at a future date</i>

NON-VOTING MEMBERS

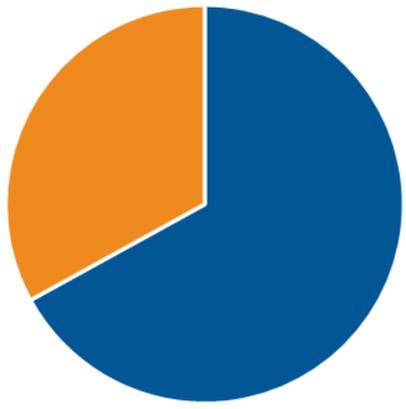
Non-Voting Members include representation types required by House Bill 2086 and additional appointments made by the Oregon Health Authority Director as permitted by statute.

	NAME	REPRESENTATION
23	Dana Hittle	Oregon Health Authority Medicaid Director
24	Ebony Clarke	Oregon Health Policy Board Member
25	Nan Waller	Oregon Judicial Department Official
26	Reginald Richardson	Oregon Alcohol and Drug Policy Commission Executive Director
27	Seth Lyon	Oregon Department of Human Services (District 15 Manager — Child Welfare and Self Sufficiency)
28	Steve Allen	Oregon Health Authority Behavioral Health Director

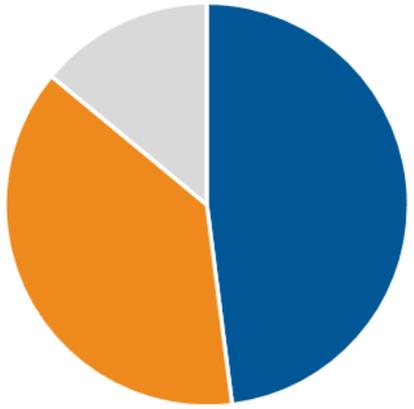
VOTING MEMBERS' DEMOGRAPHICS

Does not include any unknown demographics of Voting members or demographics of Non-voting Members.

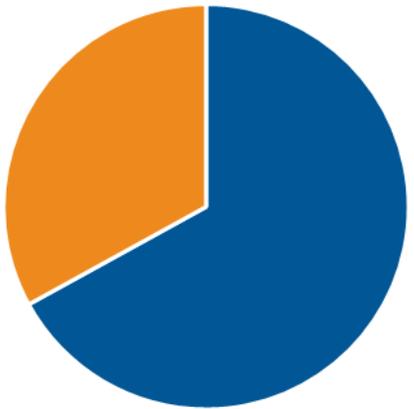
Lived experiences with behavioral health: 67%
Non-declared lived experiences: 33%



Statewide represented: 48%
Non-Portland Metro represented: 38%
Portland Metro represented: 14%



Impacted by health inequities: 62%
Non-declared impacted: 38%



Non-executive paid position: 67%
Paid executive position: 33%

